REPORT 5

ATASCADERO STATE HOSPITAL

October 20-24, 2008

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.

Table of Contents

Acronyms used in Court Monitor reports ..... **iv**

Introduction **1**

C. Integrated Therapeutic and Rehabilitation Services Planning **15**

1. Interdisciplinary Teams 15
2. Integrated Therapeutic and Rehabilitation Service Planning (WRP) 38

D. Integrated Assessments **136**

1. Psychiatric Assessments and Diagnoses 138
2. Psychological Assessments 178
3. Nursing Assessments 208
4. Rehabilitation Therapy Assessments 219
5. Nutrition Assessments 249
6. Social History Assessments 271
7. Court Assessments 281

E. Discharge Planning and Community Integration **293**

F. Specific Therapeutic and Rehabilitation Services **312**

1. Psychiatric Services 315
2. Psychological Services 359
3. Nursing Services 392
4. Rehabilitation Therapy Services 422
5. Nutrition Services 438
6. Pharmacy Services 445

7. General Medical Services 448
8. Infection Control 473
9. Dental Services 496
G. Documentation 507
H. Restraints, Seclusion, and PRN and Stat Medication 508
I. Protection from Harm 531
1. Incident Management 532
2. Performance Improvement 568
3. Environmental Conditions 578
J. First Amendment and Due Process 587

Acronyms used in Court Monitor reports

AA	Alcoholics Anonymous
ACT	Administrative Clinical Team
AD	Administrative Directive
ADR	Adverse drug reaction
AIMS	Abnormal Involuntary Movement Scale
A/N	Abuse/Neglect
ASH	Atascadero State Hospital
A-WRP	Admission Wellness and Recovery Plan
BCC	Behavioral Consultation Committee
BMI	Body Mass Index
CA	Clinical Administrator
CASAS	Comprehensive Adult Student Assessment Systems
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
COPD	Chronic Obstructive Pulmonary Disease
COT	Community Outpatient Treatment
C-PAS	Central Psychological Assessment Services
CPR	Cardio-pulmonary resuscitation
CRIPA	Civil Rights of Institutionalized Persons Act
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)

DTR	Dietetic Technician, Registered
DUE	Drug Utilization Evaluation
EKG	Electrocardiogram
EMS	Emergency Medical Service
EP	Enhancement Plan
EPPI	Enhancement Plan Performance Improvement
FRP	Forensic Review Panel
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
IA-RTS	Integrated Assessment—Rehabilitation Therapy Section
IC	Infection Control
IDN	Inter-Disciplinary Note
IMRC	Incident Management Review Committee
IPA	Integrated Assessment: Psychology section
IRC	Incident Review Committee
IT	Information Technology
LVN	Licensed Vocational Nurse
MAPP	My Activity and Participation Plan
MIRC	Mortality Interdisciplinary Review Committee
MMSE	Mini Mental Status Examination
MNT	Medical Nutrition Training
MOD	Medical Officer of the Day
MPPN	Monthly Physician's Progress Note
MRSA	Methicillin-resistant Staphylococcus aureus
MSH	Metropolitan State Hospital
MTR	Medication and Treatment Record
MVR	Medication Variance Report

NA	Narcotics Anonymous
N/A	Not applicable
NAC	North Activity Center
NCMT	Nutrition Care Monitoring Tool
NCS	Neuropsychological Consultation Service
NGA	New generation antipsychotic
NOC	Nocturnal shift
NOS	Not otherwise specified
NP	Nursing Policy
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
PBS	Positive Behavior Support
PC	Penal Code
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
POST	Physical, Occupational, and Speech/Language Pathology
PPD	Purified Protein Derivative (skin test for tuberculosis)
PPN	Physician's Progress Note
PRA	Patient Rights Advocate
PRN	Pro re nata (as needed)
PSH	Patton State Hospital
PSR	Psychosocial Rehabilitation
PSS	Psychology Specialty Services
PSSC	Psychology Specialty Services Committee
PT	• Physical Therapy/Therapist (in Sections D.4 and F.4) • Psychiatric Technician (in Sections D.3 and F.3)
P&T	Pharmacy and Therapeutics [Committee]

RD	Registered Dietician
RIAT	Rehabilitation Integrated Assessment Team
RMS	Records Management System; Recovery Mall Services
RN	Registered nurse
RNA	Restorative Nursing Assistant
R/O	Rule out
S&R	Seclusion and Restraint
SA	Substance abuse
SAMHSA	Substance Abuse and Mental Health Services Administration
SLP	Speech Language Pathology/Pathologist
SNF	Skilled Nursing Facility
SO	Special Order
S/P	Status post
SSI	Supervising Special Investigator
TB	Tuberculosis
TD	Tardive dyskinesia
TST	Tuberculin skin test
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 Court Monitor (Mohamed El-Sabaawi, MD) and four expert consultants (Vicki Lund, PhD, MSN, ARNP; Ramasamy Manikam, PhD; Elizabeth Chura, MSRN; and Monica Jackman, OTR/L) visited Atascadero State Hospital (MSH) from October 20 to 24, 2008 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 Enhancement Plan (EP) that was negotiated between the State and the United States Department of Justice. In fulfilling that responsibility, the Court Monitor makes recommendations for changes and enhancements to current practices that he and his team believe can help the facilities achieve compliance in the future. The evaluators' recommendations are suggestions, not stipulations for future findings of compliance. The facility is free to respond in any way it chooses to the recommendations as long as it meets the requirements in every action step in the EP.

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

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

B. Methodology

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

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

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

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

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

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

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

C. Statistical Reporting

The following statistical abbreviations may be used in the report and 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 provides 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. Facility management should continuously review the key indicators to assess trends and patterns and use this data to identify the factors that contribute to changes in facility trends and patterns.

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

a. Repeat acts of aggression to others appear to be trending down.
b. The number of individuals in BMI categories greater than 25 and the number of individuals showing significant weight gain over shorter periods of time have declined. Interestingly, these declines have co-occurred with an increase in the number of exercise groups available.
c. The data suggests a mild downward trend in the use of combined pharmacotherapy.
d. The number of individuals experiencing episode of hyper- and hypoglycemia appears low. The tracking methodology should be verified.
e. The facility must ensure that key indicator data are accurate. The monitor is concerned in particular about the coding of expected vs unexpected deaths. For example, the death of LA in August 2008 appears to have been coded in the key indicators as an unexpected death. While LA did expire outside the facility, his death was predictable and the logic/utility of coding the death as unexpected is not apparent.

2. Monitoring, mentoring and self-evaluation

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

a. ASH has refined most of the structures and processes that are required for implementation of the EP. The facility has begun to formalize the process of systemic and periodic review of the self-assessment data and this monitor's findings to ensure consistent feedback to the WRPTs and disciplines, identify trends and patterns and implement targeted corrective actions.
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 has presented data comparing the compliance rates from this review period to the previous period and from the last month of the current review period to the last month of the last review period, when available, as requested. In addition, the facility presented information on the barriers towards compliance as indicated and plans of correction as applicable. However, some analysis of barriers to compliance was shallow and in some cases consisted of a circular reiteration of the noncompliant item (e.g. the incompleteness of the assessments was due to the fact that some sections of the assessment were not completed). The facilities need consistently to apply critical thinking and problem-solving skills to the analysis of barriers to compliance.
d. ASH has presented process and clinical outcome data regarding its substance recovery program.
e. With few exceptions, the DMH has standardized the auditing tools required for self-monitoring across state facilities. ASH has utilized these tools for all applicable sections of the EP.
f. 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.
g. The DMH has yet to ensure that the tools and data collection are automated.

3. Implementation of the EP

a. Since the last review period, ASH has made progress in the implementation of requirements of the EP, but progress was not consistent across disciplines. This progress is summarized in each corresponding section in the body of the report.
b. ASH has yet to implement mechanisms to improve nursing and medical attention to changes in the physical status of individuals and nurse-physician communications regarding ongoing care and follow-up care upon return of individuals from outside hospitalization. The DMH is developing medical and nursing care protocols. If properly implemented, these protocols can correct many of the process deficiencies in medical services (see other findings in F.7.a).
c. ASH has yet to make significant progress in the current incident and risk management systems. The facility needs to implement an updated system, including identification of triggers and thresholds regarding high-risk behavior, establishment of levels of interventions corresponding to the level of risk and appropriate notification and follow-up mechanisms. The interventions and follow-up should include, but not be limited, to the following:

i. First-level response by the WRPTs, including timely review of incidents and analysis of contributing factors, timely and appropriate use of Stat and PRN medications, judicious use of restrictive interventions in accord with current DMH procedures and use of positive behavior supports whenever indicated as well as other corrective actions, as needed;
ii. Second-level review by clinical leadership;
iii. Outside consultations, if necessary; and
iv. An oversight mechanism to review trends and patterns and initiate systemic performance improvement projects.

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 seriously consider standardizing across all hospitals the Administrative Directives that impact these services.
e. Functional/clinical outcomes of the current structural changes have yet to be finalized and implemented to guide further implementation.
f. A well-functioning PSR Mall that meets the specific needs of the individuals is the centerpiece of the Wellness and Recovery Planning model. Progress remains to be made towards this goal, specifically in the areas of:
   i. Medication Education groups. The number of groups reported is significantly higher than that offered by the other facilities, even taking patient population into account. The facility's method of counting or justifying the number of groups is unclear. Individuals' participation in Medication Education groups must be based on assessed need. The facility needs a clearly defined methodology for measuring need for Medication Education groups and programming them on that basis.
   ii. Mall hours: Several disciplines in the acute service provided the required number of facilitation/therapy hours on average during the review period, as did several non-clinical classifications. Progress remains to be made regarding the Mall contributions of disciplines in the long-term service, psychiatry in general, and nursing. Nursing hours of service provided in the Mall were minimal, even taking the nursing position vacancy rate into account.

   The following table provides the minimum average number of hours of mall services that DMH facilities should provide:

   (Please see next page)

DMH PSR MALL HOURS REQUIREMENTS

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

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

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.

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

iii. **Progress notes**: ASH has yet to ensure 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. Without the information in the monthly progress notes, the WRPT has almost no basis for revising an individual's objectives and interventions. All hospitals must fully implement the PSR Mall Facilitator Monthly Progress Note in their PSR Malls for all groups and individual therapies.

iv. **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. All State hospitals must ensure that cognitive screening has been completed for all individuals and that their Mall groups are aligned with their cognitive levels.

v. **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.

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

4. Staffing

The table below shows the staffing pattern at ASH as of August 31, 2008:

Atascadero State Hospital Vacancy Totals as of 8/31/2008

Identified Clinical Positions	Budgeted Positions 08/09 FY	Filled Positions	Vacancies	Vacancy Rate
Assistant Coordinator of Nursing Services	1	1	0	0.00%
Assistant Director of Dietetics	3	3	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	11.4	8.6	2.8	24.56%
Clinical Laboratory Technologist (Safety)	4.5	2	2.5	55.56%
Clinical Social Worker (Health Facility/S)	70.9	50.5	20.4	28.77%
Communications Supervisor	1	1	0	0.00%
Communications Operator	9	9	0	0.00%
Coordinator of Nursing Services	1	1	0	0.00%
Coordinator of Volunteer Services	1	1	0	0.00%

Atascadero State Hospital Vacancy Totals as of 8/31/2008				
Identified Clinical Positions	**Budgeted Positions 08/09 FY**	**Filled Positions**	**Vacancies**	**Vacancy Rate**
Dental Assistant D/MH & DS	3	3	0	0.00%
Dentist, D/MH & DS	3	3	0	0.00%
Dietetic Technician (Safety)	3.6	3.6	0	0.00%
E.E.G. Technician (Psych Tech)	1	1	0	0.00%
Food Service Technician I	58.5	48.5	10	17.09%
Food Service Technician II	33	21	12	36.36%
Hospital Police Officers	113.8	97	16.8	14.76%
Hospital Police Sergeant	15	15	0	0.00%
Hospital Police Lieutenant	4	4	0	0.00%
Hospital Worker	0	0	0	0.00%
Health Record Technician	7.3	7	0.3	4.11%
Health Record Technician II (Spec)	3	3	0	0.00%
Health Record Technician II (Supv)	1	1	0	0.00%
Health Record Technician III	1	0	1	100.00%
Health Services Specialist (Safety)	26	26	0	0.00%
Institutional Artist Facilitator	1	1	0	0.00%
Licensed Vocational Nurse (Safety)	2	1	1	50.00%
Medical Technical Assistant	0	0	0	0.00%
Medical Transcriber	12	12	0	0.00%
Nurse Instructor	9	8	1	11.11%
Nurse Practitioner (Safety)	19	17	2	10.53%
Nursing Coordinator (Safety)	7	8	-1	-14.29%

Atascadero State Hospital Vacancy Totals as of 8/31/2008				
Identified Clinical Positions	**Budgeted Positions 08/09 FY**	**Filled Positions**	**Vacancies**	**Vacancy Rate**
Office Technician	57.3	51.3	6	10.47%
Pathologist	0	0	0	0.00%
Pharmacist I, D/MH & DS	14	7.6	6.4	45.71%
Pharmacist II	2	0	2	100.00%
Pharmacy Services manager	1	1	0	0.00%
Pharmacy Technician, D/MH & DS	15	14	1	6.67%
Physician & Surgeon (Safety)	12	15	-3	-25.00%
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	7	1	12.50%
Program Consultant (Psychology)	0	0	0	0.00%
Program Consultant (Rehab. Therapy)	1	1	0	0.00%
Program Consultant (Social Work)	1	0	1	100.00%
Program Director (Mental Dis. - Safety)	7	8	-1	-14.29%
Psychiatric Nursing Education Director	1	1	0	0.00%
Psychiatric Technician (Safety)	499.9	440.5	59.4	11.88%
Psychiatric Technician Trainee (Safety)	75	68	7	9.33%
Psychiatric Technician Assistant (Safety)	14	9	5	35.71%
Psychiatric Technician Instructor	2	1	1	50.00%

Atascadero State Hospital Vacancy Totals as of 8/31/2008				
Identified Clinical Positions	**Budgeted Positions 08/09 FY**	**Filled Positions**	**Vacancies**	**Vacancy Rate**
Psychologist-HF, Clinical (Safety)	81.4	49	32.4	39.80%
Public Health Nurse I (D/MH &DS)	1	0	1	100.00%
Public Health Nurse II	2	3	-1	-50.00%
Radiologic Technologist	0	0	0	0.00%
Registered Nurse (Safety)	329.2	227.4	101.8	30.92%
Rehabilitation Therapist S.F., Art-Safety	1	1	0	0.00%
Rehabilitation Therapist S.F., Dance-Safety	2	0	2	100.00%
Rehabilitation Therapist S.F., Music-Safety	15	10	5	33.33%
Rehabilitation Therapist S.F., Occup-Safety	1	1	0	0.00%
Rehabilitation Therapist S.F., Rec.-Safety	50.7	29.5	21.2	41.81%
Senior Psychiatrist (Specialist)	6	2	4	66.67%
Senior Psychiatrist, CF, (Supervisor)	1	6	-5	-500.00%
Senior Psychologist, H.F. (Specialist)	10	4	6	60.00%
Senior Psychologist, C.F. (Supervisor)	6	6	0	0.00%
Senior Psychiatric Technician (Safety)	96	86	10	10.42%
Sr. Radiologic Technologist(Specialist-Safety)	1	1	0	0.00%
Senior Special Investigator I, D/MH & DS	1	0	1	100.00%
Senior Vocational Rehab Counselor	3	3	0	0.00%
Special Investigator I, D/MH & DS	2	0	2	100.00%
Speech Pathologist I D/MH & DS	0	0	0	0.00%
Staff Psychiatrist (Safety)	86.1	15.5	70.6	82.00%
Supervising Registered Nurse (Safety)	2	2	0	0.00%

Atascadero State Hospital Vacancy Totals as of 8/31/2008				
Identified Clinical Positions	**Budgeted Positions 08/09 FY**	**Filled Positions**	**Vacancies**	**Vacancy Rate**
Teacher-Adult Educ.	28.6	9	19.6	68.53%
Teaching Assistant	8	9	-1	-12.50%
Unit Supervisor (Safety)	33	30	3	9.09%
Vocational Services Instructor	4	4	0	0.00%
Vocational Rehabilitation Counselor	0	0	0	0.00%

As the table above illustrates, ASH has numerous and significant vacancies across the range of clinical positions: staff psychiatrists, psychologists, RNs, psychiatric technicians, social workers and rehabilitation therapists. The body of the report describes numerous challenges posed by the staffing shortages.

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

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

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

E. Monitor's Evaluation of Compliance

The status of compliance is assessed considering the following factors:

1. An objective review of the facility's data and records;
2. Observations of individuals, staff and service delivery processes;
3. Interviews with individuals, staff, facility and State administrative and clinical leaders;
4. An assessment of the stability of the facility's current structure and functions in terms of potential for self-sustenance in order adequately meet the needs of individuals currently and in the future;
5. Assessment of trends and patterns of change rather than single and/or temporary occurrences of compliance or noncompliance that are inconsistent with these patterns and trends;
6. When no instance requiring implementation of a specific requirement was found in the baseline assessment, the compliance was rated as Not Applicable for this evaluation.
7. Once a hospital reaches substantial or full compliance in a section of the EP, the CM begins maintenance evaluation of that section for 18 consecutive months. If the hospital maintains substantial or full compliance during the 18-month period, 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 assume this responsibility as each section of the EP achieves maintenance status at each hospital.

F. Next Steps

1. The Court Monitor's team is scheduled to reevaluate Atascadero State Hospital April 20-24, 2009.
2. The Court Monitor's team is scheduled to tour Patton State Hospital December 8-12, 2008 for a follow-up evaluation.
3. All compliance reports should be reviewed and utilized, as applicable, by all facilities to guide implementation efforts regardless of the schedule of facility-specific assessments.

C. Integrated Therapeutic and Rehabilitation Services Planning		
	Each State hospital shall provide coordinated, comprehensive, individualized protections, services, supports, and treatments (collectively "therapeutic and rehabilitation services") for the individuals it serves, consistent with generally accepted professional standards of care. In addition to implementing the therapeutic and rehabilitation planning provisions set forth below, each State hospital shall establish and implement standards, policies, and practices to ensure that therapeutic and rehabilitation service determinations are consistently made by an interdisciplinary team through integrated therapeutic and rehabilitation service planning and embodied in a single, integrated therapeutic and rehabilitation service plan.	**Summary of Progress:** 1. ASH has implemented the WRP model hospital-wide. 2. ASH has made further progress in the WRPC process. 3. ASH has identified consistent team recorders for each WRPT, developed a team recorder duty statement and provided training to the recorders. 4. In general, the review of the Present Status section of the case formulation was much improved, including the review of symptoms, interventions and response, functional status, risk factors, progress towards discharge criteria, By Choice point allocation and medication side effects. 5. ASH has maintained progress in ensuring that WRPs include an enrichment focus, objectives and interventions. 6. ASH has taken appropriate corrective actions to facilitate implementation of the required active treatment hours. 7. ASH has provided meaningful clinical and process outcome data regarding its substance abuse services (SAS). 8. ASH has increased the number of recovery and medication education groups. 9. ASH has improved the sampling methodology in self-monitoring and refined data gathering and presentation.
1. Interdisciplinary Teams		
C.1	The interdisciplinary team's membership shall be dictated by the particular needs and strengths of the individual in the team's care. At a minimum, each State Hospital shall ensure that the team shall:	**Methodology:** <u>Interviewed</u>: 1. Donna Nelson, Director, Standards Compliance Department 2. Jan Alarcon, PhD, Master WRP Trainer

		Reviewed: 1. ASH summary outline of all WRP training provided to WRPTs, March to August 2008 2. Enhancement Plan Performance Improvement Team (EPPI) Progress Report, September 15, 2008 3. ASH list of current mentors 4. MSH Case Formulation Module, including worksheet 5. MSH Interventions and Mall Integration handouts, including Strengths: Basic Principles Addendum (revised by Dr. Alarcon in June 2008) 6. ASH Writing Stages-of-Change Objectives Training 7. ASH Wellness and Recovery Planning Conference (WRPC) Checklist 8. ASH Report: Five MSH WRP Modules Training Compliance by Discipline and Program as of August 31, 2008 9. DMH WRP Process Observation Monitoring Form 10. DMH WRP Process Observation Monitoring Form Instructions 11. ASH WRP Process Observation Monitoring summary data (March to August 2008) 12. DMH Clinical Chart Auditing Form 13. DMH Clinical Chart Auditing Form Instructions 14. ASH Clinical Chart Auditing Form summary data (March to August 2008) 15. DMH WRP Psychiatry Team Leadership Monitoring Form 16. DMH WRP Psychiatry Team Leadership Monitoring Form Instructions 17. ASH WRP Psychiatry Team Leadership summary data (March to August 2008) 18. ASH data regarding staffing ratios on admissions and long-term units (March to August 2008) Observed: 1. WRPC (Program I, unit 4) for monthly review of SMB 2. WRPC (Program II, unit 16) for monthly review of PK

		3. WRPC (Program II, unit 25) for monthly review of DJM 4. WRPC (Program II, unit 27) for monthly review of BSB 5. WRPC (Program II, unit 27) for monthly review of VL 6. WRPC (Program IV, unit 6A) for 14-day review of LL 7. WRPC (Program IV, unit 6A) for 7-day review of RTL 8. WRPC (Program IV, unit 16B) for monthly review of JC 9. WRPC (Program V, unit 19) for monthly review of AES 10. WRPC (Program VII, unit 2) for quarterly review of WST
C.1.a	Have as its primary objective the provision of individualized, integrated therapeutic and rehabilitation services that optimize the individual's recovery and ability to sustain himself/herself in the most integrated, appropriate setting based on the individual's strengths and functional and legal status and support the individual's ability to exercise his/her liberty interests, including the interests of self determination and independence.	**Current findings on previous recommendations:** **Recommendations 1 and 2, April 2008:** • Provide a summary outline of all WRP training and mentoring provided to the WRPTs during the reporting period. • Provide a summary outline of any improvements in practice made as a result of review by the Quality Council of internal monitoring data. **Findings:** The following summarizes the facility's actions since the last report: 1. ASH implemented the WRP model hospital-wide. 2. ASH continued to provide the three-hour overview WRP training. 3. The Master WRP Trainer, Jan Alarcon, PhD, provided training to 49 WRP mentors in addition to the 14 mentors who had been trained by the State's consultant, Ron Boggio, PhD, during the previous review period. With this additional training, ASH has achieved staffing of one trained mentor for each WRPT as of August 2008. 4. The facility initiated training using the five MSH modules and developed an addendum, including a worksheet, to the Case Formulation module. The Worksheet was piloted with the mentors. The facility also developed training materials on writing the Stages of Change and the development of objectives that relate to each stage. This material was added the Foci and Objectives module. An

		addendum on the basic principles in the formulation of individuals' strengths was added to the module regarding Interventions and Mall Integration. 5. ASH has provided the WRP annual Overview Training to Level of Care Staff (PTs). 6. RN and PT Core Team members were identified for each WRPT to work consistently with the individuals, provide updates to the WRPTs as to significant changes in the individuals' status and assist the individuals with understanding the WRPs and giving input into these plans. 7. Consistent team recorders were identified for each WRPT; a team recorder duty statement was developed and training provided. 8. ASH displayed posters regarding the WRP process and content in all team rooms to assist in improving the quality of the WRPCs. Some posters were translated into Spanish. 9. The facility developed and implemented a WRPC checklist to assist the teams in covering the required tasks during the meeting (as of October 1, 2008). 10. As of September 29, 2008 a senior psychiatrist has been assigned to every program to provide clinical supervision to the WRP Team Leaders. 11. Beginning in September 2008, all Program Managers had access to PLATO data to review trends and analyze data to ensure oversight of their WRPTs. PLATO data also became accessible to all WRP Mentors. Standards Compliance provided individualized and group PLATO training to Program Managers and Mentors. 12. ASH implemented a process to provide the WRPTs with team-specific summary data from the Clinical Chart Auditing and WRP Process Observation Forms so that improvement efforts can be better targeted. 13. Beginning September 1, 2008, the Clinical Administrator has implemented a process of Program oversight regarding status of compliance.

14. ASH has organized a Wellness and Recovery Enhancement Plan Performance Improvement (EPPI) Team. In recent weeks, the facility began a process of weekly review of internal monitoring data by the facility's Quality Council to assess status of implementation and ensure that the data are used to inform practice.

ASH provided other information that was not relevant to these recommendations.

Recommendation 3, April 2008:
Provide documentation of the number and percentage of WRPT members completing the three-hour overview training and training on the specific five modules in Program IV and hospital-wide.

Findings:
ASH provided data on the percentages of WRPT members who successfully completed different WRP training programs hospital-wide during this review period. The data regarding the overview training included comparisons with the previous period. The comparative data showed significant improvement since the last review. As mentioned above, training on the MSH five modules was initiated during this review period. The following is a summary of the data:

Overview training		
Discipline	Previous review	Current review
MD	64%	89%
PhD	66%	98%
SW	71%	100%
RT	74%	100%
RN	22%	90%
PT	17%	91%

	Engagement	Case Formulation	Foci and Objectives	Interventions and Mall Integration	Discharge Planning
MD	30%	25%	27%	27%	27%
PhD	58%	59%	56%	58%	53%
SW	53%	48%	46%	50%	49%
RT	54%	52%	54%	54%	49%
RN	11%	12%	12%	13%	9%
PT	7%	7%	7%	10%	7%

Other findings:
The monitor and his experts attended 10 WRPCs. The meetings showed further progress in the overall process of the team meetings. The following are examples:

1. All meetings started on time.
2. A team member was designated as facilitator in all meetings. In general, the facilitators utilized the WRPC checklist, which improved attention to the required tasks during the meetings.
3. The attendance and participation by core members was much improved.
4. Most WRPTs presented an adequate summary of the assessment data and an adequate review of risk factors prior to the individual's arrival.
5. The review and update of the Present Status section of the case formulation was generally more organized and comprehensive than noted during the previous review.
6. Most WRPTs discussed the key questions to be addressed during the individual's presence.
7. In all the meetings, the team members were respectful of the individuals and made an effort to elicit their input.
8. Most WRPTs reviewed the diagnosis, objectives and interventions

		with the individual. 9. In general, the teams updated the life goals and strengths during the meeting. 10. The teams made an effort to review the individual's attendance (and participation) at the assigned groups. The newly established role of the core nurse facilitated this review in a few meetings. 11. The teams reviewed the By Choice participation and point allocation with the individual. 12. In one meeting, the WRPT provided an excellent review of all the required tasks, except for running out of time prior to the review and revision of foci, objectives and interventions. However, the meetings showed the following pattern of process deficiencies: 1. In some meetings, the WRPT did not present or review results of disciplinary assessments. In one meeting, this omission resulted in failure by the WRPT to attend properly to the status of an individual who was suffering from severe drug-induced movement disorder that appeared to interfere with his ability to participate in various treatment/rehabilitation activities and compromised his quality of life. 2. Some WRPTs did not attend to important clinical information provided by the individuals during the meeting, failing to ask follow-up questions to evaluate the individual's current functional status. 3. Several WRPTs provided unnecessary review of some tasks at least twice during the meeting at the expense of other critical tasks. The duplicated reviews included the Present Status section, the risk factors, the By Choice point allocation and the individual's diagnosis. The omitted tasks included review of foci, objectives and interventions. The current WRPC checklist appeared to contribute to this deficiency. 4. In some meetings, the review of medical risk factors included

		unnecessary rehash of information that was not relevant to the risks. 5. The teams did not link the individuals' life goals and strengths with the WRP objectives and interventions. 6. There was no mechanism to conduct data-based review of the individuals' progress in Mall groups and to ensure that Mall offerings are properly linked to the WRP objectives. **Compliance:** Partial. **Current recommendations**: 1. Revise the WRPC checklist to avoid unnecessary duplication of some tasks (e.g. Present Status section of the case formulation, risk factors, diagnosis and By Choice point allocation). The goal is to improve attention to all important tasks during the meeting time. 2. Improve clinical mentoring of the WRPTs to ensure proper attention to important clinical data during the meeting. 3. Provide a summary outline of all WRP training and mentoring provided to the WRPTs during the reporting period. 4. Provide a summary outline of any improvements in practice made as a result of review by the Quality Council of internal monitoring data. 5. Provide documentation of the number and percentage of WRPT members completing the three-hour overview training and training on the specific five modules in Program IV and hospital-wide.
C.1.b	Be led by a clinical professional who is involved in the care of the individual.	**Current findings on previous recommendations:** **Recommendations 1 and 2, April 2008:** • Monitor this requirement using the WRP Process Observation and Team Leadership Monitoring Forms based on 20% and 100% samples, respectively. • 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 used the DMH WRP Observation Monitoring Form to assess compliance (March to August 2008), based on an average sample of 30% of all WRPCs due each month:

1.	*Each team is led by a clinical professional who is involved in the care of the individual:*	
1.a	*The clinical professional is a core team member for the individual.*	94%
1.b	*This person is the identified facilitator or the team leader appointed a team facilitator.*	24%

Although compliance remains low, the facility's comparative data showed mostly improved compliance since the last review. The following is a summary of the facility's comparative data:

	Previous period	Current period
Mean compliance rate		
1.	3%	23%
Compliance rate in last month of period		
1.	10%	36%
1.a	99%	93%
1.b	10%	37%

ASH reported that low compliance was influenced by auditors' misinterpretation of instructions, believing that the facilitators needed to state that they were the team leaders. The facility clarified the instructions in May 2008.

The facility also used the DMH WRP Psychiatry Team Leadership Monitoring Form to assess compliance (March to August 2008). The data were based on two observations per unit team by senior supervising psychiatrists per month. The average sample was 71% of the required observations. The following is a summary of the data:

1.	*Psychiatrist was present.*	99%
2.	*Psychiatrist elicited the participation of all disciplines.*	88%
3.	*Psychiatrist ensured the (integration of) assessments from other disciplines into the case formulation.*	79%
4.	*Psychiatrist ensured the "Present Status" section in the Case Formulation was updated.*	31%
5.	*Psychiatrist ensured that the interventions were linked to the measurable objectives.*	65%
6.	*Psychiatrist ensured the individual participated in the treatment, rehabilitation and enrichment activities which are goal-directed, individualized and based on a thorough knowledge of the individual's psychosocial history and previous response.*	88%

Comparative data showed mixed changes since the last review. The following is a summary:

	Previous period	Current period
Mean compliance rate		
1.	100%	99%
2.	100%	88%
3.	83%	79%
4.	65%	31%
5.	52%	65%
6.	52%	92%

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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>2.</td><td>100%</td><td>88%</td></tr>
<tr><td>3</td><td>79%</td><td>85%</td></tr>
<tr><td>4.</td><td>61%</td><td>41%</td></tr>
<tr><td>5.</td><td>50%</td><td>67%</td></tr>
</table>

The facility's corrective action plan consisted of continuations of the actions that were outlined in cell C.1.a.

Compliance:
Partial.

Current recommendations:
1. Monitor this requirement using the WRP Process Observation and Team Leadership Monitoring Forms based on 20% and 100% samples, respectively.
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).
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<tr>
<td>C.1.c</td>
<td>Function in an interdisciplinary fashion.</td>
<td>
Current findings on previous recommendations:

Recommendations 1 and 2, January 2008:
• Monitor this requirement using the DMH WRP Process Observation Form based on at least a 20% sample.
• Provide data analysis addressing sub-items of this requirement. The analysis must evaluate areas of low compliance and delineate areas of relative improvement.
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Findings:
ASH used the DMH WRP Observation Monitoring Form (March to August 2008) to assess compliance with this requirement. The average sample was 30% of the WPRCs due each month. The following is a summary of the compliance data:

2.	*Each team functions in an interdisciplinary fashion.*	
2.a	*The core team members participate by presenting or updating discipline-specific and or holistic assessment data.*	11%
2.b	*The team reviews and updates the DMH WRPC Task Tracking Form.*	75%
2.c	*Team members present their assessments and consultations as listed in the Task Tracking Form.*	63%
2.d.	*Team members discuss the individual's specific outcomes for the WRP review period.*	35%

Comparative data showed mixed changes since the last review. The following is a summary:

	Previous period	Current period
Mean compliance rate		
2.	1%	6%
Compliance rate in last month of period		
2.	3%	6%
2.a	24%	10%
2.b	85%	70%
2.c	67%	54%
2.d	12%	33%

		The facility's corrective action plan consisted of continuations of the actions that were outlined in cell C.1.a. **Compliance:** Partial. **Current recommendations**: 1. Monitor this requirement using process observation based on at least 20% sample. 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).
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:** **Recommendations 1 and 2, January 2008:** • Monitor this requirement using the Clinical Chart Auditing Form based on at least a 20% sample. • Provide data analysis addressing sub-items of this requirement. The analysis must evaluate areas of low compliance and delineate areas of relative improvement. **Findings:** Using the DMH WRP Clinical Chart Auditing Form, ASH assessed its compliance based on an average sample of 54% of quarterly and annual WRPs due for the month (March to August 2008). The following is a summary of the data: 1. *Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary, and appropriate psychiatric and medical care.*

1.a	*The present status and previous response to treatment sections of the case formulation are aligned with the assessments (focused assessment of compliance)*	6%
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)*	8%

Comparative data showed that compliance remained low but some improvement in the mean compliance rate for the review period compared to the last period was noted. The following is a summary:

	Previous period	Current period
Mean compliance rate		
1.	1%	4%
Compliance rate in last month of period		
1.	2%	5%
1.a	6%	7%
1.b	7%	6%

The facility's corrective action plan consisted of continuations of the actions that were outlined in cell C.1.a.

Compliance:
Partial.

Current recommendations:
1. Monitor this requirement using the Clinical Chart Audit form based on at least 20% sample.
2. Provide data analysis that delineates and evaluates areas of low

<table>
<tr><td></td><td></td><td>compliance and relative improvement (during the reporting period and compared to the last period).</td></tr>
<tr><td>C.1.e</td><td>Ensure that each member of the team participates appropriately in competently and knowledgeably assessing the individual on an ongoing basis and in developing, monitoring, and, as necessary, revising the therapeutic and rehabilitation services.</td><td>

Current findings on previous recommendations:

Recommendations 1 and 2, January 2008:

- Monitor this requirement using the WRP Observation Monitoring Form based on at least a 20% sample.
- Provide data analysis addressing sub-items of this requirement. The analysis must evaluate areas of low compliance and delineate areas of relative improvement.

Findings:

ASH used the DMH WRP Observation Monitoring Form to assess compliance based on an average sample of 30% of the WRPCs held each month. The following is a summary of the data (March to August 2008):

<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></td></tr>
<tr><td>3.a</td><td>Each team member presents relevant and appropriate content for the discipline-specific assessments. The Psychiatric Technician presents global observations of the individual for the WRP review period.</td><td>9%</td></tr>
<tr><td>3.b</td><td>Team members present their assessments and consultations as listed in the Task Tracking Form.</td><td>56%</td></tr>
<tr><td>3.c</td><td>Team members discuss the individual's specific outcomes for the WRP review period.</td><td>24%</td></tr>
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Comparative data showed that compliance remained low but some general improvement since the last review period was noted. The

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<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>3.</td><td>0%</td><td>5%</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>3.</td><td>1%</td><td>2%</td></tr>
<tr><td>3.a</td><td>15%</td><td>7%</td></tr>
<tr><td>3.b</td><td>52%</td><td>49%</td></tr>
<tr><td>3.c</td><td>7%</td><td>17%</td></tr>
</table>
The facility's corrective action plan consisted of continuations of the actions that were outlined in cell C.1.a.

Compliance:
Partial.

Current recommendations:
1. Monitor this requirement using the WRP Observation Monitoring Form based on at least 20% sample.
2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</td>
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<tr>
<td>C.1.f</td>
<td>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.</td>
<td>Current findings on previous recommendations:

Recommendations 1 and 2, April 2008:
• Monitor this requirement using process observation based on at least a 20% sample.
• Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period</td>
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		and compared to the last period). **Findings:** ASH used the DMH Observation Monitoring Form and reported a compliance rate of 3% for this requirement (March to August 2008). The mean compliance rate for the previous review was 0%. There was only minor improvement in the mean compliance rates when comparing the last month of previous review period to the last month in this period. The facility's corrective action plan consisted of continuations of the actions that were outlined in cell C.1.a. **Compliance:** Partial. **Current recommendations**: 1. Monitor this requirement using process observation based on at least a 20% sample. 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).
C.1.g	Be responsible for the scheduling and coordination of assessments and team meetings, the drafting of integrated treatment plans, and the scheduling and coordination of necessary progress reviews.	**Current findings on previous recommendations:** **Recommendations 1 and 2, January 2008:** • Monitor this requirement using the WRP Observation Monitoring Form based on at least a 20% sample. • Provide data analysis addressing sub-items of this requirement. The analysis must evaluate areas of low compliance and delineate areas of relative improvement. **Findings:** ASH used the WRP observation process to assess compliance (March to August 2008) based on an average sample of 30% of the WRPCs held

each month. The following is a summary of the data:

5.	*The team 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.*	
5.a	*There is an identified WRP recorder who is responsible for the scheduling and coordination of assessments and WRPCs. This person typically records the WRP.*	98%
5.b	*The identified recorder drafts the WRP on the computer and obtains all necessary signatures on the completed WRP, schedules the next conference date and time, Fills out the appointment card for the next WRPC for the individual and fills out the WRPC Task Tracking form at the conference.*	51%

Comparative data showed improvement in compliance since the last review as follows:

	Previous period	Current period
Mean compliance rate		
5.	34%	51%
Compliance rate in last month of period		
5.	43%	59%
5.a	100%	97%
5.b	43%	59%

In July 2008, ASH identified consistent team recorders for each

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<td>WRPT, developed a duty statement and implemented training for the recorders.

Compliance:
Partial.

Current recommendations:
1. Monitor this requirement using the WRP Observation Monitoring Form based on at least a 20% sample.
2. Provide data analysis addressing sub-items of this requirement. The analysis must evaluate areas of low compliance and delineate areas of relative improvement.</td>
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<tr>
<td>C.1.h</td>
<td>Consist of a stable core of members, including at least the individual served; the treating psychiatrist, treating psychologist, treating rehabilitation therapist, the treating social worker; registered nurse and psychiatric technician who know the individual best; and one of the individual's teachers (for school-age individuals), and, as appropriate, the individual's family, guardian, advocates, attorneys, and the pharmacist and other staff.</td>
<td>Current findings on previous recommendations:

Recommendations 1, 2 and 3, April 2008:
• Continue current efforts to improve attendance by core members.
• Monitor this requirement using process observation based on at least a 20% sample.
• Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).

Findings:
ASH presented data from the WRP observation process based on an average sample of 30%, a significant decrease from the sample of 63% during the last review period. The following table is a summary of attendance rates by each core member (February to July 2008):

<table>
<tr><th>WRPT member</th><th>Previous period</th><th>Current period</th></tr>
<tr><td>Individual</td><td>95%</td><td>92%</td></tr>
<tr><td>Psychiatrist</td><td>94%</td><td>93%</td></tr>
<tr><td>Psychologist</td><td>80%</td><td>73%</td></tr>
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Social Worker	78%	73%
Rehabilitation Therapist	77%	72%
Registered Nurse	75%	80%
Psychiatric Technician	22%	45%

Comparative data showed modest declines in compliance since the last review period, with the exception of RNs and PTs. Corrective actions included initiatives by the Clinical Administrator and Nurse Administrator to develop a new process for centralized staffing to ensure coverage across the facility and plan to utilize nursing staff assigned to ancillary areas to cover units during team meeting times. Other corrective actions reported by the facility did not align with results of this audit.

Recommendation 4, April 2008:
Recruit sufficient staff to fill current vacancies in core WRPT members.

Findings:
The facility has yet to implement this recommendation. As shown in the table above, psychiatry is the only discipline in compliance with the requirement.

Compliance:
Partial.

Current recommendations:
1. Continue current efforts to improve attendance by core members.
2. Monitor this requirement using process observation based on at least a 20% sample.
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).

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<tr><td></td><td></td><td>4. Recruit sufficient staff to fill current vacancies in core WRPT members.</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:

Recommendation 1, April 2008:
Same as in C.1.h.

Findings:
Same as in C.1.h.

Recommendation 2, April 2008:
Ensure that individuals remain on the admission units for up to 90 days prior to inter-unit transfer, if such transfer is needed.

Findings:
ASH did not address this recommendation. The facility plans to open an extra admission unit in November 2008 to ensure that individuals are not transferred during their first 90 days of admission.

Other findings:
The following table is a summary of the facility's data regarding admission units for this review period compared to the last period. The data showed that ASH has maintained compliance with MD and PhD ratios and reached compliance with Rehabilitation Therapist ratios. However, compliance with Social Worker ratios has decreased.
<table>
<tr><td></td><td>Mean ratio, previous period</td><td>Mean ratio, current period</td></tr>
<tr><td>MDs</td><td>1:11</td><td>1:13</td></tr>
<tr><td>PhDs</td><td>1:13</td><td>1:14</td></tr>
<tr><td>SWs</td><td>1:13</td><td>1:17</td></tr>
<tr><td>RTs</td><td>1:19</td><td>1:15</td></tr>
<tr><td>RNs</td><td>Not available</td><td>1:5</td></tr>
</table>
</td></tr>
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<td></td>
<td>
<table>
<tr><td>PTs</td><td>Not available</td><td>1:4</td></tr>
</table>

The following table summarizes the data for long-term units. The data showed that ASH has met the required ratios for MDs, RNs and PTs, but not for other disciplines. Although the ratios for PhDs are still short of compliance, improvement was noted ratios since the last review.

<table>
<tr><td></td><td>Mean ratio, previous period</td><td>Mean ratio, current period</td></tr>
<tr><td>MDs</td><td>1:26</td><td>1:22</td></tr>
<tr><td>PhDs</td><td>1:80</td><td>1:55</td></tr>
<tr><td>SWs</td><td>1:27</td><td>1:33</td></tr>
<tr><td>RTs</td><td>1:36</td><td>1:45</td></tr>
<tr><td>RNs</td><td>Not available</td><td>1:11</td></tr>
<tr><td>PTs</td><td>Not available</td><td>1:5</td></tr>
</table>

Compliance:
Partial.

Current recommendations:
1. Ensure compliance with the required ratios for Social Workers on the admission units and for PhDs, SWs and RTs on the long-term units.
2. Ensure that individuals remain on the admission units for up to 90 days prior to inter-unit transfer, if such transfer is needed.
3. Provide data regarding staffing case loads on both the admission and long-term units.
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<tr>
<td>C.1.j</td>
<td>Not include staff that is not verifiably competent in the development and implementation of interdisciplinary wellness and recovery plans.</td>
<td>

Current findings on previous recommendation:

Recommendation, March 2008:
Same as in C.1.a through C.1.f.
</td>
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</table>

		Findings: Same as in C.1.a through C.1.f. **Compliance:** Partial. **Current recommendations**: Same as in 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:** Interviewed: 1. Angelique Stansbury, RN, DCAT member 2. Brenda Collwell, Teacher's Aide 3. Brenda Gardner, PT 4. Brooke Hatcher, RT, Supplemental Activity Coordinator 5. Carrie R. Dorsey, Acting Senior Rehabilitation Therapist 6. Charlie Joslin, Clinical Administrator 7. Christine Mathiesen, PsyD, Director C-PAS 8. Cindy Duke, PsyD, Psychologist 9. Dawn Hartman, Registered Dietitian 10. Diane Imrem, PsyD, Chief of Psychology 11. Donna Nelson, Director, Standards Compliance 12. Donte Karas, [title] 13. Emmanuel Fantone, MD, Psychiatrist 14. Erin Dengate, Assistant Director of Dietetics 15. Filomena Rebelo, PhD, Psychologist 16. Gayle Pineo, PT 17. Gloria Carvel, RN 18. J. Abrahamson, MD, Psychiatrist 19. Jan Alarcon, PhD, ASH Master WRP Trainer 20. Janet Bouffard, LCSW, Chief of Social Work 21. Jean Adams, Unit Supervisor 22. Jessica Knight, PT 23. Jessica Yost, RT 24. Jim Notheis, Teacher 25. John De Morales, Executive Director 26. Karen Dubiel, Assistant to Clinical Administrator 27. Kathy Runge, Occupational Therapist 28. Kenneth Campos, M.D, Psychiatrist 29. Kristen Dunbar, LCSW

		30. Ladonna DeCou, Chief of Rehabilitation 31. Leslie Bolin, PhD, Psychologist 32. Lev Iofis, MD, Senior Psychiatrist 33. Louis Santiago, SPT, BY CHOICE Coordinator 34. Marlene Espitia, RN, Standards and Compliance 35. Matthew Hennessy, PhD, Mall Director 36. Megan Emrich, RN 37. Melissa Smet, PT 38. Michael Knapp, PhD, Psychologist 39. Nancy Fiske, Occupational Therapist 40. Rachelle Rianda, Acting Senior Rehabilitation Therapist 41. Rafael Romero, Unit Supervisor 42. Ramiro Zeron, LCSW 43. Richard Gonzales, SPT 44. Robert Ferrell, Special Education Teacher 45. Robert Hanks, SPT, Acting Unit Supervisor 46. Scott Cahill, Teacher 47. Terry Jewell, Quality Assurance Monitor, Standards Compliance <u>Reviewed</u>: 1. The charts of thefollowing206 individuals: AAA, AAM, AB, AC, AD, AEJr., AG, AJ, AJB, ALS, ALT, AMB, AMG, AML, AMM, AP, AR, ASM, AT, BA, BB-1, BB-2, BG, BJS, BM, BO, BRC, BS, BWB, CC-1, CC-2, CD, CDB, CJG, CJS, CKK, CL, CLC-1, CLC-2, CLH, CM, COP, CP, CRA, CRM, CSO, CWS, DA, DB, DC, DDM, DEA, DEG, DFJ, DG, DH, DI, DJ-1, DJ-2, DKH, DLC, DPN, DR, DRR, DRS, DS, DSC, DSM-1, DSM-2, EAM, ECD, ECE, ED, EDS, FM, FN, GA, GAB, GAJ-1, GAJ-2, GAS, GAW, GCJ, GDC, GF, GKP, GL, GM, GS, GTB, GTV, GW, HCG, HE, HME, HR, HS, HWB, IC, IK-1, IK-2, JAR, JB, JC, JCZ, JD, JFL, JHFK, JHJ, JHM, JJB, JJC, JJF, JJJ, JJT, JKC, JL, JLB, JLH, JLP, JMG, JN, JPM, JS, JSC, JSH, JT, JTM, JV, JVW, JW, KAT, KB, KBR, KED, KET, KM, KN, LH, LJC, LLS, LNC, LPM, MAD, MAP, MB, MD, ME, MG, MH, MJM, MLF, MMR, MRS, MS, MW, MWW, NJB, OC, PAA, PED, PJC, PK, PT, PVH,

		RAG, RCR, RCS, RDN, RF, RG, RJWW, RL, RLA, RLY, RPH, RRR, SAH, SAJ, SB-1, SB-2, SG, SGV, SLC-1, SLC-2, SM, SMB, SR, SS, SSM, SW, TAB, TAQ, TB, TDW, TJC-1, TJC-2, TL, TLC, TM, TMH, TWA, VAO, VV, WCO and WM 2. Sponsor Group Workbook 3. Continuous Lesson Plan: Sponsor Group 4. Therapeutic Milieu Enhancement Team: Proposed Curriculum Summary and Roll Out Plan 5. DMH WRP Process Observation Monitoring Form 6. DMH WRP Process Observation Monitoring Form Instructions 7. ASH WRP Process Observation Monitoring summary data (March to August 2008) 8. DMH Clinical Chart Auditing Form 9. DMH Clinical Chart Auditing Form Instructions 10. ASH Clinical Chart Auditing Form summary data (March to August 2008) 11. ASH Substance Abuse Services (SAS) outcomes data (April to September 2008) 12. DMH WRP Substance Abuse Monitoring Form 13. DMH WRP Substance Abuse Monitoring Form Instructions 14. ASH Substance Abuse Monitoring summary data (March to August 2008) 15. ASH MAPP data regarding active treatment hours scheduled and attended (March to August 2008) 16. ASH Monthly MAPP Report 17. ASH Activity Room Proposal 18. ASH data regarding Introduction to Wellness and Recovery and Medication Management groups (March to August 2008) 19. MSH and PSH Substance Abuse Treatment Program Plan of Improvement 20. ASH Substance Abuse Services (SAS) Data Report April 2007 to September 2008 21. ASH SAS Pre-contemplative Stage Group Facilitator Training

		22. ASH Substance Abuse Objective samples: Pre-contemplation, Contemplation, Preparation, Action and Maintenance 23. ASH SAS Preparation Stage Pre/Post Test 24. ASH SAS Action Stage Pre/Post Test 25. ASH data regarding Narrative Restructuring Therapy (NRT) provided to individuals (March to August 2008) 26. ASH Mall Curriculum 27. ASH Progress Report (October, 2008) 28. ASH Substance Abuse Services Staff Competency 29. BMI Triggers Report 30. BY CHOICE WRP Audit Tool Form and Instructions 31. Executive Director Memorandum (Sept 24, 2008): Required Hours For Mall Facilitators 32. Hospital-Wide Supplemental Activities List 33. List of Individuals with Assessed Need for Family Therapy 34. List Showing Groups for Individuals with Cognitive Disorders 35. Mentor Hotline (July 24, 2008), Communication Tools to assist staff in WRP Documentation 36. Plato Data Analyzer Report 37. PSR Mall Course Facilitator Consultation 38. Sponsor Group Workbook 39. Substance Abuse Service Employee Competency Training Workbook 40. Summary of Mall Scheduled Hours 41. Supplemental Activity List 42. Team Observation Audit 43. The Same Page Newsletter (3rd ed.), Newsletter dealing with WRP compliance issues 44. WRP Active Treatment Request <u>Observed</u>: 1. WRPC (Program I, unit 4) for monthly review of SMB 2. WRPC (Program II, unit 16) for monthly review of PK 3. WRPC (Program II, unit 25) for monthly review of DJM

		4. WRPC (Program II, unit 27) for monthly review of BSB 5. WRPC (Program II, unit 27) for monthly review of VL 6. WRPC (Program IV, unit 6A) for 14-Day review of LL 7. WRPC (Program IV, unit 6A) for 7-Day review of RTL 8. WRPC (Program IV, unit 16B) for monthly review of JC 9. WRPC (Program V, unit 19) for monthly review of AES 10. WRPC (Program VII, unit 2) for quarterly review of WST 11. Psychology Specialist Services Committee Meeting 12. PSR Mall group: Wellness and Recovery Action Plan 13. PSR Mall group: Computer Class 14. PSR Mall group: "Ready, Set, Go" 15. PSR Mall group: Community Living Skills Project 16. PSR Mall group: Substance Abuse Recovery 17. PSR Mall group: Substance Abuse Recovery2 18. PSR Mall group: Non-violent Communication 19. PSR Mall group: Cognitive Remediation 20. PSR Mall group: Trauma and Anxiety
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:** **Recommendation 1, April 2008:** Continue current training and mentoring regarding engagement of individuals. **Findings:** ASH has continued training using the MSH Engagement module and presented data regarding the percentage of WRPT members who successfully completed this training. In addition to the engagement module training, ASH developed a sponsor group training and workbook and provided hospital-wide training regarding the sponsor group process in September 2008. One section of this training was dedicated to preparing the individuals to participate fully in their WRPs.

Recommendations 2 and 3, April 2008:

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

Findings:

ASH used the DMH Observation Monitoring Form to assess compliance (March to August 2008). The average sample was 22% of all WRPCs due each month. The following is a summary of 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.*	
6.a	*The WRPT asks the individual for his or her input into the evaluation of progress on each objective, as clinically indicated.*	36%
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.*	26%
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.*	78%
6.d	*When the individual identifies cultural preferences, the team updates the case formulation and may incorporate them into the individual's WRP objectives and interventions, as relevant.*	74%

Comparative data showed improvement in compliance since the last review as follows:

	Previous period	Current period
Mean compliance rate		
6.	6%	30%
Compliance rate in last month of period		
6.	18%	27%
6.a	25%	29%
6.b	11%	30%
6.c	75%	79%
6.d	81%	88%

ASH identified the lack of trained mentors for each WRPT and insufficient staffing as the long-term barriers to compliance during this reporting period. The facility's plan of improvement included the actions outlined in C.1.a in addition to the following:

1. A sponsor group process was implemented throughout the facility (September 2008), with the Program Directors directly responsible for the implementation. This process includes a component that addresses individuals' engagement. The sponsor group workbook and lesson plan include information consistent with the Wellness and Recovery model and current generally accepted standards.
2. ASH assigned a team to initiate an Enhanced Therapeutic Milieu program, including training and mentoring of unit staff. However, no specific information was provided to explain how this program will facilitate implementation of the Wellness and Recovery model, particularly regarding the engagement of individuals.

		Other findings: See findings in C.1.a. **Compliance:** Partial. **Current recommendations**: 1. Continue current training and mentoring regarding engagement of individuals. 2. Present competency-based training data regarding engagement of the individuals and ensure accuracy of the data. 3. Provide specific information to explain how the therapeutic milieu program will facilitate implementation of the Wellness and Recovery model, including the engagement of individuals. 4. Monitor this requirement using process observation based on at least a 20% sample. 5. Provide data analysis that evaluates low compliance and delineates areas of relative improvement (during the reporting period and compared to the last period).
C.2.b	Therapeutic and rehabilitation service planning provides timely attention to the needs of each individual, in particular:	Please see sub-cells for compliance findings.
C.2.b.i	initial therapeutic and rehabilitation service plans (Admission-Wellness and Recovery Plan ("A-WRP") are completed within 24 hours of admission;	**Current findings on previous recommendations:** **Recommendations 1, 2 and 3, April 2008:** • Monitor this requirement using chart audits 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). • Implement corrective actions to improve compliance.

		Findings: ASH used the DMH Chart Auditing Form to assess compliance with the requirements in C.2.b.i to C.2.b.iii (March to August 2008). Based on an average sample of 19% of the A-WRPs, the facility reported a mean compliance rate of 38% with this requirement. No comparative data was provided due to lack of data during the past review. The facility's data are presented below in each corresponding cell (C.2.b.ii and C.2.b.iii). Corrective actions were the same as outlined in C.1.a and C.2.a. **Other findings:** This monitor reviewed the charts of 10 individuals (ASM, CRM, DEA, GAJ, KM, RPH, SGV, TJC, TL and TLC) who were admitted during this reporting period. This review found compliance in all cases. **Compliance:** Partial. **Current recommendations**: 1. Monitor this requirement using chart auditing based on at least a 20% sample. 2. Provide data analysis that evaluates low compliance and delineates areas of relative improvement (during the reporting period and compared to the last period).
C.2.b.ii	master therapeutic and rehabilitation service plans ("Wellness and Recovery Plan" (WRP)) are completed within 7 days of admission; and	**Current findings on previous recommendations:** **Recommendations 1, 2 and 3, April 2008:** • Monitor this requirement using chart audits 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). • Implement corrective actions to improve compliance. **Findings:** The facility reported a mean compliance rate of 93% for this requirement. The average sample was 15% of all master WRPs. No data was presented for the last review. **Other findings:** Reviews by this monitor found compliance in nine charts (ASM, CRM, GAJ, KM, RPH, SGV, TJC, TL and TLC) and partial compliance in one (DEA). **Compliance:** Substantial. **Current recommendations**: 1. Monitor this requirement using chart auditing based on at least 20% sample. 2. Provide data that compares compliance during the current and prior reporting periods.
C.2.b.iii	therapeutic and rehabilitation service plan reviews are performed every 14 days during the first 60 days of hospitalization and every 30 days thereafter. The third monthly review is a quarterly review and the 12th monthly review is the annual review.	**Current findings on previous recommendations:** **Recommendation 1, April 2008:** Implement the required WRPC schedule on all teams. **Findings:** ASH has implemented this recommendation as of August 2008. **Recommendations 2, 3 and 4, April 2008:** • Monitor this requirement using chart audits based on at least a 20% sample.

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Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).
Implement corrective actions to improve compliance.

Findings:
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>21%</td><td>75%</td></tr>
<tr><td>Monthly</td><td>45%</td><td>56%</td></tr>
<tr><td>Quarterly</td><td>72%</td><td>60%</td></tr>
<tr><td>Annual</td><td>67%</td><td>66%</td></tr>
</table>
No comparative data were presented due to lack of data during the last review.

Compliance:
Partial.

Current recommendations:
1. Monitor this requirement using chart audits based on at least a 20% sample.
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).
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<tr>
<td>C.2.c</td>
<td>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;</td>
<td>
Current findings on previous recommendations:

Recommendations 1 and 2, April 2008:

Monitor this requirement using the Clinical Chart Auditing Form based on at least a 20% sample.

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</table>

- 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 used the DMH Clinical Chart Auditing Form to assess compliance (March to August 2008). The average sample was 42% of the quarterly and annual WRPs due each month. The following is a summary of the data:

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.*	8%
2.b	*When substance abuse is identified on Axis I, it is written in Focus 5, and has at least one objective with an appropriately linked intervention.*	30%
2.c	*When mental retardation is identified on Axis II, all interventions are aligned with the cognitive functioning level of the individual.*	3%
2.d	*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.*	24%

Although compliance rates remained low, some improvement was noted since the last review as follows:

	Previous period	Current period
Mean compliance rate		
2.	14%	26%
Compliance rate in last month of period		
2.	24%	29%
2.a	0%	0%
2.b	27%	33%
2.c	0%	0%
2.d	50%	50%

The facility identified the following issues as contributing to low compliance:

1. WRPTs' assessment and identification of individuals with cognitive disorders;
2. WRPTs' referrals for additional testing;
3. WRPTs' assignment of individuals with cognitive disorders to interventions that align with identified needs;
4. The limited number of interventions available through Mall Services for individuals with cognitive disorders; and
5. The lack of communication from WRPTs to Mall services regarding the individuals' assessed needs.

Recommendation 3, April
Implement corrective actions to address the deficiencies outlined by this monitor above.

Findings:
The facility addressed these deficiencies as follows:
1. Cognitive Disorders:
   a. On July 28, 2008, the WRP EPPI Team established a work group

		consisting of Mall Director, Neuropsychologist, DCAT representative and Chief of Psychology. This team is working on development of group curriculums to meet the needs of cognitively impaired individuals. b. A grid outlining potential Mall courses for individuals with a variety of cognitive issues has been developed for potential use by WRPTs. c. Mall Resource Binders and WaRMSS Course Outlines were identified as resources available to the WRPTs to assist in the identification of cognitive level groups. d. As of October 2008, the facility developed a list of all Mall courses that were offered for individuals with cognitive challenges and the list was inserted into the front of all Mall Resource Binders. The list was intended to serve as a quick reference to facilitate the WRPT's task of selecting groups that align with the individual's needs. e. The curriculum committee will begin meeting monthly in October to work on developing additional curriculum for individuals with cognitive impairments. f. The head of Central Psychological Assessment Services, the Mall Director, and the neuropsychologists are developing training for psychologists and psychiatrists that defines the levels of support available in Mall services, provides guidelines on how to assess individuals and properly align Mall services, and reviews the available interventions in Mall services for individuals with cognitive issues. This training is anticipated to be completed prior to February 2009. 2. Seizure Disorders: a. The Medical Director is in the process of initiating a work group to address the seizure disorder deficiencies. b. As of September 29, 2008, a senior psychiatrist has been assigned to every program. Clinical supervision will address the deficiencies regarding seizure disorder.

		Other findings: This monitor reviewed the charts of seven individuals diagnosed with a variety of cognitive disorders and six individuals diagnosed with seizure disorders. The reviews found general evidence of improvement in the following areas: 1. Documentation of foci, objectives and interventions to address the needs of individuals diagnosed with seizure disorders; 2. Decreased use of regular treatment with anticholinergic medications for individuals suffering from dementing illnesses; 3. Documentation of the status of some individuals suffering from seizure disorders and dementing illnesses (in the Present Status section of the case formulation); and 4. Attempts to develop objectives and interventions based on learning outcomes for some individuals suffering from seizure disorders, including benefits of treatment (SLC) or factors that can decrease the risk of recurrent seizures (AR and TAQ). However, the review also found a pattern of persistent deficiencies that must be corrected to achieve substantial compliance in this area. The following is an outline of these deficiencies: 1. Individuals diagnosed with cognitive impairments (ASM, BO, DSM, IK, JCZ, LLS and TJC): a. The WRP did not include a focus statement or objectives/ interventions to address diagnoses of Dementia NOS (BO), Mild Mental Retardation (ASM) and R/O Mental Retardation (TJC). b. The WRPs included incomplete focus statements regarding diagnoses of Dementia Due to General Medical Condition (LLS) and Cognitive Disorder Due to Head Trauma (IK). c. The WRP included objectives and interventions related to a diagnosis of Dementia Due to General Medical Condition that did not address this condition (LLS).

		d. The WRP included objectives and interventions related to the cognitive impairment that did not address or account for the cognitive status of individuals diagnosed with Cognitive Disorder NOS (DSM), Borderline Intellectual Functioning (JCZ) and Cognitive Disorder Due to Head Trauma (IK). e. The WRP (and psychiatric progress notes) did not address the risks of ongoing regular treatment with a benzodiazepine (clonazepam) and the PRN uses of a benzodiazepine (lorazepam) in addition to an anticholinergic agent (chlorpromazine) for an individual diagnosed with Dementia NOS (BO). f. There was evidence of limited offerings of cognitive remediation groups to meet the needs of the relatively large number of individuals diagnosed with cognitive impairments in the facility. 2. Individuals diagnosed with seizure disorders (AD, AR, SLC, SW, TAQ and TLC): a. The WRPs did not specify the morphological diagnosis of the seizure disorder in any of the charts reviewed except one (AR). b. Some WRPs included objectives that were focused on learning about the benefits of compliance with treatment, but the case formulations did not specify that non-compliance was relevant to this individual (e.g. AD). c. The WRP included an objective and corresponding interventions for the individual to comply with anticonvulsant treatment (phenytoin) although the neurology consultation indicated no evidence of a seizure disorder (TLC). d. Some WRPs included interventions that did not address the specified objective of learning to identify factors that may decrease the risk of recurrent seizures (TAQ). e. The WRPs did not address the risks of treatment with older anticonvulsant medications, including their impact on the individual's behavior, cognitive status and quality of life. Examples include individuals receiving phenytoin (AR, SLC and

		SW), primidone (TAQ) or phenobarbital (AD). A few of these individuals (e.g. SW) also suffered from cognitive impairments, which is an added risk factor. f. The neurology consultations performed for individuals receiving older anticonvulsant medications did not reflect strategies to utilize safer treatment alternatives or provide guidance regarding the continued need for treatment with these agents. This was noted even in the case of individuals who had difficulty with recurrent seizure activity (e.g. SW). **Compliance:** Partial. **Current recommendations**: 1. Monitor this requirement using the Clinical Chart Auditing Form, based on at least a 20% sample. 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). 3. Implement adequate corrective actions to address the deficiencies outlined by this monitor above.
C.2.d	Therapeutic and rehabilitation service planning is based on a comprehensive case formulation for each individual that emanates from interdisciplinary assessments of the individual consistent with generally accepted professional standards of care. Specifically, the case formulation shall:	**Compliance:** Partial.
C.2.d.i	be derived from analyses of the information gathered from interdisciplinary assessments, including diagnosis and differential diagnosis;	**Current findings on previous recommendations:**

Recommendation 1, April 2008:
Continue training on the Case Formulation Module to all WRPTs and ensure that the training utilizes clinical case examples and addresses the deficiencies outlined by this monitor above.

Findings:
ASH has continued training using the MSH Case Formulation module and presented data regarding the percentage of WRPT members who successfully completed this training (see C.1.a).

Recommendations 2 and 3, April 2008:
- Monitor this requirement using the 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 used the DMH Clinical Chart Auditing Form to assess compliance (March to August 2008). The average sample was 42% of the quarterly and annual WRPs due each month. The following is a summary of the data regarding this requirement; data regarding the requirements in C.2.d.ii through C.2.d.vi are presented in each corresponding cell below.

3.	*The case formulation is derived from analyses of the information gathered from interdisciplinary assessments, including diagnosis and differential diagnosis.*	
3.a	*All six sections of the case formulation (i.e., pertinent history, predisposing, precipitating, perpetuating factors, previous treatment and present status) are aligned with the Integrated Assessment and/or additional discipline-specific*	7%

	assessments, including	
3.b	*All six sections of the case formulation indicate interdisciplinary participation and are not written from the point of view of one discipline.*	9%

The mean compliance rate (5%) has improved since the last review period (0%). No data were presented for the sub-items during the last review. Corrective actions for the requirements in C.2.d are outlined in C.1.a and c.2.a. In addition, in October 2008 the WRP Master Trainer reportedly began to develop a specialized training regarding linkages within different components of the formulations.

Other findings:
Chart reviews by this monitor found that the Present Status section of the case formulation, including the review of symptoms, interventions and response, functional status, risk factors, progress towards discharge criteria, By Choice point allocation and medication side effects, was much improved compared to the previous review.

However, the content of many formulations showed deficiencies that must be corrected to achieve substantial compliance. The following are examples:

1. In general, the Present Status sections did not include sufficient review and analysis of the use of restrictive interventions.
2. Some of the discharge criteria that were listed in the Present Status sections were generic and not sufficiently individualized.
3. In general, there was inadequate linkage within the 6-p components of the case formulation and between the material in the case formulations and the individual's life goals and strengths as utilized in the objectives and interventions.

<table>
<tr>
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<td>Current recommendations:
1. Continue training on the Case Formulation Module to all WRPTs and ensure that the training addresses the deficiencies outlined by this monitor above.
2. Present competency-based training data regarding case formulations and ensure accuracy of the data.
3. Monitor this requirement using the Clinical Chart Auditing Form based on at least a 20% sample.
4. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</td>
</tr>
<tr>
<td>C.2.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.a</td><td>Pertinent history</td><td>29%</td></tr>
<tr><td>4.b</td><td>Predisposing factors</td><td>47%</td></tr>
<tr><td>4.c</td><td>Precipitating factors</td><td>27%</td></tr>
<tr><td>4.d</td><td>Perpetuating factors</td><td>22%</td></tr>
<tr><td>4.e</td><td>Previous treatment</td><td>4%</td></tr>
<tr><td>4.f</td><td>Present status</td><td>5%</td></tr>
</table>

Comparative data showed that compliance rates did not meaningfully improve and in some cases declined since the last review as follows:
<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>0%</td><td>1%</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>4.</td><td>0%</td><td>0%</td></tr>
<tr><td>4.a</td><td>26%</td><td>25%</td></tr>
<tr><td>4.b</td><td>55%</td><td>38%</td></tr>
<tr><td>4.c</td><td>22%</td><td>23%</td></tr>
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<tr><td>4.d</td><td>18%</td><td>20%</td></tr>
<tr><td>4.e</td><td>0%</td><td>7%</td></tr>
<tr><td>4.f</td><td>6%</td><td>4%</td></tr>
</table>
</td>
</tr>
<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.a</td><td>There is a completed DMH WRP Case Formulation Worksheet, and</td><td>30%</td></tr>
<tr><td>5.b</td><td>The information is included in the case formulation</td><td>32%</td></tr>
</table>

Comparative data showed improvement since the last review as follows:

<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>5.</td><td>8%</td><td>24%</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>5.</td><td>0%</td><td>38%</td></tr>
<tr><td>5.a</td><td>25%</td><td>46%</td></tr>
<tr><td>5.b</td><td>0%</td><td>48%</td></tr>
</table>
</td>
</tr>
<tr>
<td>C.2.d.iv</td>
<td>consider such factors as age, gender, culture, treatment adherence, and medication issues that may affect the outcomes of treatment and rehabilitation interventions;</td>
<td>
<table>
<tr><td>6.a</td><td>All five factors: age, gender, culture, treatment adherence, and medication issues (are included)</td><td>84%</td></tr>
<tr><td>6.b</td><td>(The formulation) addresses how they affect treatment and rehabilitation outcomes</td><td>8%</td></tr>
</table>

Comparative data showed general improvement, with one exception, since the last review as follows:
</td>
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</table>

<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>6.</td><td>3%</td><td>16%</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>6.</td><td>6%</td><td>12%</td></tr>
<tr><td>6.a</td><td>79%</td><td>73%</td></tr>
<tr><td>6.b</td><td>4%</td><td>9%</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 (or the most current edition) checklists; and</td><td>
<table>
<tr><td>7.a</td><td>There is a completed DSM IV-TR Checklist that was completed prior to the 7-day WRP, and thereafter</td><td>24%</td></tr>
<tr><td>7.b</td><td>There is a completed DSM IV-TR Checklist completed when there is a change of a psychiatric diagnosis.</td><td>22%</td></tr>
</table>
Comparative data showed general improvement with one exception since the last review as follows:
<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>10%</td><td>22%</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>7.</td><td>12%</td><td>17%</td></tr>
<tr><td>7.a</td><td>13%</td><td>22%</td></tr>
<tr><td>7.b</td><td>12%</td><td>10%</td></tr>
</table>
</td></tr>
<tr><td>C.2.d.vi</td><td>enable the interdisciplinary team to reach sound determinations about each individual's</td><td></td></tr>
</table>

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.a	*The Present Status section addresses the following: Treatment, Rehabilitation and Enrichment*	17%
8.b	*The case formulation identifies required changes in individual and systems to optimize treatment, rehabilitation and enrichment outcomes*	12%
8.c	*The case formulation documents a pathway to the discharge setting*	20%
8.d	*There is evidence of proper analysis of the following information: of identification of foci, objectives treatment, rehabilitation, and enrichment interventions and there is linkage between the case formulation and the foci of hospitalization, life goals and objectives and interventions.*	5%
8.e	*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*	3%
8.f	*The case formulation is an integrated summary including the elements of the six Ps, diagnostic formulation, identification of foci, objectives, interventions, and discharge plans, and*	3%
8.g	*The case formulation identifies 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.*	5%

Comparative data showed that compliance rates remained low and in some cases declined since the last review as follows:

	Previous period	Current period
Mean compliance rate		
8.	0%	0%
Compliance rate in last month of period		
8.	0%	0%
8.a	7%	8%
8.b	15%	7%
8.c	37%	9%
8.d	9%	1%
8.e	6%	3%
8.f	4%	0%
8.g	11%	1%

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 recommendation:

Recommendation, April 2008:
Same as in C.2.c, C.2.f, C.2.g and C.2.o.

Findings:
Same as in C.2.c, C.2.f, C.2.g and C.2.o.

Other findings:
MSH used the DMH Chart Auditing Form to assess compliance with this requirement (March to August 2008). The average sample was 32% of the quarterly and annual WRPs due each month. The following is a summary of the compliance data:

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).	
4.a	*There is a focus of hospitalization for each axis I, II, and III diagnosis*	60%
4.b	*There is a focus for each discharge criteria*	53%
4.c	*Each focus has an objective and an intervention*	62%
4.d	*Each intervention includes the name of the staff responsible for implementation, the group name and the group time/day.*	45%
4.e	*Each objective includes a staff intervention in the therapeutic milieu.*	31%

No data were presented for this requirement during the last review.

Additionally, this monitor reviewed the records of 33 individuals receiving Rehabilitation Therapy Services (including Rehabilitation Therapist-facilitated PSR Mall groups and direct Occupational and Physical therapy treatment) (AAA, AAM, AJ, ALS, AMB, AML, BJS, BWB, CDC, DKH, DR, EAM, ECD, ED, GAS, GCJ, HCG, JJC, JKC, JR, JS, JSC, JT, JVW, KET, LJC, LPM, MH, MLF, MWW, RCR, SM and SSM) to assess compliance with the requirements of C.2.e. Five records (AAM, JJC, JR, KET and LJC) were found to be in substantial compliance; 10 records (ALS, AML, BWB, EAM, GAS, JT, MH, MLF, RCR and SSM) were found to be in partial compliance; and 18 records (AAA, AJ, AMB, BJS, CDC, DKH, DR, ECD, ED, GCJ, HCG, JKC, JS, JSC, JVW, LPM, MWW and SM) were found to be not in compliance with C2.e. Identified patterns of deficiencies that the facility should focus on in order to improve compliance include the following:

1. Objectives are not consistently functional, behavioral, observable and measurable and integrated into the WRP.

		2. Foci, objectives and interventions are not consistently aligned in the WRP. 3. Interventions are not consistently written as indicated by facility requirements and integrated into the WRP. This monitor also reviewed the records of 45 individuals who had IA-RTS assessments (admission and conversion) and Rehabilitation Therapy focused assessments (Occupational Therapy, Physical Therapy, Vocational Rehabilitation) during the review period (AC, AJB, AMM, AP, AT, BB-1, BS, CDB, CKK, CL, CLH, CM, CRA, DA, DEG, DI, DRS, FN, GL, GW, HS, IC, IK, JHJ, JHM, JJB, JJF, JL, JLH, JPM, JS, JSH, JW, KBR, MRS, MW, NJB, PAA, PJC, RDN, RRR, TAB, TDW, TWA and WCO) for individual to assess compliance with the requirements of C.2.e. One record (JS) was found to be in substantial compliance; 29 records were found to be in partial compliance (AMM, AT, CDB, CKK, CL, CLH, CM, DA, DEG, DI, DRS, GL, GW, HS, IC, JHJ, JHM, JJB, JJF, JL, JLH, MRS, MW, PAA, PJC, TAB, TDW, TWA and WCO), and 15 records (AC, AJB, AP, BB-1, BS, CRA, FN, IK, JPM, JSH, JW, KBR, NJB, RDN and RRR) were found to be not in compliance with C2.e. Identified patterns of deficiencies that the facility should focus on in order to improve compliance include the following: 1. Objectives are not consistently functional, behavioral, observable and measurable and integrated into the WRP. 2. Foci, objectives and interventions are not consistently aligned in the WRP. 3. Foci and interventions are not consistently written as indicated by facility requirements and integrated into the WRP. Finally, this monitor reviewed the records of 41 individuals with completed Nutrition Care assessments (AMG, BA, CC-1, CJG, CJS, COP, CP, CWS, DC, DDM, DFJ, DH, DLC, DS, DSC, FM, GAB, GAW, GM, HWB, JJJ, JJT, JLB, JS, JTM, JV, KB, KED, LH, LNC, MAD, MJM, MS, PAA, PK, RAG, RJWW, RLA, SR, TJC and VAO) assess compliance with the requirements of C.2.e.

		Twenty-three records (AMG, BA, CJG, COP, CP, CWS, DH, DSC, FM, GAB, HWB, JJJ, JJT, JLB, JS, JTM, JV, LNC, PAA, PK, RJWW, RLA and TJC) were found to be in partial compliance and 18 records (CC-1, CJS, DC, DDM, DFJ, DLC, DS, GAW, GM, KB, KED, LH, MAD, MJM, MS, RAG, SR and VAO) were found to be not in compliance with having an adequate focus, objective and intervention integrated into the WRP. Identified patterns of deficiencies that the facility should focus on in order to improve compliance include the following: 1. WRP Nutrition objectives are not consistently specific, behavioral, observable and measurable. 2. WRP Nutrition foci, objectives and interventions are not consistently aligned and written in accordance with facility requirements. **Compliance:** Partial. **Current recommendations**: 1. Monitor this requirement using the DMH Chart Auditing Form, based on at least a 20% sample. 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).
C.2.f	Therapeutic and rehabilitation service planning is driven by individualized needs, is strengths-based (i.e., builds on an individual's current strengths), addresses the individual's motivation for engaging in wellness activities, and leads to improvement in the individual's mental health, health and well being, consistent with generally accepted professional standards of care. Specifically, the interdisciplinary team shall:	Please see sub-cells for compliance findings.

C.2.f.i	develop and prioritize reasonable and attainable goals/objectives (e.g., at the level of each individual's functioning) that build on the 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:** **Recommendations 1, 2 and 3, April 2008:** • Monitor this requirement 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). • Implement corrective actions to improve compliance. **Findings:** ASH used the DMH Chart Auditing Form to assess compliance (March to August 2008) with the requirements in C.2.f.i through C.2.f.v. The average sample was 32% of the quarterly and annual WRPs due each month. The following is a summary of the data for this requirement. The data for C.2.f.ii to C.2.f.v are presented in each corresponding cell below, with the sub-indicators identified as necessary. No comparative data were presented due to lack of data for the last review period. The facility's plan of correction consisted of continuations of the actions outlined in C.1.a and C.2.a.

5.	*The team has developed and prioritized reasonable and attainable goals/objectives (e.g. at the level of each individual's functioning) that builds on the individual's strengths and addresses the individual's identified needs and if any identified needs are not addressed, provide a rationale for not addressing the need.*	
5.a	*All objectives for Focus 1, 3, and 5 are linked to the individual's stage of change*	52%
5.b	*The individual's strengths are used in the interventions.*	44%
5.c	*There is documented rationale in the focus area if any focus of hospitalization does not have an objective or an intervention.*	21%

ASH also used the DMH WRP Observation Monitoring Form (March to August 2008) to assess compliance with this requirement. The average sample was 22% of the WRPCs held each month. The following is a summary of the data:

7.	*The treatment plan includes the individual's strengths related to each enrichment, treatment, or rehabilitation objective.*	
7.a	*Strengths are identified and incorporated into the interventions offered.*	52%
7.b	*The strengths are related to each treatment, rehabilitation or enrichment objective.*	50%

Comparative data showed that compliance rates have improved since the last review as follows:

	Previous period	Current period
Mean compliance rate		
7.	8%	46%
Compliance rate in last month of period		
7.	23%	26%
7.a	25%	29%
7.b	23%	36%

Other findings:
This monitor reviewed the charts of six individuals to assess compliance. The review found partial compliance in five (CLC, ECE, EDS, GAJ and SAH) and noncompliance in one (BRC).

Compliance:
Partial.

		Current recommendations: 1. Monitor this requirement based on at least a 20% sample. 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).
C.2.f.ii	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);	**Current findings on previous recommendation:** **Recommendation, April 2008:** Same as in C.2.f.i. **Findings:** ASH used the DMH Chart Auditing Form to assess compliance with this requirement (March to August 2008). The average sample was 32% of the quarterly and annual WRPs due each month. The following is a summary of the compliance data: 6. *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.)* 6.a *There are specific skills training and support groups identified in the interventions that are linked to specific objectives and are provided in the PSR mall.* 63% 6.b *There are specific leisure and recreation groups specified in the interventions that are linked to objective derived to focus 10.* 67% **Other findings:** Chart reviews by this monitor found compliance in five charts (BRC, CLC, ECE, GAJ and SAH) and noncompliance in one (EDS).

		Compliance: Partial. **Current recommendations**: Same as in C.2.f.i.
C.2.f.iii	write the objectives in behavioral, observable, and/or measurable terms;	**Current findings on previous recommendation:** **Recommendation, April 2008:** Same as in C.2.f.i. **Findings:** ASH reported a mean compliance rate of 29% for this requirement. **Other findings:** This monitor found partial compliance in all charts reviewed (BRC, CLC, ECE, EDS, GAJ and SAH). **Compliance:** Partial. **Current recommendations**: Same as in C.2.f.i.
C.2.f.iv	include all objectives from the individual's current stage of change or readiness for rehabilitation, to the maintenance stage for each focus of hospitalization, as clinically appropriate;	**Current findings on previous recommendation:** **Recommendation, April 2008:** Same as in C.2.f.i. **Findings:** ASH reported a mean compliance rate of 55% for this requirement. The plan of correction included the actions outlined in C.2.o.

		Other findings: This monitor found compliance in four charts (CLC, EDS, GAJ and SAH) and partial compliance in two (BRC and ECE). **Compliance:** Partial. **Current recommendations**: Same as in C.2.f.i.
C.2.f.v	ensure that there are interventions that relate to each objective, specifying who will do what, within what time frame, to assist the individual to meet his/her needs as specified in the objective;	**Current findings on previous recommendation:** **Recommendation, April 2008:** Same as in C.2.f.i. **Findings:** ASH reported a mean compliance rate of 14% for this requirement. **Other findings:** This monitor found compliance in three charts (BRC, ECE and SAH) and partial compliance in three (CLC, EDS and GAH). **Compliance:** Partial. **Current recommendations**: Same as in C.2.f.i.
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	**Current findings on previous recommendations:** **Recommendation 1, April 2008:** Monitor hours of active treatment (scheduled and attended).

individual's WRP shall be provided as part of the 20 hours of active treatment per week;

Findings:
ASH's data (March to August 2008) are summarized as follows :

	Scheduled hours (number of individuals by category)	Attended hours (number of individuals by category)
N	1184	1184
Hours:		
0-5	429	792
6-10	391	237
11-15	179	107
16-20	187	49

Comparative data showed that the average numbers of scheduled and of attended hours have increased from the last month of the last period to the last month of this period (8.5 and 4.8 to 10.6 and 6.2, respectively).

Recommendation 2, April 2008:
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:
Since the last review, ASH has implemented the following actions to improve compliance:

1. Recovery Mall Services (RMS) has updated the WRPT Mall Resource Manual to facilitate scheduling and selection of groups.
2. RMS has continued a centralized coordination of MAPP Rosters, Progress Notes and Add/Drop Requests, which has improved the accuracy of reporting of active treatment hours.
3. RMS has assigned a Mall Coordinator to work with administrative leadership to ensure that staff are signing up to facilitate or co-

facilitate at least one Mall hour group. The Mall Coordinator will also serve as a link between RMS and the programs.

4. The Enhancement Plan Performance Improvement (EPPI) team has reviewed data regarding scheduled and attended groups, identified areas of low compliance and reported its findings on a monthly basis to the facility's Quality Council to initiate systemic corrections.
5. The Executive Director has directed all staff to ensure full implementation of this requirement by December 31, 2008.
6. All discipline chiefs have added the required number of PSR Mall hours to their discipline duty statements.

Other findings:
This monitor reviewed the charts of six individuals. The reviews focused on the documentation of active treatment hours listed on the most recent WRP and corresponding MAPP data regarding hours scheduled and attended. The reviews found that the facility has yet to ensure that individuals are scheduled for the required hours and that WRP and MAPP data regarding the scheduled hours are consistent. The following is an outline of the monitor's findings:

Individual	WRP scheduled hours	MAPP scheduled hours	MAPP attended hours
BRC	8	3	9
CLC	15	2	18
ECE	10	8	9
EDS	10	9	1
GAH	18	14	10
SAH	2	2	6

Compliance:
Partial.

		Current recommendations: 1. Monitor hours of active treatment (scheduled and attended). 2. Present data regarding average number of scheduled and of attended hours (previous period and last month of previous period compared to current period and last month of current period). 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 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.	**Current findings on previous recommendations:** **Recommendations 1 and 2, April 2008:** • Monitor this requirement using the Mall Alignment Monitoring Form. • 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 used the DMH Mall Alignment Monitoring Form to assess compliance (March to August 2008). Based on a target population of 20 individuals, the average sample was 17 individuals. The following is a summary of the data: 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.	
1.a	*According to the individual's Mall schedule, the individual is assigned to all the Mall courses listed as active treatment in the WRP.*	37%
1.b	*The reviewed course outlines' content (that) is aligned with the corresponding objectives in the individual's WRP.*	65%

The facility reported a mean compliance rate of 29% for this requirement, compared to a rate of 55% during the last review period. No data were presented for the sub-items during the last review. The facility attributed the decreased compliance to revised monitoring instructions and difficulties with inter-rater reliability for this tool. The facility plans to assign this monitoring to senior clinicians during the next review period.

Recommendation 3, April 2008:
Implement electronic progress note documentation by all Mall and individual therapy providers and ensure integration of data, as needed, into the WRPs.

Findings:
The facility reported that implementation, as part of the WARMMS, is underway.

Recommendation 4, April 2008:
Improve compliance with the completion of Mall progress notes and the integration of information into the WRPs.

		Findings: In August 2008, the Mall Director issued guidelines to the WRPTs and Mall Course Facilitators to ensure the following: 1. WRP and Mall schedules match. 2. Mall Facilitator Notes are printed out as soon as the WRP is finalized. 3. The Mall Course Facilitator submits a progress note during the last week of every month to ensure that a monthly note is written for each individual in group. 4. The WRPT reviews all completed progress notes and integrates information into the WRP, as appropriate. 5. WRPT notifies the Mall Coordinator if the progress note for each intervention listed in WRP has not been received. 6. As of September 2008, the Mall Coordinator reviews each progress note to identify when an individual has "Objective Met" checked. When this occurs, Mall Coordinator sends an e-mail prompt to the WRPT to either remove the individual from the course or update the objective and notify the facilitator immediately. **Other findings:** Chart reviews by this monitor found partial compliance in all cases reviewed (BRC, CLC, ECE, EDS, GAJ and SAH). The current format of the Mall Facilitator Progress Note does not provide the information needed to adequately inform the review and revision of the WRP. The DMH has revised this format, which provided needed correction. The revised format has yet to be implemented. **Compliance:** Partial. **Current recommendations**: 1. Monitor this requirement using the Mall Alignment Monitoring Form.

		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). 3. Implement the revised DMH Mall Facilitator Progress Notes and track the completion of these notes and the integration of information into the WRPs.
C.2.g	Therapeutic and rehabilitation service plans are revised as appropriate to ensure that planning is based on the individual's progress, or lack thereof, as determined by the scheduled monitoring of identified criteria or target variables, consistent with generally accepted professional standards of care. Specifically, the interdisciplinary team shall:	Please see sub-cells for compliance findings.
C.2.g.i	revise the focus of hospitalization, objectives, as needed, to reflect the individual's changing needs and develop new interventions to facilitate attainment of new objectives when old objectives are achieved or when the individual fails to make progress toward achieving these objectives;	**Current findings on previous recommendations:** **Recommendations 1 and 2 April 2008:** • Monitor this requirement using both process observation and chart auditing, 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 used the DMH Observation Monitoring Form (March to August 2008) to assess compliance with this requirement. The average sample was 22% of the WRPCs held each month. This mechanism was used to assess compliance with the requirements of C.2.g.i to C.2.g.iv. The following is a summary of the compliance data regarding this requirement. The facility's data for requirements in C.2.g.ii to C.2.g.iv are presented in each corresponding cell below. The plan of improvement was the same as in C.1.a and C.2.a.

8.	*The team revised the focus of hospitalization, objectives, as needed, to reflect the individual's changing needs and developed 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.*	
8.a	*When an objective has been achieved the team develops a new objective and associated intervention(s) for that focus of hospitalization.*	39%
8.b	*When an individual has not shown progress on an objective for two months the team revises or develops a new objective or a new intervention.*	12%

Comparative data showed mixed changes in compliance rates since the last review as follows:

	Previous period	Current period
Mean compliance rate		
8.	7%	27%
Compliance rate in last month of period		
8.	17%	24%
8.a	21%	48%
8.b	12%	0%

The corrective actions for this requirement also included actions that were outlined in C.2.f.v.iii. In addition, the facility's Master WRP Trainer is developing focused training to address the issue of revising the objectives and interventions to address the changing needs of the individuals.

The facility also used the DMH Clinical Chart Auditing Form to assess compliance (March to August 2008). The average sample was 42% of the

quarterly and annual WRPs due each month. The following is a summary of the compliance data regarding this requirement.

9.	*The team revised the focus of hospitalization, objectives, as needed, to reflect the individual's changing needs and developed 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.*	
9.a	*When an objective has been achieved the team develops a new objective and associated intervention(s) for that focus of hospitalization.*	15%
9.b	*When an individual has not shown progress on an objective for two months the team revises or develops a new objective or a new intervention.*	2%

Comparative data showed modest/mixed changes in compliance rates since the last review as follows:

	Previous period	Current period
Mean compliance rate		
9.	3%	9%
Compliance rate in last month of period		
9.	4%	6%
9.a	3%	9%
9.b	4%	2%

Recommendation 3, April 2008:
Implement corrective actions to ensure consistent implementation of the Mall progress notes and the integration of available notes to ensure timely and appropriate revisions of the WRP.

		Findings: Same as in C.2.f.v.iii. **Other findings:** Reviews by this monitor found noncompliance in four charts (CLC, ECE, EDS and SAH) and compliance in two (BRC and GAJ). Additionally, this monitor reviewed 13 records of individuals receiving direct Speech and Physical Therapy services (AJ, BWB, CDC, DR, ECD, ED, GCJ, JKC, JS, JVW, LPM, MH and MWW) and found that all records contained evidence that treatment objectives and/or treatment modalities were modified as needed. However, these changes were not consistently documented in the WRP. **Compliance:** Partial. **Current recommendations**: 1. Monitor this requirement using both process observation and chart auditing, based on at least a 20% sample. 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).
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:** **Recommendation 1, April 2008:** Implement corrective actions to ensure: a) Review by the WRPTs of the circumstances related to the use of restrictive interventions; and b) Timely and appropriate modification of the WRPs in response to the review.

Findings:
The facility's Clinical Administrator has reportedly initiated a process to improve information input in the Present Status section of the WRP to address this recommendation.

Recommendations 2 and 3, April 2008:
- Monitor this requirement using both process observation and chart auditing, 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 used the DMH Chart Auditing Form to assess compliance (March to August 2008) based on an average sample of 32% of the quarterly and annual WRPs due each month. The mean compliance rate was 26%. No data were presented during the last review.

Using the DMH WRP Observation Monitoring Form, the facility reviewed an average sample of 22% the WRPCs per month. The following is a summary of the compliance data:

9.	*The team revised the focus of hospitalization, objectives, as needed, to reflect the individual's changing needs and developed 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.*	
9.a	*When an objective has been achieved, the team develops a new objective and associated intervention(s) for that focus of hospitalization.*	66%
9.b	*When an individual has not shown progress on an objective for two months, the team revises or*	35%

	develops a new objective or a new intervention.	

Comparative data showed mixed changes in compliance rates since the last review as follows:

	Previous period	Current period
Mean compliance rate		
9.	38%	64%
Compliance rate in last month of period		
9.	55%	62%
9.a	62%	65%
9.b	50%	33%

Recommendation 4, April 2008:
Implement corrective actions to ensure consistent implementation of the Mall Progress Notes and the integration of available notes to ensure timely and appropriate revisions of the WRP.

Findings:
Same as Recommendation 3 in C.2.g.i.

Other findings:
This monitor reviewed the charts of seven individuals who experienced the use of seclusion and/or restraints during this review period (AEJr., DJ, HME, JFL, PT, SAH and SAJ). The review focused on the documentation, in the Present Status section, of the circumstances leading to the use of restrictive intervention, treatment provided to avert the use of the interventions and modifications of treatment to decrease the risk of future occurrences. The review found partial compliance in six charts (AEJr., DJ, HME, JFL, PT and SAH) and noncompliance in one (SAJ).

The main deficiencies involved lack of adequate documentation of the

		following: 1. Circumstances that necessitated the use of restrictive interventions (in specific terms); 2. Treatment provided to avert the use of restrictive intervention (in specific terms); 3. Modification of ongoing treatment to decrease future risk; and 4. Assessment of risk factors in the Present Status section, particularly regarding dangerousness to others. **Compliance:** Partial. **Current recommendations**: 1. Implement corrective actions to ensure: a. Review by the WRPTs of the circumstances related to the use of restrictive interventions; and b. Timely and appropriate modification of the WRPs in response to the review. 2. Monitor this requirement using both process observation and chart auditing, based on at least a 20% sample. 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).
C.2.g.iii	ensure that the review process includes an assessment of progress related to discharge to the most integrated setting appropriate to meet the individuals assessed needs, consistent with his/her legal status; and	**Current findings on previous recommendations:** **Recommendations 1, 2 and 3, April 2008:** • Monitor this requirement using both process observation and chart auditing, 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).

- 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 following is a summary of the facility's compliance data based on process observation:

10.	*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.*	
10.a	*The team reviews all foci that are barriers to discharge.*	62%
10.b	*The team reviews the PSR Mall Facilitator's Monthly Notes for all objectives related to discharge.*	43%

Comparative data showed improvement in compliance rates since the last review as follows:

	Previous period	Current period
Mean compliance rate		
10.	10%	46%
Compliance rate in last month of period		
10.	26%	41%
10.a	55%	60%
10.b	16%	32%

As part of its corrective actions, ASH is in the process of hiring additional Senior Social Workers to mentor and supervise social work practices

		including discharge planning. **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). The review found partial compliance in four charts (CLC, ECE, GAJ and SAH), compliance in one (EDS) and noncompliance in one (BRC). The review found general evidence of improved review of the individual's progress towards each discharge criterion as documented in the Present Status section of the case formulation. However, there continue to be deficiencies that must be corrected to achieve substantial compliance. The main deficiency involves the facility's documentation of some discharge criteria that are generic, not measurable and not sufficiently individualized. **Compliance:** Partial. **Current recommendations**: 1. Monitor this requirement using process observation and the DMH Discharge Planning and Community Integration Form (E.3), based on at least a 20% sample. 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). 3. Develop and implement corrective actions to ensure that discharge criteria are individualized and that the WRPTs document their discussion of progress towards discharge criteria.
C.2.g.iv	base progress reviews and revision recommendations on data collected as specified in the therapeutic and rehabilitation service plan.	**Current findings on previous recommendations:** **Recommendation 1, April 2008:** Same as in C.2.g.i.

Findings:
Same as in C.2.g.i.

Recommendation 2, April 2008:
Same as in C.2.f.viii.

Findings:
Same as in C.2.f.viii.

Other findings:
ASH assessed compliance with this requirement using the DMH Observation Monitoring Form,. The average sample was 22% of the WRPCs in the review month. The following is a summary of the facility's data:

11.	*Progress reviews and revision recommendations are based on data collected as specified in the therapeutic and rehabilitation service plan.*	
11.a	*The team reviews the PSR Mall Facilitator's Monthly Progress Notes for all current objectives and interventions for this individual.*	44%
11.b	*Revisions to the WRP are based on the data provided by the group facilitator or individual therapist in the PSR Mall Facilitator's Monthly Progress Notes, if applicable.*	43%

Comparative data showed mixed changes in compliance rates since the last review as follows:

	Previous period	Current period
Mean compliance rate		
11.	59%	40%

	Previous period	Current period
Compliance rate in last month of period		
11.	16%	37%
11.a	18%	36%
11.b	15%	49%

Reviews by this monitor found partial compliance in four charts (BRC, CLC, EDS and GAJ) and non-compliance in two (ECE and SAH). The main deficiencies were as follows:

1. The Mall notes were not completed and filed in a timely manner;
2. The current format of the Mall notes did not provide information needed to guide the revisions of the WRP.
3. The teams' reviews of the notes and integration and utilization of these reviews to inform revisions of the WRP were inadequate in most cases.

As mentioned earlier, the facility has yet to implement the DMH revised format of the Mall progress notes. If properly implemented, this format provides sufficient information to guide the WRP reviews/revisions.

Compliance:
Partial.

Current recommendations:
1. Monitor this requirement using process observation based on at least a 20% sample.
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).

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.	**Current findings on previous recommendations:** **Recommendation 1, April 2008:** Increase the number of PBS teams as specified in the Enhancement Plan. **Findings:** ASH has had one full PBS team for the better part of this review period. A number of recruitments occurred between July and September 2008 (psychologists, psychiatric technicians, and registered nurse). ASH currently has two full PBS teams and two partial teams. **Recommendation 2, April 2008:** Ensure that all staff implement PBS plans and collect reliable and valid outcome data. **Findings:** This monitor's documentation review (PBS plans, staff training, integrity checklists, outcome data, and graphs) found that ASH had trained staff responsible for implementing the intervention plans and continued to conduct integrity checks to ensure that the intervention plans were implemented appropriately and the data collected were reliable and valid. **Recommendation 3, April 2008:** Provide competency-based training to all staff in PBS procedures, and provide ongoing training and support for PBS team members as needed. **Findings:** This monitor's documentation review (training documentation, attendance roster, and ASH's progress report) found that ASH had provided training to its PBS team members (July 16, 17, and 30, 2008) in all of the areas involving the development and implementation of PBS plans.

		Recommendation 4, April 2008: Develop behavioral guidelines for any individual who has severe maladaptive behaviors. **Findings:** ASH has significantly increased the number of behavior guidelines developed and implemented during this review period (over 150 behavior guidelines). However, a number of individuals with severe maladaptive behaviors (including many on the trigger list) have not been assessed for behavioral interventions. The Chief of Psychology and the Psychology Specialty Services Coordinator indicated that staffing shortage was one of the barriers to address all individuals with severe maladaptive behaviors. This monitor reviewed a number of behavior guidelines (for example, AB, BB, CC, CD, DB, HE, JB, MB, MD, MG and SB). The overall quality of the behavior guidelines has improved. Further improvement can be made with attention given to prioritizing target behaviors, operationally defining the selected target behaviors, stating triggers that the staff can use to intervene before the target behavior is fully displayed, expressing prevention strategies in a form that explains what persons responsible should be doing, and most importantly looking to naturally occurring events/activities in which the individual can participate to reduce/eliminate the maladaptive target behavior(s) or increase the replacement behavior(s). For example, if aggression is a target behavior, check to see if the individual is enrolled in a social skills/anger management/mindfulness groups and energy-expending supplemental activities. **Recommendation 5, April 2008:** Ensure that WRPT members understand when they should refer individuals to the PBS team. **Findings:** This monitor's interview of the WRPT members and ASH's training

		documentation showed that WRPT members understand when they should refer individuals to the PBS teams. The Chief of Psychology and the Psychology Specialty Service Coordinator (PSSC) indicated that PBS team members participate in WRPCs to continue to provide support to WRPTs in making referrals and on documenting PBS plans in the Present Status section of the individuals' WRPs. **Compliance:** Partial. **Current recommendations**: 1. Increase the number of PBS teams as specified in the Enhancement Plan. 2. Continue to implement PBS plans and collect reliable and valid outcome data. 3. Continue to provide competency-based training to all staff in PBS procedures, and provide ongoing training and support for PBS team members as needed. 4. Develop behavioral guidelines for any individual who has severe maladaptive behaviors.
C.2.i	Adequate active psychosocial rehabilitation is provided, consistent with generally accepted professional standards of care, that:	**Compliance:** Partial.
C.2.i.i	is based on the individual's assessed needs and is directed toward increasing the individual's ability to engage in more independent life functions;	**Current findings on previous recommendations:** **Recommendation 1, April 2008:** The WRPT should integrate relevant information from discipline-specific assessments and prioritize the individual's assessed needs. **Findings:** This monitor reviewed six charts (AB, CC, CLC, JC, OC and TB). The WRPs

		in the six charts had integrated the relevant information from the discipline-specific assessments into the individuals' WRPs. **Recommendation 2, April 2008:** Ensure that group leaders are consistent and enduring for specific groups. **Findings:** This monitor's interview of the Mall Director, Matt Hennessy, found that ASH has hired Mall Coordinators and Assistant Mall Coordinators. ASH is short of two more Coordinators to cover all programs. The Mall Coordinators meet with Program Managers to review group provider coverage. The Mall Coordinators monitor Mall groups (one Mall block randomly selected daily) to ensure that groups are held as scheduled and that the assigned facilitators are present in the group. The Mall Coordinator's findings are shared with the Program Managers and the Mall Director for any necessary corrective action. This monitor observed a number of Mall groups (Wellness and Recovery Action Plan, Computer Class, "Ready, Set, Go", Community Living Skills Project, Substance Abuse Recovery, Substance Abuse Recovery 2, Non-violent Communication, and Cognitive Remediation). These groups were attended by their regular facilitators and co-facilitators. In addition, the MAPP report showed that these facilitators had been consistent and enduring with the groups. **Recommendations 3and 4 April 2008:** • Provide Motivational Interviewing, Narrative Restructuring Therapy and other cognitive behavioral interventions to individuals who refuse to attend groups as specified in their WRPs. • Track and monitor this objective. **Findings:** This monitor's interview with the Mall Director and ASH's progress report

showed that ASH had tracked and monitored participation of individuals in their assigned Mall groups. The table below showing the census (N) for the month (March to August 2008) and the number of individuals non-adherent to 80% of the Mall group participation (n) is a summary of the facility's data.

	Mar	Apr	May	Jun	Jul	Aug	Mean
N	1120	1129	1145	1152	1166	1151	1144
n	1056	1113	851	880	889	870	943

ASH has three staff trained in Narrative Restructuring Therapy (NRT). The training was conducted by Drs. Judy Singh and Robert Wahler on June 13, 2008. According to the Mall Director, ASH started its NRT services in February 2008. NRT services had been offered to nine individuals twice weekly. ASH's NRT outcome data showed that three of the nine individuals had improved significantly to require services only once a week.

In addition to providing Narrative Restructuring Therapy to the individuals who fail to attend their assigned groups regularly, ASH also offers the "Sponsors" and the "Ready, Set, Go" groups for individuals who refuse to attend their groups, including those who are not sufficiently psychiatrically stable to be out of their units and to participate in some type of activity.

Other findings:
This monitor reviewed the records of 31 individuals receiving Rehabilitation Therapy Services (including Rehabilitation Therapist facilitated PSR Mall groups and direct Occupational and Physical therapy treatment) (AAA, AAM, AJ, ALS, AMB, AML, BJS, BWB, DKH, DR, EAM, ECD, ED, GAS, GCJ, HCG, JJC, JKC, JS, JSC, JT, JVW, KET, LJC, LPM, MH, MLF, MWW, RCR, SM and SSM) and found that all records were in compliance with the requirements of C.2.i.i.

		Current recommendations: 1. The WRPT should integrate relevant information from discipline-specific assessments and prioritize the individual's assessed needs. 2. Ensure that group leaders are consistent and enduring for specific groups. 3. Provide Motivational Interviewing, Narrative Restructuring Therapy and other cognitive behavioral interventions to individuals who refuse to attend groups as specified in their WRPs. 4. Track and monitor this objective.
C.2.i.ii	Has documented objectives, measurable outcomes, and standardized methodology	**Current findings on previous recommendations:** **Recommendations 1 and 2, April 2008:** • Ensure that the objectives are written in behavioral, observable and/or measurable terms, as specified in the DMH WRP Manual. • Ensure that the learning outcomes are stated in measurable terms. **Findings:** Using item 7 (*Does the WRP plan include behavioral, observable, and measurable objectives written in terms of what the individual will do?*) from the DMH WRP Chart Audit Form, ASH analyzed its compliance based on an average sample of 32% of WRPs due for the month (February to July 2008), reporting a mean compliance rate of 29%. The compliance rate for the last month of this review period is 21%. This monitor reviewed eight charts (AG, CLC, DJ, GKP, KAT, MAP, RLY and SMB). Four of the WRPs in the charts (AG, CLC, DJ and RLY) contained objectives written in a measurable/observable manner and the remaining four (GKP, KAT, MAP, and SMB) did not have one or more of the objectives written in a measurable/observable manner. WRPTs should write objectives in observable terms and use appropriate means of measuring them. Too many of the objectives in the WRPs used the same measurement methods across objectives and across foci (for example, AEB

		report to the Mall provider, and AEB documentation in the Mall progress notes). **Recommendation 3, April 2008:** Ensure that each objective is directly linked to a relevant focus of hospitalization. **Findings:** This monitor's interview of the Mall Director found that ASH has trained WRPT members on addressing the foci and objectives following MSH's module. Eighty-eight percent of psychiatrists, 75% of psychologists, 82% of social workers, 90% of rehabilitation therapists, 35% of registered nurses and 26% of psychiatric technicians had undergone the training. This monitor reviewed eight charts (AG, GKP, JC, KAT, MAP, RG, RLY and SMB). The objectives in four of the WRPs in the charts (AG, GKP, JC and RG) were directly linked to a relevant focus of hospitalization and four of them were not directly linked to a relevant focus (KAT, MAP, RLY and SMB). According to the Mall Director and the Clinical Administrator, ASH has put in place a number of guidelines to improve the areas of low compliance. For example, WRP mentors are to work with WRPTs in areas of low compliance, and Program Managers are to identify performance issues and to indicate actions taken to improve the compliance. In addition, the WRP Master Trainer, the auditors, and the C.1 and C.2 team leaders are to meet twice monthly to review data and identify areas of low compliance. Data analysis is to be reported to WRP EPPI Team for further review and action to correct the deficits. This is ASH's plan to bring C.2 in compliance with EP. **Current recommendations**: 1. Ensure that the objectives are written in behavioral, observable

<table>
<tr><td></td><td></td><td>and/or measurable terms, as specified in the DMH WRP Manual.
2. Ensure that each objective is directly linked to a relevant focus of hospitalization.</td></tr>
<tr><td>C.2.i.iii</td><td>Is aligned with the individual's objectives that are identified in the individual's Wellness and Recovery Plan</td><td>

Current findings on previous recommendations:

Recommendation 1, April 2008:
Ensure that all therapies and rehabilitation services provided in the Malls are aligned with the assessed needs of the individuals.

Findings:
Using item 4 from the DMH Mall Alignment Monitoring Form, ASH assessed its compliance based on observation of an average sample of 2% of the individuals at ASH for the month (March to August 2008). The table below with its indicators and sub-indicators and corresponding mean compliance is a summary of the data:

<table>
<tr><td>4.</td><td>Is aligned with the individual's objectives that are identified in the individual's wellness and recovery plan.</td><td>62%</td></tr>
<tr><td>4.a</td><td>The individual is assigned to attend the course according to the Mall schedule.</td><td>80%</td></tr>
<tr><td>4.b</td><td>Based on observation the group addresses the individual's objective.</td><td>64%</td></tr>
</table>

The mean compliance rate was 41% for the previous review period and 62% for the current review period. The compliance rate was 32% in the last month of the previous review period was 32% and 54% in the last month of this review period.

This monitor reviewed seven charts (AB, DJ, GKP, KAT, MAP, ME and SMB). The services documented for four individuals in their WRPs (DJ, MAP, ME and SMB) were aligned with the individuals' assessed needs; the

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

remaining three (AB, GKP and KAT) did not meet the criteria.

Recommendation 2, April 2008:
Group leaders should be held accountable for following the Mall curricula.

Findings:
This monitor's interview of the Mall Director and documentation review (Mall course outlines and the Mall Facilitator Checklist) found that ASH assigned Mentors to each WRPT and distributed Mall Resource Binders to all teams. Senior clinicians audit facilitator competency using the Mall Facilitator Checklist. The Mall management staff also use the Mall Alignment Monitoring tool to evaluate the individual's needs and group assignments.

Using items 1 to 4 from the WRP Mall Facilitator Audit, ASH assessed its compliance based on an average sample of 8% of the clinical facilitators (RTs, psychologists, and social workers) managing groups for the month (March to August 2008). The table below with its indicators and corresponding mean compliance rates is a summary of the data:

1.	*Instructional skills*	56%
2.	*Course structure*	42%
3.	*Instructional techniques*	100%
4.	*Learning process*	60%

This monitor observed a number of PSR Mall groups (Wellness and Recovery Action Plan, Computer Class, "Ready, Set, Go", Community Living Skills Project, Substance Abuse Recovery, Substance Abuse Recovery 2, Non-violent Communication, and Trauma and Anxiety). All groups had curriculums. The providers used lesson plans and all providers were familiar with the lesson plans/materials. All groups were well organized and the individuals were attentive. Presentations were clear and orderly. A number of providers should work on increasing participation of the

		individuals instead of having them listen for too long. Engaging the individuals frequently keeps them focused and increases the opportunity to test their understanding. A number of the providers should also work on using simpler words for technical terms, or provide explanations if the technical term needs to be introduced. **Recommendation 3, April 2008:** Ensure that the Mall director has the necessary staff to assist with Mall programming and management. **Findings:** This monitor's discussion with the Mall Director found that a number of staff were hired since the last review period. The newly filled positions included Assistant Mall Director, seven Mall Coordinators, seven Assistant Mall Coordinators, five Mall Central Campus Staff, and four Office Technicians-MAPP Data Entry and coordination staff. There still is a need for additional two Assistant Mall Coordinators, and one Mall Central Campus staff vacancy. According to the Mall Director, ASH is in the process of filling in the remaining vacancies. **Current recommendations**: 1. Ensure that all therapies and rehabilitation services provided in the Malls are aligned with the assessed needs of the individuals. 2. Group leaders should be held accountable for following the Mall curricula. 3. Ensure that the Mall director has the necessary staff to assist with Mall programming and management.
C.2.i.iv	utilizes the individual's strengths, preferences, and interests;	**Current findings on previous recommendations:** **Recommendations 1 and 2, April 2008:** • Ensure that the individual's strengths, preferences, and interests are clearly specified in the interventions in the individual's WRP in

accordance with the DMH WRP manual.

- Ensure that the group facilitators and individual therapists know and use the individual's strengths, preferences and interests when delivering rehabilitation services.

Findings:
This monitor's discussion with the Mall Director found that Mall facilitators get to know the strengths of individuals in their groups through the progress note template. According to the Mall Director, the WRPTs print the strengths on the progress notes for use by the Mall facilitators.

Using item 5 from the DMH Mall Alignment Monitoring Form, ASH assessed its compliance based on observation of an average sample of 2% of the Mall groups each the month (March to August 2008). The table below with its indicators and sub-indicators and corresponding mean compliance rates is a summary of the data:

5.	*Utilizes the individual's strengths, preferences and interests.*	28%
5.a	*A strength/preference/interest was identified in the individual's WRP to be used by the facilitator during that intervention and the facilitator utilized the individual's strength/preference/ interest.*	47%
5.b	*The group facilitator correctly identifies at least one of the individual's strengths, preferences, and/or interests as noted in the individual's WRP and the facilitator can state how and when the last time it was used in group.*	32%

The mean compliance rate was 31% for the previous review period and 28% for the current review period. The compliance rate was 26% in the last

		month of the previous period and 29% in the last month of the current review period. This monitor reviewed seven charts (AB, AG, GF, JD, ME, RG and SG). Only one of the WRPs in the charts (RG) had specified the strengths of the individual in all active interventions reviewed. The remaining six WRPs either failed to include strengths in all the active interventions reviewed, or the stated strength was not in accordance with the DMH WRP manual. Many of the WRPs continue to use generic statements as strengths (for example, "the individual's desire to leave the facility") and were not individualized. This monitor's observation of the Mall groups and conversation with a number of the group facilitators found that the facilitators in the unit Mall sessions were familiar with the individuals' strengths and preferences. This is the case because the facilitators are team members of the individuals' WRPTs. However, this is not the case with many of the facilitators in the Central Mall sessions who are not familiar with the individuals. **Current recommendations**: 1. Ensure that the individual's strengths, preferences, and interests are clearly specified in the interventions in the individual's WRP in accordance with the DMH WRP manual. 2. Ensure that the group facilitators and individual therapists know and use the individual's strengths, preferences and interests when delivering rehabilitation services.
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:** **Recommendation 1, April 2008:** Undertake clinical case formulation as a team rather than by assigning the task to a team member or to non-team members.

		Findings: ASH did not provide audit data for this recommendation. This monitor's observation of the WRPCs for DJM and VL found that the teams functioned in an interdisciplinary fashion. The core team members presented their findings relative to their areas of practice, the issues presented were thoroughly discussed, appropriate decisions were made and appropriate actions taken (for example documentation in the tracking sheet, changing the individual's GAF score, or modifying the interventions). **Recommendations 2 and 3, April 2008:** • Include the individual's vulnerabilities in the case formulation under predisposing, precipitating, and perpetuating factors. • Update the present status to reflect the current status of these vulnerabilities. **Findings:** ASH did not provide audit data for these recommendations. The mean compliance rate for the previous review period was 51%. This monitor reviewed seven charts (AB, AG, DJ, GF, JD, OC and SG). Six of the WRPs in the charts (AB, AG, DJ, GF, JD and SG) included the individual's vulnerabilities to mental illness, substance abuse, and readmission due to relapse in the case formulation sections, and where applicable updated the vulnerabilities in the Present Status section of the individual's WRP. One of them (OC) did not contain this documentation. **Recommendation 4, April 2008:** Provide groups regarding the purpose of Wellness and Recovery Action Plan to all individuals in order to preempt relapse.

		Findings: This monitor's discussion with the Mall Director found that ASH has increased the number of WRAP groups offered. There is opportunity for all individuals to participate in the WRAP groups. This monitor observed a WRAP Mall group in session. The group had lesson plans and work sheets, and the group was well-organized and actively facilitated by the provider. **Current recommendations**: 1. Undertake clinical case formulation as a team rather than by assigning the task to a team member or to non-team members. 2. Include the individual's vulnerabilities in the case formulation under predisposing, precipitating, and perpetuating factors. 3. Update the present status to reflect the current status of these vulnerabilities. 4. Provide groups regarding the purpose of Wellness and Recovery Action Plan to all individuals in order to preempt relapse.
C.2.i.vi	is provided in a manner consistent with each individual's cognitive strengths and limitations;	**Current findings on previous recommendations:** **Recommendation 1, April 2008:** PSR mall groups should address the assessed cognitive levels of the individuals participating in the group. **Findings:** This monitor's interview with the Mall Director and the Chief of Psychology found that the WRPTs have access to the Mall Resource Binders and WaRMSS Course Outlines. Furthermore, the Mall Director has distributed to the WRPTs a chart listing the Mall courses appropriate for individuals with cognitive challenges and disabilities. However, the system still faces a number of barriers to fully meeting this recommendation, including the failure of the WRPTs to refer individuals for additional testing when warranted, the failure to align the individual's needs with the appropriate interventions, the failure of the WRPTs to communicate with the Mall

		services, and the lack of interventions in the Mall services for individuals with varying degrees of cognitive functioning. The Mall Director is working to expand the available interventions available for services. The Senior Mentors are to work with the WRPTs to address the barriers outlined above. This monitor observed a number of Mall groups. All Mall groups were structured and organized. The facilitators were prepared and used appropriate methods of instruction in accordance with the lesson plan and activities. However, the facilitator's language in a number of groups was not within the cognitive/comprehension levels of the individuals. This was obvious when the individuals asked for the meaning of words from their peers or the facilitator. ASH has established a number of groups specifically targeting individuals with cognitive challenges, for example the "Ready, Set, Go", Anger Management, Medication Education, Mental Health Awareness, and WRAP groups. ASH has also established a Cognitive Remediation Group (titled "Attention, Tracking and Concentration") and this group is facilitated by neuropsychologists. ASH has established a number of Mall groups in Spanish and is working to establish groups in other languages according to needs (for example in Vietnamese). **Recommendation 2, April 2008:** 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. **Findings:** This monitor's interview with the Chief of Psychology found that ASH continues to screen cognitive levels of all individuals upon admission through the Integrated Assessments: Psychology Section. The screening includes an intellectual functioning screen, reading and cognitive

functioning. The individual is given a full intellectual assessment battery if the screening results in a score below 85. Individuals with cognitive disorders are referred for a neuropsychological assessment.

Using item 7 from the DMH Mall Alignment Monitoring Form, ASH assessed its compliance based on an average sample of 2% of the individuals at ASH (March to August 2008). The table below with its indicators and sub-indicators and corresponding mean compliance is a summary of the data:

7.	*Is provided in a manner consistent with each individual's cognitive strengths and limitations.*	38%
7.a	*The course outlines for the WRP assigned Mall courses are noted as being appropriate for the individual given his cognitive level.*	45%
7.b	*The Mall course facilitator interviewed could state the individual's cognitive strengths and limitations, and at least one method of teaching at that level.*	48%

The mean compliance was 39% in the previous review period and 38% in the current period. The compliance rate was 27% in the last month of the previous review period and 41% in the last month of the current period.

This monitor reviewed five charts (GKP, KAT, MAP, RLY and SMB). Cognitive screening had been conducted on all five individuals as part of the Integrated Assessment: Psychology Section.

ASH has established a Curriculum Committee. The committee is to meet on a monthly basis to identify Mall courses at the supported level for individuals with cognitive challenges.

Current recommendations:

1. PSR Mall groups should address the assessed cognitive levels of the

		individuals participating in the group. 2. Psychologists should assess all individuals suspected of having cognitive disorders, mental retardation and developmental disabilities and other conditions that may adversely impact an individual's cognitive status.
C.2.i.vii	Provides progress reports for review by the Wellness and Recovery Team as part of the Wellness and Recovery Plan review process;	**Current findings on previous recommendations:** **Recommendations 1-3, April 2008:** • 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. • Automate this system to make it feasible for the group facilitators and individual therapists to provide progress notes in a timely manner. • Use the data from monthly Mall Progress Notes in the WRP review process. **Findings:** ASH has implemented the Mall progress notes process across the facility. However, according to the Mall Director, the process did not go smoothly because the facilitators had been confused as to when they should write the notes. This resulted in the Mall Director sending out a memo emphasizing the Mall progress note process, procedures and timing (this monitor reviewed the memo dated July 30, 2008). Since then, facilitators have been writing monthly Mall progress notes but not consistently and not for all groups attended by the individual. This monitor reviewed six charts (AB, CLC, DJ, OC, SG and TB). Five of the charts contained progress notes (AB, CLC, DJ, SG and TB), and one of them (OC) did not. Three of the WRPs in the charts (AB, CLC and TB) had incorporated the information from the progress notes into the Present Status section, and two of them (DJ and SG) did not incorporate the information.

		The progress note system is not automated. The current system involves the Mall coordinators picking up the progress note from the WRPTs (when the note is finalized with the relevant information including the individual's strength/preferences) to send to the facilitators, and to return the facilitator-completed progress notes to the WRPTs. **Other findings:** This monitor also reviewed the records of 31 individuals receiving Rehabilitation Therapy Services (including Rehabilitation Therapist facilitated PSR Mall groups and direct Occupational and Physical therapy treatment) (AAA, AAM, AJ, ALS, AMB, BJS, BWB, CDC, DKH, DR, EAM, ECD, ED, GAS, GCJ, HCG, JJC, JKC, JR, JS, JSC, JT, JVW, KET, LJC, LPM, MH, MWW, RL, SM and SSM) to assess compliance with C.2.i.vii. This monitor found that two records (JKC and KET) were in substantial compliance, sixteen records (AJ, BWB, CDC, DR, ECD, ED, GAS, GCJ, JS, JVW, LJC, LPM, MH, MWW, RL and SSM) were in partial compliance and thirteen records (AAA, AAM, ALS, AMB, BJS, DKH, EAM, HCG, JJC, JR, JSC, JT and SM) were not in compliance with C.2.i.vii. **Current recommendations**: 1. Ensure that all group and individual therapy providers provide the WRPTs with progress reports on all individuals prior to each individual's scheduled WRP review. 2. Automate this system to make it feasible for the group facilitators and individual therapists to provide progress notes in a timely manner. 3. Use the data from monthly Mall Progress Notes in the WRP review process
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	**Current findings on previous recommendations:** **Recommendation 1, April 2008:** Mandate that all staff at ASH, other than those who attend to emergency medical needs of individuals, will provide services at the PSR Mall. This

	state holidays;	includes clinical, administrative and support staff. **Findings:** All staff received (on September 24, 2008) the Executive Director's memo directing them to provide the required Mall hours as facilitators or co-facilitators. The leadership expects the staff to fully meet this requirement by December 30, 2008. In October 2008, the Mall Director had assigned a coordinator to work with the non-clinical staff to sign up as facilitators or co-facilitators for a minimum of one hour per week. According to the Mall Director, all discipline chiefs have added to their discipline duty statements the required hours of PSR Mall hours. The Clinical Administrator stated that he held a special meeting (August 14, 2008) with the Program Directors, Program Assistants, and Discipline Chiefs to direct their staff to provide their required hours of Mall services. **Recommendation 2, April 2008:** All Mall sessions should be 50 minutes in length. **Findings:** ASH did not provide audit data for this recommendation. This monitor's review of the PSR Mall Audit data (for the week of October 6, and the week of October13, 2008) showed that 75% of the groups started on time. This monitor observed a number of Mall groups. All the groups observed at the beginning of the Mall hour started on time, and all the groups observed towards the end of the Mall hour ended at the 50-minute mark. The Mall progress notes reviewed by this monitor (AB, CLC, DJ, SG and TB) had documentation indicating that the Mall groups were conducted for 50 minutes. The monitor's review of a few BY CHOICE cards had marked off the individuals as participating for 50 minutes.

		Recommendation 3, April 2008: Provide groups as needed by the individuals and written in the individuals' WRPs. **Findings:** ASH has developed a number of new Mall groups in response to the individuals' needs and WRPT requests. This monitor's documentation review (Mall courses) found that ASH opened up 27 new groups, including courses in Spanish, since the last review period. The Mall facilitator received 26 requests for new Mall groups/individual interventions during this review period. The Mall Director has fulfilled a number of the requests, and continues to work on getting the remaining requests fulfilled (for example, a request for sex offender treatment). According to the Mall Director, ASH has added over 150 hours of Mall groups in the past 30 days. ASH has also opened up a new Central Mall Campus in the NAC area. **Current recommendations**: 1. All Mall sessions should be 50 minutes in length. 2. Provide groups as needed by the individuals and written in the individuals' WRPs.
C.2.i.ix	is provided to individuals in bed-bound status in a manner and for a period that is commensurate with their medical status;	**Current findings on previous recommendations:** **Recommendations 1 and 2, April 2008:** • 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. • Therapy can be provided in any physical location within the hospital as long as the services are structured and consistent with scheduled Mall activities.

		Findings: This monitor's discussion with the Mall Director found that ASH did not have any bed-bound individuals during this review period. **Current recommendations**: 1. Ensure that bed-bound individuals are included in the planning and implementation of appropriate activities commensurate with their cognitive status and medical health, and physical limitations. 2. Therapy can be provided in any physical location within the hospital as long as the services are structured and consistent with scheduled Mall activities.
C.2.i.x	routinely takes place as scheduled;	**Current findings on previous recommendations:** **Recommendation 1, April 2008:** Implement a more focused Mall program that is regularly scheduled, implemented, and provided within the individual's cognitive, medical, physical and functional status. **Findings:** This monitor's documentation review (Mall courses by Foci, Mall hours cancelled, and enduring Mall hours by facilitators) and discussion with the Mall Director found that ASH has hired a Mall Coordinator and Assistant Mall Coordinators for each program. The Mall Coordinator attends the daily group coverage meeting and assists with coverage for the various groups when the regular facilitators are not available (for example, when facilitators are ill or are on vacation), keeps track of groups that are combined, informs Program Managers and Mall Director when groups are not conducted as scheduled, as well as audits fidelity of group facilitation. The Mall Director has developed Mall courses around all 11 Foci, ensuring that groups are developed to address the individuals' medical, physical, cognitive, functional, recreational, and community integration needs. There

are eight Mall groups specifically for the cognitively challenged ("Ready, Set, GO", Language and Cognitive Services, Supported Transitional Education Program, Community Living Skills Program Functional Life Skills, Academic Classes, "Attention, Concentration, and Tracking", Cleaning and Watering Crew and Star Track [Substance Abuse]).

Recommendation 2, April 2008:
Ensure that Mall groups and individual therapies are cancelled rarely, if ever.

Findings:
ASH audited the number of Mall groups cancelled per month (March to August 2008). The table below showing the number of Mall groups scheduled per month (N), the number of Mall groups cancelled per month (n), and the percent cancelled per month (%C) is a summary of the facility's data.

2008	Mar	Apr	May	Jun	Jul	Aug	Mean
N	5172	3825	4979	4553	4878	5549	4826
n	329	265	294	265	257	257	278
%C	6	7	6	6	5	5	6

As shown in the table above, the mean percent cancellation for this review period is 6%, compared to 11% in the previous review period.

Recommendations 3 and 4, April 2008:
- 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:
This monitor's discussion with the Mall Director on the status of staff

facilitation hours in Mall groups revealed that both clinical and administrative staff were not providing the required number of treatment hours. According to the Mall Director, on August 14, 2008, the Clinical Administrator had convened a meeting with the Program Managers and Discipline Chiefs. The Clinical Administrator shared the data with them and requested that their staff be directed to meet the required hours of Mall service. The Executive Director also had sent a memorandum addressing the same issue.

This monitor reviewed the Mall hours provided by the clinical staff. The table below shows the summary of the findings:

Discipline	Mean Mall hours scheduled per week as a percentage of required Mall hours
Clinical SW	77%
RT	51%
Psychiatry	41%
PMHNP	40%
Psychology	38%

As seen in the table above, none of the disciplines are close to meeting their required hours of service. A review of individual staff within discipline also showed the same low compliance.

Current recommendations:

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

		hours of Mall groups. 4. Ensure that administrators and support staff facilitate a minimum of one Mall group per week.
C.2.i.xi	includes, in the evenings and weekends, additional activities that enhance the individual's quality of life; and	**Current findings on previous recommendations:** **Recommendations 1-3, April 2008:** • 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. • Increase the number of hours of enrichment activities per individual provided in the evenings and weekends. • Ensure that there is uniformity in the methodology and process of how the groups are organized and managed. **Findings:** This monitor's discussion with ASH's Supplemental Activity Coordinator, Brooke Hatcher and documentation review (Activity List) found that the enrichment/supplemental activities offered at ASH have increased in number of hours offered, both on the weekdays and the weekends. For example, some units offered as many as 30 hours of activities per month in October 2008, whereas the highest number for April of 2008 was 21 hours a month. However, the mean hours of activities offered is still low (less than an hour a day) and should be increased, especially on the weekends. The activities offered are wide-ranging and span a variety of categories (Social Group, Recreation Indoor, Recreation Outdoor, Exercise, Creative and Expressive, Education, Leadership Skills, Religious/Spiritual, and Support Group). The activities are organized and conducted at the unit level. The methodology and process are not uniform. **Current recommendations**: 1. Develop a list of enrichment activities available along with staff names competent in facilitating the activities in accordance with generally

		accepted professional standards of care. 2. Increase the number of hours of enrichment activities per individual provided in the evenings and weekends. 3. Ensure that there is uniformity in the methodology and process of how the groups are organized and managed.
C.2.i.xii	is consistently reinforced by staff on the therapeutic milieu, including living units.	**Current findings on previous recommendations:** **Recommendation 1, April 2008:** All WRPs should have therapeutic milieu interventions clearly specified in the intervention sections. **Findings:** ASH did not provide audit data for this recommendation. According to the Clinical Administrator and the Mall Director, staff has received training following the Metro Module—Interventions and Mall Integration. In addition, the Master Trainer has also provided information regarding milieu interventions to unit staff via the facility's Newsletter ("Same Page") and the Mentor Hotline. This monitor reviewed nine charts (AG, CLC, GS, JC, JD, ME, RG, SG and TB). Five of the WRPs in the charts (AG, CLC, GS, RG and TB) had developed therapeutic milieu interventions for each active objective, and the remaining four (JC, JD, ME and SG,) did not have therapeutic milieu interventions for one or more active objectives. **Recommendation 2, April 2008:** Ensure that unit staff reinforces individuals appropriately during Mall group activities as well as in the units. **Findings:** This monitor learned from the Mall Director that ASH has assigned a team

		to train and mentor unit staff on developing therapeutic milieu programs. ASH has also assigned Unit Supervisors to conduct audits for this recommendation. Using item 12 from the Therapeutic Milieu Observation Monitoring Form, ASH assessed its compliance based on an average sample of 41 audits per month (March to August 2008), reporting a mean compliance rate of 30%. The mean compliance rate for the previous review period was 25%. This monitor observed a number of Mall groups. The facilitators engaged the individuals and reinforced them frequently and appropriately. **Current recommendations**: 1. All WRPs should have therapeutic milieu interventions clearly specified in the intervention sections. 2. Ensure that unit staff reinforces individuals appropriately during Mall group activities as well as in the units.
C.2.j	Adequate, individualized group exercise and recreational options are provided, consistent with generally accepted professional standards of care.	**Current findings on previous recommendations:** **Recommendations 1 and 2, April 2008:** • Establish group exercises and recreational activities for all individuals. • Ensure that there is sufficient activity programming to keep individuals active and engaged. **Findings:** This monitor's discussions with the Clinical Administrator, the Supplemental Activity Coordinator and the Mall Director as well as documentation review (Activity List, Activity Schedule/Calendar) found that ASH has the EPPI Team review data on the Fitness Groups and BMI Triggers Report on a monthly basis. Action is taken to ensure that individuals in need of exercise are promptly enrolled in appropriate activities. On July 28, 2008, the Mall Director attended the Program

		Directors' meeting to discuss issues surrounding exercise/recreational activities for individuals with high BMIs. A review of the list of exercise groups offered has increased from 89 during the previous review period to 284 during this review period. A review of the activity schedule found that the exercise/recreational activities were offered across the day on weekdays and weekends. ASH has also sponsored an "Open Gym" group sessions in which individuals choose to participate in a variety of exercises/activities. This should enable all individuals to find a time slot in which to participate. This monitor reviewed nine charts (AB, AG, CLC, GF, JC, JD, RG, SG and TB). All nine WRPs in the charts had open foci and/or interventions for exercise/recreational activities. Many of these individuals had medical issues (for example, high BMIs, asthma, diabetes, and hyperglycemia) and would benefit from regular exercise and recreational activities. **Recommendation 3, April 2008:** Provide training to Mall facilitators to conduct the activities appropriately. **Findings:** ASH continues to provide training for the instructors/facilitators on a monthly basis during the New Employee Orientation. **Recommendation 4, April 2008:** Track and review participation of individuals in scheduled group exercise and recreational activities. **Findings:** ASH is waiting to incorporate the exercise/recreational and supplemental activity attendance data in the WaRMSS system in order to track attendance.

The tables below showing the BMI categories, the number of individuals within each category, and the number of individuals enrolled in exercise groups, along with the corresponding compliance rate, is a summary of the facility's data:

BMI Range	Number of individuals	Number in exercise groups	%C
25 - 30	304	253	83%
31 - 35	215	179	83%
36 - 40	72	59	82%
>40	28	23	82%

WRPTs should pay attention to the needs of these individuals and assign all individuals with high BMIs to one or more exercise groups.

The table below shows an accounting of the number of exercise groups offered each month (March to August 2008) for individuals with high BMIs at ASH, and the number of groups needed to ensure that all the assigned to the group can participate:

Exercise Groups Offered vs. Needed						
	Mar	Apr	May	Jun	Jul	Aug
# groups offered	89	210	268	244	242	284
# groups needed	36	176	149	247	230	225
%C	247	119	180	99	105	126

As seen in the table above, ASH has typically offered a more-than-adequate number of exercise groups to enable all individuals needing the groups to participate.

Compliance:
Partial.

		Current recommendations: 1. Ensure that there is sufficient activity programming to keep individuals active and engaged. 2. Provide training to Mall facilitators to conduct the activities appropriately. 3. Track and review participation of individuals in scheduled group exercise and recreational activities.
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:** **Recommendations 1 and 2, April 2008:** • Continue with the Family Therapy Needs Assessment Survey. • Ensure that family therapy needs are fulfilled. **Findings:** This monitor's discussion with the Chief of Social Work found that ASH formed a Family Therapy/Education EPPI Team led by the Chief of Social Work, two other Social Work staff, a Standards Compliance representative and an Assistant to the Clinical Administrator. This team will address issues regarding family therapy needs. ASH is also hiring a Family Services Social Worker (FSSW). The FSSW is to track and monitor compliance with this recommendation and to provide family education and support. ASH is using the newly approved (August 2008) DMH monitoring tool to conduct the family therapy needs survey. A review of ASH's list of individuals with assessed need for Family Therapy found there were 109 individuals with family therapy needs. According to the Chief of Social Work, ASH has secured signed consent from 36 families for provision of family therapy education and support. **Compliance:** Partial.

<table>
<tr><td></td><td></td><td>Current recommendations:
1. Continue with the Family Therapy Needs Assessment Survey.
2. Ensure that family therapy needs are fulfilled.</td></tr>
<tr><td>C.2.l</td><td>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.</td><td>Current findings on previous recommendations:

Recommendations 1 and 2, April 2008:
• Implement the statewide monitoring tool to track the elements of this requirement.
• Provide data addressing this requirement.

Findings:
ASH implemented the DMH Integration of Medical Conditions in WRP Audit in June 2008. The facility reported data from the audit based on an average sample of 31% of individuals with at least one diagnosis listed on Axis III that have a WRP due each month (June-August 2008). The table below summarizes ASH's data:

<table>
<tr><td>1.</td><td>All medical conditions listed in Axis III are included on the Medical Conditions Form</td><td>53%</td></tr>
<tr><td>2.</td><td>The WRP includes each medical condition listed on the Medical Conditions Form 42</td><td>62%</td></tr>
<tr><td>3.</td><td>There is an appropriate focus statement for each medical condition or diagnosis</td><td>24%</td></tr>
<tr><td>4.</td><td>There is an appropriate objective for each medical condition or diagnosis</td><td>21%</td></tr>
<tr><td>5.</td><td>There are appropriate interventions for each objective</td><td>4%</td></tr>
</table>

ASH's progress report indicated that WRPTs have difficulty creating alignment between the medical condition problems, objectives and interventions. ASH indicated that a barrier to compliance with this requirement included a number of Axis III diagnoses that included</td></tr>
</table>

		"History of" and "Status Post," which do not require active objectives or interventions and have been removed from the lists in August 2008. The facility plans to implement interdisciplinary training sessions to address issues related to this requirement. In addition, Nursing is to address the low compliance for items 2 through 5, but specific strategies were not included in ASH's progress report. A review of the WRPs of 40 individuals (AA, AES, AJT, AKH, AOQ, AP, BCS, BDA, BEM, BM, CDG, CLC, DEA, DJW, DLC, DNF, EJA, FC, GFP, GKP, GLM, GN, GV, HKS, HP, JIJ, JN, JRR, JRW, KM, LDJ, MAF, MD, MVB, NBM, PP, RLP, SK, WMN and WWM) found that there has been basically no improvement in this area from the last review. The problematic areas continue to include inadequate and inappropriate nursing objectives and interventions. In addition, significant information contained in the admission and integrated nursing assessments was not included in the WRPs. **Compliance:** Partial. **Current recommendations**: 1. Provide specific strategies regarding plans of corrections for this requirement. 2. 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 and adolescents.
C.2.m.i	Therapy relating to traumatic family and other traumatic experiences, as clinically indicated; and	

C.2.m.ii	reasonable, clinically appropriate opportunities to involve their families in treatment and treatment decisions.	
C.2.n	Policies and procedures are developed and implemented consistent with generally accepted professional standards of care to ensure appropriate screening for substance abuse, as clinically indicated.	**Current findings on previous recommendation:** **Recommendation, April 2008:** Implement AD 414.1 regarding Screening and Assessment for Substance Abuse Disorders hospital-wide. **Findings:** ASH has implemented this recommendation. The facility reported that all WRPTs have received the required training associated with Substance Abuse Screening and Assessment as stipulated in AD #414.1. **Other findings:** This monitor's findings are the same as in C.2.o. **Compliance:** Partial. **Current recommendation**: 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:** **Recommendation 1, April 2008:** Increase and strengthen training of WRPTs and SAS providers to improve assessment by the teams of the stages of change and the development of corresponding specific and individualized objectives and interventions. **Findings:** Since the last review, ASH has taken the following actions:

1. The Master WRP trainer and representatives of SAS have developed WRP training material that included examples of substance abuse treatment stage of change objectives. The sample objectives were distributed to WRPTs and posted on the ASH Intranet "X" Drive for common access.
2. SAS staff have attended one to two WRPT meetings weekly and reviewed the sample objectives. This has resulted in increased WRPT referrals of individuals to SAS and enrollment by individuals in substance abuse treatment.

Recommendation 2, April 2008:
Provide data regarding clinical outcomes.

Findings:
ASH has implemented this recommendation. The following is a summary of the facility's clinical outcome data. No comparison data were presented due to lack of data during the last review.

Clinical Outcome	April to June 2008	July to September 2008
Individuals enrolled by 1st day of quarter	465	607
% of individuals who advanced at least one stage (based on competency criteria including pre/post tests) or reached the maintenance phase and did not regress to an earlier stage).	54%	52%
% of individuals who refused treatment or regressed at least one stage of change.	16%	7%

% of individuals who remained in same stage of change (excluding maintenance)	18%	21%
Pre/Post Test-Increase Mean	12%	8%

Recommendation 3, April 2008:
Provide data regarding process outcomes in comparison to the last review period.

Findings:
ASH has implemented this recommendation. The following is a summary of the facility's process outcome data. No comparison data were presented due to lack of data during the last review.

Clinical Outcome	April to June 2008	July to September 2008
Individuals with Substance Abuse Dx	817	767
Individuals referred for:	742	693
o SAS treatment	324	303
o AA groups	201	180
o NA groups	217	210
Individuals screened by SAS	306	303
Hours of SAS treatment offered per week	73.5	78.5
SAS sessions scheduled	871	929
%SAS sessions held	100%	100%
Individuals enrolled in SAS treatment	465	607
Individuals enrolled in AA	691	918
Individuals enrolled in NA	738	847
Individuals on wait list	18	42

Hours of staff training provided	0	6
Number of staff trained	0	34
Number of staff monitored for fidelity (re implementation of SAS curriculum)	0	4

In addition, the facility conducted consumer satisfaction surveys regarding SAS. The following is a summary of the data:

Consumer Satisfaction Survey	April to June 2008	July to September 2008
Learned New Skills		
• Agree	82%	91%
• Disagree	18%	9%
Group was helpful		
• Agree	89%	90%
• Disagree	11%	10%
Understood Information		
• Agree	96%	95%
• Disagree	4%	5%
Group Leader Respectful		
• Agree	96%	98%
• Disagree	4%	2%

Recommendation 4, April 2008:
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:
ASH used the DMH Substance Abuse Audit Form to assess compliance (March to August 2008). The average sample was 30% of all individuals with a current diagnosis of substance abuse as listed in the WRP or Integrated Psychiatric Assessment or if admitted before January 2007, the last monthly Psychiatric Progress Note. While the process and clinical outcomes data addressed the functioning of the facility's SAS, these data were focused on the WRPT's approach to the individual's needs in substance abuse treatment. The following is a summary of the data:

1.	*Substance abuse is integrated into the case formulation and discussed in the present status.*	51%
2.	*There is an appropriate Focus statement listed under Focus 5.*	90%
3.	*There is at least one objective related to the individual's stage of change.*	30%
4.	*There are interventions that are appropriately linked to the active objective(s).*	31%
5.	*The active treatment for substance abuse that is specified in the WRP is aligned with the individual's mall schedule.*	48%
6.	*The discharge criteria related to substance abuse are individualized and written in behavioral, observable and/or measurable terms.*	6%

Comparative data showed mixed changes in compliance since the last review as follows:

	Mean compliance rate, previous period	Mean compliance rate, current period
1.	49%	51%
2.	78%	90%
3.	42%	30%

	Mean compliance rate, previous period	Mean compliance rate, current period
4.	21%	31%
5.	43%	48%
6.	14%	6%

Other findings:
In collaboration with PSH, MSH developed a Substance Abuse Treatment Program Plan of Improvement to guide the implementation of SAS in all four facilities. This plan is well-aligned with current generally accepted standards.

This monitor reviewed the charts of six individuals who were diagnosed with substance use disorders. The review found partial compliance in four charts (CLC, ECE, EDS and GAJ) and compliance in two (BRC and SAH). The main deficiency involved the proper formulation of the action stage of change and its linkage to appropriate objectives/interventions.

Compliance:
Partial.

Current recommendations:
1. Present outline of substance abuse training provided to WRPTs and SAS providers during the review period.
2. 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.
3. Provide specific outline of competency criteria that permit advancement of individuals to the next stage of change.
4. Monitor this requirement using the DMH Substance Abuse Auditing

<table>
<tr><td></td><td></td><td>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).
5. Ensure that SAS are aligned with the principles outlined in the Substance Abuse Treatment Program Plan of Improvement.</td></tr>
<tr><td>C.2.p</td><td>Group facilitators and therapists providing therapeutic and rehabilitation services (in groups or individual therapy) are verifiably competent regarding selection and implementation of appropriate approaches and interventions to address therapeutic and rehabilitation services objectives, are verifiably competent in monitoring individuals' responses to therapy and rehabilitation, and receive regular, competent supervision.</td><td>
Current findings on previous recommendations:

Recommendations 1 and 2, April 2008:
• Assess the competency of group facilitators and therapists in providing rehabilitation services.
• 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.

Findings:
ASH provided the following data regarded assessed competency of Mall group facilitators:
<table>
<tr><td></td><td></td><td>Mar</td><td>Apr</td><td>May</td><td>Jun</td><td>Jul</td><td>Aug</td><td>Mean</td></tr>
<tr><td>1.</td><td>Instructional skills</td><td>50</td><td>88</td><td>78</td><td>40</td><td>40</td><td>42</td><td>56</td></tr>
<tr><td>2.</td><td>Course structure</td><td>83</td><td>50</td><td>33</td><td>20</td><td>30</td><td>42</td><td>42</td></tr>
<tr><td>3.</td><td>Instructional techniques</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td></tr>
<tr><td>4.</td><td>Learning process</td><td>71</td><td>72</td><td>59</td><td>52</td><td>51</td><td>56</td><td>60</td></tr>
</table>
This monitor observed a number of Mall groups (Wellness and Recovery Action Plan, Computer Class, "Ready, Set, Go," Community Living Skills Project, Substance Abuse Recovery, Substance Abuse Recovery 2, Non-Violent Communication, Cognitive Remediation, and Trauma and Anxiety). In general, the facilitators in these Mall groups knew the course content and were competent in their instructional techniques, but many could improve in structuring their courses and in creating a learning environment by
</td></tr>
</table>

		increasing the opportunity for the individuals to engage in the learning process. **Compliance:** Partial. **Current recommendations**: 1. Assess the competency of group facilitators and therapists in providing rehabilitation services. 2. Ensure that facilitators evaluate individuals' responses to therapy and rehabilitation and use the data to modify teaching and training of individuals to achieve their goals and objectives.
C.2.q	Group facilitators and therapists providing therapeutic and rehabilitation services in the field of substance abuse should be certified substance abuse counselors.	**Current findings on previous recommendations:** **Recommendations 1-3, April 2008:** • Ensure that all group facilitators complete the substance abuse training curriculum as per ASH training curriculum. • Evaluate and report the quality of services provided on Substance Abuse by the trained facilitators. • Ensure that providers serving individuals at the pre-contemplative stage are trained to competency and meet ASH substance abuse counseling competency. **Findings:** This monitor's documentation review (substance abuse training log, attendance roster, PSR Mall course Facilitator Consultation checklists, and curriculum and lessons plans) found that all substance abuse providers at ASH were trained. According to the Mall Director, all pre-contemplative substance abuse providers are trained (most recent training was conducted on September 10, 2008. The staff is also provided Motivational Interviewing techniques following the Federal Center for Substance Abuse Treatment and the Treatment Improvement Protocol. All substance abuse

		group providers are audited twice a year using the PSR Mall Course Facilitator Consultation check list. This monitor observed facilitation of two substance abuse Mall groups. The groups were conducted by trained facilitators. The facilitators used lesson plans and multiple methods to present the material (role-play, handouts, homework, and worksheets). An individual was a co-facilitator in one of the Substance Abuse groups. **Compliance:** Substantial. **Current recommendations**: 1. Ensure that all group facilitators complete the substance abuse training curriculum per ASH training curriculum. 2. Evaluate and report the quality of services provided on Substance Abuse by the trained facilitators. 3. Ensure that providers serving individuals at the pre-contemplative stage are trained to competency and meet ASH substance abuse counseling competency.
C.2.r	Transportation and staffing issues do not preclude individuals from attending appointments.	**Current findings on previous recommendations:** **Recommendations 1 and 2, April 2008:** • Establish an automated system to track cancellation of scheduled appointments. • Continue to ensure that all medical appointments of individuals are completed as scheduled. **Findings:** This monitor's interview of the Mall Director and the Director of Standards Compliance revealed that ASH continues to use the Central Medical Services Database to track cancellation of scheduled

<table>
<tr>
<td></td>
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<td>appointments. The table below showing the number of scheduled appointments for the month (March to August 2008), the number of appointments cancelled, and the reason for the cancellation is a summary of the facility's data.
<table>
<tr><th>Month</th><th colspan="2">Appointments</th><th>Reasons for cancellation</th></tr>
<tr><td>2008</td><td>Scheduled</td><td>Cancelled</td><td></td></tr>
<tr><td>Mar</td><td>146</td><td>1</td><td>1 transportation</td></tr>
<tr><td>Apr</td><td>170</td><td>0</td><td></td></tr>
<tr><td>May</td><td>189</td><td>2</td><td>2 transportation</td></tr>
<tr><td>Jun</td><td>176</td><td>0</td><td></td></tr>
<tr><td>Jul</td><td>163</td><td>4</td><td>4 transportation</td></tr>
<tr><td>Aug</td><td>140</td><td>0</td><td></td></tr>
</table>
As seen in the table above, seven of the 984 scheduled appointments were cancelled, and all the cancellations were due to transportation problems. ASH should try and solve the transportation problem to ensure that transportation is not a barrier to completing scheduled appointments.

Compliance:
Substantial.

Current recommendation:
Continue to ensure that all medical appointments of individuals are completed as scheduled.</td>
</tr>
<tr>
<td>C.2.s</td>
<td>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</td>
<td>Current findings on previous recommendations:

Recommendation 1-4, April 2008:
• Ensure that individuals' cognitive levels, needs, and strengths are utilized when considering group assignments.
• Ensure that providers and facilitators are knowledgeable, competent, and motivated to translate course content to individuals' needs to</td>
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	medications and substance abuse, are appropriately addressed, consistent with generally accepted professional standards of care.	maximize learning. • Develop and implement monitoring systems that address all of the required elements. • Continue the implementation of PSR Mall in all programs in the facility. **Findings:** This monitor's interview of the Mall Director and documentation review (training logs) found that ASH has rolled out Mall groups throughout the facility and groups are available to all individuals. ASH offers Mall group instructional strategies training once a month and senior clinicians supervise and mentor the group facilitators. ASH uses chart audits and direct observation of Mall groups to evaluate the quality of Mall services, including facilitator competence. Using item 10 from the DMH WRP Clinical Chart Auditing Form, ASH assessed its compliance based on an average sample of 42% of the WRPs due for the month (March to August 2008). The table below with its indicators and sub-indicators and corresponding mean compliance (with the mean compliance for the previous period in parenthesis) is a summary of the data:

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.*	
10.a	*The individual's cognitive functioning level, needs, and strengths (as documented in the case*	13% (8%)

	formulation) are aligned with the group assignments.	
10.b	*For each Axis I, II and III diagnoses, the interventions are related to excesses and deficits associated with each diagnosis.*	9% (2%)
10.c	*All interventions are offered at the cognitive functioning level of the individual.*	15% (8%)

This monitor's documentation review (Mall catalogue, Mall curriculums, and Mall lesson plans) found that ASH has developed material that is of assistance to the WRPTs to address an individual's cognitive levels and needs and to assign them to appropriate PSR services. This monitor's observation of WRPCs found that teams use the Mall catalogue when assigning individuals to Mall groups. This monitor observed a number of Mall groups (Wellness and Recovery Action Plan, Computer Class, "Ready, Set, Go", Community Living Skills Project, Substance Abuse Recovery, Substance Abuse Recovery 2, Non-Violent Communication, and Cognitive Remediation). In all cases, the groups were actively facilitated by the regular and enduring staff. The facilitators sought active participation from the individuals through questions, role-play, and written work. However, a number of facilitators in the Central Mall groups did not know the individual's strengths and limitations. The individuals were not from the facilitator's WRPTs and the Mall progress note system is not fully automated.

This monitor reviewed five charts (GKP, KAT, MAP, RLY and SMB). Two of the WRPs in the charts (GKP and MAP) had assigned the individuals to meaningful groups in line with their diagnoses and cognitive levels. The remaining three WRPs (KAT, RLY and SMB) did not assign individuals to appropriate groups corresponding to their diagnoses, needs, and/or cognitive levels, or the groups listed in the interventions were not listed in the individuals' Mall schedules.

		Compliance: Partial. **Current recommendations**: 1. Ensure that individuals' cognitive levels, needs, and strengths are utilized when considering group assignments. 2. Ensure that providers and facilitators are knowledgeable, competent, and motivated to translate course content to individuals' needs to maximize learning.
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:** **Recommendations 1 and 2, April 2008:** • Develop and implement monitoring tools to ensure the process outcomes of treatment and/or rehabilitation services. • Develop and implement monitoring tools to ensure that Mall activities are properly linked to the foci, objectives and interventions specified in the WRP. **Findings:** Using item 11 from the DMH WRP Clinical Chart Auditing Form, ASH assessed its compliance based on an average sample of 42% of the WRPs due for the month (March to August 2008). The table below with its indicators and sub-indicators and corresponding mean compliance (with the previous review period's compliance in parenthesis) is a summary of the data: 11. *Treatment, rehabilitation and enrichment services are monitored appropriately against rational, operationally defined target variables and revised as appropriate in light of significant developments, and the individual's progress, or lack thereof.* 11.a *Each objective is observable, measurable and* 15%

	behavioral.	(26%)
11.b	*All groups and individual therapies are linked directly to the foci, objective and interventions specified in the individual's WRP.*	13% (16%)
11.c	*There is a DMH PSR Mall Facilitator Monthly Progress Note for each active treatment in the individual's WRP.*	2% (7%)
11.d	*If the individual has not made progress on an objective in 2 months, the objective and/or intervention is revised, or there is documentation of clinically justifiable reasons for continuing with the objective.*	3% (4%)
11.e	*If the individual has met the objective, a new objective and related interventions have been developed and implemented.*	12% (4%)

This monitor reviewed six charts (CLC, GF, JD, KAT, ME, and RLY). All six WRPs were missing one or more elements or did not satisfy the criteria for this recommendation. Progress notes were missing, the WRP lacked a match among the foci and the objectives and interventions, or the objectives were not revised according to the individual's progress or lack thereof in his/her PSR services and there were no rationale for continuing the objectives without revision.

Compliance:
Partial.

Current recommendations:
1. Develop and implement monitoring tools to ensure the process outcomes of treatment and/or rehabilitation services.
2. Develop and implement monitoring tools to ensure that Mall activities are properly linked to the foci, objectives and interventions specified in the WRP.

C.2.u	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:** **Recommendations 1 and 2, April 2008:** • Provide data regarding each group that addresses this requirement, including the hours offered and the number of individuals attending and compare to the last review period. • Provide monitoring data related to this requirement. **Findings:** Since the last review, ASH has provided Introduction to Wellness and Recovery Groups to both newly admitted and long-term individuals. Effective September 1, 2008, the facility began a new Sponsor Group process. The purposes of Sponsor Groups include establishing the role of staff sponsor to assist in preparing the individuals to participate fully in their WRPT process and enhancing the familiarity of sponsors with individuals in their groups. The long term Introduction to Wellness and Recovery Group will be replaced by Sponsor Group. However, ASH plans to continue to offer Introduction to Wellness and Recovery groups to newly admitted individuals (also called New Admission Orientation Introduction groups)..The facility plans to provide data regarding Sponsor Groups at the next review. The following is a summary of the data regarding the Introduction to Wellness and Recovery groups during this review period. Number of Introduction to Wellness and Recovery Groups Offered During the Current and Prior Three Mall Terms Oct-Dec 2007: 131 Jan-Mar 2008: 120 Apr-Jun 2008: 94 Jul-Sep 2008: 94

<table>
<tr>
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<table>
<tr><th colspan="2">Number of Introduction to Wellness and Recovery Groups Scheduled and Attended (March to August 2008, mean)</th></tr>
<tr><td>Sessions scheduled</td><td>33</td></tr>
<tr><td>Sessions held</td><td>30</td></tr>
<tr><td>% held</td><td>91</td></tr>
<tr><td>Individuals scheduled</td><td>128</td></tr>
<tr><td>Individuals attended at least 1 group per month</td><td>104</td></tr>
<tr><td>% attended</td><td>81</td></tr>
</table>

Recommendation 3, April 2008:
Provide data to support that individuals are provided a copy of their WRPs based on clinical judgment.

Findings:
ASH has yet to implement this recommendation. Efforts are underway to provide data for the next review.

Compliance:
Partial.

Current recommendations:
1. Provide data regarding each group that addresses this requirement (Introduction to Wellness and Recovery for newly admitted individuals and Sponsor Groups). Include number of groups per term, the hours offered and the number of individuals attending and compare to the last review period.
2. Provide data to support that individuals are provided a copy of their WRPs based on clinical judgment.
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<tr>
<td>C.2.v</td>
<td>Staff educates individuals about their medications, the expected results, and the potential common and/or serious side effects of medications, and</td>
<td>Current findings on previous recommendations:</td>
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</table>

	staff regularly asks individuals about common and/or serious side effects they may experience.	**Recommendations 1 and 2, April 2008:** • Provide data regarding the number of groups scheduled and held compared to the last review period. • Increase scheduled groups and implement corrective actions to ensure that scheduled groups are held. **Findings:** ASH reports that it has implemented this recommendation. The facility presented data regarding the number of medication education groups offered during the current and prior periods but was unable to explain how the number of groups was calculated. ASH reported that 82% of the scheduled sessions were held and that 77% of the scheduled individuals attended at least one group per month during this review period. No comparative data were presented. Given that ASH requires all psychiatrists to provide Medication Education groups to all individuals on their caseloads, it is unclear how the facility's data determine implementation of this requirement. **Compliance:** Partial. **Current recommendations**: 1. Provide data regarding the number of groups scheduled and the percentage that was held compared to the last review period. 2. Provide data regarding the number of individuals scheduled and the percentage that attended compared to the last review period. 3. Explain how the facility determines if all psychiatrists have provided medication education groups to all individuals under their care. 4. Ensure that medication education is provided on the basis of need.
C.2.w	Interdisciplinary teams review, assess, and develop positive clinical strategies to overcome individual's	**Current findings on previous recommendations:**

	barriers to participation in therapeutic and rehabilitation services.	**Recommendation 1, April 2008:** Implement corrective actions to address barriers towards individuals' participation in their WRPs, including Mall groups. **Findings:** ASH is developing a proposal for activity rooms for individuals who are assigned to groups and choose not to attend, and for individuals that are not assigned to groups. **Recommendation 2, April 2008:** Provide Motivational Interviewing, Narrative Restructuring Therapy (NRT) and other cognitive behavioral interventions to individuals who refuse to attend groups as specified in their WRPs. **Findings:** The following is a summary of the facility's efforts to improve compliance with this requirement: 1. ASH began offering NRT in February 2008 to motivate individuals to attend Mall groups, and to enable them to move from the pre-contemplation to contemplation stage of change. Three clinicians were certified by DMH as having completed NRT training during the current review period. Nine individuals are currently receiving NRT services, an increase from three individuals during the last review period. Of these nine, six receive twice-weekly NRT services. The other three have made sufficient progress to receive only one session a week. The facility presented outcome data for five individuals for whom five sets of outcome measures were available: Hope Scale, Mindfulness Attention Awareness Scale (MAAS), URICA (self-assessment by the individuals), URICA (staff assessment of the individuals) and Number of PSR Mall groups Attended. On the Hope Scale, scores for four of the individuals increased and one decreased. On the MAAS Scale, scores for three individuals increased and two decreased. As assessed

		by staff on the URICA, two of the five individuals increased their scores, one stayed about the same, and the other two declined. As assessed by the individuals themselves, four of the five individuals increased their scores. ASH plans to continue to implement NRT with the expectation that results will improve over time. ASH will continue with three NRT therapists who will be able to carry a caseload of 15 individuals. 2. ASH assigned a team to develop an enhanced therapeutic milieu program of training and mentoring unit staff. This program will utilize techniques in motivational interviewing and mindfulness. This training will roll out in September 2008, including "Training for Trainers" (October 2008) regarding Building Therapeutic Alliances. Staff have been selected and approved for this training 3. ASH is currently reviewing the CVs of potential Motivational Interviewing trainers with expertise in forensic populations. 4. As mentioned above, ASH is beginning Activity Centers (Recovery Rooms) aimed at engaging unmotivated individuals on a larger scale. The first Activity Center began on Program V in October, 2008. **Compliance:** Partial. **Current recommendations**: 1. Provide data regarding the number of therapists trained in NRT, number of individuals engaged in NRT and their outcome data for the individuals. 2. Provide data regarding the status of implementation of Motivational Interviewing, Therapeutic Milieu Program and Activity Centers. 3. Provide data regarding the mean number of individuals who were non-adherence to WRP during the review period compared to the last review period.

D. Integrated Assessments		
D	Each State hospital shall ensure that, consistent with generally accepted professional standards of care, each individual shall receive, promptly after admission to each State hospital, an accurate and comprehensive assessment of the conditions responsible for the individual's admission, to the degree possible given the obtainable information at the time of admission. Thereafter, each individual shall receive an accurate and comprehensive reassessment of the reasons for the individual's continued hospitalization whenever there has been a significant change in the individual's status, or a lack of expected improvement resulting from clinically indicated treatment. The individual's interdisciplinary team shall be responsible for investigating the past and present medical, nursing, psychiatric, and psychosocial factors bearing on the individual's condition, and, when necessary, for revising assessments and therapeutic and rehabilitation plans in accordance with new information that comes to light. Each State hospital shall monitor, and promptly address deficiencies in the quality and timeliness of such assessments.	**Summary of Progress on Psychiatric Assessments and Diagnoses:** 1. ASH has increased the level of psychiatric staffing and maintained a level sufficient to meet requirements of the EP. 2. ASH hired senior psychiatrists in permanent positions and assigned them to programs in September 2008. 3. ASH began hospital-wide implementation of the DMH revised template for the Admission Psychiatric Assessment and the Integrated Psychiatric Assessment. 4. ASH has provided appropriate continuing medical education (CME) to psychiatry staff during this review period. 5. ASH has improved the sampling methodology in self-monitoring and refined data gathering and presentation. **Summary of Progress on Psychological Assessments:** 1. ASH has implemented the BY CHOICE manual. 2. ASH hired 15 WRP psychologists during the review period. **Summary of Progress on Nursing Assessments:** 1. ASH has implemented the use of the Plato data to focus on individual RN Nursing Assessment Competency training for all admission unit RNs. 2. ASH has achieved substantial compliance in some of the areas of the Nursing Admission Assessments and Integrated Assessments. 3. The timeliness of the Nursing Admission Assessments has achieved substantial compliance. **Summary of Progress on Rehabilitation Therapy Assessments:** 1. Assessments and audit tools for the IA-RTS and focused assessments for Speech Therapy, Physical Therapy, and Vocational Rehabilitation have been implemented. A D.4 Monitoring tool that aligns with Enhancement Plan requirements has been developed and

		implemented. 2. Mentoring and training has been initiated for psychosocial Rehabilitation Therapists on an individualized and group basis based on audit results. 3. Data analysis based on requisite audit samples for each area of D.4 has been initiated. This process should continue to be developed to ensure that the facility provides a thorough and meaningful analysis of all sub-items below 90% compliance, with appropriate plans of correction to improve compliance implemented as needed. **Summary of Progress on Nutrition Assessments:** 1. Timeliness and quality of D.5 Nutrition assessments continues to be affected by decreased staffing resulting in increased caseloads. 2. Data analysis based on requisite audit samples for each area of D.5 has been initiated. However, this process needs to be developed to ensure that the facility provides a thorough and meaningful analysis of all sub-items below 90% compliance, with appropriate plans of correction to improve compliance implemented as needed. **Summary of Progress on Social History Assessments:** ASH is more reliably documenting individuals' educational status. **Summary of Progress on Court Assessments:** ASH has maintained and strengthened its compliance with EP requirements regarding PC 1370 court reports.

1. Psychiatric Assessments and Diagnoses		
	Each State hospital shall provide all of the individuals it serves with routine and emergency psychiatric assessments and reassessments consistent with generally accepted professional standards of care; and,	**Methodology:** Interviewed: Jean Dansereau, MD, Chief of Psychiatry Reviewed: 1. The charts of the following 46 individuals: AEJr., AJF, ASM, BA, BO, CRM, DEA, DJ, DO, DSM, EA, ED, EDS, GAJ, GD, GM, HK, HME, JFL, KM, LCP, LRS, MA, MM, MMR, MR, MSE, PK, PS, PT, RA, RDB, RDS, RJL, RPH, SAH, SAJ, SAM, SGV, TJC, TL, TLC, TWA, TWF, UH and VDC 2. ASH database of all individuals with their diagnoses and medication regimens 3. DMH template for the Admission Psychiatric Assessment 4. DMH Admission Assessment Instructions 5. DMH Admission Psychiatric Assessment Auditing Form 6. ASH Admission Psychiatric Assessment summary data (March to August 2008) 7. DMH Integrated Psychiatric Assessment Auditing Form 8. ASH Integrated Psychiatric Assessment Auditing summary data (March to August 2008) 9. ASH Admission Medical Assessment Auditing Form 10. ASH Admission Medical Assessment Auditing summary data (March to August 2008) 11. DMH Monthly Physician Progress Note (PPN) Auditing Form 12. DMH Weekly PPN Auditing Form 13. ASH Weekly PPN Auditing summary data (March to August 2008) 14. ASH Monthly PPN Auditing summary data (March to August 2008) 15. DMH Physician Transfer Note Auditing Form 16. ASH Physician Transfer Note Auditing summary data (March to August 2008)

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:** **Recommendations 1 and 2, April 2008:** • Monitor this requirement using the DMH Admission Assessment, Integrated Psychiatric Assessment and Monthly Progress Note auditing forms 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 used the DMH Admission and Integrated Psychiatric Assessment and Monthly Physician Progress Note Auditing Forms to assess compliance (March to August 2008). The average samples were 81% (of admission assessments), 71% (of integrated assessments) and 68% (of monthly notes on individuals who have been hospitalized for more than 90 days), respectively. The Integrated Assessment data were limited to Program IV during the period of March to June 2008 (hospital-wide implementation of these assessments began July 1, 2008). The following is a summary of the data and the facility's analysis, as applicable. **Admission Assessment** 4.a — *Admission diagnoses Axis I-V are addressed* — 96% 4.b — *DSM-IV diagnosis consistent with history and presentation* — 96% The mean compliance rate for the main indicator has increased from 68% during the last review to 96% for this review period. **Integrated Assessment** 2.b — *Statements from the individual are included, if available.* — 92%

2.d	*Includes Diagnosis and medications given at previous facility are included*	89%
7.	*Includes diagnostic formulation*	45%
8.	*Includes differential diagnosis*	97%
9.	*Includes current psychiatric diagnoses*	96%

Comparative data were incomplete. The facility recognized that low compliance with item 7 was primarily due to poor understanding by practitioners of the requirement regarding diagnostic formulation. As a corrective action, ASH plans to provide focused training to the Admission Psychiatrists regarding this requirement.

Monthly PPN		
3.b.1	*The note includes the 5-Axis diagnosis and this is consistent with the current presentation and recent developments*	75%
3.b.2	*If there is a NOS diagnosis or no diagnosis on Axis I, there is documentation that justifies the diagnosis*	65%
3.b.3	*Deferred and rule-out diagnosis are resolved within 60 days of initiation of the diagnosis and there is a clear description of the rationale for the specific resolution*	40%

Comparative data showed improvement in compliance for most items since the last review as follows:

	Previous period	Current period
Mean compliance rate		
3.b	20%	68%

	Previous period	Current period
Compliance rate in last month of period		
3.b	33%	79%
3.b.1	36%	87%
3.b.2	54%	72%
3.b.3	60%	41%

To improve compliance with item 3.b.3, the facility reported that its Medical Director now provides a list of all individuals with deferred and/or rule-out diagnoses to the Chief Psychiatrist every two weeks. The Senior Psychiatrists provide follow-up to ensure that these diagnoses are finalized in a timely manner. The facility plans to provide training to the Attending Psychiatrists (November 1, 2008) to ensure that the rationale for deferred and rule-out diagnoses is incorporated into the monthly physician's progress note (MPPN).

Other findings:
The DMH has finalized a new template for the admission psychiatric assessment that includes suicide and violence risk. The new template meets current generally accepted professional standards of care and proper implementation can significantly enhance compliance with EP requirements. ASH recently began implementation of this template. Random chart reviews by this monitor found that this format was implemented in a few charts and that implementation has improved the quality of the assessments compared to the last review.

However, this monitor found a persistent pattern of deficiencies in the overall quality of the admission and integrated assessments and reassessments (see examples in D.1.c.ii, D.1.c.iii and D.1.f). These deficiencies must be corrected to achieve substantial compliance with this requirement.

		Compliance: Partial. **Current recommendations**: 1. Monitor this requirement using the DMH Admission Assessment, Integrated Psychiatric Assessment and Monthly Progress Note auditing forms based on at least a 20% sample. 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.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:** **Recommendation 1, April 2008:** Continue recruitment efforts to ensure that vacancies are filled and staffing ratios are maintained. **Findings:** ASH has continued its efforts, including advertisements in multiple psychiatric professional journals and on the internet as well as sending recruiters to national conferences and using the services of national recruiting firms. **Recommendation 2, April 2008:** Provide data regarding the number of psychiatrists who are currently board-certified compared to the last reporting period.

		Findings: The total number of psychiatrists has increased from 71 (February 2008) to 81 (August 2008). The current level of psychiatry staffing is sufficient to meet EP requirements. ASH has continued its practice of ensuring that all psychiatrists at the facility are in compliance with the requirement regarding completion of residency training. **Compliance:** Substantial. **Current recommendations**: 1. Continue current practice and provide data regarding the current total number of FTE psychiatric positions filled, including direct care and supervisory positions compared to the last reporting period. 2. Provide data regarding the number of psychiatrists who are currently board-certified compared to the last reporting period.
D.1.b.ii	Are verifiably competent (as defined by privileging at initial appointment and thereafter by reprivileging for continued appointment) in performing psychiatric assessments consistent with each State Hospital's standard diagnostic protocols.	**Current findings on previous recommendations:** **Recommendation 1, April 2008:** Implement the Psychiatric Physician Quality Profile Program and utilize data in the processes of reprivileging and performance improvement. **Findings:** ASH began implementation of the quality profile in August 2008. The profile utilized performance data from sources that were outlined in ASH Report 3. **Recommendation 2, April 2008:** Ensure that the Department of Psychiatry Procedure Manual includes clear performance expectations regarding the format and content of all assessments and reassessments as required by the EP.

		Findings: ASH did not address this recommendation. **Compliance:** Partial. **Current recommendations**: 1. Utilize data from the Psychiatric Physician Quality Profile Program in the processes of reprivileging and performance improvement. 2. Ensure that the Department of Psychiatry Procedure Manual includes clear performance expectations regarding the format and content of all assessments and reassessments as required by the EP.
D.1.c	Each State hospital shall ensure that:	Please see sub-cells for compliance findings.
D.1.c.i	Within 24 hours of an individual's admission to each State hospital, the individual receives an Admission Medical Assessment that includes:	**Current findings on previous recommendations:** **Recommendation 1, April 2008:** Finalize the DMH standardized tool regarding this requirement. **Findings:** The DMH is in the process of finalizing this tool. **Recommendation 2, April 2008:** Monitor this requirement based on at least a 20% sample using the standardized tool. This monitoring must address follow-up regarding incomplete items on the examination. **Findings:** ASH used the current ASH Medical Admission Assessment Monitoring

		tool to assess compliance with the requirements in D.1.c.i.1 to D.1.c.i.5. The average sample was 75% of admissions for the reporting month. The mean compliance rates are presented in each corresponding cell below. **Other findings:** This monitor reviewed the charts of 10 individuals (ASM, CRM, DEA, GAJ, KM, RPH, SGV, TJC, TL and TLC) who were admitted during this reporting period. The review found the following: 1. There was timely implementation of the admission medical assessment in all cases. 2. Some charts (ASM, CRM and GAJ) included medical assessments that were completed using the newly revised DMH template. This template includes appropriate prompts to correct the deficiencies outlined in the previous reports. 3. The medical assessments that were completed using the facility's old format included incomplete neurological examination and/or inadequate plans of care (DEA, KM and TLC). 4. In the chart of KM, the medical assessment was not signed by the Physician and Surgeon. This assessment noted a finding of nodules in the prostate, but did not document a plan of care or any reference to the individual's personal and family history of colon cancer (as reported in the admission psychiatric assessment). 5. Some assessments included evidence of corrections made to the document without signatures or initials of the practitioner (DEA and SGV). **Compliance:** Partial. **Current recommendations**: 1. Finalize and implement the DMH Initial Medical Examination

		Auditing Form and Instructions for use across facilities. 2. Ensure consistent implementation of the DMH's newly revised template for the admission medical assessment. 3. Monitor completeness of the admission medical examination within the specified time frame, based on at least a 20% sample. This monitoring must address follow-up regarding incomplete items on the examination. 4. Provide data analysis that evaluates and delineates areas of low compliance and relative improvement (during the reporting period and compared to the last period).
D.1.c.i.1	a review of systems;	97%, compared to 99% during the last review.
D.1.c.i.2	medical history;	99%, the same as the last review.
D.1.c.i.3	physical examination;	100%, compared to 99% during the last review.
D.1.c.i.4	diagnostic impressions; and	99%, compared to 97% during the last review.
D.1.c.i.5	management of acute medical conditions	99%, the same as the last review.
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:** **Recommendation 1, April 2008:** Finalize and implement a risk assessment tool during the first 24 hours of admission that aligns with the instructions regarding risk factors in the DMH format of the integrated psychiatric assessment. **Findings:** The DMH has developed a new template for the admission psychiatric assessment that includes a risk assessment tool. The tool aligns with the risk factors in the integrated psychiatric assessment. If properly implemented, the template provides corrections of the deficiencies

		that were reported in the previous report. In July 2008, the facility began implementation of the new template. **Recommendations 2 and 3, April 2008:** • Monitor the Admission Psychiatric Assessment, based on at least a 20% sample using the DMH standardized instrument. • Provide data analysis that evaluates and delineates areas of low compliance and relative improvement (during the reporting period and compared with the last period). **Findings:** ASH used the DMH Admission Psychiatric Assessment Auditing Form to assess compliance (March to August 2008). The average sample was 81% of the admissions each month. The mean compliance rate for this requirement has remained at 100% since the last review period. The mean compliance rates for the requirements in D.1.c.ii.2 through D.1.c .ii.6 are listed for each corresponding cell below. The comparative data are listed, as appropriate. **Other findings:** This monitor reviewed the charts of the above-mentioned 10 individuals. The review found substantial compliance in the charts of a few individuals (e.g. KM) whose assessments were completed using the DMH new template. However, most of the charts reviewed included assessments that were completed using the older template. In general, the charts contained evidence of deficiencies similar to those cited in the previous report. These deficiencies must be corrected to achieve substantial compliance with this requirement. The following are examples of the deficiencies: 1. The admission assessment was not found in several charts (ASM, GAJ and TLC).

		2. The history of present illness did not include necessary information (SGV). 3. The violence risk assessment did not include specific information in individuals who had significant histories of aggression (KM and SGV). 4. The mental status examination included reference to significant abnormalities of thought content (e.g. auditory hallucinations and magical thinking) without necessary specifics (CRM and SGV). 5. The mental status examination included generic assessment of insight and judgment in almost all the assessments reviewed. 6. The assessment of strengths was limited to a generic list of characteristics that could not be utilized in the WRP (DEA, RPH, TJG and TL). **Compliance:** Partial. **Current recommendations**: 1. Ensure full implementation of the DMH revised template for the admission psychiatric assessment. 2. Monitor the Admission Psychiatric Assessment, based on at least a 20% sample, using the DMH standardized instrument. 3. Provide data analysis that evaluates and delineates areas of low compliance and relative improvement (during the reporting period and compared with the last period). 4. 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.
D.1.c.ii.1	psychiatric history, including a review of presenting symptoms;	

2.	*Psychiatric history, including review of presenting symptoms*	
2.a	*Identifying data including legal status*	99%

<table>
<tr><td></td><td></td><td>
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<tr><td>2.b</td><td>Discharge diagnosis and condition</td><td>83%</td></tr>
<tr><td>2.c</td><td>Reason for admission and chief complaint</td><td>97%</td></tr>
<tr><td>2.d</td><td>History of present illness</td><td>99%</td></tr>
<tr><td>2.e</td><td>Psychiatric history</td><td>99%</td></tr>
<tr><td>2.f</td><td>Substance abuse history</td><td>99%</td></tr>
<tr><td>2.g</td><td>Allergies</td><td>91%</td></tr>
<tr><td>2.h</td><td>Current medications</td><td>98%</td></tr>
</table>

Comparative data showed improvement or reasonable consistency in compliance for since the last review as follows:

<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.</td><td>61%</td><td>74%</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>2.</td><td>67%</td><td>85%</td></tr>
<tr><td>2.a</td><td>98%</td><td>100</td></tr>
<tr><td>2.b</td><td>72%</td><td>93%</td></tr>
<tr><td>2.c</td><td>98%</td><td>95%</td></tr>
<tr><td>2.d</td><td>100%</td><td>98%</td></tr>
<tr><td>2.e</td><td>100%</td><td>97%</td></tr>
<tr><td>2.f</td><td>100%</td><td>99%</td></tr>
<tr><td>2.g</td><td>93%</td><td>98%</td></tr>
<tr><td>2.h</td><td>100%</td><td>96%</td></tr>
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</td></tr>
<tr><td>D.1.c.ii.2</td><td>complete mental status examination;</td><td>99%, compared to 94% during the last review.</td></tr>
<tr><td>D.1.c.ii.3</td><td>admission diagnoses;</td><td>92%, compared to 68% during the last review.</td></tr>
<tr><td>D.1.c.ii.4</td><td>completed AIMS;</td><td>98%, compared to 93% during the last review.</td></tr>
</table>

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<tr><td>D.1.c.ii.5</td><td>laboratory tests ordered; and</td><td>90%, compared to 98% during the last review.</td></tr>
<tr><td>D.1.c.ii.6</td><td>consultations ordered.</td><td>75%, compared to 53% during the last review.</td></tr>
<tr><td></td><td>plan of care</td><td>
<table>
<tr><td>8.</td><td>Plan of care</td><td></td></tr>
<tr><td>8.a</td><td>Regular psychotropic medications with rationale</td><td>93%</td></tr>
<tr><td>8.b</td><td>PRN and/or Stat medications as applicable, with specific behavioral indicators</td><td>79%</td></tr>
<tr><td>8.c</td><td>Special precautions to address risk factors as indicated</td><td>94%</td></tr>
</table>

Comparative data showed several declines in compliance for since the last review as follows:
<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>8.</td><td>85%</td><td>78%</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>8.</td><td>91%</td><td>73%</td></tr>
<tr><td>8.a</td><td>93%</td><td>92%</td></tr>
<tr><td>8.b</td><td>94%</td><td>66%</td></tr>
<tr><td>8.c</td><td>100%</td><td>95%</td></tr>
</table>

The facility assessed that the addition of new psychiatrists to the admission units has been the main factor in decreased compliance. The plan of correction included training of all psychiatrists in November 2008.
</td></tr>
<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</td><td>Current findings on previous recommendations:</td></tr>
</table>

	receives an Integrated Psychiatric Assessment that includes:	**Recommendation 1, April 2008:** Ensure facility-wide implementation of the Integrated Psychiatric Assessments. **Findings:** ASH began hospital-wide implementation of the Integrated Psychiatric Assessments on July 15, 2008. **Recommendation 2, April 2008:** Ensure that the format and content of the Integrated Psychiatric Assessment adequately integrates information that becomes available during the first seven days of hospitalization and that markings/entries in the assessments that violate the integrity of the records are not permitted. **Findings:** Reviews by this monitor found that the majority of the Integrated Psychiatric Assessments were completed within a reasonable time frame that permits integration of information that becomes available following admission. However, there continued to be evidence of few assessments that contained corrections and highlights without appropriate signatures/initials of the practitioners. **Recommendations 3 and 4, April 2008:** • Monitor the Integrated Psychiatric Assessment, based on at least a 20% sample using the DMH standardized instrument. • Provide data analysis that evaluates and delineates areas of low compliance and relative improvement (during the reporting period and compared with the last period). **Findings:** ASH used the DMH Integrated Assessment Psychiatry Section Auditing Form to assess compliance (March to August 2008). The

		average sample was 71% of the assessments. The data for March to June 2008 was based on Program IV only because hospital-wide implementation began in July 2008. The mean compliance rate for this requirement was 90%, an increase from 84% in the previous review period. The mean compliance rates for the other requirements in D.1.c.iii are listed in each corresponding cell below. Comparative data are listed, as appropriate. **Other findings:** During this review period, ASH began hospital-wide implementation of the integrated assessments (July 15, 2008). Reviewing the charts of the above-mentioned 10 individuals, this monitor found the following: 1. The integrated assessments were not completed in the charts of RPH, SGV (June 2008 admission), TJC and TL. 2. The integrated assessment did not include history of present illness or previous psychiatric history in the chart of SGV (August 2008 admission). 3. In one chart, the mental status examination did not include necessary information regarding suicidality, homicidality, nature of hallucinations and cognitive status (TLC). 4. The risk assessment was inadequate in an individual who had history of self-injurious behavior and aggression (TJC). 5. In almost all the charts reviewed, the assessment of the individual's insight and judgment was generic. 6. With the exception of one assessment (CRM), the assessments included generic strength formulations. The above deficiencies must be corrected to achieve substantial compliance with this requirement.

<table>
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<td>Compliance:
Partial.

Current recommendations:
1. Ensure full implementation of the integrated psychiatric assessments.
2. Ensure that the assessments are free of markings/corrections without appropriate signatures/initials.
3. Continue to monitor the Integrated Psychiatric Assessment using the DMH standardized instrument.
4. Provide data analysis that evaluates and delineates areas of low compliance and relative improvement (during the reporting period and compared with the last period).</td>
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<tr>
<td>D.1.c.iii.
1</td>
<td>psychiatric history, including a review of present and past history;</td>
<td>
<table>
<tr><td>2.</td><td>Psychiatric history, including a review of present and past history.</td><td></td></tr>
<tr><td>2.a</td><td>Identifying data including legal status.</td><td>99%</td></tr>
<tr><td>2.b</td><td>Statements from the individual are included, if available.</td><td>92%</td></tr>
<tr><td>2.c</td><td>Chief complaint</td><td>95%</td></tr>
<tr><td>2.d</td><td>Diagnosis and medications given at previous facility are included.</td><td>89%</td></tr>
<tr><td>2.e</td><td>Effectiveness of medications from previous facility is included</td><td>61%</td></tr>
<tr><td>2.f</td><td>Past psychiatric history is documented including a review of pertinent physical exam status.</td><td>93%</td></tr>
</table>

Comparative data showed mixed changes in compliance since the last review as follows:
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	Previous period	Current period
Mean compliance rate		
2.	32%	75%
Compliance rate in last month of period		
2.	23%	72%
2.a	92%	99%
2.b	100%	92%
2.c	92%	95%
2.d	100%	89%
2.e	92%	61%
2.f	31%	93%

The facility cited misunderstanding by the auditors to explain the decreased compliance for sub-item 2.e. By November 2008, ASH will reportedly provide training to auditors (senior psychiatrists) to improve validity of data and inter-rater reliability.

D.1.c.iii.2	psychosocial history;	

3.	*Psychosocial history is documented.*	
3.a	*Developmental history*	96%
3.b	*Family history*	98%
3.c	*Educational history*	98%
3.d	*Religious and cultural influences*	70%
3.e	*Occupational history*	97%
3.f	*Marital status*	97%
3.g	*Sexual history*	96%
3.h	*Legal history*	96%

Comparative data showed mixed changes in compliance since the last review as follows:

	Previous period	Current period
Mean compliance rate		
3.	92%	64%
Compliance rate in last month of period		
3.	85%	67%
3.a	100%	98%
3.b	100%	99%
3.c	92%	98%
3.d	100%	73%
3.e	92%	97%
3.f	100%	95%
3.g	100%	96%
3.h	100%	97%

To improve compliance, the facility reported that all Integrated Psychiatric Assessments which are missing any component will be returned directly to the senior psychiatrist for review and correction with the admitting psychiatrist.

D.1.c.iii.3 mental status examination;

4.	*Complete mental status examination is documented*	
4.a	*Attitude/cooperation*	96%
4.ba	*General appearance*	98%
4.c	*Motor Activity*	97%
4.d	*Speech*	99%
4.e	*Mood/affect*	99%
4.f	*Thought process/content*	98%
4.g	*Perceptual alterations*	92%
4.h	*Fund of general knowledge*	73%
4.i	*Abstraction ability*	93%

4.j	*Judgment*	96%
4.k	*Insight*	98%
4.l	*MMSE*	91%

Comparative data showed mixed changes in compliance since the last review as follows:

	Previous period	Current period
Mean compliance rate		
4.	84%	62%
Compliance rate in last month of period		
4.	77%	70%
4.a	100%	98%
4.b	100%	100%
4.c	100%	100%
4.d	100%	100%
4.e	100%	100%
4.f	100%	99%
4.g	100%	96%
4.h	77%	79%
4.i	100%	98%
4.j	100%	98%
4.k	100%	99%
4.l	100%	93%

The plan of correction is the same as in D.1.c.iii.2.

D.1.c.iii.4	strengths;	96% (the same as in the last review).
D.1.c.iii.5	psychiatric risk factors;	6. *Psychiatric risk factors are documented*

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<tr><td>6.a</td><td>Risk for suicide</td><td>100%</td></tr>
<tr><td>6.b</td><td>Risk for self-injurious behavior</td><td>96%</td></tr>
<tr><td>6.c</td><td>Risk factors for seclusion (medical and emotional)</td><td>94%</td></tr>
<tr><td>6.d</td><td>Risk factors for restraint (medical and emotional)</td><td>93%</td></tr>
<tr><td>6.e</td><td>Risk for aggression</td><td>99%</td></tr>
<tr><td>6.f</td><td>Risk for fire setting</td><td>92%</td></tr>
<tr><td>6.g</td><td>Risk for elopement</td><td>92%</td></tr>
<tr><td>6.h</td><td>Risk for victimization</td><td>90%</td></tr>
</table>

Comparative data showed mostly improvement in compliance since the last report as follows:

<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>24%</td><td>79%</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>6.</td><td>38%</td><td>87%</td></tr>
<tr><td>6.a</td><td>100%</td><td>100%</td></tr>
<tr><td>6.b</td><td>100%</td><td>96%</td></tr>
<tr><td>6.c</td><td>83%</td><td>94%</td></tr>
<tr><td>6.d</td><td>83%</td><td>93%</td></tr>
<tr><td>6.e</td><td>100%</td><td>99%</td></tr>
<tr><td>6.f</td><td>46%</td><td>92%</td></tr>
<tr><td>6.g</td><td>46%</td><td>92%</td></tr>
<tr><td>6.h</td><td>38%</td><td>90%</td></tr>
</table>

The plan of correction is the same as in D.1.c.iii.2
</td>
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<tr>
<td>D.1.c.iii.6</td>
<td>diagnostic formulation;</td>
<td>45%, compared to 21% during the last review. The compliance rate for the last month of this review was 46% compared to 0% for the last month of the previous review period.</td>
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D.1.c.iii.7	differential diagnosis;	97% (compared to 82% during the last review).
D.1.c.iii.8	current psychiatric diagnoses;	96% (compared to 84% during the last review).
D.1.c.iii.9	psychopharmacology treatment plan; and	

10.	*Psychopharmacology treatment plan is documented*	
10.a	*Current target symptoms*	86%
10.b	*Specific medications to be used*	97%
10.c	*Dosage titration schedules, if indicated*	74%
10.d	*Adverse reactions to monitor for*	37%
10.e	*Rationale for anticholinergics, benzodiazepines, polypharmacy and new generation antipsychotics in at-risk population, if indicated.*	39%
10.f	*Response to medications since admission, if applicable including PRN and Stat medications.*	46%
10.g	*Medication consent issues were addressed.*	61%

Comparative data showed mixed changes compliance since the last report as follows:

	Previous period	Current period
Mean compliance rate		
10.	4%	21%
Compliance rate in last month of period		
10.	0%	27%
10.a	100%	87%
10.b	100%	97%
10.c	86%	74%
10.d	0%	45%
10.e	54%	31%
10.f	89%	56%

		10.g | 67% | 74% The plan of correction is the same as in D.1.c.iii.2.
D.1.c.iii.10	management of identified risks.	92% (compared to 88% during the last review).
D.1.d	Each State hospital shall ensure that:	Please see sub-cells for compliance findings.
D.1.d.i	Clinically justifiable diagnoses are provided for each individual, and all diagnoses that cannot be clinically justified for an individual are discontinued no later than the next review;	**Current findings on previous recommendation:** **Recommendation, April 2008:** Provide continuing medical education (CME) to psychiatry staff to improve competency in the assessment of cognitive and other neuropsychiatric disorders. Ensure that the programs are relevant to the recommendation, and provide data regarding the professionals who have received training. **Findings:** Since the last review, ASH provided a variety of CME activities. The following is a list of programs that were relevant to this recommendation. The facility did not provide information regarding the instructors and the professionals who attended this training. 1. Malingering Assessment in MR populations (4/15/08); 2. "MATRICS" schizophrenia study; cognitive battery (4/29/08); 3. Anticholinergic Properties of Psychotropic Medication (5/8/08); 4. Neurocognitive Enhancement with Schizophrenia (5/13/08); 5. Age-Related Memory Impairment (7/3/08); 6. Birth Measurements and Later Cognitive Impairment (7/10/08); 7. Neuroanatomy Coloring (5/20, 5/27, 7/17 and 8/21/08); and 8. Predicting Alzheimer's and Empathy after TBI (8/28/08).

Other findings:
This monitor reviewed the charts of 11 individuals who have received diagnoses listed as NOS for three or more months. The review found that the facility has yet to correct the deficiencies in the documentation of efforts to finalize the diagnosis, as indicated, the assessment of the cognitive impairments, as indicated and/or alignment of the diagnostic information in the current WRP with the corresponding psychiatric progress notes. These deficiencies must be corrected to achieve substantial compliance with this requirement. The following table outlines the chart reviews:

Initials	Diagnosis
BO	Dementia, NOS
DSM	Cognitive Disorder, NOS
GM	Impulse Control Disorder, NOS
HK	Psychotic Disorder, NOS
MSE	Dementia, NOS
RDS	Psychotic Disorder, NOS
RJL	Mood Disorder, NOS
SAM	Depressive Disorder, NOS
TWA	Depressive Disorder, NOS and Impulse Control Disorder, NOS
TWF	Mood Disorder, NOS
UH	Cognitive Disorder, NOS

Compliance:
Partial.

Current recommendations:
1. 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 professionals who have received training and the instructors, with academic their affiliation, if applicable. 2. Same as in D.1.a.
D.1.d.ii	The documented justification of the diagnoses is in accord with the criteria contained in the most current DSM (as per DSM-IV-TR Checklist);	**Current findings on previous recommendation:** **Recommendation, April 2008:** Same as in D.1.a and D.1.d.i. **Findings:** Same as in D.1.a and D.1.d.i. **Compliance:** Partial. **Current recommendations**: 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:** **Recommendation, April 2008:** Same as D.1.d.i. **Findings:** Same as in D.1.i. **Compliance:** Partial. **Current recommendations**: Same as in D.1.a and D.1.i.

D.1.d.iv	"no diagnosis" is clinically justified and documented.	**Current findings on previous recommendation:** **Recommendation, April 2008:** Same as D.1.d.i. **Findings:** Same as D.1.d.i. **Other findings:** Chart reviews by this monitor found no evidence of "no diagnosis" listed on Axis I. The facility did not provide information related to any individuals who may have received this diagnosis during this review period. **Compliance:** Deferred due to lack of information. **Current recommendation:** Provide 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:** **Recommendations 1 and 2, April 2008:** • Monitor this requirement based on a review of at least a 20% sample. • Provide data analysis that evaluates low compliance and delineates areas of relative improvement (during the reporting period and compared to the last period).

Findings:
ASH used the DMH Weekly Physician Progress Note (PPN) Auditing Form to assess compliance (March to August 2008). The average sample was 41% of the individuals with length of stay less than 60 days of admission. The following is a summary of the data:

1.	*The reassessments are completed weekly for the first 60 days on the admission units:*	
1.a	*There is a note present every seven days from the date of admission, with the understanding that the Integrated Assessment: Psychiatry Section can serve as the first weekly note.*	53%
1.b	*The note must contain the subjective complaint, objective findings, assessment and plan of care*	48%

Comparative data showed significant declines in compliance since the last review period as follows:

	Previous period	Current period
Mean compliance rate		
1.	93%	44%
Compliance rate in last month of period		
1.	93%	14%
1.a	96%	30%
1.b	95%	20%

The facility recognized decreased compliance by the admission psychiatrists and reported plans to improve performance by November 1, 2008.

ASH also used the DMH Monthly PPN Auditing form to assess compliance (March to August 2008). The average sample was 25% of

		the individuals who have been hospitalized for 90 days or more. The mean compliance rate for this requirement for this review period was 95%, compared to 100% during the last review. **Other findings:** This monitor reviewed the charts of 10 individuals (ASM, CRM, DEA, GAJ, KM, RPH, SGV, TJC, TL and TLC) who were admitted during this reporting period. The review focused on the timeliness of the notes. Regarding the weekly notes, the review found compliance in only three charts (ASM, SGV and TL). There was timely implementation of the monthly notes in all the charts of individuals who were hospitalized for 90 or more days **Compliance:** Partial. **Current recommendations**: 1. Monitor this requirement based on a review of at least a 20% sample. 2. Provide data analysis that evaluates low compliance and delineates areas of 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:** **Recommendation 1, April 2008:** Ensure implementation of the new format of monthly progress notes facility-wide and revise the format to address this monitor's findings above. **Findings:** ASH began implementation of this format on June 2, 2008.

		Recommendations 2 and 3, April 2008: • Monitor this requirement based on a review of at least a 20% sample. • Provide data analysis that evaluates low compliance and delineates areas of relative improvement (during the reporting period and compared to the last period). **Findings:** ASH used the DMH Monthly PPN Auditing Form to assess compliance (March to August 2008). The average sample was 25% of the individuals who have been hospitalized for 90 or more days. The mean compliance rates for the requirements in D.1.f.i to D.1.f.vii are entered for each corresponding cell below. Comparative data are listed, as appropriate. The facility's plan of correction was the same as in D.1.c.ii. **Recommendation 4, April 2008:** Monitor documentation of the scope and goals of individual psychotherapy and of the individual's progress in treatment when the WRP indicates that the psychiatrist is providing this intervention. **Findings:** During this review period, the psychiatrists at ASH did not provide individual psychotherapy as a component of the WRP. The facility reported that the psychiatrists provide supportive psychotherapy on an ongoing basis as part of the daily delivery of care while performing medication management, assessing risk factors and addressing adherence to treatment interventions. This care is not claimed as part of the active treatment hours, but rather is regarded as part of the routine delivery of psychiatric care. **Other findings:** Chart reviews by this monitor found general evidence of improved consistency in the implementation of the facility's template for the

		monthly notes and minor improvement in the content in these notes compared to the last review. Examples of improved documentation were found in the charts of EA, EDS, LCP, MA, PK, RA and VDC. However, the reviews found general evidence of much lower compliance than that reported in the facility's data. The main areas of deficiency were noted in the content of documentation. The following are the main examples: 1. The documentation of interval events ignored some important developments during the interval. 2. The documentation of current status, relevant laboratory findings and risk factors did not include significant relevant changes in laboratory findings and associated risks for the individual nor adequately address these changes. 3. The documentation of risks and benefits of drug treatments was mostly a generic rehash of the theoretical side effects of medications while ignoring some actual and significant occurrences of side effects in some individuals. 4. The documentation of behavioral interventions was generally generic and reflected incomplete understanding of behavioral guidelines and PBS plans that were provided to some individuals. This monitor also reviewed the charts of seven individuals who experienced the use of seclusion and/or restraints during the review period (AEJr., DJ, HME, JFL, PT, SAH and SAJ) to assess the use of PRN/Stat medications prior to seclusion and/or restraints (as documented in the orders and progress notes). This review is also relevant to the requirements in D.1.f.vi and F.1.b. The review found that ASH has made progress in providing appropriate behavioral interventions for some individuals who were refractory to current medication trials (e.g. DJ and HME). However, the following pattern of deficiencies still exists:

		1. PRN medications were prescribed for generic indications. 2. The nursing documentation of the circumstances that led to the use of PRN/Stat medications and the individual's response to these interventions was generally inadequate. 3. There was inadequate documentation in the physician progress notes of the appropriateness and efficacy of the PRN regimen and of timely adjustments of regular treatment following the use of PRN medications. 4. The documentation of a face-to-face assessment by the psychiatrists within 24 hours of the administration of Stat medications was either missing or did not include a critical review and assessment to inform future management. **Compliance:** Partial. **Current recommendations**: 1. Ensure correction of the deficiencies in the documentation of physician progress notes that were cited by this monitor above. 2. Monitor this requirement based on a review of at least a 20% sample. 3. Provide data analysis that evaluates low compliance and delineates areas of relative improvement (during the reporting period and compared to the last period).
D.1.f.i	significant developments in the individual's clinical status and of appropriate psychiatric follow-up;	

2.a	*Subjective complaints are documented.*	88%
2.b	*Identified target symptoms are documented*	82%
2.c	*Participation in treatment is documented.*	80%
2.d	*Progress towards objectives in the WRP.*	72%
2.e	*The mental status exam is documented*	85%
2.f	*The individual's legal status and any change in legal status, if applicable.*	71%

2.g	*Current status of medical problems and treatment are documented*	74%
2.h.1	*The lab/diagnostic tests and consults for relevant medical conditions are documented and follow-up provided as indicated*	76%
2.h.2	*Current psychotropic medication dosage/laboratory monitoring/diagnostic testing and consultation protocols are followed as indicated (as per DMH Psychotropic Guidelines)*	64%

Comparative data showed improvement in point-to-point, although not mean, compliance since the last review as follows:

	Previous period	Current period
Mean compliance rate		
2.	93%	44%
Compliance rate in last month of period		
2.	33%	63%
2.a	82%	92%
2.b	75%	89%
2.c	64%	87%
2.d	45%	77%
2.e	85%	92%
2.f	67%	81%
2.g	76%	86%
2.h.1	67%	83%
2.h.2	74%	78%

D.1.f.ii	Timely and justifiable updates of diagnosis and treatment, as clinically appropriate;	3.a	*The MMSE is completed and documented in the*	51%

	progress note.	
3.b	*The current diagnosis includes resolution of NOS, deferred, and rule out diagnoses, if applicable.*	68%

Comparative data showed improvement since the last review as follows:

	Previous period	Current period
Mean compliance rate		
3.	20%	44%
Compliance rate in last month of period		
3.	19%	61%
3.a	41%	61%
3.b	33%	79%

D.1.f.iii Analyses of risks and benefits of chosen treatment interventions;

4.a	*The risks for the current psychopharmacology plan including anticholinergics, benzodiazepines, and polypharmacy are documented.*	73%
4.b	*The benefits for the current psychopharmacology plan including anticholinergics, benzodiazepines, and polypharmacy are documented.*	77%
4.c	*Rationale for the current psychopharmacology plan including anticholinergics, benzodiazepines, and polypharmacy are documented*	74%

Comparative data showed improvement since the last review as follows:

	Previous period	Current period
Mean compliance rate		
4.	40%	70%
Compliance rate in last month of period		
4.	43%	81%
4.a	47%	84%
4.b	49%	88%
4.c	49%	84%

D.1.f.iv

Assessment of, and attention to, high-risk behaviors (e.g., assaults, self-harm, falls) including appropriate and timely monitoring of individuals and interventions to reduce risks;

5.a	*There is a description of the current risks specific to this individual and the precautions instituted to minimize those risk.*	63%
5.b	*The monthly note identifies specific risk behaviors including triggers during the interval period.*	67%
5.c	*If applicable, treatment is modified to minimize risk.*	67%

Comparative data showed improvement in compliance since the last review as follows:

	Previous period	Current period
Mean compliance rate		
5.	23%	54%
Compliance rate in last month of period		
5.	24%	77%
5.a	42%	83%
5.b	29%	86%
5.c	50%	77%

D.1.f.v	Responses to and side effects of prescribed medications, with particular attention to risks associated with the use of benzodiazepines, anticholinergic medications, polypharmacy (use of multiple drugs to address the same condition), and conventional and atypical antipsychotic medications;	

6.a	*Rationale for current psychopharmacology plan including analysis of risks and benefits.*	68%
6.b	*There is a description of any side effects caused by medications, including sedation and cognitive impairment.*	73%
6.c	*The AIMS was done annually for all individuals and quarterly if there is a positive AIMS or a current diagnosis or history of Tardive Dyskinesia.*	68%
6.d	*Response to pharmacologic treatment is documented. There is a description of the response to the psychopharmacologic regimen in terms of symptom reduction or other measurable objectives*	78%

Comparative data showed improvement in compliance since the last review as follows:

	Previous period	Current period
Mean compliance rate		
6.	35%	50%
Compliance rate in last month of period		
6.	38%	63%
6.a	44%	79%
6.b	60%	82%
6.c	61%	76%
6.d	64%	86%

D.1.f.vi	Timely review of the use of "pro re nata" or "as-needed" ("PRN") and "Stat" (i.e., emergency psychoactive) medications and adjustment of regular treatment, as indicated, based on such use; and	

7.a	*Describes the rationale/specific indications for all PRN orders.*	66%
7.b	*Reviews the PRNs and Stats during the interval period.*	61%
7.c	*Discusses use of PRN/Stat as indicated to reduce the risk of restrictive interventions.*	42%
7.d	*Describes modification of regularly scheduled medication regimen based on the use of PRN/Stat medications.*	46%

Comparative data showed improvement since the last review as follows:

	Previous period	Current period
Mean compliance rate		
7.	21%	42%
Compliance rate in last month of period		
7.	22%	66%
7.a	39%	79%
7.b	33%	75%
7.c	17%	70%
7.d	21%	63%

D.1.f.vii	Verification in a clinically justifiable manner, that psychiatric and behavioral treatments are properly integrated. The psychiatrist shall review the positive behavior support plan prior to implementation to ensure consistency with psychiatric formulation, document evidence of regular exchange of data or information with	

8.a	*There is a description in the note of the response to non-pharmacologic treatment.*	46%
8.b	*If applicable, there is documentation to support that the psychiatrist reviewed the PBS plan prior to implementation to ensure consistency with psychiatric formulation.*	48%

	psychologists regarding differentiation of learned behaviors and behaviors targeted for psychopharmacological treatments, and document evidence of integration of treatments.	8.c — *There is documentation to support evidence of regular exchange of data or information with psychologists regarding differentiation of learned behaviors and behaviors targeted for psychopharmacologic treatments, and document evidence of integration of treatments.* — 28% 8.d — *There is modification, as clinically appropriate, of diagnosis and/or pharmacological treatment based on above reviews/assessments.* — 51% Previous period / Current period Mean compliance rate 8. — 3% / 26% Compliance rate in last month of period 8. — 3% / 44% 8.a — 26% / 58% 8.b — 39% / 62% 8.c — 4% / 49% The facility's plan of correction also included the creation of a Psychology Specialty Services Coordinator (PSSC) position and committee. As members of the committee, the senior psychiatrists are expected to provide supervision to the attending psychiatrists to ensure that behavioral guidelines and PBS plans are properly addressed in the progress notes.
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	**Current findings on previous recommendations:** **Recommendation 1, April 2008:** Provide ongoing feedback and mentoring by senior psychiatrists to ensure that the transfer psychiatric assessments correct the deficiencies outlined by this monitor.

discharge; and anticipated benefits of transfer.

Findings:
ASH did not address this recommendation. However, the plan of correction outlined in D.1.c.iii.2 was adequate to implement corrective actions regarding the transfer assessments.

Recommendations 2 and 3, April 2008:
- Monitor this requirement based on a review of at least a 20% sample.
- Provide data analysis that evaluates low compliance and delineates areas of relative improvement (during the reporting period and compared to the last period).

Findings:
ASH used the DMH Physician Inter-Unit Transfer Note Audit Form to assess compliance (March to August 2008). The average sample was 21% of the individuals who have experienced inter-unit transfer per month. The following is a summary of the compliance data:

1.	*Psychiatric course of hospitalization,*	26%
2.	*Medical course of hospitalization,*	28%
3.	*Current target symptoms,*	57%
4.	*Psychiatric risk assessment,*	34%
5.	*Current barriers to discharge,*	28%
6.	*Anticipated benefits of transfer.*	67%

	Previous period	Current period
Mean compliance rate		
1.	30%	26%
2.	17%	28%
3.	55%	57%
4.	32%	34%

	Previous period	Current period
Mean compliance rate		
5.	11%	28%
6.	45%	67%
Compliance rate in last month of period		
1.	30%	13%
2.	17%	24%
3.	55%	52%
4.	32%	30%
5.	11%	26%
6.	45%	74%

The facility's plan of correction included the intention to assemble a work group to ensure that transfers that occur to the medical unit after-hours are coordinated with the on-call psychiatrist to develop a transfer note. In addition, education will be provided to ensure that information that is documented in the WRP is also included in the transfer note.

Recommendation 4, April 2008:
Provide information regarding the frequency of inter-unit transfers of individuals who present severe management problems and have not received behavioral interventions in accord with PBS principles.

Findings:
ASH did not address this recommendation.

Other findings:
This monitor reviewed the charts of six individuals who experienced inter-unit transfers during this reporting period. The review found compliance in one chart (AJF), partial compliance in three (BA, LRS and

TLC) and noncompliance in three (MM, MMR and RDB). The main deficiencies were as follows:

1. The transfer assessment was limited to a statement referring to current physician orders, treatment and WRP assignment.
2. The anticipated benefits of transfer were stated in generic terms.
3. The course of hospitalization (psychiatric and medical), psychiatric risk assessment and discharge barriers were generally incomplete and inadequate to ensure continuity of care at the receiving unit.

These deficiencies must be corrected to achieve substantial compliance with this requirement. The following table outlines the reviews:

Initials	**Date of transfer**
AJF	05/23/08
BA	05/27/08
LRS	03/27/08
MM	05/15/08
MMR	03/03/08
RDB	05/28/08
TLC	09/09/08

Compliance:
Partial.

Current recommendations:
1. Provide ongoing feedback and mentoring by senior psychiatrists to ensure that the transfer psychiatric assessments correct the deficiencies outlined by this monitor.
2. Monitor this requirement based on a review of at least a 20% sample.
3. Provide data analysis that evaluates low compliance and delineates areas of relative improvement (during the reporting period and

		compared to the last period). 4. Provide information regarding the frequency of inter-unit transfers of individuals who present severe management problems and have not received behavioral interventions in accord with PBS principles.

2. Psychological Assessments		
		Methodology: <u>Interviewed</u>: 1. Charles Broderick, PhD, Senior Psychologist 2. Charlie Joslin, Clinical Administrator 3. Chris McDonald, PsyD, Psychologist 4. Christine Mathiesen, PsyD, Director C-PAS 5. Diane Imrem, PsyD, Chief of Psychology 6. Donna Nelson, Standards Compliance Director 7. John De Morales, Executive Director 8. Killorin Riddell, PhD, Acting Coordinator of Psychology Specialist Services 9. Matt Hennessy, Mall Director 10. Rich Morey, PhD, Senior Psychologist Supervisor 11. Teresa M. George, PhD, Senior Psychologist Supervisor <u>Reviewed</u>: 1. The charts of the following 76 individuals: AAC, AB, AG, AJ, ALW, AM, AR, BG, BV, CC, CM, CS, DC, DJ, DK, DKJ, DLJ, DLK, DM, DO, DP, DS, EB, GC, GG, GJ, GM, GP, GS, GV, HE, HM, JB, JC, JJ, JL, JR, JV, KC, KF, KT, LF, LS, MA, MAP, MB, ME, MF, MG, MW, NB, OA, PP, RA, RC, REZ, RG, RK, RLY, RS, SAH, SD, SF, SK, SMB, SP, SW, TJ, TM, TP, TS, WB, WDR, WP, WR, and WT 2. ASH Progress Report 3. ASH Trigger Report 4. DCAT Referrals 5. Functional Assessments completed in the last six months 6. Integrated Assessments: Psychology Section 7. List of conditions impairing cognition 8. List of individuals 23 years and under 9. List of individuals at ASH born outside the United States 10. List of individuals whose preferred/primary language is other than

		English 11. List of individuals with diagnostic uncertainties (No Diagnosis, NOS, Rule-out, and Deferred) 12. List of neuropsychological referrals 13. List of school-age/other individuals needing cognitive and academic assessments within 30 days of admission 14. Neuropsychological Assessments completed in the last six months 15. PBS Plans developed and implemented in the last six months 16. Structural Assessments completed in the last six months <u>Observed</u>: 1. WRPC (Program II, unit 25) for monthly review of DJM 2. WRPC (Program II, unit 27) for monthly review of VL 3. Psychology Specialist Services Committee Meeting
D.2.a	Each State hospital shall develop and implement standard psychological assessment protocols, consistent with generally accepted professional standards of care. These protocols shall address, at a minimum, diagnostic neuropsychological assessments, cognitive assessments, and I.Q./achievement assessments, to guide psychoeducational (e.g., instruction regarding the illness or disorder, and the purpose or objectives of treatments for the same, including medications), educational, rehabilitation, and habilitation interventions, and behavioral assessments (including functional assessment of behavior in schools and other settings), and personality assessments, to inform positive behavior support plans and psychiatric diagnoses.	**Current findings on previous recommendation:** **Recommendation, April 2008:** Finalize and get the necessary approvals for the BY CHOICE and DCAT manuals. **Findings:** This monitor's interview of the Senior Psychologist, Charles Broderick, and documentation review (BY CHOICE manual) found that ASH has finalized and implemented the BY CHOICE manual. ASH has yet to finalize the DCAT manual. **Compliance:** Substantial. **Current recommendation**: Finalize and get the necessary approvals for the DCAT manual.

D.2.b	Each State hospital shall require the completion of cognitive and academic assessments within 30 days of admission of all school-age and other individuals, as required by law, unless comparable testing has been performed within one year of admission and is available to the interdisciplinary team.	**Current findings on previous recommendations:** **Recommendations 1 and 2, April 2008:** • Ensure that all individuals admitted to the facility have their academic and cognitive assessments conducted within 30 days unless comparable testing has been performed within one year of admission and is available for review by the interdisciplinary team. • 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. **Findings:** This monitor's documentation review found that ASH cared for a total of 27 individuals below 23 years of age who required the completion of cognitive and academic assessments within 30 days of their admission. Using item 1 from the DMH Psychology Assessment Monitoring Form, ASH assessed its compliance based on an average sample of 100% of all individuals 22 years and below during this review period (March to August). The table below with its indicators and sub-indicators and corresponding mean compliance is a summary of the data:

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.*	
1.a	*Both intellectual and academic assessments were completed within 30 days of admission. The assessments provide sufficient data to inform the*	33%

	WRPT of the individual's cognitive and academic level for the purpose of educational services; or	
1.b	*Copies of prior cognitive and academic assessments completed within 12 months of admission are available in the chart. The assessments provide sufficient data to inform the WRPT regarding the individual's cognitive and academic level for the purpose of educational services.*	0%
1.c	*The individual has a high school diploma or GED and does not require further testing for receiving further educational services.*	1%

The mean compliance rate was 21% in the previous period and 33% in the current review period. The mean compliance rate was 66% in the last month of the previous review period and 50% in the last month of this review period.

According to the Chief of Psychology, Diane Imrem, and the Senior Psychologist, Charles Broderick, the low compliance rate was due to the high rate of admissions during this review period (mean of 111 admissions per month) and competing demands on the psychologists, making it impossible for the admission psychologists to complete the assessments on time. In addition, ASH had been on a "modified" Integrated Assessment (IAP) process (meaning the IAPS were not done within five days of admission).

ASH's corrective action plan includes conducting the IAPS in the usual manner, increasing the number of admission units, and having Supervising Psychologists in place to ensure oversight for completion of the assessments.

This monitor reviewed eight charts of individuals under 23 years of age

		(BV, DM, GC, HE, KC, RC, SP and TS). Two of these individuals (HE and SP) possessed a GED or a high school diploma and did not require the assessments. Assessments for two of the individuals (GC and RC) were completed in a timely fashion. Assessments for two of the individuals (BV and KC) were untimely. The remaining two individuals (DM and TS) repeatedly refused to participate in the assessments. According to Charles Broderick, examiners will complete the assessments when the individuals are willing to participate in the assessment. **Compliance:** Partial. **Current recommendations**: 1. Ensure that all individuals admitted to the facility have their academic and cognitive assessments conducted within 30 days unless comparable testing has been performed within one year of admission and is available for review by the interdisciplinary team. 2. Ensure that individuals who could not be tested within the first 30 days of admission, for medical or other reasons, are documented and followed up to make sure that such evaluations are completed when the individual is ready for assessment.
D.2.c	Each State hospital shall ensure that all clinicians responsible for performing or reviewing psychological assessments and evaluations are verifiably competent in the methodology required to conduct the assessment.	**Current findings on previous recommendation:** **Recommendation, April 2008:** Ensure that all psychologist positions are filled. **Findings:** This monitor's interview of Diane Imrem, Chief of Psychology, revealed that ASH had a severe shortage of psychologists (nearly 25 unit psychologists) for most months in this review period. ASH is currently short about 10 psychologists (five unit psychologists, three senior psychologists and two neuropsychologists). ASH is continuing the hiring

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<table>
<tr><th colspan="3">Verifiable Competence</th></tr>
<tr><td>1.a</td><td>Number of psychologists who are responsible for performing or reviewing psychological assessments and evaluations</td><td>45</td></tr>
<tr><td>1.b</td><td>Number of psychologists who meet the hospital's credentialing and privileging requirements</td><td>45</td></tr>
<tr><td>2.a</td><td>Number of psychologists observed while undertaking psychological assessments</td><td>8</td></tr>
<tr><td>2.b</td><td>Number observed to be verifiably competent in assessment procedures</td><td>8</td></tr>
</table>

As the table above shows, psychologists at ASH responsible for performing or reviewing psychological assessments and evaluations have met the facility's credentialing and privileging requirements. In addition, Senior Psychologists observed psychologists conducting assessments. This monitor's review of the observation data gathered by the senior psychologists found that the psychological examiners were competent in conducting psychological assessments.

Compliance:
Partial.

Current recommendation:
Ensure that all psychologist positions are filled.</td>
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<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:**
Partial.</td>
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<td>D.2.d.i</td>
<td>expressly state the clinical question(s) for the assessment;</td>
<td>

Current findings on previous recommendations:

Recommendation 1, April 2008:
Ensure that the statements of the reasons for referral are concise and clear.

Findings:
Using item 3 from the DMH Psychology Assessment Monitoring form, ASH assessed its compliance based on an average sample of 100% of the Focused Psychological Assessments due for the month (March to August 2008). The table below with its indicators and sub-indicators and corresponding mean compliance is a summary of the data:

<table>
<tr><td>3.</td><td>Expressly state the clinical question(s) for the assessment.</td><td>92%</td></tr>
<tr><td>3.a</td><td>The clinical question is clearly stated and</td><td>91%</td></tr>
<tr><td>3.b</td><td>The clinical question provides the rational for the assessment.</td><td>93%</td></tr>
</table>

The mean compliance rate for item 3 in the previous review period was 81%. The mean compliance rate was 60% in the last month of the previous period and 85% in the last month of this review period.

According to the Senior Supervising Psychologist, Charles Broderick, ASH hired nearly 15 WRP psychologists during this review period, and these newly hired psychologists required training and mentoring with few supervising psychologists available for the task. The plan of improvement includes having the senior supervising psychologists (ASH has hired two supervising psychologists) provide mentoring to the newly hired psychologists.

This monitor reviewed 13 Focused Psychology Assessments (BG, DLJ, DP, JJ, ME, MG, MW, NB, PP, RK, SD, SW and WR). Clear and concise

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		statements with a rationale for the referral were given in 10 of the Focused Psychological Assessments (DLJ, JJ, ME, MG, MW, PP, RK, SD, SW and WR). The clinical question in the remaining three Focused Psychological Assessments (BG, DP and NB) contained extraneous information better fitting other sections of the report and/or lacked the rationale for the referral. **Recommendation 2, April 2008:** Ensure that there is continuity among the various sections that connect referral questions to conclusions to appropriate recommendations and therapies available within ASH. **Findings:** This monitor reviewed 13 Focused Psychology Assessments (BG, DLJ, DP, JJ, MA, ME, MW, NB, PP, RK, SW, WB and WDR). All 13 Focused Psychology Assessments showed continuity among the sections, from clinical questions to conclusions and recommendations. **Current recommendations**: 1. Ensure that the statements of the reasons for referral are concise and clear. 2. Ensure that there is continuity among the various sections that connect referral questions to conclusions to appropriate recommendations and therapies available within ASH.
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:** **Recommendation, April 2008:** Ensure that all psychological assessments include findings specifically addressing the clinical question(s), but not limited to diagnoses and treatment recommendations.

Findings:
Using item 4 from the DMH Psychology Assessment Monitoring form, ASH assessed its compliance based on an average sample of 100% of the Focused Psychological Assessments due for the month (March to August 2008). The table below with its indicators and sub-indicators and corresponding mean compliance is a summary of the data:

4.	*Include findings specifically addressing the clinical question(s), but not limited to diagnoses and treatment recommendations.*	38%
4.a	*The findings clearly address the clinical question(s), and*	98%
4.b	*Include sufficient information that (i) informs the psychiatric diagnosis, (ii) identifies the individual's treatment and rehabilitation needs, and (iii) suggests intervention priorities that may be included in the individual's WRP*	38%

The mean compliance rate for item 4 in the previous review period was 80%. The compliance rate was 80% in the last month of the previous review period and 40% in the last month of this review period. According to the Assessment Coordinator, further training to fully address this recommendation is to follow to improve the compliance with this recommendation.

This monitor reviewed nine Focused Psychological Assessments (DLJ, DP, DS, JJ, MG, PP, RK, SW and WR). Seven of the Focused Psychological Assessments (DLJ, DP, DS, MG, PP, RK and SW) 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. Two of the Focused Psychological Assessments (JJ and WR) did not satisfy the required

<table>
<tr><td></td><td></td><td>elements.

Current recommendation:
Ensure that all psychological assessments include findings specifically addressing the clinical question(s), but not limited to diagnoses and treatment recommendations.</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:

Recommendation, April 2008:
Ensure that all psychological assessments specify whether the individual would benefit from individual therapy or group therapy.

Findings:
Using item 5 from the DMH Psychology Assessment Monitoring form, ASH assessed its compliance based on an average sample of 100% of the Focused Psychological Assessments due for the month (March to August 2008). The table below with its indicators and sub-indicators and corresponding mean compliance is a summary of the data:
<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>19%</td></tr>
<tr><td>5.a</td><td>Recommendations include whether the individual would benefit from group or individual therapy, and</td><td>48%</td></tr>
<tr><td>5.b</td><td>The recommendations are aligned with the findings, including a rationale for the recommendation, the anticipated benefits for the individual, and the expected outcome(s) that may be specified in an Objective in the individual's WRP.</td><td>24%</td></tr>
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		The mean compliance rate for item 5 in the previous review period was 53%. The compliance rate was 0% in the last month of the previous review period and 10% in the last month of this review period. ASH plans to train psychologists to ensure that a rationale is included for the recommendations made. This monitor reviewed eight Focused Psychological Assessments (DJ, DP, DS, RK, SW, TJ, WB and WR). Three of the assessments (DS, RK and WB) indicated if the individual would benefit from individual and/or group therapy, and the remaining five assessments (DJ, DP, SW, TJ and WR) did not. **Current recommendation**: Ensure that all psychological assessments specify whether the individual would benefit from individual therapy or group therapy.
D.2.d.iv	be based on current, accurate, and complete data;	**Current findings on previous recommendation:** **Recommendation, April 2008:** Ensure that all psychological assessments are based on current, accurate, and complete data. **Findings:** Using item 6 from the DMH Psychology Assessment Monitoring form, ASH assessed its compliance based on an average sample of 100% of the Focused Psychological Assessments due for the month (March to August 2008). The table below with its indicators and sub-indicators and corresponding mean compliance is a summary of the data:

6.	*Be based on current, accurate, and complete data.*	45%
6.a	*The identification information is stated (including but not limited to the name of individual, ID#, age/date of birth, marital status, gender, level of*	74%

	education, ethnicity and/or cultural identity, preferred language, religion/spiritual preferences, legal status, date of report) per Section I of the DMH Focused Psychological Assessment:	
6.b	*All Sources of information are listed including but not limited to medical records, individual interview, staff interviews, collateral interviews, previous assessment reports, and legal document, per Section V of the DMH Focused Psychological Assessment: and*	91%
6.c	*Behavior observations (only those observations during the course of the current assessment procedure, e.g., mood, orientation, appearance, vision, hearing, gait/movement, evidence of psychosis, motivation, testing environment, and approach to testing, are included. There are no other types of data in this section such as historical information. A statement is included as to whether the individual's behavior during testing had an impact on the validity of the tests that were administered and behavior plans, per Section VIII of the DMH Focused Psychological Assessment.*	53%

The mean compliance rate for item 6 in the previous review period was 81%. The compliance rate was 90% in the last month of the previous review period and 40% in the last month of this review period.

The Assessment Coordinator and Senior Supervising Psychologist, Charles Broderick, indicated that low compliance was due to a modification in the sub-category in the item. ASH plans on training psychologists on the revised audit criteria for this recommendation.

		This monitor reviewed 11 Focused Psychological Assessments (DLJ, DP, DS, JJ, MG, PP, RK, SW, WB, WDR and WR). Eight Focused Psychological Assessments (DLJ, DP, DS, MG, PP, RK, SW and WB) included the identification information, listed the sources of information and documented direct observation information, including the individual's cooperation and motivation during the evaluation. The remaining three assessments (JJ, WDR and WR) did not include all the necessary information. **Current recommendation**: Ensure that all psychological assessments are based on current, accurate, and complete data.
D.2.d.v	determine whether behavioral supports or interventions (e.g., behavior guidelines or mini behavior plans) are warranted or whether a full positive behavior support plan is required;	**Current findings on previous recommendation:** **Recommendation, April 2008:** Ensure that all psychological assessments of individuals with maladaptive behavior meet this requirement. **Findings:** Using item 7 from the DMH Psychology Assessment Monitoring form, ASH assessed its compliance based on an average sample of 100% of the Focused Psychological Assessments due for the month (March to August 2008). The table below with its indicators and sub-indicators and corresponding mean compliance is a summary of the data:

7.	*Determine whether behavioral supports or interventions (e.g., Behavior Guidelines) are warranted or whether a full Positive Behavior Support plan is required*	49%
7.a	*Recommendations identify whether behavior supports or interventions (e.g., Behavior Guidelines or a full PBS plan) are required, and*	56%

		7.b — *The recommendations are aligned with the findings, including clear reasoning why the psychologist recommends either Behavior Guidelines or a full PBS plan.* — 48% The mean compliance rate for item 7 in the previous review period was 34%. The compliance rate was 30% in the last month of the previous period and 25% in the last month of this review period. ASH's data analysis indicated that a higher share of the inaccuracies came from assessments conducted by the newly hired psychologists. ASH plans on providing additional training and mentoring to improve the performance of the psychologists with regard this recommendation. This monitor reviewed ten Focused Psychological Assessments (DLJ, DP, DS, JJ, MG, PP, RK, SW, WB and WR). Seven of the Focused Psychological Assessments (DP, DS, JJ, PP, RK, SW and WB) indicated whether the individual would benefit from behavioral guidelines or required Positive Behavioral Support. The remaining three assessments (DLJ, MG and WR) did not include all the relevant information. **Current recommendation**: Ensure that all psychological assessments of individuals with maladaptive behavior meet this requirement.
D.2.d.vi	include the implications of the findings for interventions;	**Current findings on previous recommendation:** **Recommendation, April 2008:** Ensure that all focused psychological assessments include the implications of the findings for interventions, especially psychosocial rehabilitation.

Findings:
Using item 8 from the DMH Psychology Assessment Monitoring form, ASH assessed its compliance based on an average sample of 100% of the Focused Psychological Assessments due for the month (March to August 2008). The table below with its indicators and sub-indicators and corresponding mean compliance is a summary of the data:

8.	*Include the implications of the findings for interventions*	24%
8.a	*Implications of the findings for interventions (i.e., recommendations) are fully documented, and*	69%
8.b	*The recommendations are aligned with the findings, including a rationale for the recommendation, the anticipated benefits for the individual, and the particular interventions that may be specified in the individual's WRP.*	24%

The mean compliance rate for item 8 in the previous review period was 72%. The compliance rate was 70% in the last month of the previous review period and 25% in the last month of this review period.

ASH assessed the low compliance rate to be a function of the psychological examiners' failure to include the rationale for their recommendations. According to the Assessment Coordinator, a template emphasizing the inclusion of a rationale for each recommendation has been produced, and further training and mentoring is to be provided to the psychologists.

This monitor reviewed ten Focused Psychological Assessments (DKJ, DP, DS, JJ, MG, PP, RK, SW, WP and WR). Five of the Focused Psychological Assessments (DP, DS, JJ, SW and WP) contained documentation of the implications of the findings for PSR and other interventions, and the remaining five assessments (DKJ, MG, PP, RK and

<table>
<tr><td></td><td></td><td>WR) did not.

Current recommendation:
Ensure that all focused psychological assessments include the implications of the findings for interventions, especially psychosocial rehabilitation.</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:

Recommendation, April 2008:
Ensure that all focused psychological assessments meet this requirement.

Findings:
Using item 9 from the DMH Psychology Assessment Monitoring form, ASH assessed its compliance based on an average sample of 100% of the Focused Psychological Assessments due for the month (March to August 2008). The table below with its indicators and sub-indicators and corresponding mean compliance is a summary of the data:
<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>30%</td></tr>
<tr><td>9.a</td><td>A statement identifying whether any unresolved issues encompassed by the assessment is present or not, and</td><td>35%</td></tr>
<tr><td>9.b</td><td>If an unresolved issue is identified, the assessment specifies further observations, review of records, interviews, or re-evaluations that may be perform-ed or considered to resolve the issue. The report specifies the timeline for resolving the issue.</td><td>32%</td></tr>
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		The mean compliance for the previous review period was 32%. The compliance rates were 30% and 10% in the last months of the previous and current review periods, respectively. ASH identified the psychologists' failure to include timelines for completing the unresolved issues as the primary factor in the low compliance. ASH plans to emphasize this factor in training psychologists on this recommendation. This monitor reviewed ten Focused Psychological Assessments (DLJ, DP, DS, JJ, MG, PP, RK, SW, WB and WR). Four of the Focused Psychological Assessments (PP, SW, WB and WR) contained statements on unresolved issues encompassed by the assessment, avenues to resolve the inconsistencies and a timeline for doing so. The remaining six (DLJ, DP, DS, JJ, MG, and RK) did not address inconsistencies and/or provide the steps and timelines to resolve them. **Current recommendation**: Ensure that all focused psychological assessments meet this requirement.
D.2.d. viii	Use assessment tools and techniques appropriate for the individuals assessed and in accordance with the American Psychological Association Ethical Standards and Guidelines for testing.	**Current findings on previous recommendations:** **Recommendations 1 and 2, April 2008:** • 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. • Ensure that the American Psychological Association Ethical Standards and Guidelines for Testing are followed.

Findings:
Using item 10 from the DMH Psychology Assessment Monitoring form, ASH assessed its compliance based on an average sample of 100% of the Focused Psychological Assessments due for the month (March to August 2008). The table below with its indicators and sub-indicators and corresponding mean compliance is a summary of the data:

10.	*Use assessment tools and techniques appropriate for the individuals assessed and in accordance with the American Psychological Association Ethical Standards and Guidelines for testing*	84%
10.a	*A clear statement of confidentiality is included in the written assessment, and*	100%
10.b	*The assessment instrument used is appropriate for the clinical question(s), and*	98%
10.c	*The instrument used is from the DMH Clinical Indicator List of approved instruments, or a clinically justified rational is provided for using an instrument that is not included in the DMH Clinical Indicator List, and*	86%
10.d	*The administration of the instrument and scoring of the individual's responses are in accordance with the User Manual for the instrument.*	100%

The mean compliance for the previous review period was 100%. The compliance for the last month of the last review period was 90% and the compliance for the last month of this review period is 100%.

This monitor reviewed ten Focused Psychological Assessments (DLK, DP, JJ, MG, PP, RK, SD, SW, WB and WR). All ten Focused Psychological Assessments had used assessment tools appropriate for the individuals in accordance with the American Psychological Association Ethical Standards and Guidelines for Testing. The

		assessment tools used were included in the DMH Clinical Indicator list of approved instruments. The assessments also included statements of confidentiality. This monitor was not privy to the administration of the instruments and scoring of the assessments to know if the assessments were conducted in accordance with the user manual for the instruments. However, this monitor's documentation review found that the Senior Supervising Psychologists had observed examiners during the interviews and test administrations. This monitor's review of the examiner observation data (AB, DC, GM, JL and TP) evidenced proper test administration procedures by the examiners. **Current recommendations**: 1. Ensure that all psychologists use assessment tools and techniques appropriate for the individuals assessed and in accordance with the American Psychological Association Ethical Standards and Guidelines for testing. 2. Ensure that the American Psychological Association Ethical Standards and Guidelines for Testing are followed.
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.	**Current findings on previous recommendation:** **Recommendation, April 2008:** Continue to conduct all Integrated Psychology Assessments in a timely manner. **Findings:** ASH did not present audit data for this recommendation. Interview of the Assessment Coordinator found that ASH has been reviewing the IAPs and re-assessing when indicated. ASH had 439 individuals admitted before June 1, 2006, at the end of the previous review period (February 2008).

		This monitor reviewed seven charts (ALW, CS, REZ, SF, SK, TM and TS) of individuals admitted before June 1, 2006 and still at ASH. All seven charts contained the revised Integrated Assessments: Psychology section. **Compliance:** Substantial. **Current recommendation:** Continue to conduct all Integrated Psychology Assessments in a timely manner.
D.2.f	Each State hospital shall ensure that all appropriate psychological assessments shall be provided in a timely manner whenever clinically indicated, consistent with generally accepted professional standards of care, including whenever there has been a significant change in condition, a lack of expected improvement resulting from treatment, or an individual's behavior poses a significant barrier to treatment, therapeutic programming, safety to self or others, or school programming, and, in particular:	**Compliance:** Partial.
D.2.f.i	before an individual's therapeutic and rehabilitation service plan is developed, a psychological assessment of the individual shall be performed that will:	**Current findings on previous recommendations:** **Recommendations 1 and 2, April 2008:** • Ensure that integrated psychological assessments are conducted in a timely manner as required. • Ensure an adequate number of psychologists to provide timely psychological assessments of individuals.

Findings:
Using item 12 from the DMH Psychology Assessment Monitoring form, ASH assessed its compliance based on an average sample of 100% of the Integrated Assessments: Psychology Section (IAP) due for the month (March to August 2008). The table below with its indicators and sub-indicators and corresponding mean compliance is a summary of the data:

12.	*Before an individual's therapeutic and rehabilitation service plan is developed, a psychological assessment of the individual shall be performed.*	
12.a	*There is a DMH Integrated Assessment: Psychology Section completed within five days of admission.*	21%

The mean compliance for the previous review period was 18%. The compliance rates for the last months of the previous and current review periods were 29% and 16% respectively.

According to the Assessment Coordinator, staffing shortage and a sharp increase in monthly admissions (averaging 111 admissions per month) contributed to the low compliance rate. Furthermore, per the Assessment Coordinator, each admissions team averaged nine admissions per month and spent six to eight hours to complete each integrated assessment. They also spend on average 12 hours per week in WRPTs and Mall team activities. In addition, seven of the 12 admissions psychologists are unlicensed, requiring four hours of supervision per week. Psychologists are also involved in developing and implementing behavior guidelines, conduct academic assessments for the 23 years old and under population, conduct focused assessments and participate in required training sessions.

ASH's plans for improvement include increasing the number of

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<td>admissions teams, and creating a database to be used to remind psychologists of their outstanding IAPs.

This monitor reviewed 15 charts (AR, CC, CM, GP, JC, JL, JV, KF, KT, MAP, MB, ME, RLY, SAH, and SMB). Three of the IAPs in the charts (CC, GP and ME) were conducted in a timely manner. The remaining 12 IAPs (AR, CM, JC, JL, JV, KF, KT, MAP, MB, RLY, SAH and SMB) were untimely.

Current recommendations:
1. Ensure that integrated psychological assessments are conducted in a timely manner as required.
2. Ensure an adequate number of psychologists to provide timely psychological assessments of individuals.</td>
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<tr>
<td>D.2.f.i.1</td>
<td>address the nature of the individual's impairments to inform the psychiatric diagnosis; and</td>
<td>Current findings on previous recommendation:

Recommendation, April 2008:
Ensure that integrated psychological assessments address the nature of the individual's impairments to inform the psychiatric diagnosis.

Findings:
Using item 13 from the DMH Psychology Assessment Monitoring form, ASH assessed its compliance based on an average sample of 50% of the Integrated Assessments: Psychology Section (IAP) due for the month (March to August 2008). The table below with its indicators and sub-indicators and corresponding mean compliance is a summary of the data:
<table>
<tr><td>13.</td><td>Address the nature of the individual's impairments to inform the psychiatric diagnosis</td><td>72%</td></tr>
<tr><td>13.a</td><td>There is documentation of the nature of the individual's psychological impairments, and</td><td>99%</td></tr>
<tr><td>13.b</td><td>The assessment provides adequate information to</td><td>74%</td></tr>
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		inform the psychiatric diagnosis (i.e., nature and extent of signs and symptoms, including excesses and deficits).	
		13.c	*A DSM-IV-TR Checklist has been completed.*	94%

The mean compliance for the last review period was 28%. The compliance rates for the last month of the previous and current review periods were 32% and 73% respectively.

ASH reported that individual psychologists having difficulties with this requirement have been identified, and these psychologists were to receive feedback and training to improve their performance. If the psychologists continue to have difficulty, they will provide corrective addendums to their IAPS to demonstrate mastery of the monitoring requirements.

This monitor reviewed 11 charts (AR, CC, GP, JC, JL, JV, LF, ME, NB, SAH and SMB). Nine of the 11 IAPs in the charts documented the nature of the individual's psychological impairments and provided adequate information to inform the psychiatric diagnosis. The remaining two (GP and SMB) did not fully address the nature of the individual's impairments and/or translate the assessment data into practical terms so the individual's WRPT could determine the nature, direction, and sequence of interventions needed for the individual's rehabilitation.

Current recommendation:
Ensure that integrated psychological assessments address the nature of the individual's impairments to inform the psychiatric diagnosis.

D.2.f.i.2	provide an accurate evaluation of the individual's psychological functioning to inform the therapeutic and rehabilitation service	**Current findings on previous recommendations:**

	planning process;	**Recommendations 1 and 2, April 2008:** • Ensure that all elements that would affect complete understanding of an individual's psychological functioning are considered when monitoring this item. • Ensure accurate evaluation of psychological functioning that informs WRPT's of individuals rehabilitation service needs. **Findings:** Using item 14 from the DMH Psychology Assessment Monitoring form, ASH assessed its compliance based on an average sample of 49% of the Integrated Assessments: Psychology Section (IAP) due for the month (March to August 2008). The table below with its indicators and sub-indicators and corresponding mean compliance is a summary of the data:

14.	*Provide an accurate evaluation of the individual's psychological functioning to inform the therapeutic and rehabilitation service planning process.*	31%
14.a	*The assessment provides an accurate and valid evaluation of the individual's psychological functioning, and*	97%
14.b	*The assessment data are translatable into practical terms so that the individual's WRPT can determine the nature, direction, and sequence of interventions needed for the individual's rehabilitation.*	30%

The mean compliance for the previous period was 29%. The compliance rate in the last month of both the previous and current review periods was 34%.

ASH had changed the monitoring guideline for this item. The requirement for this new guideline was distributed to the psychologists in August 2008. Supervisors and psychologists only recently became

		familiar with the new guidelines. Compliance is expected to improve now that the psychologists and supervisors are familiar with the guideline. This monitor reviewed 11 charts (AR, CC, GP, JC, JR, KT, LF, MAP, ME, RLY and SMB). Seven of the IAPs in the charts (AR, JC, JR, LF, MAP, ME and RLY), especially that of RLY, provided an accurate and valid evaluation of the individual's psychological functioning, and the assessment data were interpreted to assist the WRPTs to determine the interventions needed for the individual's rehabilitation. The remaining four IAPs (CC, GP, KT and SMB) could have provided more focused recommendations with goals and rationale for the recommendations made. **Current recommendations**: 1. Ensure that all elements that would affect complete understanding of an individual's psychological functioning are considered when monitoring this item. 2. Ensure accurate evaluation of psychological functioning that informs WRPT's of individuals' rehabilitation service needs.
D.2.f.ii	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 recommendations:** **Recommendations 1 and 2, April 2008:** • Ensure that PBS referrals get timely attention to assist Level of Care staff in managing individuals with significant learned maladaptive behaviors. • Ensure appropriate structured and functional assessments are undertaken by a qualified psychologist when an individual has learned maladaptive behavior. **Findings:** This monitor's interview of the Psychology Specialty Services

		Committee (PSSC) Coordinator found that ASH has established a system to identify and track individuals with maladaptive behaviors. The process involves receiving weekly trigger data, entering it in a database, and alerting the PBS teams for appropriate action. This monitor attended one of the PSSC meetings. The meeting was well-organized and -structured. The process and procedures were methodical and productive. Attendance was good at the meeting with representation from all core disciplines. A review of the PBS referrals and the response time to address the referrals found that the PBS teams were prompt in responding to the referrals. All referrals were acknowledged within 72 hours, and followed up with appropriate assessments. This monitor's review of nine PBS plans (AAC, AJ, BG, CC, GG, HM, SMB, SW and WT) found that all the plans were developed and implemented from data derived through the structural and functional assessments. The structural and functional assessments were comprehensive and of acceptable quality. This monitor's review of the trigger data for this review period and of the Behavior Guidelines and PBS plans developed and implemented during this review period found that there were a number of individuals with high triggers who were not picked up by the PBS teams for assessment, and where appropriate development and implementation of PBS plans. The Chief of Psychology and the PSSC Coordinator indicated that the shortage of PBS teams resulted in some individuals' needs not being addressed in a timely manner. **Current recommendations**: 1. Ensure that PBS referrals get timely attention to assist Level of Care staff in managing individuals with significant learned maladaptive behaviors.

<table>
<tr><td></td><td></td><td>2. Ensure appropriate structured and functional assessments are undertaken by a qualified psychologist when an individual has learned maladaptive behavior.</td></tr>
<tr><td>D.2.f.iii</td><td>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.</td><td>

Current findings on previous recommendation:

Recommendation, April 2008:
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.

Findings:
Using items 16 to 20 from the DMH Psychology Assessment Monitoring form, ASH assessed its compliance based on an average sample of 5% for item 19 and 1% for the remaining items of the Integrated Assessments: Psychology Section (IAPs) due for the month (March to August 2008). The table below with its indicators and corresponding mean compliance rates is a summary of the data:

<table>
<tr><td>16.</td><td>Differential diagnosis</td><td>17%</td></tr>
<tr><td>17.</td><td>Rule-out</td><td>67%</td></tr>
<tr><td>18.</td><td>Deferred</td><td>100%</td></tr>
<tr><td>19.</td><td>No diagnosis</td><td>83%</td></tr>
<tr><td>20.</td><td>NOS diagnosis</td><td>100%</td></tr>
</table>

The sample size is very small. ASH should increase the sample size to get a better reflection of its compliance with this requirement. The Assessment Coordinator is aware of this and plans to increase the sample size now that staffing has improved.

This monitor reviewed nine charts of individuals whose diagnoses</td></tr>
</table>

		needed clarification owing to insufficient information to form a firm diagnosis (AM, DK, DO, GS, LS, MF, OA, RG and RS). Six of the Integrated Assessments in the charts (AM, DK, DO, GS, OA and RS) had requested and/or conducted additional psychological assessments. The remaining three Integrated Assessments (LS, MF and RG) did not request and/or conduct additional assessments to clarify the diagnostic uncertainties. During the previous tour, this monitor had noted discrepancies between the individuals' diagnoses on record and the stated diagnoses in ASH's monitoring system. Donna Nelson, Director of Standards Compliance, had recognized the discrepancies and was addressing this issue. A follow-up discussion with Donna Nelson during this review found that this problem has been resolved through a number of safeguards including timely reviews, re-education of the Psychiatry Assessment team by the Medical Director, and identification of discrepancies by the Medical Director through review of the ADT/ODS system with subsequent correction or reconciliation by the treatment team and evaluators. **Current recommendation**: 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.
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	**Current findings on previous recommendations:** **Recommendations 1 and 2, April 2008:** • Ensure that examiners consider cultural aspects when choosing assessment instruments with individuals whose preferred language is not English.

	use of interpreters in the individual's primary language and dialect, if feasible.	• Ensure that psychological assessments are provided in the individual's preferred language using interpreters or cultural brokers. **Findings:** Using items 21 to 23 from 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 for the month (March to August 2008). The table below with its indicators and sub-indicators and corresponding mean compliance is a summary of the data: 21.a — *Number of individuals who needed assessment during the evaluation period whose primary language was not English* — 8 21.b — *Of those in 21.a, number of individuals who were assessed in their primary language* — 3 22.a — *Of those in 21.a, number of individuals who could not be assessed because their primary language was not English* — 5 22.b — *Of those in 22.a, number of individuals who had plans developed to meet their assessment needs* — 1 23. — *Of those in 22.b, number of individuals whose plans for assessment were implemented* — 0 This monitor's findings from report reviews of non-English speaking individuals (AG, EB, GJ, GV, JB, JJ, JR and RA) are in agreement with the facility's data. **Compliance:** Partial.

		Current recommendations: 1. Ensure that examiners consider cultural aspects when choosing assessment instruments for individuals whose preferred language is not English. 2. Ensure that psychological assessments are provided in the individual's preferred language using interpreters or cultural brokers.

3. Nursing Assessments		
		Methodology: Interviewed: 1. Belinda Roetker, RN, Standards Compliance 2. Concha Silva, RN, Standards Compliance 3. Cynthia Davis, Nurse Administrator, Central Nursing Services 4. Donna Hunt, Health Services Specialist 5. Jeannine Doolin, RN, Standards Compliance 6. Justin Alldredge, Psychiatric Technician 7. Marlene Espitia, RN, Standards Compliance 8. Rosie Morrison, Health Services Specialist 9. Teri Jewell, Psychiatric Technician, Quality Assurance Monitor Reviewed: 1. ASH's progress report and data 2. Training rosters for Admission and Integrated Assessments; Physical Assessments; Psychiatric Nursing; Nursing Assessment Competency Mentoring 3. Statewide Nurse Administrator Committee Meeting minutes dated August 13, 2008 4. Nursing Admission Assessments, Integrated Assessments, and WRPs for the following 40 individuals: AA, AES, AJT, AKH, AOQ, AP, BCS, BDA, BEM, BM, CDG, CLC, DEA, DJW, DLC, DNF, EJA, FC, GFP, GKP, GLM, GN, GV, HKS, HP, JIJ, JN, JRR, JRW, KM, LDJ, MAF, MD, MVB, NBM, PP, RLP, SK, WMN and WWM
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:** Partial.

D.3.a.i	a description of presenting conditions;	**Current findings on previous recommendations:** **Recommendation 1, April 2008:** Develop and implement the Nursing Assessment Competency Validation Form. **Findings:** ASH has implemented the use of individual RN data results from the Plato database to evaluate competency regarding nursing assessments. This information provides specific details regarding compliance for each RN completing nursing admission/integrated assessments. **Recommendation 2, April 2008:** Continue to monitor this requirement. **Findings:** The facility reported data from the DMH Nursing Admission Assessment Monitoring audit for cells D.3.a.i-D.3.a.ix based on a 100% sample of admissions for the month (March-August 2008). The following is a summary of ASH's data:

1.	*A description of presenting conditions*	
1.a	*Each section of the Psychiatric and Psychological section of the Nursing Assessment is complete.*	85%
1.b	*Each box checked that is pertinent and has an impact on the individual is elaborated on in the narrative description in the summary of the presenting observations.*	62%
2.	*Current prescribed medications.*	
2.a	*In the additional comments section there is documentation that medication records are not available and the individual is unable to confirm*	75%
2.b	*All currently prescribed medications are*	46%

	documented to include the last time taken, the dose, the side effects, the individuals understanding of the medication, and the reason for the treatment.	
3.	*Vital signs are fully documented or there is documentation that the individual was non-adherent.*	95%
4.	*Allergies*	
4.a	*The box for no known allergies is checked.*	99%
4.b	*If the individual is assessed to have allergies, include type of allergy, source of information, and a description of the signs and symptoms.*	84%
5.	*Pain - All applicable sections of the Pain Assessment are completed.*	91%
6.	*Use of assistive devices.*	89%
7.	*Activities of daily living.*	
7.a	*The entire ADL section is complete*	98%
7.b	*Any rating of 3 or greater is elaborated on in the comments section.*	71%
8.	*Immediate alerts*	
8.a	*The "none known" box is checked.*	99%
8.b	*The alerts section is completed.*	79%
9.	*For conditions needing immediate nursing interventions there are immediate nursing interventions documented.*	51%

The compliance rate has increased overall from February 2008 to August 2008, with the exception of items 1.b, 2.a, and 9, as follows:

1. Item 1.a: from 90% to 95%;
2. Item 1.b: from 63% to 62%;
3. Item 2.a: from 89% to 67%;
4. Item 2.b: from 48% to 70%;

		5. Item 3: from 90% to 95%; 6. Item 4: from 92% to 94%; 7. Item 5: from 86% to 91%; 8. Item 6: from 77% to 97%; 9. Item 7: from 90% to 97%; 10. Item 8: from 77% to 94%; and 11. Item 9: from 73% to 61%. The facility reported that barriers to compliance included the lack of descriptive details in the assessments for a number of items that require elaboration in the narrative sections; sections only partially completed; and confusion regarding immediate alerts and alerts based on historical information. To increase compliance with this requirement, the facility implemented the Psychiatric Nursing class that includes competency validation in March 2008. Thus far, 118 of the 188 facility RNs have completed the class. In addition, an eight-hour Physical Assessment class was implemented in June 2008, which 35 RNs have since completed. In July 2008, ASH implemented the use of the Plato data to focus on individual RN Nursing Assessment Competency training for all admission unit RNs. Thus far, 31 of the 41 Admission Unit RNs have received the training. Also, in efforts to provide more nursing leadership, mentoring, and supervision to all level of care staff, a proposal has been submitted to DMH headquarters regarding Supervising Registered Nurse coverage on a 24/7 basis. A review of admission assessments for 40 individuals (AA, AES, AJT, AKH, AOQ, AP, BCS, BDA, BEM, BM, CDG, CLC, DEA, DJW, DLC, DNF, EJA, FC, GFP, GKP, GLM, GN, GV, HKS, HP, JIJ, JN, JRR, JRW, KM, LDJ, MAF, MD, MVB, NBM, PP, RLP, SK, WMN and WWM) found that there was a noted improvement in both the content and quality of the initial admission assessments in each of the required areas. These

findings comport with ASH's data.

The facility used the DMH Nursing Admission Assessment Integrated Monitoring audit for cells D.3.a.i-D.3.a.ix based on a 97% average sample of integrated nursing assessments due each month (March-August 2008). The following is a summary of ASH's data:

Integrated Assessments

1.	*A description of presenting conditions*	
1.a	*Each section of the Psychiatric and Psychological section of the Nursing Assessment is complete.*	73%
1.b	*Each box checked that is pertinent and have an impact on the individual is elaborated on in the narrative description in the summary of the presenting observations.*	81%
2.	*Current prescribed medications.*	86%
3.	*Vital signs are fully documented or there is documentation that the individual was non-adherent.*	90%
4.	*Allergies*	
4.a	*The box for no known allergies is checked.*	97%
4.b	*If the individual is assessed to have allergies, include type of allergy, source of information, and a description of the signs and symptoms.*	85%
5.	*Pain - All applicable sections of the Pain Assessment are completed.*	86%
6.	*Use of assistive devices.*	92%
7.	*Activities of daily living.*	
7.a	*The entire ADL section is complete*	95%
7.b	*Any rating of 3 or greater is elaborated on in the comments section.*	56%
8.	*Immediate alerts*	

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<tr><td>8.a</td><td>The "none known" box is checked</td><td>97%</td></tr>
<tr><td>8.b</td><td>The alerts section is completed.</td><td>61%</td></tr>
<tr><td>9.</td><td>For conditions needing immediate nursing interventions there are immediate nursing interventions documented.</td><td>33%</td></tr>
</table>

There was no comparison data for Sections D.3.a.i-a.ix related to Integrated Nursing Assessments since they were not audited by ASH during the previous review period. Comparative data will be presented for the next review. ASH reported that the barriers to compliance were the same as for the Admission Assessments noted above. Along with the corrective actions discussed above, ASH will be implementing a focused training for all nurses in November 2008 regarding Integrated Assessments.

A review of the Integrated Nursing Assessments for 40 individuals (AA, AES, AJT, AKH, AOQ, AP, BCS, BDA, BEM, BM, CDG, CLC, DEA, DJW, DLC, DNF, EJA, FC, GFP, GKP, GLM, GN, GV, HKS, HP, JIJ, JN, JRR, JRW, KM, LDJ, MAF, MD, MVB, NBM, PP, RLP, SK, WMN and WWM) found the overall quality to be poor. Much of the information contained in these assessments was superficial; without much additional information noted from the initial admission assessment.

Current recommendation:
Continue to monitor this requirement.
</td></tr>
<tr><td>D.3.a.ii</td><td>current prescribed medications;</td><td>See D.3.a.i.</td></tr>
<tr><td>D.3.a.iii</td><td>vital signs;</td><td>See D.3.a.i.</td></tr>
<tr><td>D.3.a.iv</td><td>allergies;</td><td>See D.3.a.i.</td></tr>
</table>

D.3.a.v	pain;	See D.3.a.i.
D.3.a.vi	use of assistive devices;	See D.3.a.i.
D.3.a.vii	activities of daily living;	See D.3.a.i.
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	See D.3.a.i.
D.3.a.ix	conditions needing immediate nursing interventions.	See D.3.a.i
D.3.b	Nursing may use a systems model (e.g., Johnson Behavioral System Model) for the nursing evaluation.	**Current findings on previous recommendations:** **Recommendation 1, April 2008:** Continue to provide training to staff regarding Wellness and Recovery. **Findings:** See F.3. **Recommendation 2, April 2008:** Continue to monitor this requirement. **Findings:** ASH's Nursing Department has adopted the Wellness and Recovery Model throughout its training curriculums and policies and procedures. Since August 2008, the facility has implemented the Wellness and Recovery Model on all units. **Compliance:** Substantial.

		Current recommendation: Continue current practice.
D.3.c	Each State hospital shall ensure that all nurses responsible for performing or reviewing nursing assessments are verifiably competent in performing the assessments for which they are responsible. All nurses who are employed at any 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:** **Recommendation 1, April 2008:** Develop and implement the Nursing Assessment Competency Validation process. **Findings:** See F.3.a.i. **Recommendation 2, April 2008:** Continue to monitor this requirement. **Findings:** ASH's training rosters indicated that 118 out of 188 facility RNs (63%) have completed the Psychiatric Nursing Class, which includes competency-based training, and 35 RNs have completed the eight-hour Physical Assessment class implemented in June 2008. In July 2008, ASH implemented the use of the Plato data to focus on individual RN Nursing Assessment Competency training for all admission unit RNs. Thus far, 31 of the 41 Admission Unit RNs have received the training. **Compliance:** Partial. **Current recommendation**: Continue to monitor this requirement.
D.3.d	Each State hospital shall ensure that nursing assessments are undertaken on a timely basis, and	**Compliance:** Partial.

	in particular, that:	
D.3.d.i	Initial nursing assessments are completed within 24 hours of the individual's admission;	**Current findings on previous recommendation:** **Recommendation, April 2008:** Continue to monitor this requirement. **Findings:** ASH used the DMH Nursing Admission Assessment Monitoring Form based on a 100% sample of admissions for the month (March-August 2008). The following is a summary of the facility's data: 12. *Initial nursing assessments are completed within 24 hours of the individual's admission.* 98% ASH's data analysis demonstrated that the previous review period's mean for this requirement was 96%. A review of nursing admission assessments for 40 individuals (AA, AES, AJT, AKH, AOQ, AP, BCS, BDA, BEM, BM, CDG, CLC, DEA, DJW, DLC, DNF, EJA, FC, GFP, GKP, GLM, GN, GV, HKS, HP, JIJ, JN, JRR, JRW, KM, LDJ, MAF, MD, MVB, NBM, PP, RLP, SK, WMN and WWM) found that 35 were timely completed, two were not timely completed (BDA and DLC) and three did not have the "Sections Completed" area filled out to accurately determine timeliness (BCS, HP and JRR). **Current recommendation**: Continue to monitor this requirement.
D.3.d.ii	Further nursing assessments are completed and integrated into the individual's therapeutic and rehabilitation service plan within seven days of admission; and	**Current findings on previous recommendations:** **Recommendation 1, April 2008:** Ensure that a nurse attends all WRPTs.

Findings:
ASH's progress report indicated that from March through August 2008, 80% of WRPTs were attended by an RN. The facility reported that the limitations of RN attendance were related to unit staffing coverage requirements and that in November 2008, it will implement a procedure to provide coverage for the core team nurse and psychiatric technician to ensure WRPT attendance.

Recommendation 2, April 2008:
Continue to monitor this requirement.

Findings:
The facility reported data from the DMH Nursing Assessment - Integrated audit based on an average sample of 97% of integrated assessments due for the month (March-August2008). The table below summarizes ASH's data:

13.	*Further nursing assessments are completed and integrated into the individual's therapeutic and rehabilitation service plan within 7 days of admission.*	55%

ASH's data analysis showed a decrease in compliance from 83% in February 2008 to 50% in August 2008. ASH report that shortage of RNs and the opening of new admission units were barriers to compliance. The plan of correction for this requirement included following up with shift leads, unit supervisors and nurse coordinators regarding scheduling issues and tracking integrated assessments.

A review of 40 integrated assessments (AA, AES, AJT, AKH, AOQ, AP, BCS, BDA, BEM, BM, CDG, CLC, DEA, DJW, DLC, DNF, EJA, FC, GFP, GKP, GLM, GN, GV, HKS, HP, JIJ, JN, JRR, JRW, KM, LDJ, MAF, MD, MVB, NBM, PP, RLP, SK, WMN and WWM) found that 34 were timely

		completed and 6 were not timely completed (AA, BEM, GFP, JN, JRW and MAF). **Current recommendations**: 1. Implement procedure to provide coverage for the core team nurse and psychiatric technician to ensure WRPT attendance. 2. Continue to monitor this requirement.
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 a quarterly review and the 12th monthly review shall be the annual review.	**Current findings on previous recommendation:** **Recommendation, April 2008:** Provide data addressing this requirement. **Findings:** Although ASH reported during the last review that data collection for this requirement would begin on 3/1/08, no data was provided. **Current recommendation**: Provide data addressing this requirement.

4. Rehabilitation Therapy Assessments		
		Methodology: Interviewed: 1. Carrie R. Dorsey, Acting Senior Rehabilitation Therapist 2. Kathy Runge, Occupational Therapist 3. Ladonna Decou, Chief of Rehabilitation 4. Nancy Fiske, Occupational Therapist 5. Rachelle Rianda, Acting Senior Rehabilitation Therapist Reviewed: 1. DMH Rehabilitation Therapy Service Manual draft 2. DMH Rehabilitation Therapy Monitoring Form and Instructions (D4 monitoring tool for admission and focused assessments) 3. DMH Rehabilitation Therapy IA-RTS audit data for March-August 2008 4. Focused assessment audit data for April-August 2008 for Speech Therapy, Vocational Rehabilitation and June-August 2008 for Physical Therapy 5. DMH Vocational Rehabilitation Assessment Tool and Instructions (implemented 4/08) 6. DMH Vocational Rehabilitation Assessment Monitoring Tool and Instructions (implemented 4/08) 7. Draft of Vocational Rehabilitation Screening Tool 8. DMH Occupational Therapy Focused Assessment and Instructions 9. DMH Occupational Therapy Focused Assessment Monitoring Tool and Instructions drafts 10. DMH Physical Therapy Focused Assessment and Instructions (implemented 4/08) 11. DMH Physical Therapy Focused Assessment Monitoring Tool and Instructions (implemented 6/08) 12. DMH Comprehensive Integrated Physical Rehabilitation Therapy

		Assessment and Instructions 13. DMH Comprehensive Integrated Physical Rehabilitation Therapy Assessment Monitoring Tool and Instructions 14. List of individuals who had IA-RTS assessments from March-August 2008 15. Records of the following 20 individuals who had IA-RTS assessments from March-August 2008: AMM, AT, CKK, CL, CLH, DA, DEG, DI, DPN, GL, JHM, JJB, JJF, JL, JLH, JS, JS-2, PAA, TDW and WCO 16. Records for the following 10 individuals who had Vocational Rehabilitation Assessments from April-August 2008: AC, AP, BB, FN, GW, JPM, JW, MRS, TAB and TWA 17. List of individuals with Physical Therapy assessment in March-August 2008 18. Records for the following seven individuals with Physical Therapy assessment in June-August 2008: AJB, BM, BS, CRA, IK, JSH and KBR 19. List of individuals with Speech Therapy assessment in April-August 2008 20. Records for the following eight individuals with Speech Therapy assessment in April-August 2008: ALT, BG, CM, DRS, KED, NJB, RF and RRR 21. List of individuals who had type D.4.d assessments from March-August 2008 22. Records of the following eight individuals who had type D.4.d assessments from March-April 2008: CDB, CSO, HS, IC, JHJ, MW, PJC and RDN 23. POST Services Referral form (draft) and instructions 24. POST Services Clarification Form (draft) 25. Training rosters and post tests for Rehabilitation Therapy focused assessment trainings 26. RT Service Manual training rosters and corresponding post tests 27. IA-RTS training rosters and post tests

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 recommendations:** **Recommendation 1, April 2008:** Revise and implement the Department of Mental Health Rehabilitation Therapy Service Manual draft based on changes, new protocols and procedures, and system development; ensure that all discipline-specific service procedures and manuals are integrated into and consistent with Rehabilitation Therapy practice in relation to Wellness and Recovery model and EP requirements. **Findings:** The draft of the statewide Rehabilitation Therapy Manual has been subsequently updated as procedures and processes have evolved. The current draft addresses the role of the Rehabilitation Therapist in the WRPT, as well as the role of the RIAT team, POST team, Occupational Therapist, Physical Therapist, Speech Therapist, and Vocational Rehabilitation Counselors and Instructors. The manual includes a description of the Rehabilitation Therapist's role in acting as a liaison to report findings of the POST disciplines and Vocational Rehabilitation Services, as well as information related to 24-hour support plans and discipline-specific progress notes. The final draft is pending statewide implementation. The Manual should continue to be updated as procedures and systems develop. The facility reported that 34 out of 34 Rehabilitation Therapists received training on the new RT Service Manual on 8/28/08. This was verified by review of training roster and post tests. **Recommendation 2, April 2008:** Implement focused assessment tools and instructions including Physical, Occupational, Speech, Vocational Rehabilitation, and Comprehensive Physical Rehabilitation Therapy assessments, and ensure that process/format is consistent with those of the other three state

		hospitals. **Findings:** The following assessment tools and instructions have been revised and approved and were implemented on 4/1/08: MH-C 9078 DMH Vocational Rehabilitation Assessment and Instructions; MH-C 9079 DMH Speech-Language Therapy Focused Assessment and Instructions; and MH-C 9080 DMH Physical Therapy Focused Assessment and Instructions. This is verified upon review of corresponding procedures and record review of individuals who received focused assessments between March and August 2008. MH-C 9081 DMH Occupational Therapy Focused Assessment and Instructions and MH-C 9082 DMH Comprehensive Integrated Physical Rehabilitation Therapy Assessment and Instructions were approved on 4/1/08 and will be implemented in the next review period due to recent hiring of an Occupational Therapist. It is noted upon review of Vocational Rehabilitation assessments and audit data that no standardized assessments have been used to contribute to assessment objective findings. It is recommended that standardized assessments, such as the relevant subsections of the CASAS, be incorporated into the current Vocational Rehabilitation focused assessment in order to supplement and strengthen objective findings. **Recommendation 3, April 2008:** Develop and implement a plan to ensure that individuals (both new admissions and individuals residing at ASH) who would benefit from a Comprehensive Physical Rehabilitation Therapy assessment or a Vocational Rehabilitation assessment are referred for this service by the WRPT.

		Findings: The facility reported that the current referral process for Vocational Rehab Assessments by the WRPT through Recovery Mall Services is effective in ensuring that individuals are referred for this focused assessment when clinically indicated. A POST services referral form (draft) and corresponding instructions were developed to list services available through the POST team to encourage WRPT referral for a CIPRTA or discipline-specific focused assessment on an individualized basis. The facility reported that its informal plan is for the POST team to make a determination of whether a CIPRTA would be completed based on the POST team referral. A POST Services Clarification Order form draft was also developed to communicate POST treatment plan and type of assessment completed and services recommended. **Other findings:** The facility reported that all admission unit Rehabilitation Therapists are currently performing IA-RTS admission assessments, and that all unit-based Rehabilitation Therapists are currently performing D.4.d conversion IA-RTS assessments. This practice should continue. **Compliance:** Partial. **Current recommendations**: 1. Implement Occupational Therapy and Comprehensive Integrated Physical Rehabilitation Therapy focused assessment, instructions, and auditing tools. 2. Implement the Department of Mental Health Rehabilitation Therapy Service Manual draft and revise as needed based on changes, new protocols and procedures, and system development; ensure that all discipline-specific service procedures and manuals

<table>
<tr><td></td><td></td><td>continue to be consistent with Rehabilitation Therapy practice in relation to the Wellness and Recovery model and Enhancement Plan requirements.
3. Utilize standardized assessments (e.g., CASAS) when available as part of the Vocational rehabilitation focused assessments as clinically indicated.</td></tr>
<tr><td>D.4.b</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>Using the DMH Integrated Assessment Rehabilitation Therapy Section Monitoring Tool, ASH assessed its compliance with timeliness based on an average sample of 83% of Integrated Rehabilitation Therapy assessments due each month for the review period of March-August 2008 (total of 543 out of 654). The following table outlines the indicators with corresponding mean compliance rates:
<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></td></tr>
<tr><td>1.a</td><td>The assessment was completed within 5 calendar days of the individual's admission, and</td><td>34%</td></tr>
<tr><td>1.b</td><td>Filed in the medical record</td><td>98%</td></tr>
</table>
The facility reported that low compliance with item 1.a was due to one admissions therapist being out on medical leave, all RTs not following protocols for assessment timeliness, an increased admission rate from May-July, and varying admission rates from week to week. The facility implemented the following corrective actions in efforts to improve compliance: re-assigned two RTs to admission units 8 and 21 in June and August; provided feedback training to individual RTs in March, May, and June; assigned an additional Senior RT to provide mentoring, monitoring, training, and auditing; reviewed compliance data for May, June, July and August with Admission Unit RTs; addressed performance issues with individual RTs to correct low compliance; and</td></tr>
</table>

encouraged the re-structuring of RT admission assessment groups.

Using the DMH Vocational Rehabilitation Focused Assessment Monitoring Tool, ASH assessed its compliance with timeliness based on an average sample of 60% of Vocational Rehabilitation focused assessments due each month for April-August 2008 (80 out of 131). The following table outlines the indicators with corresponding mean compliance rates:

1.	*Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:*	
1.a	*The assessment was completed within 30 calendar days of the individual's admission, and*	91%
1.b	*Filed in the medical record*	99%

No comparable data were available from the last review period as the assessment was implemented in April 2008.

Using the DMH Speech Therapy Focused Assessment Monitoring Tool, ASH assessed its compliance with timeliness based on an average sample of 65% of Speech Therapy Focused Assessments due each month for April-August 2008 (31 out of 48). The following table outlines the indicators with corresponding mean compliance rates:

1.	*Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:*	
1.a	*The assessment was completed within 14 calendar days of the individual's admission, and*	71%
1.b	*Filed in the medical record*	100%

No comparable data were available from the last review period as the assessment was implemented in April 2008. The facility reported that compliance for 1.a was less than 90% due to an increase in referrals by WRPTs in May driven by the increased identification of individuals with cognitive deficits, which caused a backlog resulting in late assessments; a limited contract for SLP services (32 hours per week); and no SLP services being available in July due to budget constraints and a delay in the approval of the contract, which created a backlog of referrals in August. The facility reported that the RT Chief met with the Speech Therapists to address requirements for timeliness of Speech Therapy focused assessments. The facility plans to evaluate and justify the need for an increase in Speech Therapy services and submit the proposal to HR.

Using the DMH Physical Therapy Focused Assessment Monitoring Tool, ASH assessed its compliance with timeliness based on an average sample of 25% of Integrated Assessment assessments due each month for June-August 2008 (11 out of 44). The following table outlines the indicators with corresponding mean compliance rates:

1.	*Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:*	
1.a	*The assessment was completed within 14 calendar days of the individual's admission, and*	73%
1.b	*Filed in the medical record*	100%

No comparable data were available from the last review period as the assessment was implemented in June 2008. The facility reported that less than 90% compliance with item 1.a was due to a limited contract for Physical Therapy services (25 hours a week). The facility amended

		the PT contract by 30% to increase the number of Physical Therapy hours. The facility plans to continue to make recommendations to increase Physical Therapy services to 2 FTE. **Other findings:** This monitor reviewed the records of twenty individuals (AMM, AT, CKK, CL, CLH, DA, DEG, DI, DPN, GL, JHM, JJB, JJF, JL, JLH, JS, JS-2, PAA, TDW and WCO) to assess compliance with timeliness of D.4 IA-RTS assessments. Nine records (AMM, AT, CKK, CL, JHM, JJB, JS, JS-2 and WCO) were found to be in compliance, and eleven records (CLH, DA, DEG, DI, DPN, GL, JJF, JL, JLH, PAA and TDW) were not in compliance. This monitor reviewed the records of nine individuals (AC, AP, BB, FN, GW, JW, MRS, TAB and TWA) to assess compliance with timeliness of type D.4 Vocational Rehabilitation focused assessments. Seven records (AP, BB, FN, GW, JW, MRS and TAB) were found to be in compliance, and two records (AC and TWA) were not in compliance. This monitor reviewed the records of eight individuals (ALT, BG, CM, DRS, KED, NJB, RF and RRR) to assess compliance with timeliness of type D.4 Speech Therapy focused assessments. Three records (BG, CM and RF) were found to be in compliance and five records (ALT, DRS, KED, NJB and RRR) were not in compliance. This monitor reviewed the records of seven individuals (AJB, BM, BS, CRA, IK, JSH and KBR) to assess compliance with timeliness of type D.4 Physical Therapy focused assessments. Three records (AJB, IK and JSH) were found to be in compliance and four records (BM, BS, CRA and KBR) were found to be not in compliance with timeliness of assessment completion.

		Compliance: Partial. **Current recommendations**: Ensure that each individual served receives Integrated Rehabilitation Therapy assessments (upon admission) and focused Rehabilitation Therapy assessments (as clinically indicated) that are completed in accordance with facility standards for timeliness.
D.4.b.i	Is accurate and comprehensive as to the individual's functional abilities;	**Current findings on previous recommendations:** **Recommendation 1, April 2008:** Implement D.4 monitoring tool(s) for admission and focused assessments that report data on EP cells pertaining to all Rehabilitation Therapy assessments (Integrated Admission and focused) according to DMH format/standards. **Findings:** The MH-C 9044 IA-RTS Monitoring Tool and Instructions were implemented in March 2008. The MH-C 9044e DMH Speech-Language Pathology Assessment Monitoring Form Instructions and the MH-C 9044f DMH Vocational Rehabilitation Assessment Monitoring Form Instructions were implemented in April 2008. MH-C 9044d DMH Physical Therapy Assessment Monitoring Form and Instructions were implemented in June 2008. The MH-C 9044b DMH Comprehensive Integrated Physical Rehabilitation Therapy Assessment Monitoring Form Instructions and MH-C 9044c DMH Occupational Therapy Assessment Monitoring Form Instructions are pending implementation. Implementation of audit tools was verified by review of audit data provided by the facility. **Recommendation 2, April 2008:** Ensure that auditors have received training on monitoring tools and

inter-rater agreement has been established for Integrated Assessment-Rehabilitation Services section and focused assessments monitoring prior to implementation.

Findings:
All auditors (two out of two Speech-Language Services auditors, one out of one Physical Therapy auditor, one out of one Vocational Services auditor and four out of four IA-RTS auditors) have been trained to competency on monitoring tools that they are using. No inter-rater agreement data was provided during this review.

Recommendation 3, April 2008:
Ensure that all Rehabilitation Services admission and focused assessments are accurate and comprehensive as to the individual's functional abilities.

Findings:
Using the DMH Integrated Assessment Rehabilitation Therapy Section Monitoring Tool, ASH assessed its compliance with D.4.b.i based on an average sample of 83% of Integrated Rehabilitation Therapy assessments due each month for the review period of March-August 2008 (543 out of 654). The following table outlines the indicators with corresponding mean compliance rates:

2.	*Is accurate and comprehensive as to the individuals functional abilities;*	
2.a	*Identifying information is fully documented*	96%
2.b	*Previous rehabilitation therapy assessments, POST evaluations, vocational evaluations, WRPs and other salient medical records (e.g., 24-hour admission assessments), interview of individual, chart review, observation of structured activities used in the assessment process, and consultations*	98%

	are reviewed and documented	
2.c	*Structured assessment activities and pertinent information related to setting/time are listed*	78%
2.d	*Leisure and enrichment profile items are completed*	92%
2.e	*Functional observation items are completed for [all pertinent sections]*	71%

No comparable data were collected on sub-items in the last review period.

The facility reported that less than 90% compliance with item 2.e was due to Unit 12 "1370" RTs not consistently completing the "Life Skills" section of the assessment. The facility reported that an additional RT was assigned to the Unit 12 admissions unit. The facility's plan of correction is to provide further training and mentoring to the Rehabilitation Therapy staff in the areas of structured assessment activities and functional observations.

Using the DMH Vocational Rehabilitation Focused Assessment Monitoring Tool, ASH assessed its compliance with D.4.b.i based on an average sample of 61% of Vocational rehabilitation focused assessments due each month for the review period of April-August 2008 (80 out of 131). The following table outlines the indicators with corresponding mean compliance rates:

2.	*Is accurate and comprehensive as to the individuals functional abilities;*	
2.a	*Identifying information is fully documented*	98%
2.b	*Previous Vocational evaluations, rehabilitation therapy assessments, POST evaluations, WRP plans and other salient medical records (e.g. 24 hour admission assessment), interview of*	96%

	individual, chart review, observation of structured activities used in the assessment process, and consultations are reviewed and documented.	
2.c	*Educational background items are completed.*	99%
2.d	*Employment history items are completed.*	99%
2.e	*Personal grooming and appearance items are completed.*	99%
2.f	*All physical functioning items are completed and specific functional measurements are documented if appropriate.*	99%
2.g	*All standardized assessments, as indicated.*	97%

No comparable data were available from the last review period, as the assessment was implemented in April 2008.

Using the DMH Speech Therapy Focused Assessment Monitoring Tool, ASH assessed its compliance with D.4.b.i based on an average sample of 65% of Speech Therapy focused assessments due each month for the review period of April-August (31 out of 48). The following table outlines the indicators with corresponding mean compliance rates:

2.	*Is accurate and comprehensive as to the individuals functional abilities;*	
2.a	*Identifying information is fully documented*	94%
2.b	*Onset date completed*	97%
2.c	*Previous pertinent clinical assessments, WRPs and other salient medical records, interview of individual, chart review, observation, and consultations are reviewed and documented.*	100%
2.d	*Prior level of functioning completed including equipment owned*	97%
2.e	*Pertinent medical history completed, including precautions.*	94%

2.f	*Current functional abilities are addressed including:*	100%

No comparable data were available from the last review period, as the assessment was implemented in April 2008.

Using the DMH Physical Therapy Focused Assessment Monitoring Tool, ASH assessed its compliance with D.4.b.i based on an average sample of 25% of Physical Therapy focused assessments due each month for the review period of June-August 2008 (11 out of 44). The following table outlines the indicators with corresponding mean compliance rates:

2.	*Is accurate and comprehensive as to the individuals functional abilities;*	
2.a	*Identifying information is fully documented*	82%
2.b	*Diagnosis*	91%
2.c	*Functional PT diagnosis*	91%
2.d	*Onset date*	100%
2.e	*Age*	91%
2.f	*Chief complaint/mechanism of injury*	100%
2.g	*Past Medical History*	91%
2.h	*Prior level of function*	55%
2.i	*Special precautions*	86%
2.j	*Orientation*	100%

No comparable data were available from the last review period, as the assessment was implemented in June 2008.

The facility reported that the reason for less than 90% compliance with items 2.a, 2.h and 2.i was that the Physical Therapists were not completing these sections according to assessment instructions and protocol. The facility's plan of correction is to provide training to Physical Therapy staff on addressing these sections according to

		assessment instructions. **Recommendation 4, April 2008:** Ensure that all staff has been trained to competency on assessment protocols and instructions. **Findings:** See D.4.c for findings regarding this recommendation. **Other findings:** This monitor reviewed the records of twenty individuals (AMM, AT, CKK, CL, CLH, DA, DEG, DI, DPN, GL, JHM, JJB, JJF, JL, JLH, JS, JS-2, PAA, TDW and WCO) to assess compliance with D.4.b.i for D.4 IA-RTS assessments. Fifteen records (AMM, AT, CL, CLH, DA, DEG, DI, DPN, GL, JJB, JJF, JL, JLH, PAA and TDW) were found to be in substantial compliance, three records (CKK, JHM and JS-2) were in partial compliance, and two records (JS and WCO) were not in compliance. Identified patterns of deficiencies that the facility should focus on in order to improve compliance include the following: 1. Assessments are not consistently comprehensive and accurate. 2. Assessments do not consistently adequately address and specify functional abilities. This monitor reviewed the records of ten individuals (AC, AP, BB, FN, GW, JPM, JW, MRS, TAB and TWA) to assess compliance with D.4.b.i in type D.4 Vocational Rehabilitation focused assessments. Nine records were found to be in substantial compliance, and one record (TWA) was found to be in partial compliance. However, no records were found to include standardized assessment data. This monitor reviewed the records of seven individuals (ALT, BG, CM, DRS, NJB, RF and RRR) to assess compliance with D.4.b.i in type D.4

		Speech Therapy focused assessments. All seven records were found to be in substantial compliance. This monitor reviewed the records of seven individuals (AJB, BM, BS, CRA, IK, JSH and KBR) to assess compliance with D.4.b.i in type D.4 Physical Therapy focused assessments. Four records (BS, CRA, IK and KBR) were found to be in substantial compliance, two records (AJB and BM) were found to be in partial compliance, and one record (JSH) was found to be not in compliance. **Compliance:** Partial. **Current recommendations**: 1. Ensure that all Rehabilitation Services admission and focused assessments are accurate and comprehensive as to the individual's functional abilities. 2. Implement plans of correction based on review of audit data to improve compliance with D.4.b.i criteria.
D.4.b.ii	Identifies the individual's current functional status and the skills and supports needed to facilitate transfer to the next level of care; and	**Current findings on previous recommendation:** **Recommendation:** 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. **Findings:** Using the DMH Integrated Assessment Rehabilitation Therapy Section Monitoring Tool, ASH assessed its compliance with D.4.b.ii based on an average sample of 83% of Integrated Rehabilitation Therapy assessments due each month for the review period of March-August

2008 (543 out of 654). The following table outlines the indicators with corresponding mean compliance rates:

3.	*Identifies the individual's current functional status, and*	
3.a	*The functional status is described for Physical Functioning*	78%
3.b	*The functional status is described for Social Functioning*	59%
3.c	*The functional status is described for Life Skills*	53%
4	*The skills and supports needed to facilitate transfer to the next level of care; and*	
4.a	*A description of the skills and supports necessary to live in the setting in which she/he will be placed, and*	78%
4.b	*A discussion of possible progression/steps towards this level of independence.*	61%

No comparable data were collected on sub-items in the last review period.

The facility attributed the poor compliance with items 3 and 4 to the following factors: Unit 12 (1370) Admission Unit RTs did not consistently complete all sections pertinent to 3.c; RTs had difficulty understanding and describing in written terms the "implications" of their findings; and RTs had difficulty describing 4.b in written terms. The facility plan of correction is to provide training and mentoring to the Rehabilitation Therapy staff in all areas relating to functional status and skills and supports needed to transfer to the next level of care.

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

average sample of 61% of Vocational Rehabilitation focused assessments due each month for April-August 2008 (80 total of 131). The following table outlines the indicators with corresponding mean compliance rates:

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

No comparable data were available from the last review period, as the assessment was implemented in April 2008.

Using the DMH Speech Therapy Focused Assessment Monitoring Tool, ASH assessed its compliance with D.4.b.ii based on an average sample of 65% of Speech Therapy focused assessments due each month for April-August 2008 (31 out of 48). The following table outlines the indicators with corresponding mean compliance rates:

3.	*Identifies the individual's current functional status, and*	93%
4.	*The skills and supports needed to facilitate transfer to the next level of care*	85%

No comparable data were available from the last review period, as the assessment was implemented in April 2008. The facility's plan of correction is to provide training and mentoring to Speech Therapists in the area of skills and supports needed to transfer to the next level of care.

Using the DMH Physical Therapy Focused Assessment Monitoring Tool, ASH assessed its compliance with D.4.b.ii based on an average sample of 25% of Physical Therapy focused assessments due each month for

June-August 2008 (11 out of 44). The following table outlines the indicators with corresponding mean compliance rates:

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*	55%

No comparable data were available from the last review period, as the assessment was implemented in June 2008.

The facility reviewed the data and reported that the low compliance with item 4 was "due to a technical error."

The facility's plan of correction is to provide training and mentoring to Physical Therapists regarding assessment and documentation of skills and supports needed to facilitate transfer to the next level of care.

Other findings:
This monitor reviewed the records of twenty individuals (AMM, AT, CKK, CL, CLH, DA, DEG, DI, DPN, GL, JHM, JJB, JJF, JL, JLH, JS, JS-2, PAA, TDW and WCO) to assess compliance with D.4.b.ii in D.4 IA-RTS assessments. Eight records (AMM, DA, DI, GL, JJB, JJF, JL and PAA) were found to be in substantial compliance, ten records (AT, CKK, CL, CLH, DEG, DPN, JLH, JS, JS-2 and TDW) were in partial compliance, and two records (JHM and WCO) were not in compliance. Identified patterns of deficiencies that the facility should focus on in order to improve compliance include the following:

1. Assessments do not consistently provide thorough analysis of functional status.
2. Assessments do not consistently discuss skills and supports needed to facilitate transfer to the next level of care that are in line with

		the individual's needs. This monitor reviewed the records of ten individuals (AC, AP, BB, FN, GW, JPM, JW, MRS, TAB and TWA) to assess compliance with D.4.b.ii in type D.4 Vocational Rehabilitation focused assessments. Nine records were found to be in substantial compliance, and one record (TWA) was found to be in partial compliance. This monitor also reviewed the records of seven individuals (ALT, BG, CM, DRS, NJB, RF and RRR) to assess compliance with D.4.b.ii in type D.4 Speech Therapy focused assessments. All records were found to be in substantial compliance. Finally, this monitor reviewed the records of seven individuals (AJB, BM, BS, CRA, IK, JSH and KBR) to assess compliance with D.4.b.ii in type D.4 Physical Therapy focused assessments. Two records (IK and KBR) were found to be in substantial compliance, two records (BS and CRA) were found to be in partial compliance, and three records (AJB, BM and JSH) were found to be not in compliance. An identified area of deficiency that the facility should focus on in order to improve compliance is that the assessments do not consistently analyze both functional status and potential skills and supports needed to facilitate transfer to the next level of care. **Compliance:** Partial. **Current recommendations**: 1. 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. 2. Implement plans of correction based on review of audit data to

		improve compliance with D.4.b.ii criteria.
D.4.b.iii	Identifies the individual's life goals, strengths, and motivation for engaging in wellness activities.	**Current findings on previous recommendation:** **Recommendation:** Ensure that all Rehabilitation Services admission and focused assessments identify the individual's life goals, strengths, and motivation for engaging in wellness activities. **Findings:** Using the DMH Integrated Assessment Rehabilitation Therapy Section Monitoring Tool, ASH assessed its compliance with D.4.b.iii based on an average sample of 83% of Integrated Rehabilitation Therapy assessments due each month for the review period of March-August 2008 (543 out of 654). The following table outlines the indicators with corresponding mean compliance rates:

5.	*Identifies the individual's life goals,*	
5.a	*The individual's life goals are identified, including at least one of the following: dreams, hopes, aspirations, desire for future education, desire for occupational skills, or other explicit relevant statements.*	92%
5.b	*Direct quotes in the individual's own words are used or if quotes are not used as a result of individual's non-verbal status it is stated as such.*	92%
6.	*Strengths, and:*	
6.a	*The individual's strengths for engaging in wellness activities are identified*	85%
6.b	*Strengths may include both direct quotes from the individuals as well as the therapist's assessment of the individual's strengths. If quotes are not used as a result of the individual's non-*	76%

	verbal status it is stated as such.	
7.	*Motivation for engaging in wellness activities*	
7.a	*Individual's motivation for engaging in wellness activities are identified with individual's response to the following [required] questions*	75%
7.b	*The individual's current level of motivation has been identified by considering the individual's stage of change, and;*	62%
7.c	*Motivation may include both direct quotes from the individual as well as the therapist's assessment of the individual's motivation*	69%

No comparable data were collected on sub-items in the last review period.

The facility attributed less than 90% compliance with all sub-items of items 6 and 7 to "clinicians not having a full understanding of the requirements." The facility plan of correction is to provide training and mentoring to the Rehabilitation Therapy staff in all areas related to items 6 and 7.

Using the DMH Vocational Rehabilitation Focused Assessment Tool, ASH assessed its compliance with D.4.b.iii based on an average sample of 61% of Vocational Rehabilitation Focused Assessments due each month for the review period of April-August 2008 (80 out of 131). The following table outlines the indicators with corresponding mean compliance rates:

5.	*Identifies the individual's life goals,*	
5.a	*The individual's life goals are identified, including at least one of the following: dreams, hopes, aspirations, desire for future education, desire for occupational skills, or other explicit relevant*	99%

	statements.	
5.b	*Direct quotes in the individual's own words are used or if quotes are not used as a result of individual's non-verbal status it is stated as such.*	98%
6.	*Strengths, and:*	
6.a	*The individual's strengths for engaging in wellness activities are identified*	98%
6.b	*Strengths may include both direct quotes from the individuals as well as the therapist's assessment of the individual's strengths. If quotes are not used as a result of the individual's non-verbal status it is stated as such.*	96%
7.	*Motivation for engaging in wellness activities*	
7.a	*Individual's motivation for engaging in wellness activities are identified with individual's response to the following [required] questions*	99%
7.b	*The individual's current level of motivation has been identified by considering the individual's stage of change, and;*	70%
7.c	*Motivation may include both direct quotes from the individual as well as the therapist's assessment of the individual's motivation*	99%

No comparable data were available from the last review period, as the assessment was implemented in April 2008.

The facility attributed low compliance with 7.b to a "lack of understanding of required content" by one Vocational Counselor. The facility plan of correction is to provide training and mentoring to this identified Vocational Counselor.

Using the DMH Speech Therapy Focused Assessment Tool, ASH assessed its compliance with D.4.b.iii based on an average sample of

65% of Speech Therapy Focused Assessments due each month for the review period of April-August 2008 (31 out of 48). The following table outlines the indicators with corresponding mean compliance rates:

5.	*Identifies the individual's life goals,*	
5.a	*The individual's life goals are identified*	88%
5.b	*Direct quotes in the individual's own words are used or if quotes are not used as a result of individual's non-verbal status it is stated as such*	79%
6.	*Strengths, and:*	
6.a	*The individual's strengths for engaging in wellness activities are identified*	85%
6.b	*Strengths may include both direct quotes from the individual as well as the therapist's assessment of the individual's strength*	88%
7.	*Motivation for engaging in wellness activities*	
7.a	*Individual's motivation for engaging in wellness activities are identified with individual's response to the following [required] questions*	79%
7.b	*The individual's current level of motivation has been identified by considering the individual's stage of change, and;*	83%
7.c	*Motivation may include both direct quotes from the individual as well as the therapist's assessment of the individual's motivation*	79%

No comparable data were available from the last review period, as the assessment was implemented in April 2008.

The facility plan of correction is to provide training to Speech Therapists regarding compliance with all sub-items of items 5, 6 and 7.

Using the DMH Physical Therapy Focused Assessment Tool, ASH

assessed its compliance with D.4.b.iii based on an average sample of 25% of Physical Therapy Focused Assessments due each month for the review period of June-August 2008 (11 out of 44). The following table outlines the indicators with corresponding mean compliance rates:

5.	*Identifies the individual's life goals,*	
5.a	*The individual's life goals are identified*	82%
5.b	*Direct quotes in the individual's own words are used or if quotes are not used as a result of individual's non-verbal status it is stated as such*	82%
6.	*Strengths, and:*	
6.a	*The individual's strengths for engaging in wellness activities are identified*	73%
6.b	*Strengths may include both direct quotes from the individual as well as the therapist's assessment of the individual's strength*	73%
7.	*Motivation for engaging in wellness activities*	
7.a	*Individual's motivation for engaging in wellness activities are identified with individual's response to the following [required] questions*	73%
7.b	*The individual's current level of motivation has been identified by considering the individual's stage of change, and;*	11%
7.c	*Motivation may include both direct quotes from the individual as well as the therapist's assessment of the individual's motivation*	55%

No comparable data were available from the last review period, as the assessment was implemented in June 2008.

The facility plan of correction is to provide training to Physical Therapists regarding compliance with sub-items of items 5, 6 and 7, and to initiate bi-weekly meetings with POST services to address areas

		of low compliance. **Other findings:** This monitor reviewed the records of twenty individuals (AMM, AT, CKK, CL, CLH, DA, DEG, DI, DPN, GL, JHM, JJB, JJF, JL, JLH, JS, JS-2, PAA, TDW and WCO) to assess compliance with D.4.b.iii in D.4 IA-RTS assessments. Ten records (AMM, CL, CLH, DI, DPN, JJB, JJF, JL, JS and WCO) were found to be in substantial compliance, eight records (AT, DA, DEG, GL, JLH, JS-2, PAA and TDW) were in partial compliance, and two records (CKK and JHM) were not in compliance. Identified patterns of deficiencies that the facility should focus on in order to improve compliance include the following: 1. Assessments do not consistently provide thorough analysis of individual strengths for engaging in wellness activities. 2. Assessments do not consistently provide thorough analysis of individual motivation for engaging in wellness activities. This monitor reviewed the records of ten individuals (AC, AP, BB, FN, GW, JPM, JW, MRS, TAB and TWA) to assess compliance with D.4.b.iii in type D.4 Vocational Rehabilitation focused assessments. All records were found to be in substantial compliance. This monitor also reviewed the records of five individuals (ALT, CM, DRS, NJB and RRR) to assess compliance with D.4.b.iii in type D.4 Speech Therapy focused assessments. Three records (CM, DRS and RRR) were found to be in substantial compliance, and two records (ALT and NJB) were not in compliance. Finally, this monitor reviewed the records of seven individuals (AJB, BM, BS, CRA, IK, JSH and KBR) to assess compliance with D.4.b.iii in type D.4 Physical Therapy focused assessments. Six records (BM, BS, CRA, IK, JSH and KBR) were found to be in substantial compliance and

		one record (AJB) was found to be not in compliance. **Compliance:** Partial. **Current recommendations**: 1. Ensure that all Rehabilitation Services admission and focused assessments identify the individual's life goals, strengths, and motivation for engaging in wellness activities. 2. Implement plans of correction based on review of audit data to improve compliance with D.4.b.iii criteria.
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 recommendations:** **Recommendation 1, April 2008:** Ensure that staff who are performing assessments (admission and focused) have been trained to competency. **Findings:** According to facility report, 33 out of 35 Wellness and Recovery Plan Team Rehabilitation Therapists were trained to competency on the IA-RTS assessment during the last review period. The facility reported that all seven newly hired Rehabilitation Therapists were trained to competency on the IA-RTS on the following dates: 3/28/08, 6/11/08 7/18/08, and 7/22/08. This was verified by review of training rosters and post tests. Both Senior Vocational Counselors who are performing Vocational Rehabilitation assessments received competency-based training on the Vocational Rehabilitation Assessment on 3/5/08 and were trained to competency. This training was verified by review of raw data from training rosters and training post tests.

		Both Physical Therapy staff members who are performing Physical Therapy assessments received competency-based training on the Physical Therapy focused assessment on 6/5/08 and were trained to competency. This training was verified by review of raw data from training rosters and training post tests. Both Speech Therapy staff members who are performing Physical Therapy assessments received competency-based training on the Speech Therapy focused assessment on 4/15/08 and were trained to competency. This training was verified by review of raw data from training rosters and training post tests. An Occupational Therapist has been hired and will be trained on performing Occupational Therapy assessments during the next review period. The facility reported that all POST team members who are performing Comprehensive Integrated Physical Rehabilitation Therapy assessments will be trained during the next review period. **Recommendation 2, April 2008:** Develop and implement a system by which to analyze audit data for focused assessments (Vocational Rehabilitation, Occupational, Physical, and Speech Therapy assessments and Comprehensive Physical Rehabilitation assessments) and provide feedback to staff regarding performance improvement and recommendations for training/CEU courses based on these findings, and track CEU courses attended by Rehabilitation Therapy staff. **Findings:** The facility reported that Vocational Services training is scheduled bi-monthly to provide direct feedback utilizing Plato data to address areas of low compliance. The facility reported that Rehabilitation Therapists are provided opportunities to attend discipline-specific association trainings to obtain CEU credits for certifications.

		However, it does not appear at this time that specific course recommendations are suggested based on areas of identified need. **Recommendation 3, April 2008:** Develop and implement a system by to analyze IA-RTS audit data and provide group trend-based training. **Findings:** Trend training based on Plato data is provided by Senior Rehabilitation Therapists through group training, individual feedback, and at Rehabilitation Therapy Service Meetings. A group training based on audit findings was provided to 30 out of 42 Rehabilitation Therapists on 6/26/08. A group training based on Plato audit data findings was provided by the Senior Rehabilitation Therapist to eight out of 12 Admission Unit Rehabilitation Therapists on 7/3/08. **Compliance:** Partial. **Current recommendations**: 1. Ensure that all clinicians responsible for performing or reviewing rehabilitation therapy assessments are verifiably competent in performing the assessments for which they are responsible. 2. Develop and implement a system to recommend training CEU courses based on findings of audit data, and track CEU courses attended by Rehabilitation Therapy staff.
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 § [IV.D.2], above.	**Current findings on previous recommendation:** **Recommendation, April 2008:** Ensure that all individuals admitted to ASH prior to June 1, 2006 receive an Integrated Assessment-Rehabilitation Therapy Section Assessment within the next twelve months.

		Findings: According to facility report, 116 out of 332 type D.4.d assessments (35%) were completed during the March-August review period. **Other findings:** This monitor reviewed the records of eight individuals (CDB, CSO, HS, IC, JHJ, MW, PJC and RDN) who were reported to have received type D.4.d IA-RTS assessments. All records had evidence of completed assessments. Three records (CDB, CSO and PJC) were in substantial compliance with D.4.d and five records (HS, IC, JHJ, MW and RDN) were in partial compliance with the requirements of D.4.d in regards to assessment quality. **Compliance:** Partial. **Current recommendation**: Ensure that all individuals admitted to ASH prior to June 1, 2006 receive an Integrated Assessment-Rehabilitation Therapy Section Assessment within the next six months.

5. Nutrition Assessments		
D.5	Each State hospital shall provide nutrition assessments, reassessments, and interventions consistent with generally accepted professional standards of care. A comprehensive nutrition assessment will include the following:	**Methodology:** Interviewed: 1. Erin Dengate, Assistant Director of Dietetics 2. Dawn Hartman, Registered Dietitian Reviewed: 1. Nutrition Care Monitoring audit data for March-August 2008 for each assessment type 2. Lists of individuals with Nutrition Care Assessments due from March-August 2008 for each assessment type 3. Records for the following six individuals with type D.5.a assessment from March-August 2008: CC, CWS, FM, JJJ, SR and TJC 4. Records for the following two individuals with type D.5.b assessments from March-August 2008: DDM and JTM 5. Records for the following seven individuals with type D.5.d assessments from March-August 2008: BA, DC, DFJ, DH, DS, MAD and PAA 6. Records for the following six individuals with type D.5.e assessments from March-August 2008: DLC, GAB, KB, LH, RLA and VAO 7. Records for the following four individuals with type D.5.f assessments from March-August 2008: HWB, KED, KN and MS 8. Records for the following eight individuals with type D.5.g assessments from March-August 2008: DG, GA, GM, JHFK, JLB, JLP, JS and JV 9. Records for the following 13 individuals with type D.5.i assessments from March-August 2008: AMG, CJG, COP, CP, GAW, GDC, HR, JAR, JMG, JN, MJM, PVH and TM 10. Records for the following 10 individuals with type D.5.j.i assessments from March-August 2008: CJS, DSC, DSM, GTV, JJT, LNC, PK, RAG, TMH and WM

		11. Records for the following eight individuals with type D.5.j.ii assessments from March-August 2008: DRR, MMR, PED, RCS, RJWW, SB, SLC and SS
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 recommendation:** **Recommendation, April 2008:** Continue current efforts to achieve compliance. **Findings:** 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 of March-August 2008 (total of 8). The following table outlines the indicators with corresponding mean compliance rates:

1.	Assessment is completed on time per policy	75%
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	86%
5.	Assessment utilizes findings from subjective and objective data	71%
6.	Nutrition diagnosis is correctly formulated, prioritized and validated	71%
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	43%

11.	Recommendations are appropriate and complete	29%
12.	NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment	86%
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	86%
16.	Assessment is concise	100%
17.	Assessment is legible	100%
18.	Each page of the assessment is signed	83%

The facility reviewed the audit data and reported that compliance was less than 90% for relevant sub-items due to small sample size. They reported that compliance with item 1 was less than 90% due to staff not being notified by referral in time to comply with the 24-hour requirement. Staff was reminded to fax referrals to Nutrition Services according to procedure. The facility plan for corrective action to improve compliance efforts for other sub-items is to provide feedback and training to RDs as a group during meetings and individually.

Other findings:
This monitor reviewed the records of six individuals (CC, CWS, FM, JJJ, SR and TJC) to assess compliance with Nutrition type D.5.a assessment criteria. Four records (CWS, JJJ, SR and TJC) were found to be in substantial compliance and two records (CC and FM) were found to be in partial compliance. Identified patterns of deficiencies that the facility should focus on in order to improve compliance with Nutrition type D.5.a assessment criteria include the following:

1. Nutrition objectives are not consistently specific, behavioral, observable and measurable.

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<td></td>
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<td>2. Nutrition recommendations are not consistently appropriate and complete.

Compliance:
Partial.

Current recommendation:
Continue current efforts to achieve compliance.</td>
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<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:

Recommendation, April 2008:
Continue current efforts to achieve compliance.

Findings:
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 of March-August 2008 (three type D.5.b assessments were completed and two were audited; one record was not available for audit due to transfer). The following table outlines the indicators with corresponding mean compliance rates:
<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>50%</td></tr>
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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*	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*	100%
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%

The facility reviewed the audit data and reported that compliance was less than 90% for item 6 due to a small sample size. The facility plan for corrective action to improve compliance efforts is to provide feedback and training to RDs as a group during meetings and individually.

Other findings:
This monitor reviewed the records of two individuals (DDM and JTM) to assess compliance with Nutrition type D.5.b assessment criteria. Both records were found to be in substantial compliance.

Compliance:
Partial.

		Current recommendation: Continue current efforts to achieve compliance.
D.5.c	For new admissions directly into the skilled nursing facility unit, a comprehensive Admission Nutrition Assessment will be completed within 7 days of admission.	Not applicable. ASH does not have a skilled nursing facility unit.
D.5.d	For new admissions with identified nutritional triggers from Nursing Admission Assessment or physician's consult (e.g., for severe food allergies, tube feeding, extensive dental problems or dental surgery, NPO/clear liquid diet for more than three days, uncontrolled diarrhea/vomiting more than 24hrs, and MAOI, as clinically indicated), a comprehensive Admission Nutrition Assessment will be completed within 7 days of admission.	**Current findings on previous recommendation:** **Recommendation, April 2008:** Continue current efforts to achieve compliance. **Findings:** Using the DMH Nutrition Care Monitoring Tool, ASH assessed its compliance based on an average sample of 95% of Nutrition Type D.5.d Assessments due each month for the review period of March-August 2008 (total of 144 out of 152). The following table outlines the indicators with corresponding mean compliance rates:

1.	*Assessment is completed on time per policy*	83%
2.	*All required subjective concerns are addressed*	97%
3.	*All pertinent objective nutrition information is accurately addressed*	99%
4.	*Estimated daily needs for nutrients specified are appropriate*	94%
5.	*Assessment utilizes findings from subjective and objective data*	79%
6.	*Nutrition diagnosis is correctly formulated, prioritized and validated*	92%
7.	*Nutrition education is documented*	88%
8.	*Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers*	94%

	identified	
9.	*Progress is monitored, measured, and evaluated*	100%
10.	*Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable*	65%
11.	*Recommendations are appropriate and complete*	69%
12.	*NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment*	90%
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*	100%
15.	*Assessment utilizes approved abbreviations*	96%
16.	*Assessment is concise*	99%
17.	*Assessment is legible*	100%
18.	*Each page of the assessment is signed*	92%

According to facility report, the audit sample size for type D.4.d. assessments was less than 100% due to individuals being discharged prior to audit.

The facility attributed low compliance with item 1 to staff vacancies and high caseloads. The mean compliance rate for item 10 improved to 65% from a mean of 58% last period, and improved to 70% in August 2008 from 36% in February 2008. The facility reported that mean compliance for item 11 decreased to 69% from 75% in the last reporting period, but increased from 43% in February 2008 to 63% in August 2008. The decline in the mean for item 11 this period was attributed to stricter auditing to include recommendations related to WRP. A trend was noted in which RDs were not being notified of referrals, and the facility attributed low compliance with item 1 to this trend. The facility plan of correction is to address the issue of the need for unit staff to consistently fax referrals on a hospital-wide basis.

		Other findings: This monitor reviewed the records of seven individuals (BA, DC, DFJ, DH, DS, MAD and PAA) to assess compliance with Nutrition type D.5.d assessment criteria. Two records (DH and DS) were found to be in substantial compliance and five records (BA, DC, DFJ, MAD and PAA) were found to be in partial compliance. Identified areas of deficiency that the facility should focus on in order to improve compliance with Nutrition type D.5.d assessment criteria include: 1. Nutrition diagnoses are not consistently correctly formulated, prioritized and validated. 2. Nutrition recommendations are not consistently appropriate and complete. 3. Nutrition objectives are not consistently specific, behavioral, observable and measurable. **Compliance:** Partial. **Current recommendation**: Continue current efforts to achieve compliance.
D.5.e	For new admissions with therapeutic diet orders for medical reasons, a comprehensive Admission Nutrition Assessment will be completed within 7 days of admission.	**Current findings on previous recommendation:** **Recommendation, April 2008:** Continue current efforts to achieve compliance. **Findings:** 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 of March-August 2008 (total of seven). The following table outlines the indicators with

corresponding mean compliance rates:

1.	*Assessment is completed on time per policy*	71%
2.	*All required subjective concerns are addressed*	100%
3.	*All pertinent objective nutrition information is accurately addressed*	83%
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*	83%
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*	67%
11.	*Recommendations are appropriate and complete*	83%
12.	*NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment*	83%
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*	83%

The facility reviewed the audit data and reported that compliance was

		less than 90% for relevant sub-items due to small sample size. The facility plan for corrective action to improve compliance efforts is to provide feedback and training to RDs as a group during meetings and individually. **Other findings:** This monitor reviewed the records of six individuals (DLC, GAB, KB, LH, RLA and VAO) to assess compliance with Nutrition type D.5.e assessment criteria. Two records (DLC and VAO) were found to be in substantial compliance and four records (GAB, KB, LH and RLA) were found to be in partial compliance. Identified areas of deficiency that the facility should focus on in order to improve compliance include the following: 1. Nutrition objectives are not consistently specific, behavioral, observable and measurable. 2. Nutrition recommendations are not consistently appropriate and complete. **Compliance:** Partial. **Current recommendation:** Continue current efforts to achieve compliance.
D.5.f	For individuals with therapeutic diet orders for medical reason after admission, a comprehensive Admission Nutrition Assessment will be completed within 7 days of the therapeutic diet order but no later than 30 days of admission.	**Current findings on previous recommendation:** **Recommendation, April 2008:** Continue current efforts to achieve compliance. **Findings:** 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 of March-August 2008 (total of 11). The following table outlines the indicators with corresponding mean compliance rates:

1.	*Assessment is completed on time per policy*	82%
2.	*All required subjective concerns are addressed*	100%
3.	*All pertinent objective nutrition information is accurately addressed*	91%
4.	*Estimated daily needs for nutrients specified are appropriate*	91%
5.	*Assessment utilizes findings from subjective and objective data*	91%
6.	*Nutrition diagnosis is correctly formulated, prioritized and validated*	91%
7.	*Nutrition education is documented*	64%
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*	64%
11.	*Recommendations are appropriate and complete*	64%
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*	91%
16.	*Assessment is concise*	91%
17.	*Assessment is legible*	100%
18.	*Each page of the assessment is signed*	100%

		No facility data analysis was provided for items below 90% compliance. The facility plan for corrective action to improve compliance efforts is to provide feedback and training to RDs as a group during meetings and individually. **Other findings:** This monitor reviewed the records of four individuals (HWB, KED, KN and MS) to assess compliance with Nutrition type D.5.f assessment criteria. Two records (KED and KN) were found to be in substantial compliance and two records (HWB and MS) were found to be in partial compliance. **Compliance:** Partial. **Current recommendation:** Continue current efforts to achieve compliance.
D.5.g	For all other individuals, a comprehensive Admission Nutrition Assessment will be completed within 30 days of admission.	**Current findings on previous recommendation:** **Recommendation, April 2008:** Continue current efforts to achieve compliance. **Findings:** Using the DMH Nutrition Care Monitoring Tool, ASH assessed its compliance based on an average sample of 21% of Nutrition Type D.5.g Assessments due each month for the review period of March-August 2008 (85 out of 401). The following table outlines the indicators with corresponding mean compliance rates: 1. *Assessment is completed on time per policy* 87% 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*	94%
5.	*Assessment utilizes findings from subjective and objective data*	82%
6.	*Nutrition diagnosis is correctly formulated, prioritized and validated*	93%
7.	*Nutrition education is documented*	96%
8.	*Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified*	91%
9.	*Progress is monitored, measured, and evaluated*	100%
10.	*Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable*	73%
11.	*Recommendations are appropriate and complete*	73%
12.	*NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment*	94%
13.	*Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present*	100%
14.	*Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support*	n/a
15.	*Assessment utilizes approved abbreviations*	95%
16.	*Assessment is concise*	100%
17.	*Assessment is legible*	100%
18.	*Each page of the assessment is signed*	87%

No facility data analysis was provided regarding type D.5.g Nutrition Assessments for items below 90% compliance. The facility plan for corrective action to improve compliance efforts is to provide feedback and training to RDs as a group during meetings and individually.

		Other findings: This monitor reviewed the records of eight individuals (DG, GA, GM, JHFK, JLB, JLP, JS and JV) to assess compliance with Nutrition type D.5.g assessment criteria. One record (GA) was found to be in substantial compliance and seven records (DG, GM, JHFK, JLB, JLP, JS and JV) were found to be in partial compliance. Identified areas of deficiency that the facility should focus on in order to improve compliance with Nutrition type D.5.g assessments include the following: 1. All pertinent objective data is not consistently documented. 2. Nutrition objectives are not consistently specific, behavioral, observable and measurable. 3. Nutrition recommendations are not consistently appropriate and complete. **Compliance:** Partial. **Current recommendation**: Continue current efforts to achieve compliance.
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:** **Recommendation, April 2008:** Continue current efforts to achieve compliance. **Findings:** Using the DMH Nutrition Care Monitoring Tool, ASH assessed its compliance based on an average sample of 30% of Nutrition Assessments (all types) due each month for the review period of March-August 2008 (total of 466 out of 1545). Based on this data, the facility reports that 91% (weighted mean) of Nutrition admission assessments had evidence of a correctly assigned NST level.

		Other findings: This monitor reviewed records of 64 individuals (AMG, BA, CC, CJG, CJS, COP, CP, CWS, DC, DDM, DFJ, DG, DH, DLC, DRR, DS, DSC, DSM, FM, GA, AB, GAW, GDC, GM, GTV, HR, HWB, JAR, JHFK, JJJ, JJT, JLB, JLP, JMG, JN, JS, JTM, JV, KB, KED, KN, LH, LNC, MAD, MJM, MMR, MS, PAA, PED, PK, PVH, RAG, RCS, RJWW, RLA, SB, SLC, SR, SS, TJC, TM, TMH, VAO and WM) and found that 61 records had evidence of a correctly assigned Nutritional Status Type Level, and were in compliance with D.5.h, while three records (CP,MS and RLA) were not in compliance with D.5.h. **Compliance:** Substantial. **Current recommendation**: Continue current practice.
D.5.i	The frequency of a comprehensive Nutrition Assessment Update will be determined by the NST. Updates should include, but not be limited to: subjective data, weight, body-mass index ("BMI"), waist circumference, appropriate weight range, diet order, changes in pertinent medication, changes in pertinent medical/psychiatric problems, changes in nutritional problem(s), progress toward goals/objectives, effectiveness of interventions, changes in goals/plan, recommendations, and follow-up as needed.	**Current findings on previous recommendation:** **Recommendation, April 2008:** Continue current efforts to achieve compliance. **Findings:** Using the DMH Nutrition Care Monitoring Tool, ASH assessed its compliance based on an average sample of 16% of Nutrition Type D.5.i Assessments due each month for the review period of March-August 2008 (total of 86 out of 523). The following table outlines the indicators with corresponding mean compliance rates: 1. *Assessment is completed on time per policy* 57% 2. *All required subjective concerns are addressed* 96% 3. *All pertinent objective nutrition information is* 65%

	accurately addressed	
4.	*Estimated daily needs for nutrients specified are appropriate*	60%
5.	*Assessment utilizes findings from subjective and objective data*	98%
6.	*Nutrition diagnosis is correctly formulated, prioritized and validated*	82%
7.	*Nutrition education is documented*	73%
8.	*Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified*	75%
9.	*Progress is monitored, measured, and evaluated*	92%
10.	*Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable*	70%
11.	*Recommendations are appropriate and complete*	69%
12.	*NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment*	84%
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*	96%
16.	*Assessment is concise*	98%
17.	*Assessment is legible*	100%
18.	*Each page of the assessment is signed*	98%

The facility reported that compliance with timeliness was low due to vacancies and high caseloads. Compliance with item 11 was reported to be low due to stricter auditing criteria. Facility data analysis was not provided for all items below 90% compliance. The facility plan for corrective action to improve compliance efforts is to provide feedback and training to RDs as a group during meetings and individually.

		Other findings: This monitor reviewed the records of thirteen individuals (AMG, CJG, COP, CP, GAW, GDC, HR, JAR, JMG, JN, MJM, PVH and TM) to assess compliance with Nutrition type D.5.i assessment criteria. One record (MJM) was found to be in substantial compliance, seven records (AMG, CJG, COP, CP, GAW, GDC and TM) were found to be in partial compliance, and five records (HR, JAR, JMG, JN and PVH) were found to be not in compliance (as they were not completed). Identified patterns of deficiency that the facility should focus on in order to improve compliance with Nutrition type D.5.i assessments include the following: 1. Type D.5.i assessments are not consistently completed. 2. Nutrition diagnosis is not consistently correctly formulated, prioritized and validated. 3. Nutrition objectives are not consistently specific, behavioral, observable and measurable. 4. Nutrition recommendations are not consistently appropriate and complete. **Compliance:** Partial. **Current recommendation**: Continue current efforts to achieve compliance.
D.5.j.i	Individuals will be reassessed when there is a significant change in condition.	**Current findings on previous recommendation:** **Recommendation, April 2008:** Continue current efforts to achieve compliance.

Findings:
Using the DMH Nutrition Care Monitoring Tool, ASH assessed its compliance based on an average sample of 33% of Nutrition Type D.5.j.i Assessments due each month for the review period of March-August 2008 (total of 79 out of 243). The following table outlines the indicators with corresponding mean compliance rates:

1.	*Assessment is completed on time per policy*	86%
2.	*All required subjective concerns are addressed*	99%
3.	*All pertinent objective nutrition information is accurately addressed*	67%
4.	*Estimated daily needs for nutrients specified are appropriate*	79%
5.	*Assessment utilizes findings from subjective and objective data*	95%
6.	*Nutrition diagnosis is correctly formulated, prioritized and validated*	96%
7.	*Nutrition education is documented*	79%
8.	*Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified*	81%
9.	*Progress is monitored, measured, and evaluated*	90%
10.	*Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable*	69%
11.	*Recommendations are appropriate and complete*	72%
12.	*NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment*	89%
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*	100%
15.	*Assessment utilizes approved abbreviations*	99%

16.	*Assessment is concise*	97%
17.	*Assessment is legible*	100%
18.	*Each page of the assessment is signed*	97%

The facility attributed less than 90% compliance with timeliness to vacancies, high caseloads, and prioritizing higher acuity assessments over lower-risk referrals. No data analysis was provided for other items below 90% compliance. The facility plan for corrective action to improve compliance efforts is to provide feedback and training to RDs as a group during meetings and individually.

Other findings:
The facility reported that Nutrition Services continues to receive referrals for weight changes, which are duplicative, as they are addressed monthly by dietitians according to facility procedure. A BMI workgroup has been developed to address this issue.

This monitor reviewed the records of ten individuals (CJS, DSC, DSM, GTV, JJT, LNC, PK, RAG, TMH and WM) to assess compliance with Nutrition type D.5.j.i assessment criteria. Six records (CJS, LNC, PK, RAG, TMH and WM) were found to be in substantial compliance and four records (DSC, DSM, GTV and JJT) were found to be in partial compliance. Identified patterns of deficiencies that the facility should focus on in order to improve compliance with Nutrition type D.5.j.i assessments include the following:

1. Nutrition objectives are not consistently specific, behavioral, observable and measurable.
2. Nutrition recommendations are not consistently accurate and complete.

Compliance:
Partial.

		Current recommendations: 1. Continue current efforts to achieve compliance. 2. Ensure that Nutrition Services receives referrals for type D.5.j.i assessments according to facility procedure.
D.5.j.ii	Every individual will be assessed annually.	**Current findings on previous recommendation:** **Recommendation, April 2008:** Continue current efforts to achieve compliance. **Findings:** Using the DMH Nutrition Care Monitoring Tool, ASH assessed its compliance based on an average sample of 22% of Nutrition Type D.5.j.ii assessments due each month for the review period of March-August 2008 (43 out of 198). The following table outlines the indicators with corresponding mean compliance rates:

1.	*Assessment is completed on time per policy*	19%
2.	*All required subjective concerns are addressed*	89%
3.	*All pertinent objective nutrition information is accurately addressed*	78%
4.	*Estimated daily needs for nutrients specified are appropriate*	78%
5.	*Assessment utilizes findings from subjective and objective data*	89%
6.	*Nutrition diagnosis is correctly formulated, prioritized and validated*	100%
7.	*Nutrition education is documented*	67%
8.	*Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified*	89%
9.	*Progress is monitored, measured, and evaluated*	56%

10.	*Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable*	67%
11.	*Recommendations are appropriate and complete*	56%
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*	89%
16.	*Assessment is concise*	100%
17.	*Assessment is legible*	100%
18.	*Each page of the assessment is signed*	100%

The facility attributed low compliance with timeliness to vacancies, high caseloads, and prioritizing higher acuity assessments over lower-risk annual assessments. The facility plan for corrective action to improve compliance efforts is to provide feedback and training to RDs as a group during meetings and individually.

Other findings:
This monitor reviewed the records of eight individuals (DRR, MMR, PED, RCS, RJWW, SB, SLC and SS) to assess compliance with Nutrition type D.5.j.ii assessment criteria. One record (RJWW) was found to be in partial compliance and seven records (DRR, MMR, PED, RCS, SB, SLC and SS) were found to be not in compliance (they were not completed). An identified deficiency that the facility should focus on in order to improve compliance with Nutrition type D.5.j.ii assessments is the inconsistent completion of type D.5.j.ii assessments.

Compliance:
Partial.

		Current recommendation: Continue current efforts to achieve compliance.

6. Social History Assessments		
	Each State hospital shall ensure that each individual has a social history evaluation that, consistent with generally accepted professional standards of care:	**Methodology:** Interviewed: 1. Amy Watson, LCSW 2. Carrie Friend, CSW 3. Donna Nelson, Director of Standards Compliance 4. Janet Bouffard, LCSW, Acting Chief of Social Work 5. Veronica Taylor, Behavior Specialist Reviewed: 1. Charts of the following 14 individuals: AB, AG, AK, BI, DM, GKP, GLP, GR, KAT, KN, MAP, RLY, SMB, and SW 2. ASH's Social History Progress Report (March to August 2008) 3. DMH Social History Assessments Monitoring Form 4. DMH Social History Assessments Monitoring Form Instructions 5. Family Therapy Needs Assessment Survey Observed: 1. WRPC (Program II, unit 25) for monthly review of DJM 2. WRPC (Program II, unit 27) for monthly review of VL
D.6.a	Is, to the extent reasonably possible, accurate, current and comprehensive;	**Current findings on previous recommendation:** **Recommendation, April 2008:** Implement the five-day and 30-day assessments in a timely fashion and improve the quality of the assessments. **Findings:** Using items 1-3 from the DMH Social History Assessment Monitoring Form, ASH assessed its compliance based on an average sample of 37% of the Integrated Assessments: Social Work sections due for the month (March to August 2008). The table below with its indicators and

sub-indicators and corresponding mean compliance (compliance for the previous review period given in parenthesis) is a summary of the data:

1.	*Is, to the extent reasonably possible, accurate*	41% (24%)
1.a	*Section 1: Identifying information is complete and accurate*	88%
1.b	*Section 2: Sources of information includes the individual, collateral information sources and specific documents reviewed, or an explanation for not using these sources. Dates of contacts are listed as appropriate. Dates of source documents are listed*	53%
1.c	*The information in the assessment is factually correct and internally consistent.*	76%
2.	*Is current*	24% (0%)
2.a	*Assessment includes information from current interview, collateral sources, and source documents, or there is sufficient documentation in the assessment to indicate why these sources of information were not utilized.*	66%
2.b	*Includes behavioral observations since the time of admission*	28%
3.	*Is comprehensive*	15% (39%)
3.a	*All sections are completed with at least the minimum information required in the instructions as applicable or indicate why information is not available.*	15%

This monitor reviewed 11 charts to evaluate the Integrated Assessments: Social Work Section (AB, AK, BI, DM, GR, KAT, KN, MAP,

RLY, SMB and SW). Seven assessments were timely and comprehensive (AK, BI, DM, GR, KAT, MAP and SMB) and four (AB, KN, RLY and SW) were untimely and/or were not comprehensive.

Using items 1-3 from the DMH Social History Assessment Monitoring Form, ASH assessed its compliance based on an average sample of 29% of the 30-Day Social Work Assessments due for the month (March to August 2008). The table below with its indicators and sub-indicators and corresponding mean compliance (compliance for the previous review period given in parenthesis) is a summary of the data:

1.	*Is, to the extent reasonably possible, accurate*	39% (2%)
1.a	*Section 1: Identifying information is complete and accurate*	88%
1.b	*Section 2: Sources of information includes the individual, collateral information sources and specific documents reviewed, or an explanation for not using these sources. Dates of contacts are listed as appropriate. Dates of source documents are listed*	45%
1.c	*The information in the assessment is factually correct and internally consistent.*	86%
2.	*Is current*	14% (5%)
2.a	*Assessment includes information from current interview, collateral sources, and source documents, or there is sufficient documentation in the assessment to indicate why these sources of information were not utilized.*	64%
2.b	*Includes behavioral observations since the time of admission*	29%
3.	*Is comprehensive*	22%

3.a	*All sections are completed with at least the minimum information required in the instructions as applicable or indicate why information is not available.*	6% (0%)
		6%

The compliance for the last month of the previous review period was 0% for all three items.

This monitor reviewed 10 charts (AB, AK, BI, DM, GR, KAT, KN, RLY, SMB and SW) to evaluate the 30-day Social Work Assessments. Six of the assessments were timely (AB, AK, DM, KAT, RLY and SW), and four were untimely (BI, GR, KN and SMB).

This monitor's discussion with the Chief of Social Work revealed that ASHs SW staff turnover was high. Thirty-three percent of the SW staff in the admission units is new (assigned within the last three months or less). Compliance was adversely affected by assessments conducted by new as well as non-enduring staff (staff conducting assessments occasionally in light of the unit staff being away on vacation/illness). ASH also is in need of additional senior SW staff for mentoring.

ASH has instituted a number of steps to improve compliance. The steps include additional training and mentoring, adopting a policy of having assessments completed only by trained staff, and providing individual supervision to staff having difficulty meeting assessment standards.

Compliance:
Partial.

		Current recommendation: Implement the five-day and 30-day assessments in a timely fashion and improve the quality of the assessments.
D.6.b	Expressly identifies factual inconsistencies among sources, resolves or attempts to resolve inconsistencies, and explains the rationale for the resolution offered;	**Current findings on previous recommendations:** **Recommendations 1 and 2, April 2008:** • Ensure that social workers identify and address the inconsistencies in current assessments. • Monitor factual inconsistencies in social histories and revise to correct the inconsistencies. **Findings:** Using items 4-6 from the DMH Social History Assessments Monitoring Form, ASH assessed its compliance based on an average sample of 29% of the WRPs due for the month (March to August 2008). The table below with its indicators and sub-indicators and corresponding mean compliance is a summary of the data:

4.	*Expressly identifies factual inconsistencies among sources,*	78% (5%)
4.a	*Factual inconsistencies are listed in Section 20: Identification/ Resolution/ Explanation of Factual Inconsistencies*	41%
4.b	*There is a statement in Section 20 indicating that no factual inconsistencies were identified*	79%
5.	*Resolves or attempts to resolve inconsistencies,*	71% (9%)
5.a	*Attempts to resolve factual inconsistencies are listed in Section 20: Identification / Resolution/ Explanation of Factual Inconsistencies*	15%
5.b	*There is a statement in Section 20 indicating that no factual inconsistencies were identified.*	79%

		6. *Explains the rationale for the resolution offered* — 70% (5%) 6.a *Rationale for resolution of factual inconsistencies are listed in Section 20: Identification /Resolution / Explanation of Factual Inconsistencies* — 13% 6.b *There is a statement in Section 20 indicating that no factual inconsistencies were identified in the assessment.* — 79% This monitor reviewed six charts (AB, AG, BI, DM, GR and KN) to evaluate the 30-Day Social Work Assessments for documentation of factual inconsistencies. Four of the assessments (AB, AG, DM and GR) had identified and resolved factual inconsistencies, and two of them (BI and KN) did not. **Compliance:** Partial. **Current recommendations**: 1. Ensure that social workers identify and address the inconsistencies in current assessments. 2. Monitor factual inconsistencies in social histories and revise to correct the inconsistencies.
D.6.c	Is included in the 7-day integrated assessment and fully documented by the 30th day of an individual's admission; and	**Current findings on previous recommendations:** **Recommendation 1, April 2008:** Ensure all SW Integrated assessments are completed and available to the WRPT before the seven-day WRPC. **Findings:** Using item 7 from the DMH Social History Assessments Monitoring

Form, ASH assessed its compliance based on an average sample of 37% of the Integrated Assessments: Social Work section due for the month (March to August 2008). The table below with its indicators and sub-indicators and corresponding mean compliance is a summary of the data:

7.	*Is included in the 7th day Integrated Assessment*	35% (38%)
7.a	*The assessment was completed within five calendar days of the individual's admission*	66%
7.b	*Filed in the medical record.*	36% (46%)

The compliance for the last month of the previous period was 30% and the compliance for the last month of this review period is 29%.

This monitor reviewed eight charts (AB, GKP, KAT, KN, MAP, RLY, SMB and SW) to evaluate timeliness of the Social Work Integrated Assessments. Four of the assessments in the charts (KAT, MAP, RLY and SMB) were timely and four (AB, GKP, KN and SW) were untimely.

Recommendation 2, April 2008:
Ensure that all 30-day social histories are completed and available to the individual's WRPT by the 30th day of admission.

Findings:
Using item 8 from the DMH Social History Assessment Monitoring Form, ASH assessed its compliance based on an average sample of 29% of the 30-Day Psychosocial Assessment due for the month (March to August 2008). The table below with its indicators and sub-indicators and corresponding mean compliance (compliance for the previous review period given in parenthesis) is a summary of the data:

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<tr><td>8.</td><td>Fully documented by the 30th day of an individual's admission,</td><td>42% (5%)</td></tr>
<tr><td>8.a</td><td>Completed no earlier than the first work day after the 7-day WRPC and no later than the 30th calendar day after admission</td><td>55%</td></tr>
<tr><td>8.b</td><td>Filed in the medical record.</td><td>44% (9%)</td></tr>
</table>

The compliance for the last month of the previous review period was 5%, and the compliance for the last month of this review period is 38%.

This monitor reviewed seven charts (BI, GKP, GR, KAT, KN, RLY and SMB) to evaluate timeliness of the 30-day Social Work Assessments. One of the assessment in the charts (GKP) was timely, and five of them (BI, GR, KAT, KN and SMB) were untimely. One of them (RLY) was conducted within the 30 days time-period, however it was completed on the sixth day of admission (DOA 4/18/08 and DOE 4/23/08), and defeats the intended purpose of the 30-day assessment.

Compliance:
Partial.

Current recommendations:
1. Ensure all SW Integrated assessments are completed and available to the WRPT before the seven-day WRPC.
2. Ensure that all 30-day social histories are completed and available to the individual's WRPT by the 30th day of admission.
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<td>D.6.d</td>
<td>Reliably informs the individual's interdisciplinary team about the individual's relevant social factors and educational status.</td>
<td>Current findings on previous recommendation:

Recommendation, April 2008:
Ensure that social history assessments contain sufficient information</td>
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on the individual's social factors and educational status to reliably inform the individual's WRPT.

Findings:
This monitor's discussion with the Chief of Social Work and documentation review (training log) found that ASH had conducted training to address this and other elements in Integrated Assessments and the 30-Day Assessments. A review of the attendee sign-sheet found that training was conducted on May 29 and June 12, 2008, with remediation and make-up training on August 24, 2008. Individual attention also was provided to SW staff in programs without a Supervising SW staff.

Using item 10 from the DMH Social History Assessment Monitoring Form, ASH assessed its compliance based on an average sample of 37% of the IAPs due for the month (March to August 2008). The table below with its indicators and sub-indicators and corresponding mean compliance (compliance for the previous review period given in parenthesis) is a summary of the data:

10.	*Educational status*	94% (38%)
10.a	*Section 14: Education includes educational level(s) completed by the individual and subject of any degrees or focus of any vocational training, or*	94%
10.b	*"Unknown" is checked.*	4%

The compliance for the last month of the previous period was 42%, and the compliance for the last month of this review period is 100%.

This monitor reviewed six charts (AB, AG, BI, DM, GR and KN) to evaluate documentation of the individual's educational status in the 30-

		day Social Work Assessment. All six assessments included information on the individual's educational status. This monitor reviewed four charts (AG, BI, DM, and GR) to evaluate documentation of the individual's social factors in the 30-day Social Work Assessment. Three of the assessments reviewed (BI, DM and GR) included information on the individual's social factors, and one of them (AG) did not. **Compliance:** Partial. **Current recommendation**: Ensure that social history assessments contain sufficient information on the individual's social factors and educational status to reliably inform the individual's WRPT.

7. Court Assessments		
		Methodology: Interviewed: 1. David Fennel, MD, Chief of Forensic Psychiatry 2. Jennifer Brush, Forensic Services Manager 3. Robert Knapp, MD, Medical Director Reviewed: 1. The charts of six individuals who were admitted under PC 1026 (AW, DB, FL, JN, JW and RMG) 2. The charts of six individuals who were admitted under PC 1370 (AR, EB, JSF, LO, RL and WA) 3. DMH PC 1026 Court Report Monitoring Form 4. ASH PC 1026 Court Report Monitoring summary data (March to August 2008) 5. DMH PC 1370 Court Report Monitoring Form 6. ASH PC 1370 Court Report Monitoring summary data (March to August 2008) 7. Minutes of the Forensic Review Panel during this review period
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:** Partial.
D.7.a.i	clinical progress and achievement of stabilization of signs and symptoms of mental illness that were the cause, or contributing	**Current findings on previous recommendations:**

	factor in the commission of the crime (i.e., instant offense);	**Recommendations 1 and 2, April 2008:** • Continue to monitor this requirement and provide data analysis that evaluates decrease in compliance and delineates relative improvement (during the reporting period and compared to the past period), as indicated. • Ensure that symptoms contributing to the offense and persisting during hospitalization are better specified regarding their nature, course and setting within which they occur. **Findings:** ASH used the DMH Court Report PC 1026 Monitoring Form to assess compliance (March to August 2008). The facility reviewed 100% of the court reports. The mean compliance rate was 95% compared to 86% during the last review. 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 represented sub-criteria of the requirement. Comparative data are listed, as appropriate. ASH reported that the chair of the forensic review panel has met with the report authors individually to give feedback and instruction on making proper revisions to include all the necessary data. **Other findings:** This monitor reviewed the charts of six individuals who were admitted under PC 1026. The review found compliance in three charts (AW, JN and JW), partial compliance in two (DB and RMG) and non-compliance in one (FL). **Current recommendations**: 1. Continue to monitor this requirement and provide data analysis that evaluates the decrease in compliance observed by this monitor and

		delineates relative improvement (during the reporting period and compared to the past period), as indicated. 2. Ensure that symptoms contributing to the offense and persisting during hospitalization are better specified regarding their nature, course and setting within which they occur.
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:** **Recommendation, April 2008:** Continue to monitor this requirement and provide data analysis that evaluates decrease in compliance and delineates relative improvement (during the reporting period and compared to the past period), as indicated. **Findings:** The facility reported a mean compliance rate of 100% compared to 96% during the last review. **Other findings:** This monitor found compliance in four charts (DB, FL, JW and RMG) and partial compliance in two (AW and JN). **Current recommendation:** Continue to monitor this requirement and provide data analysis that evaluates the decrease in compliance observed by this monitor and delineates relative improvement (during the reporting period and compared to the past period), as indicated.
D.7.a.iii	understanding of potential for danger and precursors of dangerous/criminal behavior, including instant offense;	**Current findings on previous recommendation:** **Recommendation, April 2008:** Same as above.

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Findings:
The facility reported a mean compliance rate of 98% compared to 87% during the last review.

Other findings:
Reviewing the above-mentioned charts, this monitor found compliance in three charts (AW, FL and RMG) and partial compliance in three (DB, JN and JW).

Current recommendations:
1. Same as above.
2. Ensure proper formulation and individualization of the precursors.

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<td>D.7.a.iv</td>
<td>acceptance of mental illness and understanding of the need
for treatment, both psychosocial and biological, and the need to adhere to treatment;</td>
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Current findings on previous recommendation:

Recommendation, April 2008:
Same as above.

Findings:
The facility reported the following data:

<table>
<tr><td>14.</td><td>Individual's acceptance of mental illness</td><td>99%</td></tr>
<tr><td>15.</td><td>Individual's understanding of the need for treatment</td><td>99%</td></tr>
<tr><td>16.</td><td>Individual's adherence to treatment</td><td>99%</td></tr>
</table>

Comparative data showed that the rates have remained above 90% since the last review as follows:

<table>
<tr><th>Item</th><th>Mean compliance rate, previous period</th><th>Mean compliance rate, current period</th></tr>
<tr><td>14.</td><td>95%</td><td>99%</td></tr>
<tr><td>15.</td><td>95%</td><td>99%</td></tr>
<tr><td>16.</td><td>97%</td><td>99%</td></tr>
</table>

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Other findings:
This monitor found compliance in three charts (AW, DB and RMG) and partial compliance in three (FL, JN and JW).

Current recommendation:
Continue to monitor this requirement and provide data analysis that evaluates the decrease in compliance observed by this monitor and delineates relative improvement (during the reporting period and compared to the past period), as indicated.

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<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 2008:
Same as above.

Findings:
The facility reported the following data:

<table>
<tr><td>17.</td><td>Individual's development of relapse prevention plan for mental illness symptoms</td><td>99%</td></tr>
<tr><td>18.</td><td>Individual's recognition of precursors and warning signs and symptoms (that may mediate) future dangerous acts</td><td>99%</td></tr>
</table>

Comparative data showed improvement in compliance since the last review e as follows:

<table>
<tr><th>Item</th><th>Mean compliance rate, previous period</th><th>Mean compliance rate, current period</th></tr>
<tr><td>17.</td><td>89%</td><td>99%</td></tr>
<tr><td>18.</td><td>86%</td><td>99%</td></tr>
</table>

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</tr>
</table>

		Other findings: Reviews found compliance in four charts (DB, JN, JW and RMG) and partial compliance in two (AW and FL). **Current recommendation**: Same as above.
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:** **Recommendation, April 2008:** Same as above. **Findings:** The facility reported a mean compliance rate of 99%, compared to 91% during the last review. **Other findings:** This monitor found compliance in five charts (DB, FL, JN, JW and RMG) and partial compliance in one (AW). **Current recommendation**: Same as above.
D.7.a.vii	previous community releases, if the individual has had previous CONREP revocations;	**Current findings on previous recommendation:** **Recommendation, April 2008:** Same as above. **Findings:** The facility reported a mean compliance rate of 100%, compared to 86% during the last review.

		Other findings: This monitor found compliance in all three charts where this requirement was applicable (AW, FL and JN). **Current recommendation**: Same as above.
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:** **Recommendation, April 2008:** Same as above. **Findings:** The facility reported a mean compliance rate of 99%, compared to 85% during the last review. **Other findings:** This monitor found compliance in two charts (AW and RMG) and partial compliance in four (DB, FL, JN and JW). **Current recommendation**: Same as above.
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:** **Recommendation, April 2008:** Same as above. **Findings:** The facility reported a mean compliance rate of 94%, compared to 77% during the last review.

		Other findings: This monitor found compliance in all six charts. **Current recommendation**: Same as above.
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:** 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:** **Recommendation, April 2008:** Continue to monitor this requirement and provide data analysis that evaluates decrease in compliance and delineates relative improvement (during the reporting period and compared to the past period), as indicated. **Findings:** ASH used the DMH Court Report PC 1370 Monitoring Form to assess compliance (March to August 2008). The facility reviewed 100% of the

		court reports. The mean compliance rate was 100% compared to 93% during the last review. The mean compliance rates for the requirements in D.7.b.ii through D.7.b.iv. The indicators are listed if they represented sub-criteria of the requirement. Comparative data are listed, as appropriate. **Other findings:** This monitor reviewed the charts of six individuals who were admitted under PC 1370 (AR, EB, JSF, LO, RL and WA). The review found compliance in all cases. **Current recommendation**: Continue to monitor this.
D.7.b.ii	clinical description of the individual at the time of admission to the hospital;	**Current findings on previous recommendation:** **Recommendation, April 2008:** Same as above. **Findings:** The mean compliance rate was 100%. No data were available during the last review. **Other findings:** Reviews by this monitor found compliance in all six charts. **Current recommendation**: Same as above.
D.7.b.iii	course of hospital stay, describing any progress or lack of progress, response to treatment, current relevant mental status, and	**Current findings on previous recommendation:**

<table>
<tr>
<td></td>
<td>reasoning to support the recommendation; and</td>
<td>
Recommendation, April 2008:
Same as above.

Findings:

<table>
<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>88%</td></tr>
<tr><td>16.</td><td>Current relevant mental status</td><td>87%</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>85%</td></tr>
</table>

Comparative data showed improvement in compliance since the last review e as follows:

<table>
<tr><th>Item</th><th>Mean compliance rate, previous period</th><th>Mean compliance rate, current period</th></tr>
<tr><td>14.</td><td>100%</td><td>100%</td></tr>
<tr><td>15.</td><td>88%</td><td>100%</td></tr>
<tr><td>16.</td><td>87%</td><td>100%</td></tr>
<tr><td>17.</td><td>85%</td><td>100%</td></tr>
</table>

Other findings:
The review found compliance in all six charts.

Current recommendation:
Same as above.
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<tr>
<td>D.7.b.iv</td>
<td>all self-harm behaviors and relevant medical issues, to inform the courts and the facility where the individual will be housed after</td>
<td>Current findings on previous recommendation:</td>
</tr>
</table>

	discharge.	**Recommendation, April 2008:** Same as above. **Findings:** The facility reported a mean compliance rate of 100%, compared to 93% during the last review. **Other findings:** The review found compliance in all six charts. **Current recommendation**: 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 may warrant modifications in their forensic status and/or level of restriction	**Current findings on previous recommendation:** **Recommendation, April 2008:** Continue current practice. **Findings:** ASH has maintained compliance with this requirement. **Compliance:** Substantial. **Current recommendation**: Continue current practice.
D.7.c.i	The membership of the FRP shall include Director of Forensic Psychiatry, Facility Director or designee, Medical Director or designee, Chief of Psychology or designee, Chief of Social Services or designee, Chief of Nursing Services or designee, and Chief of Rehabilitation Services or designee.	**Current findings on previous recommendation:** **Recommendation, April 2008:** Provide specifics regarding the forensic training provided to all members of the PRP by ASH and/or other authorities. Indicate if members have received any training other than through staff meetings

	The Director of Forensic Psychiatry shall serve as the chair and shall be a board certified forensic psychiatrist. A quorum shall consist of a minimum of four FRP members or their designee.	and discussions at ASH. **Findings:** ASH has provided training to FRP members through forensic seminars coordinated by the Director of Forensic Psychiatry/Chair of the FRP on a weekly basis since August 2008. These seminars discuss general forensic issues and specific cases concerning Penal Code sections 2962, 1026, and 1370. In addition, the facility reported that members of the FRP plan to attend the annual meeting of Forensic Psychiatrists in October 2008 in Seattle. **Compliance:** Substantial. **Current recommendation**: Continue current practice and provide specific information regarding training provided/facilitated during the reporting period.

E. Discharge Planning and Community Integration		
		Summary of Progress: There is no significant/substantial progress in any area of 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:** <u>Interviewed</u>: 1. Amy Watson, LCSW 2. Carrie Friend, CSW 3. Charlie Joslin, Clinical Administrator 4. Diane Imrem, PhD, Chief of Psychology 5. Donna Nelson, Director of Standards Compliance 6. Jan Marie Alarcon, PhD, WRP Master Trainer 7. Janet Bouffard, LCSW, Acting Chief of Social Work 8. Matt Hennessy, PhD, Mall Director 9. Ramiro Zeron, LCSW 10. Theresa George, PhD, Psychologist 11. Veronica Taylor, Behavior Specialist <u>Reviewed</u>: 1. Charts of the following 19 individuals: AR, BG, CLC, DEA, DG, EMB, ES, GKP, JLB, JPC, KAT, MAP, MD, RA, RLY, RN, RO, RY, and SMB 2. CONREP WRPT Participation Process 3. List of individuals ready for discharge but still in hospital 4. Training Sign-in Sheets <u>Observed</u>: 1. WRPC (Program II, unit 25) for monthly review of DJM 2. WRPC (Program II, unit 27) for monthly review of VL 3. Psychology Specialist Services Committee Meeting 4. PSR Mall group: Wellness and Recovery Action Plan 5. PSR Mall group: Computer Class

		6. PSR Mall group: "Ready, Set, Go" 7. PSR Mall group: Community Living Skills Project 8. PSR Mall group: Substance Abuse Recovery 9. PSR Mall group: Substance Abuse Recovery2 10. PSR Mall group: Non-violent Communication 11. PSR Mall group: Cognitive Remediation 12. PSR Mall group: Trauma and Anxiety NB: In the previous review, audits related to discharge planning were conducted on Program IV only.
E.1	Each State hospital shall identify at the 7-day therapeutic and rehabilitation service planning conference, and address at all subsequent planning conferences, the particular considerations for each individual bearing on discharge, including:	**Compliance:** Partial.
E.1.a	those factors that likely would foster successful discharge, including the individual's strengths, preferences, and personal life goals;	**Current findings on previous recommendations:** **Recommendations 1 and 2, April 2008:** • 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:** This monitor's discussion with the Chief of Social Work revealed that ASH has assigned mentors for all WRPTs (as of August 2008). In addition, the Clinical Administrator has been meeting with Program Managers and requesting them to identify reasons for low compliance and action plans to improve the compliance. Furthermore, the WRPT Master Trainer has been providing the team members with guidance on

documentation of strengths in interventions, alignment of the various sections in the WRP, and discharge planning.

Using item 1 from the DMH Discharge Planning and Community Integration Auditing Form, ASH assessed its compliance based on an average sample of 24% of the WRPs due for the month (March to August 2008). The table below with its indicators and sub-indicators and corresponding mean compliance rates (previous period compliance given in parenthesis) is a summary of the data:

1.	*Those factors that likely would foster successful discharge, including the individual's strengths, preferences, and personal life goals*	33% (64%)
1.a	*There is at least one objective that is aligned with the individual's personal life goals that are stated on the first page of the WRP, and*	44%
1.b	*The interventions will use the individual's strengths and preferences to achieve the respective objective*	36%

The compliance rate for item 1 was 67% in the last month of the previous period and 40% in the last month of the current review period.

This monitor reviewed eight charts (AR, DG, ES, MD, RA, RN, RO and RY). Three of the WRPs in the charts (DG, ES and RN) had utilized the individual's strengths, preferences, and life goals and these were aligned with the intervention(s) that impacted the individual's discharge goals. The remaining five (AR, MD, RA, RO and RY) did not.

According to the SW Chief, low compliance was due to staffing shortage (a number of WRPTs were not fully staffed) and changes in enduring team members.

		The Acting Chief of Social Work described the following actions being taken to improve performance: the addition of supervising Social Work staff for mentoring Social Workers; the inclusion of competency data in staff employment evaluation criteria; and encouragement to Program Management to provide monthly feedback using data to help Programs understand their performance status. **Compliance:** Partial. **Current recommendations**: 1. Ensure that the individual's strengths and preferences are utilized to achieve discharge goals. These should be linked to the interventions that impact the individual's discharge criteria. 2. The individual's life goals should be linked to one or more foci of hospitalization, with associated objectives and interventions.
E.1.b	the individual's level of psychosocial functioning;	**Current findings on previous recommendations:** **Recommendation 1, April 2008:** Ensure that the level of psychosocial functioning (functional status) is included in the individual's Present Status section of the case formulation section of the WRP. **Findings:** This monitor's discussion with the Chief of Social Work found that ASH had trained 49 WRPT mentors in the last six months to provide guidance and feedback to WRPT members on aspects of discharge planning and community integration. The Master Trainer has been providing training using the Case Formulation module. Using item 2 from the DMH Discharge Planning and Community Integration Auditing Form, ASH assessed its compliance based on an

average sample of 24% of the Quarterly and Annual WRPs due for the month (March to August 2008). The table below with its indicators and sub-indicators and corresponding mean compliance rates (compliance for the previous review period is given in parenthesis) is a summary of the data:

2.	*The individual's level of psychosocial functioning*	24% (26%)
2.a	*The individual's level of psychosocial functioning is mentioned in the Present Status section of the WRP*	59%
2.b	*The interventions linked to the discharge criteria are provided at the level of the individual's psychosocial functioning*	25%

The compliance rates for item 2 for the last month of the previous and current review periods were 20% and 26% respectively.

This monitor reviewed 13 charts (AR, DG, ES, GKP, KAT, MAP, MD, RA, RLY, RN, RO, RY and SMB). Five of the WRPs in the charts (KAT, MAP, MD, RLY and SMB) included the individual's psychosocial functioning in the Present Status section. The remaining eight (AR, DG, ES, GKP, RA, RN, RO and RY) did not include the information or the information was not comprehensive.

Recommendation 2, April 2008:
Use the DMH WRP Manual in developing and updating the case formulation.

Findings:
This monitor's discussion with the WRP Master Trainer revealed that outlines of the DMH WRP Manual requirements on case formulation were developed and distributed on WRPTs, and mentoring and training

		is ongoing. **Recommendation 3, April 2008:** Ensure that team members are aware of and trained in elements to consider in updating GAF scores. **Findings:** This monitor's observation of WRPCs and discussion with the WRPT members found that they were aware of and trained in elements to consider in updating GAF scores. This monitor reviewed five WRPs (GKP, KAT, MAP, RLY and SMB). GAF scores had been revised in four of them. The revised GAF scores reflected the changes in the individual's functioning/performance documented in the Present Status section of the individual's WRP. **Compliance:** Partial. **Current recommendations**: 1. 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. 2. Use the DMH WRP Manual in developing and updating the case formulation.
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:** **Recommendations 1 and 2, April 2008:** • Ensure that discharge barriers, especially difficulties in previously unsuccessful placements, are discussed with the individual at scheduled WRPCs. • Report to the WRPT, on a monthly basis, the individual's progress in overcoming the barriers to discharge.

Findings:
Using item 3 from the DMH Discharge Planning and Community Integration Auditing Form, ASH assessed its compliance based on an average sample of 24% of the Quarterly and Annual WRPs due for the month (March to August 2008). The table below with its indicators and sub-indicators and corresponding mean compliance rates (compliance for the previous review period is given in parenthesis) is a summary of the data:

3.	*Any barriers preventing the individual from transitioning to a more integrated environment, especially difficulties raised in previously unsuccessful placements*	6% (2%)
3.a	*The individual's barriers to discharge, including difficulties encountered in previous placements are mention in the Present Status section of the WRP and*	14%
3.b	*These barriers are listed in Focus 11, with appropriate objectives and interventions.*	7%

The compliance rates for item 3 for the last month of the previous and current review periods were 0% and 7% respectively.

This monitor reviewed eight charts (AR, DG, ES, MD, RA, RN, RO and RY). Two of the WRPs in the charts (MD and RN) contained documentation that the discharge barriers were discussed with the individual. The remaining six WRPs (AR, DG, ES, RA, RO and RY) did not. This monitor observed two WRPCs (DJM and VL), and the two teams discussed matters relating to the individuals' discharge barriers, though one of the teams did not do a thorough review with the individual.

		Recommendation 3, April 2008: Include all skills training and supports in the WRP so that the individual can overcome barriers and meet discharge criteria. **Findings:** This monitor also reviewed eight charts (AR, DG, ES, MD, RA, RN, RO and RY). Two of the WRPs in the charts (MD and RN) included the skills training and supports the individual needed to overcome barriers to discharge. The remaining six WRPs (AR, DG, ES, RA, RO and RY) did not. **Compliance:** Partial. **Current recommendations**: 1. Ensure that discharge barriers, especially difficulties in previously unsuccessful placements, are discussed with the individual at scheduled WRPCs. 2. Report to the WRPT, on a monthly basis, the individual's progress in overcoming the barriers to discharge. 3. Include all skills training and supports in the WRP so that the individual can overcome barriers and meet discharge criteria.
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:** **Recommendations 1 and 2, April 2008:** • Assess the skills and supports that will be needed by the individual for a successful transition to the identified setting. • Ensure that WRPT members focus on these requirements and update the individual's WRP as necessary. **Findings:** Using item 4 from the DMH Discharge Planning and Community

Integration Auditing Form, ASH assessed its compliance based on an average sample of 24% of the Quarterly and Annual WRPs due for the month (March to August 2008). The table below with its indicators and sub-indicators and corresponding mean compliance rates (compliance for the previous review period is given in parenthesis) is a summary of the data:

4.	*The skills and supports necessary to live in the setting in which the individual will be placed*	24% (28%)
4.a	*The Present Status section of the individual's WRP includes the anticipated discharge placement and*	52%
4.b	*The scheduled PSR groups listed in the interventions include skills and supports the individual will need in the anticipated placement.*	27%

The compliance rates for item 4 for the last month of the previous and current review periods were 16% and 29% respectively.

This monitor reviewed eight charts (AR, DG, ES, MD, RA, RN, RO and RY). Two of the WRPs in the charts (MD and RN) documented the skills and supports needed by the individual for a successful transition to the identified setting. The remaining six WRPs (AR, DG, ES, RA, RO and RY) did not contain such documentation.

Compliance:
Partial.

Current recommendations:
1. Assess the skills and supports that will be needed by the individual for a successful transition to the identified setting.
2. Ensure that WRPT members focus on these requirements and update the individual's WRP as necessary.

<table>
<tr>
<td>E.2</td>
<td>Each State hospital shall ensure that, beginning at the time of admission and continuously throughout the individual's stay, the individual is an active participant in the discharge planning process, to the fullest extent possible, given the individual's level of functioning and legal status.</td>
<td>

Current findings on previous recommendations:

Recommendations 1 and 2, April 2008:

- Ensure that the individual is an active participant in the discharge planning process.
- Ensure that the individual understands all of the discharge requirements before leaving the WRPC.

Findings:

Using item 12 from the DMH Discharge Planning and Community Integration Auditing Form, ASH assessed its compliance based on an average sample of 22% of the Quarterly and Annual WRPs due for the month (March to August 2008). The table below with its indicators and sub-indicators and corresponding mean compliance (compliance for the previous review period is given in parenthesis) is a summary of the data:

<table>
<tr><td>12.</td><td>Each State hospital shall ensure that, beginning at the time of admission and continuously throughout the individual's stay, the individual is an active participant in the discharge planning process to the fullest extent possible, given the individual's level of functioning and legal status</td><td>27% (5%)</td></tr>
<tr><td>12.a</td><td>The WRPT asks the individual for his or her input into the evaluation of progress on each objective related to discharge</td><td>37%</td></tr>
<tr><td>12.b</td><td>The WRPT asks the individual if he or she is able to easily understand the materials presented in the PSR Mall groups or individual therapy that are related to the discharge criteria.</td><td>44%</td></tr>
</table>

The compliance rates for item 12 for the last month of the previous and current review periods were 12% and 24% respectively.

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		This monitor reviewed eight charts (AR, DG, ES, MD, RA, RN, RO and RY). One WRP in the charts (RN) contained documentation indicating that the individual was an active participant in the discharge process. The remaining seven (AR, DG, ES, MD, RA, RO and RY) had no evidence that the individual participated in the discussion. This monitor observed two WRPCs (DJM and VL) and the teams engaged the individuals when discussing discharge matters. The teams explained the discharge criteria to the individuals, but there was no indication that the individuals understood the functional aspects of the criteria (i.e. where they are regarding meeting the criteria, or what they are doing/could be doing to meet the criteria, etc.). **Recommendation 3, April 2008:** Implement the DMH WRP Manual on discharge process. **Findings:** This monitor's discussion with the Chief of Social Work and documentation review (WRP training modules and hard copy of slide presentation used for training) found that ASH's training is aligned with the DMH WRP Manual on discharge process. ASH has prepared a summary of the salient aspects of the discharge process from the DMH WRP Manual for use by the WRPTs. This monitor observed one of these summaries posted on the wall in the room where WRPTs meet. According to the WRP Master Trainer, ASH is using the Metro Modules for WRP training. **Recommendation 4, April 2008:** Prioritize objectives and interventions related to the discharge processes. **Findings:** This monitor reviewed five charts (GKP, KAT, MAP, RLY and SMB). Three of the WRPs in the charts (MAP, RLY and SMB) had prioritized

		objectives and interventions related to the discharge processes with appropriate foci, objectives, and relevant PSR Mall services. The remaining two WRPs (GKP and KAT) did not. **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 requirements before leaving the WRPC. 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:	**Compliance:** Partial.
E.3.a	measurable interventions regarding these discharge considerations;	**Current findings on previous recommendation:** **Recommendation, April 2008:** Write all interventions, including those dealing with discharge criteria, in behavioral and measurable terms as outlined in the DMH WRP Manual. **Findings:** Using item 6 from the DMH Discharge Planning and Community Integration Auditing Form, ASH assessed its compliance based on an average sample of 24% of the Quarterly and Annual WRPs due for the

<table>
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<td></td>
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<td>month (March to August 2008). The table below with its indicators and sub-indicators and corresponding mean compliance rates (compliance for the previous review period is given in parenthesis) is a summary of the data:
<table>
<tr><td>6.</td><td>Measurable interventions regarding these discharge considerations</td><td>14% (47%)</td></tr>
<tr><td>6.a</td><td>The interventions are aligned with their respective objectives, and</td><td>24%</td></tr>
<tr><td>6.b</td><td>All the objectives are written in a way that explains what the individuals will do or learn, and how it will be measured.</td><td>35%</td></tr>
</table>
The compliance rates for item 6 for the last month of the previous and current review periods were 24% and 14% respectively.

This monitor reviewed 11 charts (AR, DG, ES, MAP, MD, RA, RLY, RN, RO, RY and SMB). Two of the WRPs in the charts (MAP and RN) had the objectives and discharge criteria written in behavioral and/or measurable terms, and the remaining nine (AR, DG, ES, MD, RA, RLY, RO, RY and SMB) did not have the objectives and/or the discharge criteria written in observable and/or measurable terms.

Compliance:
Partial.

Current recommendation:
Write all interventions, including those dealing with discharge criteria, in behavioral and measurable terms as outlined in the DMH WRP Manual.</td>
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<tr>
<td>E.3.b</td>
<td>the staff responsible for implementing the interventions; and</td>
<td>Current findings on previous recommendations:</td>
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		Recommendation 1, April 2008: Ensure that for each intervention, responsible staff members are clearly stated in the individual's WRP. **Findings:** Using item 7 (*The staff responsible for implementing the interventions are identified*) from the DMH Discharge Planning and Community Integration Auditing Form, ASH analyzed its compliance based on an average sample of 24% of WRPs due for the month (March to August 2008), reporting a mean compliance rate of 50% (the mean compliance rate for the previous review period was 64%). The compliance rate for the last month of the previous review was 55% and the compliance rate for the last month of the current review period is 53%. This monitor reviewed eight charts (AR, DG, ES, MD, RA, RN, RO and RY). Seven of the WRPs in the charts (AR, ES, MD, RA, RN, RO and RY) identified the staff member responsible for the interventions, and one of them (DG) did not do so for one or more of the interventions. **Recommendation 2, April 2008:** Confirm that the staff to be listed in the WRP is actually involved in facilitating the activity, group, or intervention. **Findings:** This monitor's discussion with the SW Chief and the Mall Director revealed that ASH uses the MAPP roster to cross-reference with the groups facilitators on a daily basis and conducts random group checks to ensure facilitators are accurate. This monitor observed a number of Mall groups (Wellness and Recovery Action Plan, Computer Class, "Ready, Set, Go", Community Living Skills Project, Substance Abuse Recovery, Substance Abuse Recovery2, Non-violent Communication, Cognitive Remediation, and Trauma and Anxiety).

		The facilitators listed in the WRPs of the individuals' WRPs were the same ones facilitating the groups observed. **Compliance:** Partial. **Current recommendations**: 1. Ensure that for each intervention, responsible staff members are clearly stated in the individual's WRP. 2. Confirm that the staff to be listed in the WRP is actually involved in facilitating the activity, group, or intervention.
E.3.c	The time frames for completion of the interventions.	**Current findings on previous recommendation:** **Recommendation, April 2008:** 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. **Findings:** Using item 8 (*The staff responsible for implementing the interventions are identified*) from the DMH Discharge Planning and Community Integration Auditing Form, ASH analyzed its compliance based on an average sample of 24% of WRPs due for the month (March to August 2008), reporting a mean compliance rate of 61% (the mean compliance rate for the previous review period was 47%). The compliance rates for the last month of the previous and current review periods were 57% and 67% respectively. This monitor reviewed seven charts (AR, BG, ES, RA, RN, RO and RY). Six of the WRPs in the charts (AR, ES, RA, RN, RO and RY) had a clearly stated time frame for the next scheduled review for each intervention in the Mall or for individual therapy. One of them (BG) did

		not have a time frame or the time frame was not aligned with the next WRPC schedule. **Compliance:** Partial. **Current recommendation**: 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.
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:** Partial.
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:** **Recommendations 1 and 2, April 2008:** • Reduce the overall number of individuals still hospitalized after referral for discharge has been made. • Identify and resolve system factors that act as barriers to timely discharge. **Findings:** This monitor's discussion with the SW Chief revealed that ASH has taken numerous steps within the facility and with CONREP to solve systemic factors that may contribute to delay in discharging individuals from the facility. Some of these steps include the "CONREP WRPT Participation Program" that engages CONREP as early as the individual's 90-day WRPC, requesting CONREP to analyze factors contributing to acceptance/rejection of referrals, and requesting a change regarding CONREP referrals and referral packets. In addition, ASH is refining its database to better track the time it takes from the point an

		individual is referred and the point of actual discharge from the facility. This monitor's review of ASH's data on individuals referred for discharge and are still hospitalized (as of September 29, 2008) consisted of a list of 12 individuals. One individual was discharge-ready in March, one in April, two each in June and July, and the remaining six in August 2008. An analysis of the reasons for the delays in discharge generated a number of factors. Some of the reasons include CONREP reviewing the referral packet, CONREP working at capacity and unable to work through the cases, financial constraints as a barrier to CONREP visiting ASH, and awaiting Court approval. **Recommendation 3, April 2008:** Write all discharge criteria in behavioral terms. **Findings:** ASH did not present audit data for this recommendation. This monitor reviewed five charts (CLC, DEA, EMB, JLB and JPC). Three of the WRPs in the charts (EMB, JLB and JPC) contained discharge criteria written in behavioral terms, and the remaining two (CLC and DEA) contained one or more of the discharge criteria written in non-behavioral/measurable terms. **Current recommendations**: 1. Reduce the overall number of individuals still hospitalized after referral for discharge has been made. 2. Identify and resolve system factors that act as barriers to timely discharge. 3. Write all discharge criteria in behavioral terms.

E.4.b	Individuals receive adequate assistance in transitioning to the new setting.	**Current findings on previous recommendations:** **Recommendations 1 and 2, April 2008:** • Develop and implement a monitoring and tracking system to address the key elements of this requirement. • Ensure and document specific assistance provided to the individual and/or appropriate others when the individual is transitioned to a new setting. **Findings:** This monitor's discussion with the SW Chief revealed that ASH is still refining its comprehensive database to track individuals from their discharge readiness date to actual discharge. Using item 10 from the DMH Discharge Planning and Community Integration Auditing Form, ASH assessed its compliance based on an average sample of 24% of the Quarterly and Annual WRPs due for the month (March to August 2008). The table below with its indicators and sub-indicators and corresponding mean compliance (compliance for the previous review period is given in parenthesis) is a summary of the data:

10.	*Individuals receive adequate assistance in transitioning to the new setting*	3% (2%)
10.a	*The Present Status section of the individual's WRP describes the assistance needed to transition to the discharge setting*	7%
10.b	*Identifies the persons (i.e., agency staff) responsible for providing transitional assistance*	3%

The compliance rates for item 10 for the last month of the previous and current review periods were 2% and 1% respectively.

This monitor reviewed eight charts (AR, DG, ES, MD, RA, RN, RO and

		RY). Three of the WPRs in the charts (ES, MD and RO) contained documentation of the assistance needed by the individual in the new setting and the remaining five (AR, DG, RA, RN, and RY) did not. **Current recommendations**: 1. Develop and implement a monitoring and tracking system to address the key elements of this requirement. 2. Ensure and document specific assistance provided to the individual and/or appropriate others when the individual is transitioned to a new setting.
E.5	For all children and adolescents it serves, each State hospital shall:	The requirements of Section E.5 are not applicable to ASH because it does not serve children or adolescents.
E.5.a	develop and implement policies and protocols that identify individuals with lengths of stay exceeding six months; and	
E.5.b	establish a regular review forum, which includes senior administration staff, to assess the children and adolescents identified in § V.E.1 above, to review their treatment plans, and to create an individualized action plan for each such child or adolescent that addresses the obstacles to successful discharge to the most integrated, appropriate placement as clinically and legally indicated.	

F. Specific Therapeutic and Rehabilitation Services	
	Summary of Progress on Psychiatric Services: 1. ASH hired senior psychiatrists in permanent positions and assigned them to programs in September 2008. 2. ASH has implemented adequate data collection tools and other procedures in the reporting and investigating of adverse drug reactions and medication variances. 3. The DMH has standardized an auditing tool regarding the use of New Generation Antipsychotic Medications. 4. ASH has improved the sampling methodology in self-monitoring and refined data gathering and presentation. **Summary of Progress on Psychological Services:** 1. ASH has increased the number and quality of its PBS plans. 2. ASH has increased the number and quality of its Behavioral Guidelines. 3. ASH has improved the quality of its structural and functional assessments. 4. ASH has established a Psychology Specialty Services Committee that now reviews and analyzes challenging cases that are not amenable to behavioral interventions. The PSSC works with the facility's Quality Council when its recommended behavioral intervention plans are not effective. **Summary of Progress on Nursing Services:** 1. ASH will implement policies and procedures associated with Special Order 136: Provision of Care in November 2008. 2. WRP training has been incorporated into ASH's new employee assessment training class, which includes a post-test for competence. 3. The Nursing Department candidly reported their barriers to compliance in the effort to identify and implement meaningful plans

	of correction to increase compliance. **Summary of Progress on Rehabilitation Therapy Services:** 1. An F.4 Monitoring tool has been developed and implemented. 2. Twelve-week lesson plans were developed and approved for five Rehabilitation Therapy PSR Mall groups. PSR Mall groups facilitated by Rehabilitation Therapy staff currently do not consistently utilize curricula and lesson plans that have been written, implemented, and approved by the facility curriculum committee. **Summary of Progress on Nutrition Services:** Review of data from the Meal Accuracy report shows substantial compliance with tray accuracy. **Summary of Progress on Pharmacy Services:** The Pharmacy Department reported a wider range of types of recommendations to physicians. **Summary of Progress on General Medical Services:** 1. ASH has revised and implemented Medical Policies and Procedures that align with requirements of the EP. 2. ASH began implementation of quarterly medical reassessments of individuals with Axis III diagnoses. 3. ASH began monitoring of medical services using the new DMH standardized tools that assess Medical Surgical Progress Notes, Integration of Medical Conditions into the WRPs and Medical Transfers. 4. ASH has initiated self-monitoring to assess care provided to individuals suffering from diabetes mellitus, asthma/COPD, hypertension and dyslipidemia using DMH standardized tools.

	Summary of Progress on Infection Control: 1. ASH's Infection Control Department has achieved and maintained substantial compliance for most of the requirements of the Enhancement Plan. 2. ASH's Infection Control Department, in conjunction with the Department of Medicine and Nursing Services, has implemented a number of strategies to increase compliance regarding infection control issues, Focus 6 and the WRPs. **Summary of Progress on Dental Services** 1. ASH's Dental Department has achieved and maintained substantial compliance with most of the requirements of the Enhancement Plan. 2. ASH's Dental Department continues to work with the Department of Medicine and Nursing Services regarding after-hours dental emergencies.

1. Psychiatric Services		
		Methodology: Interviewed: 1. Donna Nelson, Director of Standards Compliance 2. Jean Dansereau, MD, Chief of Psychiatry 3. Stephen Mohaupt, MD, Chairman of the Medication Management EP Performance Improvement Committee Reviewed: 1. The charts of the following 39 individuals: AA, ABP, AJF, ARC, BB, CDS, DR, EMB, FC, GP, JC, JCZ, JG, JGJ, JH, JHM, JJC, JTC, KDR, KED, KT, LAS, LBB, LG, LJ, MLD, MM, MM-2, RDB, RLB, RP, RW, SB, SR, SRB, TE, UH and WCB 2. Current DMH Policies and Medication Guidelines (effective June 14, 2007) 3. DMH Admission Psychiatric Assessment Auditing Form 4. DMH Admission Psychiatric Assessment Auditing Form Instructions 5. ASH Admission Psychiatric Assessment Auditing summary data (March to August 2008) 6. DMH Integrated Assessment: Psychiatry Section Auditing Form 7. DMH Integrated Assessment: Psychiatry Section Auditing Form Instructions 8. ASH Integrated Assessment: Psychiatry Section Auditing summary data (March to August 2008) 9. DMH Monthly Psychiatric Progress Notes Auditing Form 10. DMH Monthly Psychiatric Progress Notes Auditing Form Instructions 11. ASH Monthly Psychiatric Progress Notes Auditing summary data (March to August 2008) 12. DMH Nursing Services Monitoring Form (PRN) 13. DMH Nursing Services Monitoring Form (Stat) 14. ASH summary data of PRN/Stat medication use (March to August

		2008) 15. DMH Benzodiazepine Auditing Form 16. DMH Benzodiazepine Auditing Form Instructions 17. ASH Benzodiazepine Auditing summary data (March to August 2008) 18. DMH Anticholinergic Auditing Form 19. DMH Anticholinergic Auditing Form Instructions 20. ASH Anticholinergic Auditing summary data (January and February 2008) 21. DMH Polypharmacy Auditing Form 22. DMH Polypharmacy Auditing Form Instructions 23. ASH Anticholinergic Auditing summary data (March to August 2008) 24. ASH New Generation Antipsychotic Monitoring Form 25. ASH New Generation Antipsychotic Monitoring summary data (March to August 2008) 26. ASH Tardive Dyskinesia Database 27. ASH AD #516.7, Screening for Possible Movement Disorders Related to Neuroleptic Medication, September 23, 2008 28. Memorandum from Chief Psychiatrist, Tardive Dyskinesia Practice and Protocols, September 29, 2008 29. DMH Tardive Dyskinesia (TD) Auditing Form 30. DMH TD Auditing Form Instructions 31. ASH TD Auditing summary data (March to August 2008) 32. ASH data regarding Adverse Drug Reactions (ADRs) and medication variances (March to August 2008) 33. Last ten completed ADR reporting forms 34. ASH AD #528, ADR Reporting and Monitoring, July 29, 2008 35. ASH Guidelines for Completing ADR Reporting and Monitoring Form 36. ASH Intensive Case Analyses (5) for ADRs during this review period 37. ASH AD, Drug Utilization Evaluation (DUE) Reporting and Monitoring, August 26, 2008

		38. ASH Anticholinergic DUE, June 11, 2008 39. ASH Benzodiazepine DUE, July 16, 2008 40. ASH Polypharmacy DUE, August 13, 2008 41. ASH AD #530, Medication Variances, August 26, 2008 42. Last ten completed medication variance reporting forms 43. Format of Intensive Case Analysis regarding medication variances 44. Minutes of the Pharmacy and Therapeutics (P&T) Committee meetings (March to August 2008)
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:** **Recommendations 1 and 2, April 2008:** • Finalize individualized guidelines for psychotropic and anticonvulsant medications listed in the formulary. • Ensure that the individualized medication guidelines are continually revised, as appropriate, to reflect current literature, relevant clinical experience and professional practice guidelines. **Findings:** The DMH Medication Policy, including individualized medication guidelines, was implemented statewide. The most recent revision of these guidelines was completed on June 14, 2007. These guidelines do not include the mood stabilizers lithium and carbamazepine and the antidepressants venlafaxine, buproprion and mirtazapine. ASH has made some provisional revisions in these guidelines. These revisions will be finalized during the next reporting period. **Recommendations 3 and 4, April 2008:** • Monitor these requirements using the standardized DMH tools 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: ASH used the previously mentioned DMH Admission Psychiatric Assessment, Integrated Assessment: Psychiatry Section and Monthly PPN Auditing Forms to assess compliance based on average samples of 81%, 71% and 25%, respectively. Regarding the Integrated Assessments, the data for March to June were based on Program IV only. The compliance data with corresponding indicators and sub-indicators and comparative data are summarized in each cell below. The facility's analysis showed that a variable number of providers still require education to ensure compliance with all requirements of F.1.a and that plans are underway to provide this education in a variety of settings. **Other findings:** See this monitor's findings in D.1.c.ii, D.1.c.iii, D.1.d.i and D.1.f. **Compliance:** Partial. **Current recommendations**: 1. Ensure that the individualized medication guidelines are continually revised, as appropriate, to reflect current literature, relevant clinical experience and professional practice guidelines. These guidelines need to address the use of lithium and carbamazepine, the antidepressants venlafaxine, buproprion and mirtazapine and anticonvulsant medications. 2. Monitor these requirements using the standardized DMH tools based on at least a 20% sample. 3. 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.1.a.i specifically matched to current, clinically justified diagnoses or clinical symptoms;

Admission Psychiatric Assessment		
8.	*Plan of care includes:*	
8.a	*Regular psychotropic medications, with rationale.*	93%
8.b	*PRN and/or Stat medication as applicable, with specific behavioral indications*	79%
8.c	*Special precautions to address risk factors, as indicated.*	94%

No comparative data were available for the sub-items due to lack of data during the last review. The mean compliance rate for the main item was 78% during this review compared to 85% during the last review.

Integrated Psychiatric Assessment		
7.	*Diagnostic formulation is documented*	45%
10.	*Psychopharmacology treatment plan includes:*	
10.a	*Current target symptoms*	86%
10.b	*Specific medication to be used*	97%
10.c	*Dosage titration schedules, if indicated.*	74%
10.d	*Adverse reactions to monitor for*	37%
10.e	*Rationale for anticholinergics, benzodiazepines, polypharmacy and new generation*	39%
10.f	*Response to medication since admission, if applicable, including PRN and Stat medications.*	46%
10.g	*Medication consent issues were addressed*	61%

Comparative data showed mixed changes since the last review as follows:

	Previous period	Current period
Mean compliance rate		
7.	21%	45%
10.	4%	21%
Compliance rate in last month of period		
7.	0%	46%
10.	0%	27%
10.a	100%	87%
10.b	100%	97%
10.c	100%	74%
10.d	0%	45%
10.e	54%	31%
10.f	67%	56%
10.g	92%	74%

Monthly PPN		
2.b	*The current target symptoms which are the focus of treatment are identified in the progress note.*	82%
6.a.1	*The risks, benefits and rationale for the current psychopharmacology plan including anticholinergics, benzodiazepines, and polypharmacy are documented.*	71%
6.a.2	*There is a clear description of the reasoning for continuing the current medication regiment and the proposed future plans, such as augmentation, dose tapering, change in medication, etc.*	74%

Comparative data showed improved compliance since the last review as follows:

<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>29%</td><td>82%</td></tr>
<tr><td>6.1.a</td><td>44%</td><td>71%</td></tr>
<tr><td>6.1.b</td><td>46%</td><td>74%</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>2.b</td><td>32%</td><td>89%</td></tr>
<tr><td>6.1.a</td><td>48%</td><td>81%</td></tr>
<tr><td>6.1.b</td><td>50%</td><td>83%</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>
<table>
<tr><td colspan="3">Monthly PPN</td></tr>
<tr><td>2.h.2</td><td>Current Psychotropic medication dosage/laboratory monitoring/diagnostic testing and consultation protocols are followed as indicated (as per DMH Psychotropic guidelines.)</td><td>64%</td></tr>
</table>

The mean compliance rate has decreased from 70% during the last review to 64% during this review. However, the rate for the last month of this review period was 78% compared to 74% during the last month of the last review period.
</td></tr>
<tr><td>F.1.a.iii</td><td>tailored to each individual's symptoms;</td><td>Same as in F.1.a.i.</td></tr>
<tr><td>F.1.a.iv</td><td>monitored for effectiveness against clearly identified target variables and time frames;</td><td>
<table>
<tr><td colspan="3">Monthly PPN</td></tr>
<tr><td>2.b</td><td>Identified target symptoms are documented.</td><td>82%</td></tr>
<tr><td>2.c</td><td>Participation in treatment is documented.</td><td>80%</td></tr>
<tr><td>2.d</td><td>Progress towards objective in the Wellness and</td><td>72%</td></tr>
</table>
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</table>

	Recovery Plan (is documented).	

Comparative data showed improved compliance since the last review as follows:

	Previous period	Current period
Mean compliance rate		
2.b-d	59%	78%
Compliance rate in last month of period		
2.b-d	61%	84%
2.b	75%	89%
2.c	63%	87%
2.d	44%	77%

F.1.a.v monitored appropriately for side effects;

Monthly PPN		
6.b	*Monitoring of side effects (is documented.)*	73%
6.c	*AIMS is completed.*	68%

Comparative data showed improved compliance since the last review as follows:

	Previous period	Current period
Mean compliance rate		
6.b-c	59%	71%
Compliance rate in last month of period		
6.b-c	60%	79%
6.b	59%	82%
6.c	60%	76%

<table>
<tr><td>F.1.a.vi</td><td>modified based on clinical rationales;</td><td>
<table>
<tr><td colspan="3">Monthly PPN</td></tr>
<tr><td>6.a.1</td><td>The risks, benefits and rationale for the current psychopharmacology plan including anticholinergics, benzodiazepines, and polypharmacy are documented.</td><td>71%</td></tr>
<tr><td>6.a.2</td><td>There is a clear description of the reasoning for continuing the current medication regimen and the proposed future plans, such as augmentation, dose tapering, change in medication, etc.</td><td>74%</td></tr>
</table>

Comparative data showed improved compliance since the last review as follows:
<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.a.1-2</td><td>45%</td><td>73%</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>6.a.1-2</td><td>49%</td><td>82%</td></tr>
<tr><td>6.a.1</td><td>48%</td><td>81%</td></tr>
<tr><td>6.a.2</td><td>50%</td><td>83%</td></tr>
</table>
</td></tr>
<tr><td>F.1.a.vii</td><td>are not inhibiting individuals from meaningfully participating in treatment, rehabilitation, or enrichment and educational services as a result of excessive sedation; and</td><td>
<table>
<tr><td colspan="3">Monthly PPN</td></tr>
<tr><td>2.c</td><td>Participation in treatment is documented.</td><td>80%</td></tr>
<tr><td>6.b</td><td>Monitoring of side effects (is documented.)</td><td>73%</td></tr>
<tr><td>6.c</td><td>AIMS is completed.</td><td>68%</td></tr>
</table>

Comparative data showed improved compliance since the last review as follows:
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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>2.c</td><td>63%</td><td>80%</td></tr>
<tr><td>6.b-c</td><td>59%</td><td>71%</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>2.c</td><td>63%</td><td>87%</td></tr>
<tr><td>6.b-c</td><td>60%</td><td>79%</td></tr>
<tr><td>6.b</td><td>59%</td><td>82%</td></tr>
<tr><td>6.c</td><td>60%</td><td>76%</td></tr>
</table>
</td></tr>
<tr><td>F.1.a.viii</td><td>Properly documented.</td><td>
<table>
<tr><td>Admission Psychiatric Assessment</td><td>8.a, 8.b and 8.c</td><td>89%</td></tr>
<tr><td>Integrated Assessment (Psychiatry)</td><td>7 and 10</td><td>29%</td></tr>
<tr><td>Monthly PPN</td><td>2.b, 2.c, 2.d, 2.h.2, 6.a.1, 6.a.2, 6.b and 6.c</td><td>73%</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:

Recommendation 1, April 2008:
Consolidate the monitoring instruments regarding PRN and Stat medications, and report data that address EP requirements regarding each of the following:
a) Psychiatric documentation of PRN medication use.
b) Psychiatric documentation Stat medication use.
c) Nursing documentation of PRN medication use.
d) Nursing documentation of Stat medication use.
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Findings:
The DMH has revised and finalized standardized tools regarding nursing services' documentation of PRN/Stat medication use. The DMH Monthly PPN Auditing Form is sufficient to monitor this requirement regarding physicians' prescriptions and review of PRN/Stat medications.

Recommendations 2, 3 and 4, April 2008:
- Monitor the use of PRN and Stat medications based on at least a 20% sample.
- Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period).
- Provide ongoing feedback and mentoring by senior psychiatrists to ensure correction of the deficiencies noted by this monitor.

Findings:
ASH used the DMH standardized Monthly PPN tool to audit this requirement. The average sample size was 25% of individuals who have been hospitalized for 90 or more days (March to August 2008). The facility also used the DMH Nursing Services Monitoring Forms for PRN and Stat medication uses. The average samples were 18% and 20% of the number of PRN and Stat medications given per month, respectively. The following is a summary of the data, including comparative data:

Monthly PPN		
7.	*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:*	
7.a	*Describes the rationale/specific indications for all PRN orders.*	66%
7.b	*Reviews the PRNs and Stats during the interval*	61%

	period.	
7.c	*Discusses use of PRN/Stat as indicated to reduce the risk of restrictive interventions.*	42%
7.d	*Describes modification of regularly scheduled medication regimen based on the use of PRN/Stat medications.*	46%

Comparative data showed improvement in compliance since the last review as follows:

	Previous period	Current period
Mean compliance rate		
7.	21%	42%
Compliance rate in last month of period		
7.	22%	66%
7.a	39%	79%
7.b	33%	75%
7.c	17%	70%
7.d	21%	63%

Nursing Services PRN		
1.	*Safe administration of PRN medication.*	89%
2.	*Documentation of the circumstances requiring PRN medication.*	25%
3.	*Documentation of the individual's response to PRN medication.*	24%

Comparative data showed mixed changes since the last review as follows:

	Previous period	Current period
Mean compliance rate		
1.	97%	89%
2.	15%	25%
3.	18%	24%
Compliance rate in last month of period		
1.	97%	86%
2.	14%	31%
3.	20%	31%

Nursing Services Stat		
1.	*Safe administration of Stat medication.*	63%
2.	*Documentation of the circumstances requiring Stat medication.*	16%
3.	*Documentation of the individual's response to Stat medication.*	15%

	Previous period	Current period
Mean compliance rate		
1.	91%	63%
2.	9%	16%
3.	22%	15%
Compliance rate in last month of period		
1.	100%	78%
2.	0%	8%
3.	0%	19%

Regarding this requirement of the EP, the facility recognized that barriers to compliance included the following:

		1. PRN/Stat orders did not indicate specific, individualized criteria for administration of the medication; 2. There was incomplete documentation relating to the specific reason(s) for giving PRN/Stat, on both the MTR and the progress notes; and 3. Documentation often confused Stat as PRN medications and vice versa. Corrective actions included the following: 1. Access by attending psychiatrists to information in the PRN/Stat module of WaRMSS; 2. Supervision by the senior psychiatrists to identify problems early and provide follow-up; 3. One-to-one focused remediation for requirements regarding nursing documentation of PRN and Stat medication use; and 4. Formation of a work group of Unit Supervisors, HSSs, Shift Leads and Medication Staff to clarify responsibilities for assessment of individuals, medication administration and follow-up documentation of effectiveness. **Other findings:** See findings in D.1.f. **Compliance:** Partial. **Current recommendations**: 1. Monitor this requirement using the DMH Monthly PPN, DMH Nursing Services PRN and DMH Nursing Services Stat Auditing Forms based on at least 20% samples. 2. 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.1.c	Each State hospital shall monitor the psychiatric use of benzodiazepines, anticholinergics, and polypharmacy to ensure clinical justification and attention to associated risks.	**Current findings on previous recommendations:** **Recommendations 1-4, April 2008:** • Monitor the use of benzodiazepines, anticholinergics and polypharmacy based on at least a 20% sample. • Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period). • Provide ongoing feedback and mentoring by senior psychiatrists to improve compliance and correct the deficiencies outlined above. • Identify patterns and trends regarding use of benzodiazepines, anticholinergics and polypharmacy and implement corrective and educational actions. **Findings:** ASH used the DMH Benzodiazepine, Anticholinergics and Polypharmacy Audit Forms to assess compliance (March to August 2008). The following is a summary outline of the monitoring indicators, corresponding mean compliance rates and comparative data, as applicable.

Benzodiazepines (average sample has varied depending on the indicator, ranging from 34 to 92% of all individuals receiving regularly scheduled benzodiazepines)		
1.	*Indication for regularly scheduled use of benzodiazepine clearly documented in medical record*	53%
2.	*Benzodiazepine used for individuals with alcohol / drug use problems justified in PPN*	18%
3.	*Benzodiazepine used for individuals with cognitive disorders justified in PPN*	15%

	Routine Benzodiazepine use for more than 2 months, PPN clearly documents the risks of:	
4.	*Drug dependence*	46%
5.	*Cognitive decline*	49%
6.	*Sedation*	49%
7.	*Gait unsteadiness / falls if indicated*	45%
8.	*Respiratory depression (for those with underlying respiratory problems e.g. COPD)*	8%
9.	*Toxicity if used in individuals with liver impairment (if using long acting agents)*	4%
10.	*Treatment modified in an appropriate and timely manner to ensure proper indications and to minimize risk.*	48%

Comparative data showed improvement in compliance for most items since the last review as follows:

	Previous period	Current period
Mean compliance rate		
1.	45%	53%
2.	12%	18%
3.	0%	15%
4.	16%	46%
5.	10%	49%
6.	19%	49%
7.	15%	45%
8.	0%	8%
9.	6%	4%
10.	42%	48%

	Previous period	Current period
Compliance rate in last month of period		
1.	33%	79%
2.	5%	26%
3.	0%	10%
4.	8%	79%
5.	8%	79%
6.	8%	79%
7.	22%	63%
8.	0%	0%
9.	0%	0%
10.	33%	26%

Anticholinergics ((average sample has varied depending on the indicator, ranging from 27 to 85% of all individuals receiving regularly scheduled anticholinergic medications)		
1.	Indication for use of anticholinergic clearly documented in PPN (N = All individuals on any of the the four anticholinergics)	52%
	Regularly scheduled anticholinergics for more than two months clearly documented in the PPN risks of: (N= All individuals over age 60 and with cognitive impairment of any type for 2-6.)	
2.	Cognitive impairment	41%
3.	Sedation	34%
4.	Gait unsteadiness/falls	46%
5.	Blurred vision, constipation, urinary retention	41%
6.	Worsening narrow angle glaucoma	10%
	Regularly scheduled anticholinergics use for more than	

	2 months clearly document in PPN risks of: (N= all individuals on anticholinergics for more than two months regardless of age or cognitive status for 7-13.)	
7.	Cognitive impairment	51%
8.	Sedation as indicated	48%
9.	Gait unsteadiness / falls (as indicated)	57%
10.	Blurred vision, constipation, urinary retention	52%
11.	Worsening narrow angle glaucoma, if present	37%
12.	Substance abuse/dependence if listed on Axis I	44%
13.	Worsening TD if present	7%
14.	Dosage is within DMH psychotropic medication policy (unless TRC/MRC consult was obtained. N= all individuals on the four anticholinergics for 14.	87%
15.	Treatment modified in an appropriate and timely manner to ensure proper indications and minimize risk. N= all individuals on anticholinergics for more than two months regardless of age or cognitive status for 15.	48%

Comparative data showed improvement in compliance for most items since the last review as follows:

	Previous period	Current period
Mean compliance rate		
1.	45%	52%
2.	12%	41%
3.	14%	34%
4.	14%	46%
5.	11%	41%
6.	N/A	10%

	Previous period	Current period
Mean compliance rate		
7.	27%	51%
8.	21%	48%
9.	21%	57%
10.	11%	52%
11.	0%	37%
12.	7%	44%
13.	0%	7%
14.	99%	87%
15.	24%	48%
Compliance rate in last month of period		
1.	33%	62%
2.	20%	46%
3.	31%	38%
4.	30%	45%
5.	19%	49%
6.	N/A	0%
7.	36%	63%
8.	25%	38%
9.	39%	68%
10.	24%	71%
11.	0%	63%
12.	12%	67%
13.	0%	20%
14.	98%	76%
15.	23%	37%

Polypharmacy (average S varied depending on indicator, ranging from 30% to 33% of individuals receiving inter or intra-class polypharmacy		
1.	*Target symptoms were clearly identified.*	51%
2.	*Documentation in PPN justifies the need for inter-class polypharmacy.*	25%
3.	*Documentation in PPN justifies the need for intra-class for polypharmacy.*	30%
4.	*The PPN documents the risks of the polypharmacy including drug-to-drug interactions*	32%

Comparative data showed improvement in compliance for most items since the last review as follows:

	Previous period	Current period
Mean compliance rate		
1.	31%	51%
2.	16%	25%
3.	24%	32%
4.	5%	5%
Compliance rate in last month of period		
1.	31%	51%
2.	16%	25%
3.	24%	32%
4.	5%	5%

The facility's plan of correction for this requirement included the following:

1. Supervision and follow-up by the senior psychiatrists, with special attention to the providers who have low compliance rates;

		2. Educational activities through the Department of Psychiatry and other staff meetings; 3. Increased prescribers' knowledge and use of the standardized monthly progress note format; and 4. Refinement of inter-rater reliability issues. **Other findings:** This monitor reviewed the facility's databases regarding individuals receiving long-term treatment with the following types of medication use: 1. Benzodiazepines in presence of diagnoses of substance use disorders and/or cognitive disorders; 2. Anticholinergic medications for individuals diagnosed with cognitive disorders; 3. Anticholinergic medications for elderly individuals; and 4. Various forms of polypharmacy. This monitor also reviewed the charts of individuals receiving the above types of medication regimens. The reviews found that too many individuals are still receiving long-term regular treatment with benzodiazepines (lorazepam and/or clonazepam) and/or anticholinergic medications (benztropine and/or diphenhydramine) and/or polypharmacy without documented justification and/or assessment of the individuals for the risks associated with this practice. This monitor also found some inaccuracies in the facility's databases regarding individuals who are receiving anticholinergic medications and diagnosed with cognitive disorders. The following tables outlines these reviews (diagnoses are listed only if they signify conditions that increase the risk of use):

Benzodiazepine use

Individual	Medication(s)	Diagnosis
AA	Clonazepam	Polysubstance Dependence
BB	Clonazepam	Polysubstance Dependence
DR	Lorazepam	Alcohol Abuse and Cannabis Abuse
JJC	Lorazepam	Alcohol Dependence and Cannabis Abuse
KED	Lorazepam	Polysubstance Dependence
MLD	Diazepam	Alcohol Abuse
RP	Clonazepam (and benztropine)	Borderline Intellectual Functioning and Polysubstance Dependence
SRB	Lorazepam	Alcohol Abuse

Anticholinergic use

Individual	Medication(s)	Diagnosis
AJF	Trihexyphenidyl	Borderline Intellectual Functioning
GP	Diphenhydramine	Dementia Due to Neurosyphilis
JCZ	Diphenhydramine	Borderline Intellectual Functioning
JH	Diphenhydramine	Borderline Intellectual Functioning
RP	Benztropine (and clonazepam)	Borderline Intellectual Functioning
RW	Benztropine	Mild Mental Retardation
UH	Diphenhydramine and chlorpromazine	Mild Mental Retardation and Cognitive Disorder NOS

Polypharmacy use

Individual	Medication(s)	Diagnosis
ABP	Olanzapine, risperidone, haloperidol, divalproex and benztropine	
BSB	Fluphenazine, quetiapine, ziprasidone, benztropine and clonazepam	Polysubstance Dependence
EMB	Haloperidol, olanzapine, chlorpromazine, divalproex, trihexyphenidyl and diphenhydramine	
KT	Quetiapine, chlorpromazine, fluphenazine and lithium	
LJ	Ziprasidone, olanzapine, chlorpromazine, clonazepam and divalproex	
RLB	Loxapine, risperidone, clonazepam and diphenhydramine	Alcohol Dependence
TE	Olanzapine, risperidone, chlorpromazine, clonazepam and benztropine	Polysubstance Dependence

Compliance:
Partial.

Current recommendations:
1. Continue to monitor this requirement using the DMH instruments based on at least 20% samples.
2. 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.1.d	Each State hospital shall ensure the monitoring of the metabolic and endocrine risks associated with	**Current findings on previous recommendations:**

	the use of new generation antipsychotic medications.	**Recommendations 1, April 2008:** Standardize the monitoring tool regarding the use of new generation antipsychotic medications. **Findings:** The DMH has implemented this recommendation. The tool was standardized in July 2008. **Recommendation 2, April 2008:** Ensure that the monitoring indicator regarding serum amylase/lipase also include quetiapine. **Findings:** ASH did not address this recommendation. **Recommendations 3, 4 and 6, April 2008:** • Monitor the use of new generation antipsychotic medications 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). • Identify patterns and trends regarding use of new generation antipsychotic medications and implement corrective and educational actions. **Findings:** The facility used the ASH New Generation Antipsychotic Audit Form to assess compliance (March to August 2008). The average sample size was 51% of individuals receiving these medications during the review month. The following is a summary of the indicators and corresponding mean compliance rates. No comparative data were available due to lack of data during the last review.

		1.	*Family/personal risk factors addressed in PPN (if medication started within last 90 days)*	39%
		2.	*Justification for use documented in PPN for individuals with diagnosis of (for olanzapine, risperidone, quetiapine)*	14%
		2.a	*Dyslipidemia*	16%
		2.b	*Diabetes*	12%
		2.c	*Obesity*	19%
		3.	*Justification for use documented in PPN for individuals on risperidone with hyperprolactinemia.*	9%
		4.	*Appropriate monitoring for postural hypotension for individual >60y/o with BP<90/60 on quetiapine*	4%
		5.	*ECG within previous 12 months.*	77%
		6.	*Appropriate baseline and regular monitoring of:*	12%
		6.a	*Body Mass Index*	48%
		6.b	*Waist Circumference*	50%
		6.c	*Fasting Blood Sugar (FBS) monthly (if started olanzapine or clozapine w/in last 6 months)*	64%
		6.d	*FBS quarterly (including olanzapine and clozapine after first 6 months)*	78%
		6.e	*Triglycerides*	75%
		6.f	*Cholesterol*	75%
		6.g	*HgbA1C if FBS high*	78%
		6.h	*Prolactin level*	48%
		6.i	*Breast exam*	62%
		6.j	*AIMS exam*	70%
		7.	*Serum amylase/lipase (if on clozapine, olanzapine, risperidone)*	29%
		8.	*PPN documentation of potential and actual risk for each medication used.*	42%
		9.	*Treatment modified in an appropriate and timely manner to address identified risks*	59%

The facility recognized overall low compliance with this requirement. Corrective actions were the same as those noted in F.1.c.

Recommendation 5, April 2008:
Provide ongoing feedback and mentoring by senior psychiatrists to improve compliance and correct the deficiencies outlined above.

Findings:
ASH hired senior psychiatrists in permanent positions and assigned them to programs as of September 29, 2008. The facility reported that senior psychiatrists will begin to provide feedback and mentoring as of November 1, 2008 in an effort to improve compliance.

Other findings:
This monitor reviewed the charts of 13 individuals who are receiving new-generation antipsychotic agents and suffering from a variety of metabolic disorders. The following table outlines the initials of the individuals, the medication(s) used and the metabolic disorder(s):

Individual	Medication(s)	Diagnosis
AA	Quetiapine	Hypercholesterolemia
ARC	Risperidone	Obesity
CDS	Olanzapine	Diabetes mellitus
FC	Quetiapine	Diabetes mellitus, obesity and hypertension
JC	Ziprasidone	Hyperlipidemia
JG	Olanzapine	Diabetes mellitus and hypertension
JGJ	Clozapine (and trifluperazine)	Diabetes mellitus and hyperlipidemia
JTC	Risperidone	Diabetes mellitus and overweight
LAS	Olanzapine	Diabetes mellitus and hypertension

LBB	Clozapine (and haloperidol)	Obesity
MM	Olanzapine	Diabetes mellitus
MM-2	Risperidone (and loxapine)	Diabetes mellitus, hyperlipidemia, obesity and hypertension
RDB	Risperidone	Diabetes mellitus, hyperlipidemia and obesity

In general, the facility provided adequate laboratory monitoring of the metabolic indicators, blood counts and vital signs in individuals at risk. In addition, reviews by this monitor found that the facility has improved laboratory monitoring regarding the risks of endocrine and pancreatic dysfunction using serum prolactin and lipase/amylase, respectively. Overall, this monitor found fewer deficiencies during this review period than in the last period. However, the remaining deficiencies must be corrected to achieve substantial compliance. The following are examples of the deficiencies:

1. The WRPs did not include a diagnosis of Diabetes Mellitus or Obesity for individuals who were diagnosed with these disorders and receiving high-risk treatment with olanzapine (ALS and CDS), risperidone (ARC) or quetiapine (FC). However, foci were identified with corresponding objectives and interventions that were appropriate to meet these individuals' needs.
2. The WRP and psychiatric progress notes did not identify a diagnosis of hyperlipidemia in individuals who had repeated laboratory findings suggesting this condition, were diagnosed with Diabetes Mellitus and receiving ongoing treatment with olanzapine (ALS and JG).
3. The psychiatric progress notes did not address the risk of pancreatic dysfunction in an individual who experienced an elevation of serum lipase while receiving ongoing treatment with olanzapine (MM).

		4. The psychiatric progress notes included a risk/benefit analysis that did not address hyperlipidemia and obesity in an individual who was diagnosed with both of these conditions (in addition to Diabetes Mellitus) and receiving high-risk treatment with risperidone (RDB). 5. The WRP and psychiatric progress notes did not address a diagnosis of hypertriglyceridemia in an individual with persistent elevation of triglycerides who was receiving ongoing high-risk treatment with quetiapine (AA). 6. The psychiatric progress notes included a risk benefit analysis that did not address the recent increase in weight in an individual who was diagnosed with Diabetes mellitus and receiving high risk treatment with risperidone (JTC). 7. The psychiatric progress notes did not address relevant laboratory findings during the previous interval in an individual who was diagnosed with Diabetes Mellitus, Hyperlipidemia, Obesity and Hypertension and receiving high-risk treatment with risperidone (MM-2). **Compliance:** Partial. **Current recommendations**: 1. Monitor this requirement using the DMH New Generation Antipsychotic Medications Auditing Form based on at least a 20% sample. 2. 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). 3. Ensure that the monitoring indicator regarding serum amylase/lipase also includes quetiapine. 4. Provide ongoing feedback and mentoring by senior psychiatrists to improve compliance and correct the deficiencies outlined above.

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:** **Recommendation 1, April 2008:** Develop and implement a policy and procedure to ensure that: a. The diagnoses listed on the WRP are aligned with those listed in psychiatric documentation, including TD; b. TD is recognized as one of the foci of hospitalization and that appropriate objectives and interventions are identified for treatment and/or rehabilitation; c. The individuals receive appropriate periodic screening; and d. The individuals receive care at a specialized TD clinic. **Findings:** ASH did not address this recommendation. However, the facility reported that the responsibility for completing AIMS was transferred from the family nurse practitioners to the psychiatrists (July 16, 2008) to improve compliance. In addition, the facility developed a tracking system, including utilization of a Psychiatric Services Coordinator, to ensure that neurology consults and AIMS are completed in a timely manner for individuals with positive AIMS, history of TD and current diagnosis of TD. **Recommendations 2 and 3 April 2008:** • Monitor the use of new generation antipsychotic medications 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:** ASH used the DMH TD Auditing Form to assess compliance (Marc h to August 2008). The average sample ranged from 34% to 96% depending on the indicator. The following is a summary of the compliance and

comparative data:

1.	*A baseline assessment shall be performed for each individual at admission.*	88%
2.	*Subsequent monitoring of the individual every 12 months while he/she is receiving antipsychotic medication.*	56%
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.*	34%
4.	*If an older generation antipsychotic is used there is evidence in monthly physician progress note of justification of using the older generation medication.*	24%
5.	*A neurology consultation / TD Clinic evaluation was completed as indicated.*	37%
6.	*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.*	49%
7.	*Tardive Dyskinesia is included in Focus 6 of the WRP.*	82%
8.	*The WRP reflect objectives and interventions for Tardive Dyskinesia.*	29%
9.	*The WRP reflect objectives and interventions for Tardive Dyskinesia.*	28%

Comparative data showed mixed changes since the last review as follows:

	Previous period	Current period
Mean compliance rate		
1.	95%	88%
2.	75%	56%
3.	40%	34%
4.	22%	24%
5.	33%	37%
6.	39%	49%
7.	50%	82%
8.	30%	29%
9.	30%	28%
Compliance rate in last month of period		
1.	93%	98%
2.	79%	33%
3.	41%	19%
4.	18%	12%
5.	0%	100%
6.	41%	30%
7.	44%	86%
8.	33%	37%
9.	33%	37%

The facility cited poor communication between the family nurse practitioners and psychiatry service relative to completion of AIMS as the main barrier to compliance. The plan of correction was the same as mentioned in the findings for previous recommendation 1.

Recommendation 4, April 2008:
Provide ongoing feedback and mentoring by senior psychiatrists to improve compliance and correct the deficiencies outlined above.

		Findings: Same as F.1.d, findings for previous recommendation 5. **Other findings:** This monitor reviewed the charts of seven individuals (JHM, KDR, LG, MLD, SB, SR and WCB) who were diagnosed with tardive dyskinesia per the facility's database. The database identified 25 individuals as currently having this diagnosis. This review found that ASH has made some progress as follows: 1. The WRPs included diagnosis, focus and corresponding objectives and interventions related to tardive dyskinesia in most of the charts reviewed. 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. 3. AIMS testing was completed on a quarterly basis in most charts (JHM, KDR, LG and SR). 4. A few charts documented attempts to use safer treatment alternatives (e.g. SR). However, the review found a pattern of deficiencies as follows: 1. During this review period, some individuals diagnosed with TD received long-term treatment with anticholinergic agents, including benztropine (MLD and SB) and hydroxyzine (JHM), without appropriate justification or documentation of the potential risks associated with this practice. 2. The WRP of an individual who appeared to have developed TD since admission did not include focus, objectives or interventions to address this condition (KDR). In this chart, the psychiatric progress notes did not address this development despite notation

		by neurology of its occurrence. 3. Some WRPs included objectives that were not appropriate or attainable for the individual (JHM and LG). 4. Some WRPs included objectives that were not stated in behavioral, measurable and/or observable terms (MLD and SB). 5. The AIMS tests were not completed quarterly as required in some charts (MLD, SB, SR and WCB). **Compliance:** Partial. **Current recommendations**: 1. Develop and implement a policy and procedure to ensure that: a. The diagnoses listed on the WRP are aligned with those listed in psychiatric documentation, including TD; b. TD is recognized as one of the foci of hospitalization and appropriate objectives and interventions are identified for treatment and/or rehabilitation; c. The individuals receive appropriate periodic screening; and d. The individuals receive care at a specialized TD clinic. 2. Monitor the use of new generation antipsychotic medications based on at least a 20% sample. 3. 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.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:** **Recommendation 1, April 2008:** Finalize and implement the draft instructions and AD regarding ADR reporting.

		Findings: ASH has implemented this recommendation effective July 29, 2008. **Recommendations 2-5, April 2008:** • Increase reporting of ADRs and provide data regarding ADRs reported during each review period, compared with the previous period. • Improve current tracking log and data analysis systems to provide adequate basis for identification of patterns and trends of ADRs. • Provide information for each review period regarding each ADR that required additional medication to treat and/or resulted in increased length of hospitalization, transfer to acute care setting, serious morbidity or death, including any intensive case analysis done and any follow-up corrective/educational actions. • Ensure accuracy of the data submitted to the CM. **Findings:** During this review period, ASH reported 35 ADRs compared to 39 during the previous period. The classification by probability showed that 12 reactions were rated as probable and one as definite. Regarding outcome, five reactions were rates as severe. Of the severe reactions, four had no negative sequelae and one reaction possibly contributed to a diagnosis of Diabetes Mellitus that required treatment with insulin. ASH conducted intensive case analyses (ICAs) on all severe ADRs. The ICAs utilized appropriate methodology and the recommendations for systemic corrective/educational actions were generally adequate. As mentioned earlier, the facility began implementation of the revised ADR reporting tool and instructions on July 29, 2008. The ADR database was recently (September 2008) rebuilt to improve efficiency. The old ADR database was not capable of producing adequate pattern and trending reports. Analysis of ADR-related patterns/trends will

		reportedly begin in November 2008, utilizing ASH's new database. **Compliance:** Partial. **Current recommendations**: 1. Increase reporting of ADRs. 2. Present summary data to address the following: a. Number of ADRs reported during the review period compared with the number during the previous period; b. Classification of ADRs by outcome category compared with the number during the previous period; c. Clinical information regarding each ADR that was classified as severe and the outcome to the individual involved; d. Information regarding any intensive case analysis done for each reaction that was classified as severe and for any other reaction. e. Outline of intensive case analysis including description of ADR, recommendations and actions taken. 3. Provide analysis of patterns and trends, with corrective/educational actions related to ADRs.
F.1.g	Each State hospital shall ensure drug utilization evaluation ("DUE") occurs in accord with established, up-to-date medication guidelines that shall specify indications, contraindications, and screening and monitoring requirements for all psychotropic medications; the guidelines shall be in accord with current professional literature. A verifiably competent psychopharmacology consultant shall approve the guidelines and ensure adherence to the guidelines.	**Current findings on previous recommendations:** **Recommendation 1, April 2008:** Develop and implement a DUE policy and procedure, based on the individualized medication guidelines, to ensure systematic review of all medications, with priority given to high-risk, high-volume uses. **Findings:** ASH has implemented this recommendation. The ASH AD regarding DUE became effective on August 26, 2008.

		Recommendations 2 and 3, April 2008: • Conduct DUEs that include review of the use, analysis of trends/patterns, conclusions regarding findings and recommendations for corrective actions/education activities based on the review. • Ensure proper aggregation and analysis of DUE data to determine practitioner and group patterns and trends. **Findings:** ASH presented DUE data based on self-monitoring regarding the use of benzodiazepines, anticholinergic medications and polypharmacy. The DUEs included adequate conclusions regarding the need for process improvements (anticholinergic medications) and patterns of deficiency in practice (benzodiazepines and polypharmacy). The facility reported that corrective actions (anticholinergic DUE) and training (benzodiazepines and polypharmacy DUEs) were implemented to address the DUE findings. The facility has yet to conduct DUEs to address the use of other medication classes, including new generation antipsychotic medications. **Recommendation 4, April 2008:** Ensure that the individualized medication guidelines are continually updated to reflect current literature, relevant clinical experience and current professional practice guidelines. **Findings:** Same as those for previous recommendations 1 and 2 in F.1.a. **Compliance:** Partial. **Current recommendations**: 1. 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. Ensure that the DUEs address the use of all medication classes beginning with new generation antipsychotic medications and the metabolic risks of their use. 2. Ensure proper aggregation and analysis of DUE data to determine practitioner and group patterns and trends.
F.1.h	Each State hospital shall ensure documentation, reporting, data analyses, and follow-up remedial action regarding actual and potential medication variances ("MVR") consistent with generally accepted professional standards of care.	**Current findings on previous recommendations:** **Recommendation 1, April 2008:** Finalize and implement the AD regarding Medication Variances. **Findings:** ASH has implemented this recommendation. The ASH AD regarding DUE became effective on August 26, 2008. **Recommendation 2, April 2008:** Implement the new policy and procedure regarding medication variances facility-wide. **Findings:** The facility implemented this recommendation on August 1, 2008. **Recommendations 3 and 4, April 2008:** • Develop and implement adequate tracking log and data analysis systems and identify patterns and trends related to medication variances facility-wide. • Present data regarding medication variances, including number of actual and potential variances, number of variances in each category, outcomes of the variances and any intensive case analysis performed during the reporting period.

		Findings: ASH presented data regarding medication variances that occurred during this review period. As mentioned earlier, the updated data collection tools were implemented on August 1, 2008 and the data prior to that date were based on the older tools. The total number of variances was 1,475 compared to 598 during the previous review period. Overall, the data represents improved capacity to capture potential variances. None of the variances had a severity outcome of category F (temporary harm to the individual and required initial or prolonged hospitalization) or higher. The facility conducted intensive case analyses for the two variances that met the required severity threshold (temporary harm to the individual and required intervention). The analyses utilized appropriate methodology and included adequate corrective actions. The facility has yet to gather sufficient data based on the updated system to determine practitioner and system trends/patterns and to implement appropriate corrective actions. **Compliance:** Partial. **Current recommendations**: 1. Present data to address to address the following: a. Total number of actual and potential variances during the review period compared with numbers reported during the previous period; b. Total number of variances by category (e.g. prescription, administration, documentation, etc) and by potential vs. actual during the review period compared with numbers reported during the previous period; c. Clinical information regarding each variance (category E or above) and the outcome to the individual involved;

		d. Information regarding any intensive case analysis done for each reaction that was classified as category E or above and for any other reaction e. Outline of ICAs, including description of variance, recommendations and actions taken 2. Provide analysis of patterns and trends, with corrective/ educational actions related to variances.
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 recommendations:** **Recommendation 1, April 2008:** Same as in F.1.a through F.1.h. **Findings:** Same as in F.1.a through F.1.h. **Recommendation 2, April 2008:** Improve IT resources to the pharmacy to facilitate the development of databases regarding medication use. **Findings:** ASH reported that the pharmacy currently has adequate resources to facilitate the implementation of this requirement. **Compliance:** Partial. **Current recommendation**: 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	**Current findings on previous recommendation:**

	generally accepted professional standards of care.	**Recommendation, April 2008:** Same as in F.1.b and F.1.i. **Findings:** Same as in F.1.b and F.1.i. **Compliance:** Partial. **Current recommendation**: 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 the Pharmacy & Therapeutics, Therapeutics Review, and Mortality and Morbidity Committees consistent with generally accepted professional standards of care.	**Current findings on previous recommendation:** **Recommendation, April 2008:** Same as in F.1.b and F.1.i. **Findings:** In addition, the facility reported that the Chairman of the Medication Management EPPI team will ensure needed communication between committees to facilitate integration of information. **Compliance:** Partial. **Current recommendation**: 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	**Current findings on previous recommendation:** **Recommendation, April 2008:** Same as in D.1.b, D.1.c, D.1.f.viii and F.1.a through F.1.h.

	integration of behavioral and pharmacological treatments.	**Findings:** Same as in D.1.b, D.1.c, D.1.f.viii and F.1.a through F.1.h. **Compliance:** Partial. **Current recommendation:** Same as in D.1.b, D.1.c, D.1.f.viii and F.1.a through F.1.h.
F.1.m	Each State hospital shall review and ensure the appropriateness and safety of the medication treatment, consistent with generally accepted professional standards of care, for:	**Compliance:** Partial.
F.1.m.i	all individuals prescribed continuous anticholinergic treatment for more than two months;	**Current findings on previous recommendations:** **Recommendation 1, April 2008:** Same as in F.1.c. **Findings:** Same as in F.1.c. **Recommendation 2, April 2008:** Same as in D.1.b, D.1.c, D.1.f.viii and F.1.a through F.1.h. **Findings:** Same as in D.1.b, D.1.c, D.1.f.viii and F.1.a through F.1.h. **Current recommendations:** 1. Same as in F.1.c. 2. Same as in D.1.b, D.1.c, D.1.f.viii and F.1.a through F.1.h.
F.1.m.ii	all elderly individuals and individuals with cognitive disorders who are prescribed	**Current findings on previous recommendation:**

	continuous anticholinergic treatment regardless of duration of treatment;	**Recommendation, April 2008:** Same as above. **Findings:** Same as above. **Current recommendation**: Same as above.
F.1.m.iii	all individuals prescribed benzodiazepines as a scheduled modality for more than two months;	**Current findings on previous recommendation:** **Recommendation, April 2008:** Same as above. **Findings:** Same as above. **Current recommendation**: Same as above.
F.1.m.iv	all individuals prescribed benzodiazepines with diagnoses of substance abuse or cognitive impairments, regardless of duration of treatment; and	**Current findings on previous recommendation:** **Recommendation, April 2008:** Same as above. **Findings:** Same as above. **Current recommendation**: Same as above.
F.1.m.v	all individuals with a diagnosis or evidencing symptoms of tardive dyskinesia.	**Current findings on previous recommendation:**

		Recommendation, April 2008: Same as F.1.e. **Findings:** Same as F.1.e. **Current recommendation:** Same as F.1.e.
F.1.m.vi	all individuals diagnosed with dyslipidemia, and/or obesity, and/or diabetes mellitus who are prescribed new generation antipsychotic medications	**Current findings on previous recommendation:** **Recommendation, April 2008:** Same as in F.1.d. and F.1.g. **Findings:** Same as in F.1.d. and F.1.g. **Current recommendation:** Same as in F.1.d. and F.1.g.
F.1.n	Each State hospital shall ensure that the medication management of individuals with substance abuse disorders is provided consistent with generally accepted professional standards of care.	**Current findings on previous recommendation:** **Recommendation, April 2008:** Same as in C.2.o and F.1.c. **Findings:** Same as in C.2.o and F.1.c. **Compliance:** Partial. **Current recommendation:** 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 may be provided either onsite or through attendance at conferences elsewhere.	

2. Psychological Services		
	Each State hospital shall provide adequate and appropriate psychological supports and services that are derived from evidence-based practice or practice-based evidence and are consistent with generally accepted professional standards of care, to individuals who require such services; and:	**Methodology:** <u>Interviewed</u>: 1. Charles Broderick, PhD, Senior Psychologist 2. Charlie Joslin, Clinical Administrator 3. Chris McDonald, PsyD, Psychologist 4. Christine Mathiesen, PsyD, Director C-PAS 5. Diane Imrem, PsyD, Chief of Psychology 6. Donna Nelson, Standards Compliance Director 7. John De Morales, Executive Director 8. Killorin Riddell, PhD, Coordinator of Psychology Specialist Services 9. Matt Hennessy, PhD, Mall Director 10. Rich Morey, PhD, Senior Psychologist Supervisor 11. Theresa M. George, PhD, Senior Psychologist Supervisor <u>Reviewed</u>: 1. Charts of the following 42 individuals: AAC, AJ, AJT, BB, BG, CC, CV, CW, DB, DEG, GG, GKP, HE, HM, IB, JB, JDS, JI, JM, JR, JS, KC, KD, KLW, KW, LH, MA, MAP, MS, PG, RA, RC, RE, RG, RLY, SMB, SW, SWC, TM, TWF, WST and WT 2. ASH Trigger Data 3. Behavior Guidelines developed and implemented during this review period 4. List of individuals receiving DCAT services 5. List of individuals needing neuropsychological services 6. List of individuals with higher than threshold levels 7. List of individuals with substance disorders 8. PBS Plans developed and implemented during this review period 9. PBS Training Protocols 10. PBS/Behavior Guideline outcome data and graphs 11. PBS/Behavior Guidelines Fidelity Checks

		12. Psychology Progress Notes documenting interdisciplinary consultation 13. Structural/Functional Assessments conducted in the last six months 14. Verification of competency for providing Substance Abuse groups <u>Observed</u>: 1. WRPC (Program II, unit 25) for monthly review of DJM 2. WRPC (Program II, unit 27) for monthly review of VL 3. Psychology Specialist Services Committee Meeting 4. PSR Mall group: Wellness and Recovery Action Plan 5. PSR Mall group: Computer Class 6. PSR Mall group: "Ready, Set, Go" 7. PSR Mall group: Community Living Skills Project 8. PSR Mall group: Substance Abuse Recovery 9. PSR Mall group: Substance Abuse Recovery2 10. PSR Mall group: Non-Violent Communication 11. PSR Mall group: Cognitive Remediation 12. PSR Mall group: Trauma and Anxiety
F.2.a	Each State hospital shall ensure that it has positive behavior support teams (with 1 team for each 300 individuals, consisting of 1 clinical psychologist, 1 registered nurse, 2 psychiatric technicians (1 of whom may be a behavior specialist), and 1 data analyst (who may be a behavior specialist) that have a demonstrated competence, consistent with generally accepted professional standards of care, in the following areas:	**Current findings on previous recommendations:** **Recommendation 1, April 2008:** Recruit additional staff to fulfill the required number of teams to meet the 1:300 ratio as stated in the EP. **Findings:** This monitor's discussion with the Chief of Psychology revealed that ASH does not yet have the necessary number of PBS teams to meet the 1:300 ratio. ASH had one full PBS team for the major part of this review period. Since March 2008, ASH has hired eight PBS staff (two psychologists, five psychiatric technicians, and one registered nurse). With these hires, ASH now has three full PBS teams and one partial

		PBS team. ASH continues with the hiring process to fill the remaining vacancies. **Recommendation 2, April 2008:** Ensure that all direct care staff system-wide are competent in the principles and practice of PBS. **Findings:** This monitor's discussion with the Chief of Psychology and the Psychology Specialty Service Coordinator and documentation review (training logs) found that ASH had conducted numerous training sessions with the direct care staff on PBS matters. Training had occurred during the New Employee Training sessions (3/10, 4/12, 4/14, 6/10, and 7/7) with a total of 174 new hires trained; each training session was two hours long. Additional training sessions (six hours of PBS training) were held through March, June, and July 2008 (3/2, 3/10, 3/11, 3/12, 3/17, 3/19, 3/20, 3/24, 3/26, 6/19, and 7/29) with over 50% of the direct care staff. ASH is tracking staff completing the training but not meeting the expected 90% competency score for further review and feedback. **Compliance:** Partial. **Current recommendations**: 1. Recruit additional staff to fulfill the required number of teams to meet the 1:300 ratio as stated in the EP. 2. Ensure that all direct care staff system-wide are competent in the principles and practice of PBS.
F.2.a.i	the development and use of positive behavior support plans, including methods of monitoring program interventions and the effectiveness	**Current findings on previous recommendations:**

	of the interventions, providing staff training regarding program implementation, and, as appropriate, revising or terminating the program; and	**Recommendation 1, April 2008:** Ensure that all PBS staff members receive systematic training in all aspects of the PBS plans, including the relationship between PBS and recovery principles. **Findings:** This monitor's documentation review found that ASH had conducted numerous training sessions for all PBS team members. Training had been provided on PBS Operations; data collection, analysis and graphing; and functional behavioral assessment. **Recommendation 2, April 2008:** Conduct treatment implementation fidelity checks regularly. **Findings:** This monitor's documentation review (fidelity/integrity check documentation on AAC, AJ, BG, CC, GG, HE, HM, SMB, SW and WT) found that ASH had conducted fidelity checks on all PBS plans and PBS-driven behavior guidelines. **Recommendations 3 and 4, April 2008:** • Revision of treatment plans should be directly related to the outcome data and reported at all scheduled WRPCs of the individual. • Data should be reviewed regularly to determine treatment effectiveness and to decide if plans should be revised, terminated, or if further training of level of care staff is necessary to improve treatment implementation. **Findings:** This monitor's discussion with the PBS teams and documentation review (structural/functional assessments, PBS plans, baseline and intervention data/graphs, and chart review) found that PBS teams

		review the plans at the weekly PSSC meetings. This monitor's documentation review (PBS plan review, outcome data, and chart review) found that PBS teams reviewed and revised PBS plans based on data trends. The WRPs reviewed by this monitor (GKP, MAP, RLY and SMB) contained documentation of the plan implementation data in the Present Status sections of the individuals' WRPs. **Recommendation 5, April 2008:** 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). **Findings:** This monitor's documentation review (PBS Training Protocol, Staff Training Post-Test, and staff training documentation) found that PBS teams use a standardized PBS Training Protocol to train staff responsible for implementing the PBS plans. The training methods included in the training protocol include didactic instruction skills, demonstration, rehearsal, observation of practice, and a post-test. This monitor reviewed six PBS plans (AJ, GG, HM, SMB, SW and WT) and their assessment and staff training data. The review found that the staff responsible for implementing the PBS plans had been trained to competency. **Compliance:** Substantial. **Current recommendations**: 1. Ensure that all PBS staff members receive systematic training in all aspects of the PBS plans, including the relationship between PBS and recovery principles.

		2. Conduct treatment implementation fidelity checks regularly. 3. Revision of treatment plans should be directly related to the outcome data and reported at all scheduled WRPCs of the individual. 4. Data should be reviewed regularly to determine treatment effectiveness and to decide if plans should be revised, terminated, or if further training of level of care staff is necessary to improve treatment implementation. 5. Develop a training protocol for all PBS plans to ensure that all staff who will be responsible for implementing the plan are consistently and appropriately trained prior to implementation of the plan (i.e., behavioral rehearsals, demonstrations, role plays, modeling).
F.2.a.ii	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:** **Recommendation 1, April 2008:** Ensure all staff correctly implements the BY CHOICE program. **Findings:** Using items 1 to 10 from the BY CHOICE Monitoring Form: Clinical Staff Competency and Fidelity Check, ASH assessed its compliance based on an average sample of 13% of clinical nursing staff in the units (March to August 2008). The table below with its indicators and corresponding mean compliance is a summary of the data:

	Staff correctly implements the BY CHOICE program	91%
1.	*Staff correctly states the current point cycle.*	80%
2.	*Staff correctly states the procedure for assigning participation levels on point cards.*	100%
3.	*Staff correctly assigns a participation level and marks an individual's card per the BY CHOICE Manual*	100%
4.	*Staff correctly assigns a participation level and marks an individual's card per the BY CHOICE Manual.*	97%

5.	*Staff can locate the current BY CHOICE Manual.*	97%
6.	*Staff correctly states the difference between a "baseline" point card and a reallocated point card.*	92%
7.	*Staff correctly states where the point reallocation documentation is located.*	90%
8.	*Staff can locate a current BY CHOICE Manual in their work site.*	95%
9.	*There is a system to orient new Individuals to the BY CHOICE Incentive Program.*	84%
10.	*Staff is able to state their unit's Incentive Store hours of operation.*	72%

ASH also assessed the status of the BY CHOICE Incentive Program by evaluating individuals' knowledge, participation, and performance in the BY CHOICE program. Using items 1 to 8 from the BY CHOICE Monitoring Form: Competency and Fidelity Check (Individual), ASH assessed its compliance based on an average sample of 18% of the individuals. The table below with its indicators and corresponding mean compliance is a summary of the data:

1.	*Individual is holding his/her own point card.*	68%
2.	*The Individual states, to the best of their ability, how points are earned.*	99%
3.	*The Individual states, to the best of their ability, how points are spent.*	99%
4.	*The Individual states, to the best of their ability, the expectations for earning FP (Full Participation), MP (Moderate Participation) and NP (Non Participation).*	96%
5.	*The Individual states, to the best of their ability, the possible number of points that may be earned each day.*	95%
6.	*The Individual states, to the best of their ability, how the points are re-allocated for their point card.*	56%

7.	*The Individual states, to the best of their ability, the hours their Incentive Store is open.*	78%
8.	*The Individual can identify, to the best of their ability, the cycles of "high priority" on their point card.*	53%

Using items 1 to 10 from the BY CHOICE Monitoring Form: Incentive Store Staff Competency and Fidelity Check, ASH assessed its compliance based on an average sample of 40% of the Incentive Store Staff. The table below with its indicators and corresponding mean compliance is a summary of the data:

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 assures that all individuals have access to incentive items.*	100%
3.	*The incentive store is well stocked with approved items from the incentive list.*	100%
4.	*The incentive store has an inventory control system.*	100%
5.	*The incentive store has a system to track and remove outdated food items.*	100%
6.	*There is a BY CHOICE Manual located in the incentive store.*	100%
7.	*The incentive store staff has completed "Incentive Store" training.*	100%
8.	*The individuals bring their point cards to the store to make a purchase.*	100%
9.	*There is a BY CHOICE Calorie Activity Guide located in the incentive store.*	100%
10.	*There is an Alert list in the incentive store, for staff reference.*	100%

This monitor's findings from observing the Incentive Store are in agreement with the facility's data on Incentive Store Procedures and Functions.

ASH surveyed the individuals in the facility to evaluate their satisfaction with the BY CHOICE Incentive program. Using items 1 to 7 from the BY CHOICE Monitoring Form: Satisfaction Check, ASH assessed its compliance based on an average sample of 13% of the individuals in the facility. The table below with its indicators and corresponding mean compliance is a summary of the data:

	Satisfaction	75%
1.	*Is the point system helpful to you?*	96%
2.	*Do staff explain how you earn an "FP," "MP" or "NP" for all your activities?*	71%
3.	*Do staff tell you if you earned an "FP," "MP" or "NP" for all your activities?*	58%
4.	*Are you satisfied with the number of points you can earn for each cycle or group?*	95%
5.	*Do you like what is offered in the incentive stores?*	85%
6.	*Do you hold on to your point card during the day?*	57%
7.	*Do you discuss how you want your points allocated when you meet with your team during your conferences?*	66%

Recommendation 2, April 2008:
Implement the program as per the manual.

Findings:
According to the BY CHOICE Coordinator, the BY CHOICE Manual is under revision. Meanwhile, the program continues to be implemented using the model from the existing manual.

According to the BY CHOICE Coordinator, ASH provided training on the BY CHOICE incentive program at the "New Employee Orientation" training schedule. The table below showing the number of staff eligible for training (N), the number of staff trained each month (n), and the percentage of staff trained (%C) is a summary of the facility's data.

Staff Training in BY CHOICE							
2008	Mar	Apr	May	Jun	Jul	Aug	Mean
N	26	24	16	45	33	30	
n	26	24	16	45	33	30	
%S	100	100	100	100	100	100	
%C	100	100	100	100	100	100	100

Recommendation 3, April 2008:
BY CHOICE point allocation should be determined by the individual at the WRPC, with facilitation by the staff.

Findings:
Using item 7 (*Do you discuss how you want your points allocated when you meet with your team during your conferences?*) from the BY CHOICE Monitoring: Individual Satisfaction Check Form, ASH analyzed its compliance based on a sample of 13% of the individuals in the facility (March to August 2008), reporting a mean compliance rate of 66%.

This monitor reviewed eight charts (RE, DEG, KLW, JR, JI, LH, JM, and TWF). Five of the WRPs in the charts (RE, JM, TWF, DEG, and KLW) had documented evidence that the individual was a participant in his/her BY CHOICE point allocation. The remaining three (JR, JI, and LH) did not contain such documentation.

This monitor observed two WRPCs (DJM and VL). Both teams engaged

		the individuals in the BY CHOICE point allocation process. **Recommendation 4, April 2008:** Report BY CHOICE point allocation in the Present Status section of the individual's case formation and update at every scheduled WRPC. **Findings:** ASH did not present chart audit data for this recommendation. This monitor reviewed nine charts (DEG, JI, JM, JR, JS, KLW, LH, RE and TWF). Five of the WRPs in the charts (DEG, JM, KLW, LH, and RE) reported the BY CHOICE point allocation in the Present Status section of the individuals' case formulation and updated the information in the subsequent WRPs. The BY CHOICE point allocation documentation in the remaining four WRPs (JI, JR, JS and TWF) was not properly documented or was not updated (in many cases, the documentation was duplicated across WRPs). **Compliance:** Partial. **Current recommendations**: 1. Ensure all staff correctly implements the BY CHOICE program. 2. Implement the program per the manual. 3. BY CHOICE point allocation should be determined by the individual at the WRPC, with facilitation by the staff. 4. Report BY CHOICE point allocation in the Present Status section of the individual's case formation and update at every scheduled WRPC.
F.2.b	Each State Hospital shall ensure that the Chief of Psychology has the clinical and administrative responsibility for the Positive Behavior Supports	**Current findings on previous recommendation:**

	Team and the By CHOICE incentive program.	**Recommendation, April 2008:** Continue current practice. **Findings:** This monitor's discussion with the Chief of Psychology revealed that the Chief of Psychology has the clinical and administrative responsibility for the Positive Behavior Supports Team and the BY CHOICE incentive program. However, ASH has recently established the Psychology Specialty Services Committee (PSSC), headed by the PSSC Coordinator. The PSSC deals with matters related to behavioral interventions including the System-Wide Positive Support Plan and the behavioral interventions (Behavior Guidelines and the Positive Behavioral Support Plans). As such, the Chief of Psychology has designated the PSSC Coordinator to oversee PBS-related matters for ease of communication and operation. **Compliance:** Substantial. **Current recommendation:** Continue current practice.
F.2.c	Each State Hospital shall ensure that:	**Compliance:** Partial.
F.2.c.i	behavioral assessments include structural and functional assessments and, as necessary, functional analysis;	**Current findings on previous recommendations:** **Recommendation 1, April 2008:** Train all PBS team members in functional assessment, data collection, data analysis, graphing, plan implementation and data interpretation. **Findings:** This monitor's documentation review (training logs, sign-in sheets, and

		training protocols) found that ASH had conducted a series of PBS training sessions for PBS team members. The training topics, among others, included data collection, data analysis, graphing, data interpretation, functional assessments and plan implementation (training dates: July 16, 17and 30, 2008). **Recommendation 2, April 2008:** Develop a system for identifying and tracking individuals in the hospital who are in need of behavioral interventions. **Findings:** This monitor's discussion with the Chief of Psychology and the PSSC Coordinator found that ASH has expanded on the system set up during the last review period to track individuals in need of behavioral interventions. In addition to using the task tracking log and the unit psychologist to identify individuals in need of behavioral services, ASH now tracks needs through weekly reporting to the Executive team of names of individuals who triggered (aggression, self-injury, suicide threat/attempt, restraint, and seclusion 1:1/2:1 supervision). The cases referred are discussed by the team and triaged according to severity of the presenting problems. **Recommendation 3, April 2008:** Use the PBS-BCC pathway for all consultations. **Findings:** This monitor's discussion with the Chief of Psychology revealed that ASH has established the Psychology Specialty Services Committee (PSSC) on July 14, 2008. All behavioral consultations now are channeled through the PSSC. The enduring team members from the BCC have been incorporated into the PSSC. This monitor attended one of the PSSC meetings. The meeting was well-organized, attendance was high, participation was interdisciplinary, cases were thoroughly

		reviewed, and actions items and responsibility were appropriately designated. **Current recommendations**: 1. Continue to train new PBS team members, and re-training of the enduring PBS team members to keep them updated with developments in the field. 2. Use the PBS-PSSC pathway for all consultations.
F.2.c.ii	hypotheses of the maladaptive behavior are based on structural and functional assessments;	**Current findings on previous recommendation:** **Recommendation, April 2008:** Ensure that hypotheses of the maladaptive behaviors are based on structural and functional assessments and clearly stated in the PBS documentation. **Findings** Using item 5 from the DMH Psychology Services Monitoring Form, ASH assessed its compliance based on a 100% sample of the PBS plans developed and implemented during this review period (March to August 2008). The table below with its indicators and sub-indicators and corresponding mean compliance is a summary of the data:

5.	*PBS assessments include structural and functional assessments, and as necessary, functional analysis*	100%
5.a	*Pertinent records were reviewed (e.g., individual's chart/record, meeting notes, anecdotal records, evaluations, previous interventions),*	100%
5.b	*Structural assessments (e.g., ecological, sleep, medication effects, mall attendance) were conducted, as needed, to determine broader variables affecting the individual's behavior,*	100%
5.c	*Functional assessment interviews were conducted*	100%

	with people (e.g., individual, parents and family members, therapists and care staff, teachers) who often interact with the individual within different settings and activities, as needed.	
5.d	*Direct observations were conducted across relevant circumstances (e.g., multiple settings, over time) and by more than one observer, as appropriate,*	100%
5.e	*Other assessment tools (e.g., rating scales, checklists) were used to produce objective information regarding events preceding and following the behavior of concern, as well as ecological and motivational variables that may be affecting the individual's behavior, as needed, and*	100%
5.f	*If necessary, suspected maintaining variables were manipulated to assess the motivation(s) for the individual's behavior.*	100%

This monitor's findings from review of the facility's structural and functional assessments and the PBS plans are in agreement with the facility's findings.

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

F.2.c.iii	There is documentation of previous behavioral interventions and their effects;	**Current findings on previous recommendations:** **Recommendations 1 and 2, April 2008:** • Document previous behavioral interventions. • Document effectiveness of previous interventions.

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Findings:
Using item 7 from the DMH Psychology Services Monitoring Form, ASH assessed its compliance based on a 100% sample of the structural and functional assessments developed and implemented during this review period (March to August 2008). The table below with its indicators and sub-indicators and corresponding mean compliance is a summary of the data:

<table>
<tr><td>7.</td><td>There is documentation of previous behavioral interventions and their effects</td><td>100%</td></tr>
<tr><td>7.a</td><td>There is documentation of previous behavioral interventions, and</td><td>100%</td></tr>
<tr><td>7.b</td><td>The effects of these interventions.</td><td>100%</td></tr>
</table>

This monitor's review of PBS plans (AAC, AJ, BG, CC, GG, HM, SMB, SW and WT) found that the PBS team members had documented previous interventions and their effects as part of their structural and functional assessments.

Current recommendations:
1. Document previous behavioral interventions.
2. Document effectiveness of previous interventions.

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<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>
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Current findings on previous recommendation:

Recommendation, April 2008:
Ensure that all behavioral interventions are based on a positive behavioral supports model without any use of aversive or punishment contingencies.

Findings:
Using item 8 from the DMH Psychology Services Monitoring Form, ASH assessed its compliance based on a 100% sample of the PBS/behavioral

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<td>interventions during this review period (March to August 2008). The table below with its indicators and sub-indicators and corresponding mean compliance is a summary of the data:
<table>
<tr><td>8.</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>100%</td></tr>
<tr><td>8.a</td><td>The Behavior Guidelines and PBS plans meets the criteria on the DMH PBS Plan Monitoring Form*, and</td><td>100%</td></tr>
<tr><td>8.b</td><td>The Behavior Guidelines and PBS plans do not include any aversive or punishment contingencies.</td><td>100%</td></tr>
</table>
This monitor's review of a number of PBS plans (AAC, AJ, BG, CC, GG, HE, HM, SMB, SW and WT), and Behavior Guidelines (BB, CV, DB, IB, JB, MA, RA and RC) found that all behavioral interventions were based on a positive behavioral supports model without any use of aversive or punishment contingencies.

Current recommendation:
Ensure that all behavioral interventions are based on a positive behavioral supports model without any use of aversive or punishment contingencies.</td>
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<td>F.2.c.v</td>
<td>behavioral interventions are consistently implemented across all settings, including school settings;</td>
<td>Current findings on previous recommendations:

Recommendation 1, April 2008:
Ensure that staff across settings is aware of each individual's behavioral plan, and that they receive written plans and training.

Findings:
This monitor's discussion with the PBS team members and the PSSC</td>
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		Coordinator revealed that staff across settings (where the plans are to be implemented) are aware of individuals with behavioral plans, and that training and written plans are presented to the staff. The staff in the settings where the behavioral plans are implemented are trained to implement the protocols, and the behavioral plans are emailed to the staff responsible for implementing the plans. This monitor's Mall group observations found that behavioral plans were available in groups attended by individuals with the behavioral plans, and when interviewed, the group facilitators were able to state the essential elements in an individual's behavioral plan (for example, the "Ready, Set, Go" group). **Recommendation 2, April 2008:** Ensure that all behavioral interventions are consistently implemented across all settings, including mall, vocational and education settings. **Findings:** Using item 9 (*Behavioral interventions are consistently implemented across all settings, including school settings*) from the DMH Psychology Services Monitoring Form, ASH analyzed its compliance based on a 100% sample of the PBS plans/Behavior Guidelines developed and implemented during this review period (March to August 2008), reporting a mean compliance rate of 53%. This monitor's findings from review of the PBS plans/behavior guidelines are in agreement with the facility's data. ASH may want to report the PBS and Behavior Guideline data separately so that the data in one is not skewed by the other. **Current recommendations**: 1. Ensure that staff across settings is aware of each individual's behavioral plan, and that they receive written plans and training.

<table>
<tr><td></td><td></td><td>2. Ensure that all behavioral interventions are consistently implemented across all settings, including mall, vocational and education settings.</td></tr>
<tr><td>F.2.c.vi</td><td>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;</td><td>

Current findings on previous recommendations:

Recommendations 1 and 2, April 2008:
- Continue to refine the trigger system.
- Ensure that staff is aware of the PBS-BCC pathway.

Findings:
Using item 10 from the DMH Psychology Services Monitoring Form, ASH assessed its compliance based on a 100% sample of individuals who have triggered one or more of the thresholds during this review period (March to August 2008). The table below with its indicators and sub-indicators and corresponding mean compliance is a summary of the data:

<table>
<tr><td>10.</td><td>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</td><td>100%</td></tr>
<tr><td>10.a</td><td>A referral has been made to the Coordinator of Psychology Specialist Services, and</td><td>27%</td></tr>
<tr><td>10.b</td><td>Appropriate assessment and/or interventions have been initiated</td><td>27%</td></tr>
</table>

As the table above shows, ASH is tracking and monitoring all the individuals who meet/surpass the trigger threshold. However, the barrier to assessment and/or psychological services was due to the absence of referrals. As indicated in F2.c.i, ASH has expanded the tracking and monitoring system to track individuals in need of behavioral interventions, including the weekly report to the executive
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		team of individuals who triggered (aggression, self-injury, suicide threat/attempt, restraint, and seclusion 1:1/2:1 supervision). The cases referred are discussed by the team and triaged according to severity of the presenting problems. This process, if followed correctly, should ensure that all individuals with maladaptive behaviors are referred for behavioral assessment and services. One other factor that limits services to individuals is staffing shortage. Discussion with the Chief of Psychology and the PSSC Coordinator found that WRPTs now use the same process as the PBS-BCC pathway, except now the referral goes from PBS to the PSSC since the BCC has been dissolved. **Current recommendations**: 1. Continue to refine the trigger system. 2. Ensure that staff is aware of the PBS-PSSC pathway.
F.2.c.vii	positive behavior support teams and team psychologists integrate their therapies with other treatment modalities, including drug therapy;	**Current findings on previous recommendations:** **Recommendation 1, April 2008:** Conduct appropriate structural and functional assessments to derive data-based hypotheses that will guide specific treatment options. **Findings:** This monitor's documentation review (PBS plans and structural/ functional assessments) of ten individuals (AAC, AJ, BG, CC, GG, HE, HM, SMB, SW and WT) found that PBS teams conducted structural and functional assessments to formulate hypotheses and identify behavioral functions to develop treatments. **Recommendation 2, April 2008:** Integrate all behavioral interventions with other treatment modalities including drug therapy.

Findings:
Using item 11 from the DMH Psychology Services Monitoring Form, ASH assessed its compliance based on a 100% sample of the PBS plans and behavior guidelines developed and implemented during this review period (March to August 2008). The table below with its indicators and sub-indicators and corresponding mean compliance is a summary of the data:

11.	*Positive Behavior Support teams and team psychologists integrate their therapies with other treatment modalities, including drug therapy.*	80%
11.a	*Initial consultation between the PBS psychologist and the WRPT psychiatrist and psychologist regarding specific pharmacological and behavioral interventions to be used for managing the individual's psychiatric illness and learned maladaptive behavior.*	80%
11.b	*Joint review of the following by the PBS psychologist with the WRPT psychiatrist and psychologist:*	80%
11.b.i	*Review of PBS plans prior to implementation*	80%
11.b. ii	*Review of individual's progress in behavioral treatment*	80%
11.b. iii	*Differentiation, as clinically appropriate, of learned behaviors from behaviors that are targeted for pharmacological treatment, and*	80%
11.b. iv	*Modification, as clinically appropriate, of diagnosis and/or pharmacological and/or treatment based on above reviews/assessments.*	80%

This monitor's findings from documentation review (PBS plans,

		structural/functional assessments, and interdisciplinary progress notes) are in agreement with the facility's data. A review of the interdisciplinary progress notes (AJ, BB, CC, PG, SMB, SW and WT) found that in most cases, PBS team members were consulting with other disciplines regarding the individual's mental illness/nutrition/ medication issues in relation to the individual's targeted maladaptive behaviors. PBS teams should also focus on such consultation during the assessment phase, prior to development of the plan, to evaluate the influence of non-environmental factors on the individual's maladaptive behaviors. The data from such consultation will help in formulating the hypotheses and developing the intervention plans. **Current recommendations**: 1. Conduct appropriate structural and functional assessments to derive data-based hypotheses that will guide specific treatment options. 2. Integrate all behavioral interventions with other treatment modalities including drug therapy.
F.2.c.viii	all positive behavior support plans are specified in the objectives and interventions sections of the individual's Wellness and Recovery Plan;	**Current findings on previous recommendations:** **Recommendations 1 and 2, April 2008:** • Specify PBS plans in the objectives and interventions sections of the individual's WRP plan as outlined in the DMH WRP Manual. • Ensure that WRPTs are aware of the DMH WRP Manual, as the Manual specifies how this is done. **Findings:** Using item 12 from the DMH Psychology Services Monitoring Form, ASH assessed its compliance based on a 100% sample of the PBS plans and behavior guidelines developed and implemented during this review period (March to August 2008). The table below with its indicators and sub-indicators and corresponding mean compliance is a summary of the

data:

12.	*All positive behavior support plans are specified in the objectives and interventions sections of the individual's Wellness and Recovery Plan*	70%
12.a	*There is an Objective in the WRP that specifies in behavioral, observable and/or measurable terms that the individual will learn alternative ways of behaving, and*	70%
12.b	*There are at least two interventions in the WRP aligned with the Objective, one of which is an active treatment and refers to a Behavior Guideline or PBS plan and the other is a reference to the implementation of the Behavior Guideline or PBS plan in the therapeutic milieu.*	70%

This monitor reviewed seven charts (GKP, RLY, SW, WST, SMB, MAP, and HE) of individuals with PBS plans or PBS assessments. Five 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. One of them did not have appropriate objectives and/or active and milieu interventions, and one of them is still in the assessment stage, which was documented in the Present Status section.

According to the Chief of Psychology, WRPTs are aware of the DMH WRP manual. In addition, PBS team members attend WRPCs and assist the WRPTs with the information and documentation.

Current recommendation:
Specify PBS plans in the objectives and interventions sections of the individual's WRP plan as outlined in the DMH WRP Manual.

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 recommendations:** **Recommendations 1 and 2, April 2008:** • 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. • Implement the steps that will improve collaboration among all parties that participate in/support PBS plans. **Finding:** Using item 13 from the DMH Psychology Services Monitoring Form, ASH assessed its compliance based on a 100% sample of the PBS plans and behavior guidelines developed and implemented during this review period (March to August 2008). The table below with its indicators and sub-indicators and corresponding mean compliance is a summary of the data: 13. *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* — 60% 13.a *There are quantitative outcome data for the plan,* — 60% 13.b *The outcome data are documented monthly in the Present Status section of the case formulation of the individual's WRP, and* — 60% 13.c *The Behavior Guidelines and PBS plans are updated, as indicated by the outcome data* — 60% This monitor's findings from the review of seven charts (GKP, HE, MAP, RLY, SMB, SW and WST) of individuals with PBS plans are in agreement with the facility's data. While the PBS plans are documented at the initial WRPC when the plans are implemented, updates with

		outcome data at subsequent monthly WRPCs are inconsistent. WRPTs may want to document "change data" (for example, it is more meaningful when the documentation reads "Aggression was reduced from 10 episodes last month to five episodes this month," or "There were five aggressive episodes this month, a 50% reduction," instead of "Individual is continuing to have aggressive triggers"). In one case, the WRPT chose to list the frequency of the target behaviors for each month. This is another way to document change data. According to the PSSC Coordinator, collaboration among parties in the PBS plans is addressed through delivery of plan copies to all staff involved in the plan and through the weekly interdisciplinary PSSC meetings. **Current recommendation**: 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.
F.2.c.x	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.	**Current findings on previous recommendation:** **Recommendation, April 2008:** 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. **Findings:** This monitor's documentation review (staff training sign-in sheets, PBS staff training protocols for PBS, and staff training post-test) and discussion with the PSSC Coordinator found that PBS teams always train to competency the staff responsible for implementing the PBS plans.

		Using item 14 (*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*) from the DMH Psychology Services Monitoring Form, ASH analyzed its compliance based on a sample of 100% of the PBS plans developed and implemented during this review period (March to August 2008), reporting a mean compliance of 100%. This monitor's findings from review of eight PBS plans (AJ, BG, CC, GG, HM, SMB, SW and WT) are in agreement with the facility's data. All eight PBS plans had data on staff training, post-test, and fidelity checks. **Current recommendation**: Ensure that staff is competent in implementing specific behavioral interventions for which they are responsible, and have performance improvement measures in place for monitoring the implementation of such interventions.
F.2.c.xi	all positive behavior support team members shall have as their primary responsibility the provision of behavioral interventions;	**Current findings on previous recommendation:** **Recommendation, April 2008:** Hire additional staff to add PBS teams to meet the 1:300 ratio. **Findings:** The current number of PBS teams in ASH does not meet the 1:300 ratio. Since March 2008, ASH has hired eight staff (two psychologists, five psychiatric technicians, and one registered nurse). With these hires, ASH now has three full PBS teams, one partial PBS team and one partial DCAT team. ASH continues its efforts to fill the remaining vacancies.

		The 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. **Current recommendation**: Hire additional staff to add PBS teams to meet the 1:300 ratio.
F.2.c.xii	the By CHOICE point allocation is updated monthly in the individual's Wellness and Recovery Plan.	**Current findings on previous recommendation:** **Recommendation, April 2008:** Ensure that BY CHOICE point allocation is updated monthly in the individual's Wellness and Recovery Plan. **Findings:** Using items 1 to 6 from the BY CHOICE Chart Audit Form, ASH assessed its compliance based on a sample of 26% of the individuals at ASH per month during this review period (March to August 2008). The table below with its indicators and corresponding mean compliance is a summary of the data:

1.	*Is BY CHOICE addressed in the Case Formulation/ Present Status of the WRPC?*	99%
2.	*Is there documentation whether the individual is on a baseline or reallocated point card?*	79%
3.	*Did the TX team reallocate the point card at this conference?*	85%
4.	*Did the team state "rationale" for reallocation or non-reallocation of points?*	65%
5.	*Did the individual have input in the reallocation or non-reallocation of points?*	73%
6.	*Does the WRP show a "Continuity of Care" in regards*	33%

		to BY CHOICE? This monitor reviewed nine charts (AJT, CW, JDS, KC, KD, MS, RG, SWC and TM). Three of the nine WRPs in the charts (KC, MS and TM) had documentation of the individual's BY CHOICE point allocation in the Present Status section of the individual's WRP. The documentation in the remaining six WRPs was not comprehensive. This monitor's discussion with the BY CHOICE Coordinator revealed that training and support to WRPTs is ongoing. This monitor also reviewed a number of materials that the BY CHOICE Coordinator had prepared that show examples of proper BY CHOICE point allocation documentation. According to the BY CHOICE Coordinator, shortage of staffing (psychologists in the WRPTs), and lack of senior supervising psychologists contribute to the low compliance. Furthermore, many of the newly hired psychologists are under training. **Current recommendation**: Ensure that BY CHOICE point allocation is updated monthly in the individual's Wellness and Recovery Plan.
F.2.d	Each State hospital shall ensure that it has at least one developmental and cognitive abilities team (DCAT; consisting of 1 clinical psychologist, 1 registered nurse, 1 social worker, 1 psychiatric technician, and 1 data analyst (who may be a behavior specialist) who have a demonstrated competence, consistent with generally accepted professional standards of care, in assessing individuals with cognitive disorders/challenges; developing therapeutic interventions (including	**Current findings on previous recommendation:** **Recommendation, April 2008:** Ensure that all DCAT team members receive appropriate training. **Findings:** This monitor's documentation review (training log/sign-in sheets) and discussion with the Chief of Psychology and the BY CHOICE Coordinator found that DCAT members attend the same training as the PBS team members. Multiple training sessions had been conducted

	positive behavior supports); advising therapy and rehabilitation providers on the implementation of interventions at the cognitive level of the individuals; and managing discharge processes for individuals with developmental disabilities and cognitive disorders/challenges,. This team shall assume some of the functions of the positive behavior support teams if the individuals they serve also need positive behavioral supports.	during this review period (July 9, 16, 17 and 30, 2008). **Compliance:** Substantial. **Current recommendation:** Continue to train new DCAT members, and re-train the enduring team members to keep them updated with developments in the field.
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 recommendations:** **Recommendation 1, April 2008:** Schedule regular meetings and ensure that all standing members of the BCC attend the meetings regularly. **Findings:** This monitor's discussion with the Chief of Psychology and the PSSC Coordinator revealed that the BCC now is dissolved. The PSSC (beginning July 14, 2008) addresses the PBS/behavioral intervention services previously handled through the BCC. Most of the enduring members of the BCC now participate in the PSSC. The PSSC, chaired by the PSSC Coordinator, meets weekly. The standing members include the Chiefs of Psychiatry and Psychology, Clinical Administrator, Program Directors, and Unit Supervisors. The primary purpose of the PSSC is to address staff coordination and matters related to challenges in providing behavioral interventions. The cases discussed at the PSSC meetings include individuals not making progress in their behavioral interventions and individuals who trigger. According to the PSSC Coordinator, individuals not making progress despite the PSSC recommended interventions are referred to the Quality Council. The plans are implemented and monitored by the PBS teams with support from the unit psychologists and the Program Directors.

		This monitor's observation of a PSSC meeting and review of their meeting minutes found that the PSSC is well-structured and -managed. The process and procedures at each case discussion are well-organized. The meeting was well-attended and productive with strong participation. **Compliance:** Substantial. **Current recommendations**: 1. Schedule regular meetings and ensure that all standing members of the PSSC attend the meetings regularly. 2. Ensure that PSSC plans are properly implemented when indicated.
F.2.f	Each State Hospital shall ensure that it has sufficient neuropsychological services for the provision of adequate neuropsychological assessment of individuals with persistent mental illness.	**Current findings on previous recommendations:** **Recommendation 1, April 2008:** Make referrals, when appropriate, for neuropsychological assessments. **Findings:** This monitor's discussion with Christine Mathiesen, the C-PAS Director, revealed that ASH has conducted a number of training sessions to further educate staff on making appropriate and timely neuropsychological assessment referrals. Written documents entitled "Neuropsychology Referral Guidelines" and "Neuropsychology Services" was sent to all physicians and psychologists. ASH also developed a database to review neuropsychology reports and referrals to track if appropriate referrals were being made. **Recommendation 2, April 2008:** Ensure that neuropsychologists provide cognitive remediation and cognitive retraining groups in the PSR Mall.

Findings:
This monitor's discussion with the Director of C-PAS and observation of the Mall groups found that neuropsychologists are providing cognitive remediation and cognitive retraining groups in the PSR Mall. This monitor observed the Cognitive Rehabilitation group "Attention, Concentration, and Tracking." The facilitators had well-prepared lesson plans and teaching materials. The group is new, offered since August 2008. WRPTs should become familiar with this group, its course contents and objectives and assign individuals to the group. The Neuropsychology Service intends to add more cognitive remediation and retraining groups when additional neuropsychology staff is on board.

Recommendation 3, April 2008:
Increase the number of neuropsychologists to meet the anticipated demand for neuropsychological services.

Findings:
This monitor's discussion with the Chief of Psychology and the Neuropsychology Service Director revealed that ASH continues to have Neuropsychology staffing shortage. ASH is actively seeking to fill these vacant positions with advertisements and postings through many outlets.

Using item 8 from the DMH Psychology Services Monitoring form, ASH assessed its compliance regarding the time taken to complete referrals based on a 100% of the referrals received for the month (March to August 2008). The table below with its indicators and sub-indicators and corresponding mean compliance is a summary of the data:

	Mar	Apr	May	Jun	Jul	Aug	Mean
18a.i Number of neuropsychological	11	15	9	9	6	10	10

assessments due for completion in the review month								
18a.ii Of those in 18.a.i, number completed	2	2	4	4	4	2	3	
18a.iii Average time taken from referral to completion for all neuropsychological assessments during the current evaluation period							138	

As the table above shows, the number of referrals varies based on the needs of the individuals; the number is expected to increase with the education/training provided by the Neuropsychology Service staff to the WRPTs, psychologists, and psychiatrists on making appropriate referrals. The table also shows that the assessment team is unable to complete assessments in a timely manner, taking an average of 138 days as opposed to the expected 30 calendar days. This data highlights the need for additional Neuropsychology staff.

Compliance:
Partial.

Current recommendations:
1. Make referrals, when appropriate, for neuropsychological assessments.
2. Ensure that neuropsychologists provide cognitive remediation and cognitive retraining groups in the PSR Mall.
3. Increase the number of neuropsychologists to meet the anticipated demand for neuropsychological services.

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	**Current findings on previous recommendation:**

	support plans, consultation for educational or other testing, and positive behavior support plan updates.	**Recommendation, April 2008:** Ensure that this authority is fully approved and implemented. **Findings:** This monitor's discussion with the Chief of Psychology and the PBS staff found that clinical psychologists at ASH have received the authority to write orders for the implementation of positive behavior support plans, positive behavior support plan updates and consultation for educational or other testing. In accordance with the authority, ASH has revised the Department of Psychology Scope of Practice, rules and regulations, and procedures manuals, and the documents have received the approval of the Medical Executive Committee. In addition, the psychologists responsible for writing orders have received training on order-writing. **Compliance:** Substantial. **Current recommendation**: Continue current practice.

3. Nursing Services		
	Each State hospital shall provide adequate and appropriate nursing care and services consistent with generally accepted professional standards of care to individuals who require such services.	**Methodology:** Interviewed: 1. Belinda Roetker, RN Standards Compliance 2. Concha Silva, RN Standards Compliance 3. Cynthia Davis, Nurse Administrator, Central Nursing Services 4. Donna Hunt, Health Services Specialist 5. Jeannine Doolin, RN Standards Compliance 6. Justin Alldredge, Psychiatric Technician 7. Marlene Espitia, RN Standards Compliance 8. Rosie Morrison, Health Services Specialist 9. Teri Jewell, Psychiatric Technician, Quality Assurance Monitor Reviewed: 1. ASH progress report and data 2. Nursing Procedure 307.0, Administration of Medication and Treatments 3. Nursing Procedure 307.0.1, Documentation of Medication and Treatments 4. Nursing Procedure 218.0, Shift Change Communication and Primary Sponsor Assignments 5. Nursing Procedure 203.0, Nursing Assessments 6. RN Significant Change in Condition Assessment Note form 7. Guidelines for Items to Report/Discuss at Shift Change 8. Curriculum for PRN/Stat/Emergency Medication Documentation; Conversion of Nursing Care Plans and Temporary Conditions into the Wellness and Recovery Plan 9. HSS Committee Meeting minutes dated April 7, May 12 and June 30, 2008 10. ASH's Medication System Failure-Successful Interventions data from March to August 2008 11. Training rosters for Change of Shift and Psychiatric Nursing

		12. Sponsor Group Training schedule for July-September 2008 13. Medication Treatment Records for Units 1, 3, 7, 9, 21, 22, 26, 27 and 34 14. Medical records of the following 73 individuals: AA, AES, AHL, AJT, AKH, AOQ, AP, AS, BCS, BDA, BEM, BM, BU, CC, CDG, CLC, CLW, DAB, DEA, DJW, DLC, DNF, DR, DRS, ED, EJA, EV, FC, FG, FT, GET, GFP, GKP, GLM, GN, GP, GV, HE, HKS, HLC, HP, JIJ, JM, JN, JRR, JRW, JS, KM, LDJ, MAF, MCJ, MD, MM, MVB, MW, NBM, PP, RH, RLP, RS, SK, SW, TH, TJC, TS, TW, VJJ, VT, WM, WMN, WST, WT and WWM <u>Observed</u>: 1. Medication pass (7 a.m.) on Unit 18 2. Shift report on Unit 13 3. WRPTs on Unit 6 (7-day) and Unit 19 (monthly)
F.3.a	Each State hospital shall develop and implement policies and protocols regarding the administration of medication, including pro re nata ("PRN") and "Stat" medication (i.e., emergency use of psychoactive medication), consistent with generally accepted professional standards of care, to ensure:	**Compliance:** Partial.
F.3.a.i	safe administration of PRN medications and Stat medications;	**Current findings on previous recommendation:** **Recommendation, April 2008:** Continue to monitor this requirement. **Findings:** ASH's compliance data from the DMH Nursing Services Monitoring PRN audit based on an average sample of 18% of behavioral PRNs administered each month (March-August 2008) indicated the following:

	Safe administration of PRN medications	
a.	*PRN medication administered based on a complete physician's order*	98%
c.	*Nurse administered correct med, dose, form, route, on the correct date, and for correct indication to the correct individual*	90%

ASH's data analysis indicated that the compliance rates decreased from February 2008 to August 2008 as follows:

1. Item a: from 100% to 96%; and
2. Item c: from 97% to 88%.

ASH's compliance data from the DMH Nursing Services Monitoring Stat audit based on an average sample of 20% of behavioral Stats administered each month (March-August, 2008) indicated the following:

	Safe administration of Stat medications	
b.	*Stat medication administered based on a complete physician's order*	70%
c.	*Nurse administered correct med, dose, form, route, on the correct date, and for correct indication to the correct individual*	85%

ASH's data analysis indicated that the compliance rates decreased from February 2008 to August 2008 as follows:

1. Item b: from 88% to 79%; and
2. Item c: from 94% to 82%.

Barriers to compliance included PRN and Stat orders not containing

		specific and individualized indications for administration of the medications and multiple documentation compliance requirements regarding the MTR and interdisciplinary notes (IDNs). ASH's progress report indicated that its plan of correction for this requirement included follow-up with the psychiatrists regarding documentation of PRN and Stat orders and revision and clarification of Nursing Procedures regarding who should document the circumstances and effectiveness of PRN and Stat medications: the medication nurse versus the unit staff. In addition, the facility has provided training to staff in March and June 2008 regarding the documentation of PRNs and Stats and plans to form a work group to address compliance with this requirement. A review of 100 PRNs and Stat medications orders for 24 individuals (AS, DAB, DR, ED, EV, FG, FT, GP, HE, JM, JS, MCJ, MM, PP, SW, TH, TJC, TS, TW, VJJ, VT, WM, WST and WT) found that 87 orders did not include specify individual behaviors. In addition, 78 incidents noted in the IDNs did not include either the correct notation of Stat or PRN, the name of the medication administered, the dosage administered, the route given, or an IDN documenting the PRN or Stat medication was not found in the medical record. Observing 7 a.m. medication administration on Unit 18, this monitor found that the staff administering the medications did not consistently check the medication packages with the MTR; did not use the appropriate texture (honey-thick) fluids for an individual at risk for aspiration; and had a number of medications to administer after the appropriate time limitation was up. Although the staff member demonstrated a good rapport with the individuals that received medications, there was very little medication education provided. **Current recommendations**: 1. Ensure that staff administering medications are familiar with

<table>
<tr><td></td><td></td><td>individuals' medications.
2. Ensure accuracy of data regarding medication administration.
3. Continue to monitor this requirement.</td></tr>
<tr><td>F.3.a.ii</td><td>documentation of the circumstances requiring PRN and Stat administration of medications;</td><td>

Current findings on previous recommendations:

Recommendation 1, April 2008:
Continue to implement training and competency validation regarding this requirement.

Findings:
No data was provided regarding this recommendation.

Recommendation 2, April 2008:
Continue to monitor this requirement.

Findings:
ASH's compliance data from the DMH Nursing Services PRN audit based on an average sample of 18% of PRNs administered each month (March-August 2008) indicated the following:

<table>
<tr><td>2.</td><td>Documentation of all the circumstances requiring PRN administration of medication.</td><td></td></tr>
<tr><td>2.a</td><td>In the MTR, there is a brief description of the circumstances and behavior requiring PRN medication.</td><td>55%</td></tr>
<tr><td>2.b</td><td>In the IDN, there is a comprehensive assessment of the individual prior to the PRN medication and circumstances requiring the PRN.</td><td>36%</td></tr>
</table>

ASH's analysis demonstrated that compliance for the documentation on the MTR of the circumstances requiring PRN slightly decreased from 56% in February 2008 to 54% in August 2008 and the documentation in

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

the IDNs increased from 38% to 44% during the same time period. The facility identified barriers to compliance as noted above in F.3.a.i and also identified PRNs that are erroneously documented as Stats and confusion regarding who should be doing the required documentation as factors in low compliance. The plan is correction is as above in F.3.a.i.

A review of 50 incidents of PRN medications for 12 individuals (AS, DR, FT, GP, JM, JS, PP, SW, TS, VT, WM and WST) found that 27 incidents included the documentation of circumstances requiring the PRN and seven incidents documented a comprehensive assessment in the IDNs prior to the administration of the PRN.

ASH's compliance data from the DMH Nursing Services Monitoring Stat audit based on an average sample of 20% of behavioral Stats administered each month (March-August, 2008) indicated the following:

2.	*Documentation of all the circumstances requiring Stat administration of medication.*	
2a.	*In the MTR, there is a brief description of the circumstances and behavior requiring Stat medication.*	32%
2b.	*In the IDN, there is a comprehensive assessment of the individual prior to the Stat medication.*	37%

ASH's data analysis demonstrated that compliance for the documentation in the MTR of the circumstances requiring Stat increased only slightly from 31% in February 2008 to 32% in August 2008 and the documentation in the IDNs significantly decreased from 75% to 29%. Barriers and plan of correction are noted above and in F.3.a.i.

A review of 50 incidents of Stat medications for 13 individuals (DAB,

		ED, EV, FG, HE, JS, MCJ, MM, TH, TJC, TW, VJJ and WT) found that 13 incidents included the documentation of circumstances requiring the Stat and 10 incidents included documentation of a comprehensive assessment in the IDNs prior to the administration of the Stat. **Other findings:** There continues to be a number of examples in the IDNs of PRN and Stat medication administrations that are not appropriately documented as being a PRN or Stat medication. **Current recommendation:** Continue to monitor this requirement.
F.3.a.iii	documentation of the individual's response to PRN and Stat medication.	**Current findings on previous recommendation:** **Recommendation, April 2008:** See F.3.a.i. **Findings:** ASH's compliance data from the DMH Nursing Services PRN and Stat Monitoring audit, based on an average sample of 18% (PRN) and 20% (Stat) of administrations each month during the reporting period (March-August 2008), indicated the following: 3. *Documentation of the individual's response to PRN medications.* 3.a *In the MTR, there is a brief description of the individual's response to the administered PRN medication which was documented within one hour of the administration.* 63% 3.b *In the IDN, there is a comprehensive assessment of the individual's response to the administered PRN medication.* 31%

ASH's data analysis showed that compliance for documentation of the individual's response to PRN medication slightly increased from 64% (February 2008) to 68% (July 2008) regarding documentation in the MTR; documentation in the IDNs increased from 29% to 37%. Barriers and plans of correction are noted above and in F.3.a.i and F.3.a.ii.

3.	*Documentation of the individual's response to Stat medications.*	
3.a	*In the MTR, there is a brief description of the individual's response to the administered Stat medication which was documented within one hour of the administration.*	50%
3.b	*In the IDN, there is a comprehensive assessment of the individual's response to the administered Stat medication.*	25%

ASH's data analysis showed that compliance for documentation of the individual's response to Stat medication in the MTR and in the IDNs decreased from 44% (February 2008) to 42% (August 2008) and 38% to 26% respectively. See F.3.a.i and F.3.a.ii for barriers and plan of improvement.

A review of 50 incidents of PRN medications for 12 individuals (AS, DR, FT, GP, JM, JS, PP, SW, TS, VT, WM and WST) found that 15 incidents contained documentation of a comprehensive assessment of the individual's response, and 28 individuals were assessed within one hour.

A review of 50 incidents of Stat medications for 13 individuals (DAB, ED, EV, FG, HE, JS, MCJ, MM, TH, TJC, TW, VJJ and WT) found that 17 incidents contained documentation of a comprehensive assessment of the individual's response, and 28 individuals were assessed within one hour.

<table>
<tr><td></td><td></td><td>Current recommendation:
Continue to monitor this requirement.</td></tr>
<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:

Recommendation 1, April 2008:
Implement the medication variance reporting system facility-wide.

Findings:
ASH has fully implemented the medication variance reporting (MVR) system facility-wide since August 2008.

Recommendation 2, April 2008:
Continue to monitor this requirement.

Findings:

<table>
<tr><td>1.</td><td>Each State Hospital shall ensure that all failures to properly sign the 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>100%</td></tr>
</table>

ASH's progress report indicated that from March through August 2008, there were associated MVRs for all reported missed signatures or initials on the MTRs. However, a review of MTRs for Units 1, 3, 7, 9, 21, 22, 26, 27 and 34 found five missing signatures from the controlled medication log and the facility could not produce the associated MVRs. In addition, the MTRs for Unit 3 indicated that noon medications had not been given on the day of the review as of 2:30 pm. However, the Unit Supervisor verified with the medication nurse that the medications had been given but not signed off on the MTRs at the time</td></tr>
</table>

<table>
<tr><td></td><td></td><td>the individuals received the medications as required. MVRs were completed that day and reviewed by this reviewer.

Other findings:
Although the facility reported 100% compliance with this requirement, data from this reviewer as noted above did not support ASH's compliance data, thus indicating partial compliance.

Compliance:
Partial.

Current recommendations:
1. Ensure the accuracy of the data for this requirement.
2. Continue to monitor this requirement.</td></tr>
<tr><td>F.3.c</td><td>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.</td><td>Current findings on previous recommendations:

Recommendation 1, April 2008:
Increase the number of existing staff attending the WRP Competency-Based training.

Findings:
ASH's progress report included the following data regarding this recommendation for August and September 2008 (although September is not part of this review period):
<table>
<tr><td></td><td colspan="2">Percentage of nursing staff* trained</td></tr>
<tr><td></td><td>Aug</td><td>Sep</td></tr>
<tr><td>WRP Overview Training</td><td></td><td></td></tr>
<tr><td>RNs</td><td>98</td><td>99</td></tr>
<tr><td>PTs</td><td>98</td><td>100</td></tr>
</table></td></tr>
</table>

	Percentage of nursing staff* trained	
	Aug	Sep
MSH Module: Case Formulation		
RNs	32	50
PTs	22	44
MSH Module: Discharge Planning		
RNs	26	50
PTs	23	46
MSH Module: Engagement of the Individual		
RNs	29	48
PTs	24	45
MSH Module: Foci and Objectives		
RNs	29	55
PTs	27	45
MSH Module: Interventions and Mall Integration		
RNs	32	51
PTs	11	47

*Hospital-wide level of care nursing staff

No barriers to compliance or plan of correction were provided by the facility. ASH's progress report did indicate that all staff will have completed training in all modules by January 2009.

Recommendation 2, April 2008:
Implement mandatory care plan training.

Findings:
Review of curriculum verified that care plan training has been incorporated into the new employee assessment training class, which includes a post-test for competence.

Recommendation 3, April 2008:
Include quality and appropriateness in the auditing criteria regarding WRPs.

Findings:
ASH is using appropriate WRP monitoring tools.

Recommendation 4, April 2008:
Continue to monitor this requirement.

Findings:
Using the DMH Nursing Interventions audit, ASH assessed its compliance based on an average sample of 30% of the WRPs due for the month (March-August 2008). The following table summarizes ASH's data:

1.	*If a DMH WRP Attachment was developed, it was filed with the previous WRP*	55%
2.	*If a DMH Attachment was developed, it has been reviewed and integrated into the current WRP.*	27%
3.	*There are interventions (both active treatment and in the therapeutic milieu) specific as to how nursing is going to assist the individual in meeting his or her goals for each open focus.*	
3.a	*Focus 1: Psychiatric and Psychological*	75%
3.b	*Focus 2: Social Skills*	76%
3.c	*Focus 3: Dangerousness and Impulsivity*	76%
3.d	*Focus 4: Hope and Spirituality*	46%
3.e	*Focus 5: Substance Abuse*	73%
3.f	*Focus 6: Medical, Health, and Wellness*	64%
3.g	*Focus 7: Legal*	75%
3.h	*Focus 8: School and Education*	84%
3.i	*Focus 9: Occupational Skills*	81%

3.j	*Focus 10: Leisure and Recreation*	79%
3.k	*Focus 11: community Integration*	80%
4.	*The nursing interventions include specific strategies to assist the individual in meeting his or her objectives.*	37%
5.	*The nursing interventions align and complement other interventions (including interventions in the therapeutic milieu) in the WRP to assist the individual 24 hours a day.*	46%
7.	*Only the approved DMH forms are used.*	100%
8.	*There are no Nursing Diagnoses (NANDA) statements in the WRP.*	100%

ASH's data analysis indicated decreases in many of the areas regarding WRPs as demonstrated in the table of compliance rate below:

Item	Mean Last Month Previous Period(February 2008)	Mean Last Month Current Period (August 2008)
1.	100%	50%
2.	75%	50%
3.		
3.a	92%	39%
3.b	33%	50%
3.c	83%	35%
3.d	3%	50%
3.e	83%	30%
3.f	81%	23%
3.g	7%	33%
3.h	46%	53%
3.i	44%	46%
3.j	93%	38%
3.k	54%	50%

4.	63%	16%
5.	5%	43%

ASH reported that barriers to compliance included the full implementation of the WRP to all the programs and the training requirements for staff that have been challenging to implement. ASH plans to work with the Clinical Administrator and Program Directors to increase compliance with the required training and implement and complete the training regarding comprehensive care planning focused on writing focus statements, objectives and interventions. In addition, mentoring for WRPs will be implemented during the next review period.

See C.2.l for additional reviewer findings. No separate nursing care plans or nursing diagnoses were found during this review.

Other findings:
Item 6, "Nursing interventions are written in observable, behavioral, and/or measurable terms," was not included in ASH's data. In addition, there were no nursing objectives or interventions found other than in focus 6 in the 40 WRPs that were reviewed.

Compliance:
Partial.

Current recommendations:
1. Continue to implement strategies to increase compliance with this requirement.
2. Continue to monitor this requirement.

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:** **Recommendation 1, April 2008:** Implement monitoring of this requirement on other units as planned.

Findings:
ASH's progress report indicated that the facility has implemented the EP requirements on all units since August 2008.

Recommendation 2, April 2008:
Continue to monitor this requirement.

Findings:
ASH's compliance data from the DMH Nursing Staff Familiarity Monitoring audit, based on an average sample of 32% of the nursing staff on the AM/PM shift that are assigned to a sponsor group, indicated the following:

1.a	*Nursing staff working with an individual are able to discuss the individual's goals (foci of hospitalization).*	82%
1.b	*Nursing staff working with an individual are able to discuss the individual's objectives*	73%
1.c	*Nursing staff working with an individual are able to discuss the individual's interventions in the therapeutic milieu.*	83%

Although ASH had only one month of data from the previous review period for comparison, the compliance rate has increased from February 2008 to August 2008 as noted below.

1. Item 1.a:from 76% to 88%;
2. Item 1.b: from 71% to 78%; and
3. Item 1.c: from 73% to 82%.

ASH reported that the barrier to compliance for this requirement was the level of care staff's knowledge of the Wellness and Recovery plans. To continue to increase compliance, ASH will continue with the training

		of the "Metro Module" and sponsor groups and has implemented from the shift report guidelines a review of WRP objectives and interventions for each individual monthly. As previously noted, a staffing plan will be implemented in November 2008 regarding coverage to ensure attendance by the core RN and PT atWRPCs. A review of 40 individuals' admission, integrated assessments and WRPs (AA, AES, AJT, AKH, AOQ, AP, BCS, BDA, BEM, BM, CDG, CLC, DEA, DJW, DLC, DNF, EJA, FC, GFP, GKP, GLM, GN, GV, HKS, HP, JIJ, JN, JRR, JRW, KM, LDJ, MAF, MD, MVB, NBM, PP, RLP, SK, WMN and WWM), observation on Unit 13 for shift report and observations of WRPTs on Unit 19 and Unit 6 found that there has been overall improvement in staff's familiarity with individuals' goals and objectives. **Compliance:** Partial. **Current recommendation**: Continue to monitor this requirement.
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:** **Recommendations 1 and 2, April 2008:** • Ensure that nursing staff are documenting adequate assessments of individuals prior to and upon return from ER visits or hospitalizations. • Continue to monitor this requirement. **Findings:** The facility reported the following data from the DMH Medical Transfer Audit form, based on a 100% sample of individuals transferred to community hospitals each month (March-August 2008):

1.	*There is an appropriate documentation by the nurse that identifies the symptoms of concern and notification of the physician*	
1.a	*There is an appropriate identification of the change in the individual's condition including vital signs*	65%
1.b	*There is documentation of when the change in the individual's status changed*	89%
1.c	*There is documentation of when the physician was notified and the physician's name*	57%
1.d	*There is timely (immediate for emergent conditions and no later than one hour for urgent conditions) notification by the nurse to the physician*	73%
1.e	*There is documentation in the record when the individual was transferred from the DMH hospital to the acute medical facility including date and time*	89%

No comparison data or barriers to compliance were included in ASH's progress report. To increase compliance with this requirement, ASH will implement policies and procedures associated with Special Order 136: Provision of Care (RN documentation for change of condition, transfer notes) in November 2008. Training will begin in September 2008, starting with training-for-trainers statewide for physicians and nurses that includes the statewide Administrative Directives for Provision of Care to Individuals, Psychiatric and Medical Coverage, Medical Emergencies, Transfer to and Return from Outside Facilities and RN and MD Communication about Physical Status Changes. Also, joint medical and nursing policies to address triggers for prevention and early indicators for treatment will be included. In March 2008, ASH revised NP 203.0: Nursing Assessments, and the RN Significant Change in Condition Assessment note to be included in the

Interdisciplinary Notes section is being developed. Interdisciplinary training will be provided to the physicians, family nurse practitioners, and nursing staff on the specific documentation requirements regarding the transfer of individuals to outside facilities for emergency and urgent medical treatment.

A review of the records of 11 individuals who were transferred to a community hospital/emergency room (AHL, BU, CC, CLW, DRS, GET, HLC, MW, RH, RS and TJC) found that overall there has been improvement in the nursing assessments when a change of status occurs. When adequately completed, the RN Significant Change in Condition Assessment Note contains appropriate information. However, these notes were not consistently completed. In addition, other areas that were not consistently addressed included complete assessments prior to and upon return from the hospital, and complete and appropriate assessments of symptoms. With the implementation of ASH's plan of correction noted above, this area should show improvement by the next review.

Shift Report

The facility reported the following data from the DMH Triggers and Shift Change Monitoring form, based on an average sample of 52% of target triggers that fired per review month (March-August 2008):

6.	*The nursing staff reports to the oncoming shift the target variable that the individual exhibited.*	62%
7.	*The nursing staff discusses with the oncoming shift the specific interventions for the individual, including the appropriate continuum of care across shifts.*	52%

ASH's data analysis indicated the compliance rates have held essentially steady from February 2008 to August 2008 as follows:

		1. Item 6: 68% to 67%; and 2. Item 7: 68% to 67%. No assessment of barriers to compliance was provided by the facility. To increase compliance with this requirement, ASH has revised NP 218.0:Shift Change Communication and Primary Sponsor Assignments, and plans to continue to refine the Shift Change process with a mentoring program. Observation of shift report on Unit 13 revealed that there continues to be a significant lack of clinical information transmitted regarding the status of individuals. There is little to no connection with individuals' status, Axis diagnoses, goals and objectives. This area continues to need much attention in order to achieve compliance. **Compliance:** Partial. **Current recommendations**: 1. Implement training addressing the provision and administration of medical care. 2. Continue to implement strategies addressing shift report to meet the elements of this requirement. 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:** Partial.
F.3.f.i	nursing staff are knowledgeable regarding each individual's prescribed medications;	**Current findings on previous recommendations:** **Recommendation 1, April 2008:** Increase sample size audited for this requirement.

Findings:
ASH's mean sample size for this requirement remains below 20% (18%).

Recommendation 2, April 2008:
Continue to monitor this requirement.

Findings:
ASH used the DMH Medication Administration Monitoring audit, based on an average sample of 18% level of care nursing staff who are licensed and medication-certified, to report the following:

1.	*Nursing staff are knowledgeable regarding each individual's prescribed medications.*	
1.a	*If a medication requires vital sign assessment prior to administration, the nursing staff is observed reviewing this reading.*	94%
1.b	*If a medication requires a blood glucose level prior to administration, the nursing staff is observed reviewing this reading.*	98%
1.c	*The nursing staff is able to answer questions about one medication that is administered to the individual. (The question may include purpose of medication, common side effects, etc.)*	92%

Although ASH's compliance rates for this requirement indicated an increase from 89% (March 2008) to 90% (August 2008), observations from medication administration pass on Unit 18 did not support ASH's data. (See F.3.a.i.)

Current recommendations:
1. Increase sample size to 20%.
2. See F.3.a.i.

F.3.f.ii	education is provided to individuals during medication administration;	**Current findings on previous recommendation:** **Recommendation, April 2008:** Same as F.3.f.i. **Findings:** The DMH Medication Administration Monitoring audit, based on an average sample of 18% of level of care nursing staff who are licensed and medication-certified, found the following: 2. *Education is provided to individuals during medication administration.* 2.a *If an individual asks a question, the nursing staff is able to competently answer the question.* 97% 2.b *When an individual has been prescribed a new medication, the nursing staff provides education about the medication.* 95% 2.c *Nursing staff makes at least one inquiry or comment to the individual about his or her medication at each medication administration.* 88% ASH's data analysis indicated that the compliance rates for items 2.a and 2.c decreased slightly, while the compliance rate for item 2.b increased from February 2008 to August 2008 as follows: 1. Item 2.a: from 100% to 95%; 2. Item 2.b:from 96% to 100%; and 3. Item 2.c: from 79% to 78%. ASH identified the barrier to compliance with this requirement related to nursing staff not inquiring or commenting about medications during medication administration. ASH will continue to follow up with new and existing employees regarding medication education for individuals.

		As noted in F.3.a.i, observations of medication administration pass on Unit 18 did not support ASH's data. **Current recommendation**: See F.3.a.i.
F.3.f.iii	nursing staff are following the appropriate medication administration protocol; and	**Current findings on previous recommendation:** **Recommendation, April 2008:** Same as F.3.f.i. **Findings:** The DMH Medication Administration Monitoring audit, based on an average sample of 18% of level of care nursing staff who are licensed and medication-certified, found the following:

3.	*Nursing staff are following the appropriate medication administration protocol.*	
3.a	*The correct medications are administered.*	99%
3.b	*The medications are administered to the correct individual.*	100%
3.c	*The medications are administered in the ordered form.*	99%
3.d	*The medications are administered by the correct route.*	100%
3.e	*The medications are administered at the correct time.*	100%
3.f	*The medications are administered on the correct date.*	100%
3.g	*The medications are administered for the right indication.*	100%

<table>
<tr><td></td><td></td><td>There was no comparison data provided for items 3.a-g. See F.3.a.i for reviewer's findings.

Current recommendations:
See F.3.a.i.</td></tr>
<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:

Recommendation, April 2008:
Same as F.3.f.i.

Findings:
The DMH Medication Administration Monitoring audit, based on an average sample of 18% of level of care nursing staff who are licensed and medication-certified, demonstrated the following:

<table>
<tr><td>4.</td><td>Medication administration is documented in accordance with the appropriate medication administration protocol.</td><td></td></tr>
<tr><td>4.a</td><td>Medications are documented upon administration, prior to administering medications to the next individual.</td><td>96%</td></tr>
<tr><td>4.b</td><td>Nursing staff correctly documents the MTR to reflect what actually occurred.</td><td>99%</td></tr>
</table>

No comparison data was provided for items 4.a and 4.b.

A review of the Medication Treatment Records for Units 1, 3, 7, 9, 21, 22, 26, 27 and 34 found that the noon medications for Unit 3 had not been initialed as given by 2:30 pm. The Unit Supervisor verified that the medication nurse reported that the noon medications had been administered but had not been signed out on the MTR at the time the medication was administered, as required. In addition, there were a</td></tr>
</table>

		number of blanks and signatures pre-signed on the controlled medication logs. Medication Variance Reports for these variances were completed that day and reviewed by this monitor. **Other findings:** It was noted that the controlled medication log sheet does not clearly specify when counts are conducted upon passing of the narcotics keys from the medication nurse to another staff member during breaks or lunch hours. The form only allows for signatures for on-coming and off-going shift changes. Thus, it becomes difficult to accurately verify that the correct count procedures were completed at the appropriate times. **Current recommendations:** 1. Modify the controlled medication signature sheet to accurately reflect when the narcotic counts occur. 2. Ensure accuracy of data regarding medication administration. 3. Continue to monitor this requirement.
F.3.g	Each State hospital shall ensure that individuals remain in a "bed-bound" status only for clinically justified reasons.	**Current findings on previous recommendation:** **Recommendation, April 2008:** Continue to monitor this requirement in the event this issue arises. **Findings:** There were no individuals found to be bed-bound during the review period. **Compliance:** Not applicable. **Current recommendation:** Continue to monitor this requirement in the event this issue arises.

F.3.h	Each State hospital shall ensure that, before they work directly with individuals, all nursing and psychiatric technicians have successfully completed competency-based training regarding:	**Compliance:** Partial.
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 recommendations:** **Recommendation 1, April 2008:** Provide data for existing staff training regarding this requirement. **Findings:** ASH's progress report indicated that all existing staff has been trained regarding this requirement. However, no supporting documentation was provided for verification. **Recommendation 2, April 2008:** Continue to monitor this requirement. **Findings:** The table below summarizes ASH's data regarding training of level-of-care nursing staff (RNs and PTs) that required the training per review month (March-August 2008). Review of ASH's training rosters verified the compliance rates listed below. <u>New Employee Medication Certification Training</u> 1. *Mental health diagnoses and related symptoms.* 94% The compliance rate increased from 89% in the previous review period to 94% in the current review period.

New Employee Psychiatric Nursing Training

1.	*Psychotropic medications and their side effects, monitoring of symptoms and target variables.*	84%

The data for this table covers the level-of-care nursing staff (RNs) that required the training per review month. ASH"s progress report noted that comparison data were not available.

New Employee Nursing Assessment Training

1.	*Documenting and reporting of the individual's status.*	96%

The data for this table covers the level-of-care nursing staff (RNs) who required the training per review month. ASH"s progress report noted that comparison data were not available.

ASH reported that barriers to compliance with this requirement included staffing issues or emergency or other multiple required trainings that prevented staff from attending or completing the class during the scheduled month. To increase compliance, ASH will implement in October 2008 a process by which graduated pre-licensed Psychiatric Technicians will remain out of the staffing numbers for two weeks to attend mandatory trainings. Also, staff that has not completed the required training during their assigned months will be scheduled the following month.

Current recommendations:

1. Provide training rosters/supporting documentation for verification of compliance with this requirement.
2. Continue to monitor this requirement.

<table>
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<td>F.3.h.ii</td>
<td>the provision of a therapeutic milieu on the units and proactive, positive interventions to prevent and de-escalate crises; and</td>
<td>

Current findings on previous recommendation:

Recommendation, April 2008:
Same as F.3.h.i.

Findings:
The table below summarizes ASH's data regarding training of level of care nursing staff (RNs and PTs) that required the training per review month (March-August 2008):

<table>
<tr><td>1.</td><td>The provision of a therapeutic milieu on the units.</td><td>74%</td></tr>
</table>

ASH"s progress reported noted that comparison data was not available. Barriers and plans of correction are as noted in F.3.h.ii.

<u>New Employee PMAB in Recovery Training</u>

<table>
<tr><td>1.</td><td>Proactive, positive interventions to prevent and deescalate crises.</td><td>100%</td></tr>
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ASH"s progress report noted that the compliance rate from the last review period was also 100%.

No supporting documentation was provided for verification regarding the above training compliance data.

Current recommendation:
See F.3.h.i.

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<tr>
<td>F.3.h.iii</td>
<td>positive behavior support principles.</td>
<td>

Current findings on previous recommendation:

Recommendation, April 2008:
Same as F.3.h.i.

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Findings:
The tables below summarize ASH's data regarding training of level-of-care nursing staff (RNs and PTs) that required the training per review month (March-August, 2008).

<u>New Employee Positive Behavior Support Training</u>

1.	*Positive behavior support principles.*	86%

ASH"s progress report noted that the compliance rate decreased from 100% in February 2008 to 86% in August 2008.

<u>Current Employee Positive Behavior Support Training (Final 6 Hours)</u>

1.	*Positive behavior support principles.*	37%

ASH"s progress report noted that comparison data was not available. Barriers and plans of correction are as noted in F.3.h.ii.

No supporting documentation was provided for verification regarding the above training compliance data.

Current recommendation:
See F.3.h.i.

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<tr>
<td>F.3.i</td>
<td>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.</td>
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Current findings on previous recommendation:

Recommendation, April 2008:
Same as F.3.h.i.

Findings:
The table below summarizes ASH's data regarding training of level-of-

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care nursing staff (RNs and PTs) that required the training per review month (March-August 2008). Review of ASH's training rosters verified the compliance rates listed below.

New Employee Medication Certification Training

1.	*Completion of the MTR and the controlled medication log.*	94%

The compliance rate increased from 89% in the last review period to 94% in the current period.

Current Employee Medication Re-Certification Training

1.	*Completion of the MTR and the controlled medication log.*	32%

ASH reported that no comparison data was available for this item. ASH indicated that barriers to compliance regarding this item were related to the facility's new requirement that medication recertification training is required every year, rather than the previous requirement of once every two years and to staffing issues for unit coverage that prevent attendance. See F.3.h.i regarding ASH's plan of correction.

No supporting documentation was provided for verification regarding the above training compliance data. In addition, observations of medication administration and review of the MTRs indicated problematic issues regarding the completion of the MTRs and controlled medication logs.

Compliance:
Partial.

		Current recommendation: See F.3.h.i.

4. Rehabilitation Therapy Services		
	Each State hospital shall provide adequate, appropriate, and timely rehabilitation therapy services to each individual in need of such services, consistent with generally accepted professional standards of care.	**Methodology:** Interviewed: 1. Alicia Nowicki, Music Therapist 2. Carrie R. Dorsey, Acting Senior Rehabilitation Therapist 3. Jeff Russell, Vocational Instructor 4. Jooyung Hong, Music Therapist 5. Kathy Runge, Occupational Therapist 6. Ladonna Decou, Chief of Rehabilitation 7. Nancy Fiske, Occupational Therapist 8. Rachelle Rianda, Acting Senior Rehabilitation Therapist 9. Ron Hagadone, Rehabilitation Therapist 10. Tara Marriott, Music Therapist Reviewed: 1. DMH Rehabilitation Therapy Service Manual 2. DMH Rehabilitation Therapy F.4 Audit Tool and instructions 3. DMH MH-C 9090 POST Monthly Progress Note 4. F.4 Audit data for July-August 2008 5. 24-Hour Rehabilitation Support Plan (implemented 7/1/08) 6. Criteria for 24-Hour Support Plan (implemented 7/1/08) 7. ASH Mall Course Schedule for Rehabilitation Therapy PSR Mall groups for week of review 8. List of individuals with adaptive equipment and current adaptive equipment database 9. Records for the following 20 individuals participating in observed Mall groups: AAA, AAM, ALS, AMB, AML, BJS, DKH, EAM, GAS, HCG, JJC, JSC, JT, KET, LJC, MLF, RCR, RL, SM and SSM 10. List of individuals who received direct Physical Therapy services from March-August 2008 11. Records for the following six individuals who received direct Physical Therapy services between March-August 2008: BWB, ECD,

		GCJ, JS, LPM and MH 12. List of individuals who received direct Speech Therapy services from March-August 2008 13. Records for the following seven individuals who received direct Speech Therapy services from March-August 2008: AJ, CDC, DR, ED, JKC, JVW and MWW 14. DMH MH-C 9091 24 Rehabilitation Support Plan guidelines and instructions 15. ASH AD 409.1 – POST Services 16. "Task list" to address the implementation of "24 Rehab Support Plans" through POST Services 17. Metro Modules Training Compliance by Discipline report 18. Teaching Manual for Vocational Graphic Arts PSR Mall Group 19. Wheelchair Assessment draft 20. Functional Wheelchair Assessment draft 21. Adaptive Devices Tracking Report for Wheelchairs 22. Physical Therapy Wheelchair assessment list 23. Training materials for "Role of Rehabilitation Therapist in WRPC" 24. Lesson Plan and course outline for Interacting through Music 25. 12-Week Lesson Plan for Interacting through Music 26. 12-Week Lesson plan for Social Skills through Music Performance 27. Lesson Plan for Non-aggressive Communication 1 28. Course outline and lesson plan for Physical Wellness through Light Stretching and Movement 29. Course outline and lesson plan for Stress Management through Tai Chi Movements 30. Course Outline and lesson plan for Increasing Motivation through Music <u>Observed</u>: 1. Physical Wellness Through Exercise PSR Mall group 2. Painting Workshop PSR Mall group 3. Music Appreciation for 1370s PSR Mall group

		4. Social Skills through Music Performance PSR Mall group 5. Interacting through Music PSR Mall group 6. Vocational Services Graphic Design PSR Mall Group 7. Arts and Crafts 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:** Partial.
F.4.a.i	the provision of direct services by rehabilitation therapy services staff; and	**Current findings on previous recommendations:** **Recommendation 1, April 2008:** Develop and implement a procedure that specifies criteria for the need for, format of, and implementation (including training and monitoring) of a 24-hour support plan related to physical and nutritional rehabilitation supports that is consistent among the state hospitals. **Findings:** The DMH MH-C 9091 24 Rehabilitation Support Plan guidelines and instructions were approved on 9/22/08. ASH AD #409.1 – POST Services was finalized and approved in October 2008. The facility reported that the process for the development and implementation of 24-hour plans as clinically indicated will begin during the next review period. **Recommendation 2, April 2008:** Develop and implement formats for progress notes for Vocational Rehabilitation, and Occupational, Physical and Speech Therapy direct treatment that are consistent with those at the other state hospitals as well as with individual discipline practice act requirements.

		Findings: DMH MH-C 9090 POST Monthly Progress note was developed and approved on 9/22/08 and implementation is pending. Currently, Speech Therapists are using the Monthly Mall Progress Note and have not yet implemented the use of the POST progress note. **Recommendation 3, April 2008:** Provide training to all Rehabilitation Therapy staff (Rehabilitation Therapists, Vocational Rehabilitation staff, and POST team members) regarding the role of the RT as WRPT liaison. **Findings:** The facility reported that 32 out of 38 Wellness and Recovery Plan Rehabilitation Therapists were trained and 84% were trained to competency regarding the "Role of the RT in the WRPT" on 5/22/08. On 8/22/08, three out of three POST team members and 11 out of 11 Vocational Services staff were trained to competency regarding the "Role of the RT in the WRPT." This training was verified by review of training rosters and post-tests. **Recommendation 4, April 2008:** Develop and implement an F.4 audit tool to ensure the adequate and timely provision and implementation of Rehabilitation Services, including direct treatment (1:1 and PSR Mall group) and indirect supports (e.g., 24-hour plan, adaptive equipment). Implementation findings should also include recommendations regarding foci, objectives and interventions made by Rehabilitation Therapy Services, quality of these objectives in regards to Wellness and Recovery criteria, documentation of progress towards objectives, modification of objectives/ interventions as needed, and WRP inclusion. **Findings:** An F.4 Audit Tool to assess the adequate and timely provision of

Rehabilitation Therapy Services was developed on 6/25/08 and implemented for sections F.4.a.i and F.4.c on 8/01/08.

Recommendation 5, April 2008:
Establish inter-rater agreement among staff performing audits prior to implementation.

Findings:
This recommendation has not yet been addressed.

Other findings:
Using the DMH F.4 Monitoring Tool, ASH assessed its compliance based on an average sample of 43% of individuals receiving Speech and/or Physical Therapy direct treatment for the month of August (20 out of 46 individuals). The following table outlines the indicators with corresponding mean compliance rates for August 2008:

1.	*The provision of direct services by rehabilitation therapy services staff*	
1.a	*There is an appropriate Focus of Hospitalization (typically Focus 6).*	55%
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.*	25%
1.c	*The intervention aligned with this objective states what OT, PT, and SLP will do to assist the individual in achieving the objective.*	35%
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.*	35%

No comparable data were available from the last evaluation period, as this tool was implemented in August 2008.

The facility analyzed the data and reported that the reason for low compliance in with items 1.a-1.d was due to the Rehabilitation Therapist not reporting POST input to the WRPT. The facility plan of correction is to provide training to Rehabilitation Therapists and WRPTs to ensure that the appropriate focus, objective and progress are documented.

In addition, the facility reported that the Chief of Rehabilitation Therapy, the Senior Rehabilitation Therapists and the POST Services staff will analyze data to determine if RTs are effectively carrying out their role as liaison to increase compliance.

The data below presents the number of scheduled vs. actual hours of direct services provided by Occupational and Physical Therapy between 8/11/08 and 8/15/08:

	Scheduled	Provided
PT	44	38
OT	n/a	n/a
SLP	63	48

The facility reported that the reason for discrepancy between scheduled and provided hours of direct Physical Therapy treatment was due to two individuals refusing without reason, three individuals not attending by choice, and one individual not attending because of a staff shortage.

The facility reported that 14 individuals did not attend Speech Therapy sessions by choice, and one individual did not attend Speech Therapy sessions due to illness. No plan for corrective action by the facility was proposed.

		There were no Occupational Therapy direct services provided during the review period. This monitor reviewed the records of six individuals receiving direct Physical Therapy treatment (BWB, ECD, GCJ, JS, LPM and MH) to assess compliance with provision of direct services. This monitor found two records (BWB and MH) to be in partial compliance with F.4.a.i criteria, and four records (ECD, GCJ, JS and LPM) to be not in compliance with F.4.a.i. All records reviewed contained evidence that treatment activities were aligned with assessed needs, and documentation of progress with changes to objectives and treatment modalities was made as needed. Identified patterns of deficiencies that the facility should focus on in order to improve compliance include the following: 1. Objectives are not consistently functional, behavioral, observable and measurable. 2. Foci, objectives and interventions are not consistently included in the WRP. 3. Progress in Physical Therapy treatment is not consistently documented in the Present Status section of the WRP. This monitor also reviewed seven records of individuals receiving direct Speech Therapy treatment (AJ, CDC, DR, ED, JKC, JVW and MWW) to assess compliance with F.4.a.i criteria. This monitor found one record (JKC) to be in partial compliance and six records (AJ, CDC, DR, ED, JVW and MWW) to be not in compliance with F.4.a.i criteria. All records reviewed contained evidence that treatment activities were aligned with assessed needs, and documentation of progress with changes to objectives and treatment modalities was made as needed. Identified patterns of deficiencies that the facility should focus on in order to improve compliance include the following:

		1. Objectives are not consistently functional, behavioral, observable and measurable. 2. Foci, objectives and interventions are not consistently included in the WRP. 3. Progress in Speech Therapy treatment is not consistently documented in the Present Status section of the WRP. **Current recommendations**: 1. Ensure that data for F.4 audit tool is reliable and valid. 2. 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 are documented in the Present Status section of the WRP.
F.4.a.ii	the oversight by rehabilitation therapists of individualized physical therapy programs implemented by nursing staff.	**Current findings on previous recommendations:** **Recommendation 1, April 2008:** Develop and implement a procedure for nursing staff provision of indirect Physical and Occupational Therapy programs. **Findings:** This recommendation has not yet been addressed. **Recommendation 2, April 2008:** Develop and implement a database to track individuals receiving these services, as well as when staff has received competency-based training/return demonstration, and how often the individual should be reassessed by the Physical or Occupational Therapist to determine the continued appropriateness of the program.

		Findings: This recommendation has been partially met; the Occupational Therapist is currently working with IT to create a database to effectively track required components. **Recommendation 3, April 2008:** Develop and implement an audit tool to provide oversight to individuals receiving Physical or Occupational Therapy programs implemented by nursing staff to assess for appropriateness of program, alignment with assessment/reassessment findings, timeliness of reassessment, and whether program is modified as needed. **Findings:** These elements have been incorporated into the F.4 monitoring tool, but this section is pending implementation as the F.4.a.ii process has not yet been developed and initiated. **Current recommendations**: 1. Develop and implement a procedure for nursing staff provision of indirect Physical and Occupational Therapy programs, with Physical and Occupational Therapy oversight available to all individuals who require it facility-wide. 2. Develop and implement a facility-wide database to track individuals receiving these services, as well as when staff has received competency-based training/return demonstration if indicated, and how often the individual should be re-assessed by the Physical or Occupational Therapist to determine the continued appropriateness of the program.
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	**Current findings on previous recommendations:** **Recommendation 1, April 2008:** Develop and implement a plan to ensure that competency-based training

	promote individuals' independence.	on the use and care of adaptive equipment, transferring, and positioning, as well as the need to promote individuals' independence, occurs as needed. **Findings:** This recommendation has not yet been addressed. **Recommendation 2, April 2008:** Ensure that databases for Physical and Occupational Therapy programs implemented by nursing staff, adaptive equipment, 24-hour plans, track the need for and provision of competency-based training for individuals and/or staff. **Findings:** This recommendation has been partially addressed; the Occupational Therapist is currently working with IT to create a database to effectively track required components. **Compliance:** Noncompliance. **Current recommendations**: 1. 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. 2. Develop and populate database to track required components related to F.4.b.
F.4.c	Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.	**Current findings on previous recommendations:** **Recommendation 1, April 2008:** Ensure that for all individuals receiving direct treatment by Rehabilitation Therapists, progress towards objectives is documented

in the WRP and focus, objectives, and interventions are modified as needed.

Findings:
According to facility report, 36 out of 40 Rehabilitation Therapists were trained to competency on the Metro Module for Foci and Objectives and the Metro Module for Interventions and Mall.

Auditing to assess Rehabilitation Therapy services began in August 2008, following the implementation of the F.4 monitoring tool.

Using the DMH F.4 Monitoring Tool, ASH assessed its compliance based on an average sample of 3% of individuals receiving PSR Mall groups facilitated by Rehabilitation Therapists and Vocational Rehabilitation staff for the month of August (29 out of 894). The following table outlines the indicators with corresponding mean compliance rates for August 2008:

4.	*Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.*	
4.a	*There is an appropriate Focus of Hospitalization.*	97%
4.b	*The objective aligned with this focus of hospitalization is functional for the individual and written in behavioral, observable, and/or measurable terms.*	55%
4.c	*The intervention in the PSR Mall Aligned with this objective states the name of the RT mall facilitator, group name, time and place, and the individual's strengths that will be used by the RT staff to assist the individual in achieving this objective.*	62%
4.d	*There is documentation in the Present Status*	72%

	Section of the individual's WRP of interventions provided by the RT and Voc Rehab.	

No comparable data were available from the last review period as the audit tool was implemented in August 2008.

The facility reported that sample sizes of audits were low due to staff vacancies. The facility indicated that low compliance with 4.b was secondary to Rehabilitation Therapists not ensuring that objectives are written in behavioral, observable, and measurable terms. No analysis of reasons for compliance below 90% for items 4.c and 4.d was provided.

The facility plan of correction is for the Senior RT staff to provide in vivo mentoring as well as monitoring and training to Rehabilitation Therapy and Vocational Services staff.

The following table outlines the average number of scheduled versus provided Rehabilitation Therapist-facilitated PSR Mall group hours during the week of 8/18/08-8/22/08.

	Scheduled	Provided
RT	174	159
Voc Rehab (PSR Mall)	111	103
Voc Rehab (outside PSR Mall hours)	148	137

The facility reported that the discrepancies between scheduled versus provided hours were due to MAPP sheets not being consistently turned in and to decreased staff coverage.

Recommendation 2, April 2008:
Develop and implement a database to track individuals with 24-hour plans, as well as when staff has received competency-based training/return demonstration, and how often the individual should be

		reassessed by the POST team member(s) to determine the continued appropriateness of the plan. **Findings:** This recommendation has been partially met; the Occupational Therapist is currently working with IT to create a database to effectively track required components. **Recommendation 3, April 2008:** Develop and implement an audit tool to provide oversight to individuals with 24-hour plans to assess for appropriateness of program, alignment with assessment/reassessment findings, timeliness of reassessment, and whether plan was modified as needed. **Findings:** These elements have been incorporated into the F.4 monitoring tool, but this section is pending implementation as the F.4.a.ii process has not yet been developed and initiated. **Other findings:** Five Rehabilitation Therapy PSR Mall course outlines and lesson plans have been developed through the Curriculum Committee. The facility reported that twelve additional lesson plans and course outlines are in development. Upon observation of PSR Mall groups led by Rehabilitation Therapists, it was noted that three out of six observed had lesson plans in place and in use, though only one of these had been approved through the facility curriculum committee. This monitor reviewed twenty records of individuals participating in Rehabilitation Therapist-facilitated PSR Mall groups (AAA, AAM, ALS, AMB, AML, BJS, DKH, EAM, GAS, HCG, JJC, JR, JSC, JT, KET, LJC,

		MLF, RCR, SM and SSM) to assess compliance with F.4.c. This monitor found one record (KET) to be in substantial compliance, twelve records (AAM, ALS, AML, EAM, GAS, JJC, JR, JT, LJC, MLF, RCR and SSM) to be in partial compliance and seven records (AAA, AMB, BJS, DKH, HCG, JSC and SM) to be not in compliance with F.4.c. Identified patterns of deficiencies that the facility should focus on in order to improve compliance include the following: 1. Objectives are not consistently functional, behavioral, observable and measurable. 2. Foci, objectives and interventions are not consistently aligned in the WRP. 3. Progress in Rehabilitation Therapy PSR Mall groups is not consistently documented in the Present Status section of the WRP. **Compliance:** Partial. **Current recommendations**: 1. 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. 2. Provide training to Rehabilitation Therapy staff on writing quality foci, objectives and interventions based on content of the revised PSR Mall Manual. 3. Ensure that all Rehabilitation Therapy PSR Mall group lesson plans, course outlines and curricula meet the facility curriculum committee requirements. 4. Ensure that all individuals with Dining Plans and Physical Support Plans are reviewed to ensure that they meet the criteria for the new 24-hour Rehabilitation Support plans, with conversion to the

		new format as clinically indicated.
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 recommendations:** **Recommendation 1, April 2008:** Develop and implement a database to track all individuals with adaptive equipment, including when a piece of equipment is ordered compared to the date of implementation, level of assistance of individual with device, whether training was necessary, when training was provided if appropriate, and if/how often the individual should be reassessed by the POST team member(s) to determine the continued appropriateness of the equipment. **Findings:** This recommendation has been partially met. A proposed database which includes all recommended elements was developed, but has not yet been implemented and populated. **Recommendation 2, April 2008:** Develop and implement an audit tool to provide oversight to individuals with adaptive equipment to assess for appropriateness of equipment, use/repair of equipment, alignment with assessment/reassessment findings, timeliness of reassessment, and whether equipment was modified as needed. **Findings:** These criteria were included in the F.4 audit tool, which was implemented in August 2008. However, the facility did not present data regarding adaptive equipment or data analysis for this review period. **Recommendation 3, April 2008:** Revise and implement Wheelchair Assessment draft to screen

		individuals to determine level of assistance with wheelchair, indication, and clinical need. **Findings:** Drafts for a Wheelchair Assessment and a Functional Wheelchair Assessment were developed and are pending implementation. The facility reported that 52 wheelchair assessments were completed using a previous wheelchair assessment draft, but these assessments were not available for review, and no data was collected from assessments to provide information on assessed individuals' level of assistance with wheelchair or indications of clinical need. According to the current adaptive equipment tracking report, 29 wheelchairs and one custom wheelchair were issued by Rehabilitation Services during the March-August review period. **Compliance:** Partial. **Current recommendations**: 1. 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. 2. Implement F.4 audit process to present data and data analysis regarding provision and re-assessment of adaptive equipment.

5. Nutrition Services		
	Each State hospital shall provide the individuals it serves, particularly those experiencing weight-related problems, adequate and appropriate dietary services consistent with generally accepted professional standards of care.	**Methodology:** Interviewed: 1. Dawn Hartman, Registered Dietitian 2. Erin Dengate, Assistant Director of Dietetics Reviewed: 1. Lists of individuals with Nutrition Care Assessments due from March-August 2008 for each assessment type 2. Records for the following 65 individuals with type a-j.ii. assessment from March-August 2008: AMG, BA, CC, CJG, CJS, COP, CP, CWS, DC, DCKW, DDM, DFJ, DG, DH, DLC, DRR, DS, DSC, DSM, FM, GA, GAB, GAW, GDC, GM, GTV, HR, HWB, JAR, JHFK, JJJ, JJT, JLB, JLP, JMG, JN, JS, JTM, JV, KB, KED, KN, LH, LNC, MAD, MJM, MMR, MS, PAA, PED, PK, PVH, RAG, RCS, RJWW, RLA, SB, SLC, SR, SS, TJC, TM, TMH, VAO and WM 3. Meal Accuracy Report audit data from March-August 2008 4. Nutrition Care Monitoring Tool audit data from March-August 2008 regarding Nutrition Education Training and response to MNT (weighted mean across assessment sub-types) 5. Audit data for March-August 2008 regarding WRP integration of Nutrition Services recommendations 6. Facility training data and competency scores for RNs, as well as raw data binders 7. Lesson Plan for Teaching Responsible Eating and Exercise PSR Mall group 8. Records for the following three individuals participating in the Teaching Responsible Eating and Exercise PSR Mall group: GAJ, GTB and VV Observed: Teaching Responsible Eating and Exercise 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 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.	**Current findings on previous recommendations:** **Recommendation 1, April 2008:** Ensure that dietitians provide at least one hour of PSR Mall groups per week. **Findings:** Clinical dietitians continue to average 0.5 hour per week per FTE, as provision of groups is limited due to high assessment caseload and vacancies. The addition of 2.5 hours of group facilitation per week is planned in October 2008 for a total of 0.9 hour per week per FTE. This monitor observed the PSR Mall group for Teaching Responsible Eating and Exercise and found that the group facilitator was using a lesson plan with corresponding curriculum, all individuals were engaged, and the content of teaching materials was aligned with the individuals' assessed needs. **Recommendation 2, April 2008:** Continue current efforts to achieve compliance. **Findings:** Current procedures for Nutrition services appear to meet generally accepted standards of practice. Nutrition Education and documentation of Medical Nutrition Training response are direct services provided by dietitians at ASH. Using the DMH Nutrition Care Monitoring Tool, ASH assessed its compliance with these indicators based on an average sample of 30% of Nutrition Assessments (all types) due each month for the review period of March-August 2008 (466 out of 1545). The following table presents these indicators with corresponding mean compliance rates:

7.	*Nutrition education is documented*	86%
8.	*Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified*	90%

A facility data analysis of item 7 (below 90%) was not provided.

According to review of Meal Accuracy Report data, 95% of trays (regular and modified diets) audited from March-August 2008 (total of 1694 out of 6224, for a 27% sample) were 100% accurate.

Other findings:
This monitor reviewed the records of 51 individuals (AMG, BA, CC, CJG, CJS, COP, CP, CWS, DC, DCKW, DDM, DFJ, DG, DH, DLC, DS, DSC, DSM, FM, GA, GAB, GAW, GDC, GM, GTV, HWB, JHFK, JJJ, JJT, JLB, JLP, JS, JTM, JV, KB, KED, LH, LNC, MJM, MS, PAA, PK, RAG, RJWW, RLA, SR, TJC, TM, TMH, VAO and WM) with completed Nutrition Care assessments across sub-types to assess compliance with documentation of provision of Nutrition Education Training and documentation of response to Medical Nutrition Training, and found that 38 records were in substantial compliance (BA, CC, CJG, CJS, COP, CWS, DCKW, DDM, DFJ, DG, DH, DLC, DS, DSM, FM, GA, GAB, GAW, GDC, GTV, HWB, JHFK, JJJ, JS, JTM, KB, LH, LNC, MS, PAA, PK, RAG, RJWW, RLA, SR, TJC, VAO and WM), eleven records (AMG, CP, DC, DSC, GM, JLB, JV, KED, MJM, TM and TMH) were in partial compliance, and two records (JJT and JLP) were not in compliance.

Compliance:
Partial.

Current recommendation:
Continue current efforts to achieve compliance.

F.5.b	Each State hospital shall ensure that one or more treatment team members demonstrate competence in the dietary and nutritional issues affecting the individuals they serve and the development and implementation of strategies and methodologies to address such issues.	**Current findings on previous recommendations:** **Recommendation 1, April 2008:** Implement revised Nutrition Care Assessment and NCMT tool instructions for writing Nutrition recommendations in WRP format (focus, objective, intervention) to ensure efficient WRP integration. **Findings:** The revised NCMT criteria to audit the WRP were implemented in March 2008, and the corresponding DMH form was approved in June 2008. However, dietitians did not begin to write goals and recommendations in the format of foci, objectives and interventions until August 2008, with training provided in July and August 2008. Nursing implemented a "WRP Preparation Guide" worksheet in August 2008 for RNs that includes a summary of any nutrition assessment completed. **Recommendation 2, April 2008:** 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 30% of Nutrition Assessments (all types) due each month for the review period of March-August 2008 (466 out of 1545). The following presents these indicators with corresponding mean compliance rates: 19. *The WRP has at least ONE Focus that pertains to nutrition recommendations as clinically indicated* — 86% 20. *The WRP has at least one objective and interventions linked to the Focus that pertains to the nutrition recommendation as clinically indicated* — 25%

		The facility reported that the mean compliance rate for item 19 improved from 17% in the last month of the previous review period (2/08) to 88% during the last month of the current review period (8/08). Data analysis or corrective action plans were not provided to address low compliance for item 20. According to facility report, 35 out of 36 of new RNs were trained to competency during the review period on incorporating Nutrition component into the WRP. This is verified by review of training rosters and quizzes. **Other findings:** This monitor reviewed 41 records (AMG, BA, CC, CJG, CJS, COP, CP, CWS, DC, DDM, DFJ, DH, DLC, DS, DSC, FM, GAB, GAW, GM, HWB, JJJ, JJT, JLB, JS, JTM, JV, KB, KED, LH, LNC, MAD, MJM, MS, PAA, PK, RAG, RJWW, RLA, SR, TJC and VAO) of individuals with completed Nutrition Care assessments to assess compliance with having an adequate focus, objective and intervention integrated into the WRP. This monitor found that 23 records (AMG, BA, CJG, COP, CP, CWS, DH, DSC, FM, GAB, HWB, JJJ, JJT, JLB, JS, JTM, JV, LNC, PAA, PK, RJWW, RLA and TJC) were in partial compliance and 18 records (CC, CJS, DC, DDM, DFJ, DLC, DS, GAW, GM, KB, KED, LH, MAD, MJM, MS, RAG, SR and VAO) were not in compliance. Identified patterns of deficiencies that the facility should focus on in order to improve compliance include the following: 1. WRP Nutrition objectives are not consistently specific, behavioral, observable and measurable. 2. WRP Nutrition foci, objectives and interventions are not consistently aligned and written in accordance with facility requirements. This monitor reviewed three records (GAJ, GTB and VV) for individuals

		participating in Nutrition PSR Mall group to assess compliance with WRP inclusion of adequate focus, objective and intervention and found one of the three (GTB) in partial compliance and two of three (GAJ and VV) not in compliance. All three contained evidence that treatment activities were aligned with assessed needs. **Compliance:** Partial. **Current recommendations**: 1. Continue current efforts to achieve compliance. 2. Provide training to dietitians on writing quality foci, objectives and interventions that meet WRP criteria, and are aligned. 3. Ensure that for individuals participating in Nutrition PSR Mall groups, appropriate foci, objectives and interventions are present in the WRP.
F.5.c	Each State hospital shall develop and implement policies and procedures to address the needs of individuals who are at risk for aspiration or dysphagia, including but not limited to, the development and implementation of assessments and interventions for mealtimes and other activities involving swallowing.	**Current findings on previous recommendation:** **Recommendation, April 2008:** Continue current practice. **Findings:** The DMH Statewide Dietetics Department Policy: Dysphagia and Aspiration Management addresses the dietitian's role in the team process regarding dysphagia and aspiration prevention and management and appears to meet generally accepted standards of practice. **Compliance:** Substantial. **Current recommendation**: Continue current practice.

F.5.d	Each State hospital shall ensure that staff with responsibilities for assessments and interventions regarding aspiration and dysphagia has successfully completed competency-based training commensurate with their responsibilities.	**Current findings on previous recommendation:** **Recommendation, April 2008:** Continue current practice. **Findings:** According to facility report, no new Nutrition employees (RDs or DTRs) have been hired during the review period. At the time of the last review, it was noted that 100% of dietitians had received Dysphagia Training to competency. **Compliance:** Substantial. **Current recommendation**: Continue current practice.
F.5.e	Each State hospital shall develop and implement policies and procedures requiring treatment of the underlying causes for tube feeding placement, and ongoing assessment of the individuals for whom these treatment options are utilized, to determine the feasibility of returning them to oral intake status.	**Current findings on previous recommendation:** **Recommendation, April 2008:** Continue current practice. **Findings:** The DMH Statewide Dietetics Department Policy for Tube Feeding appears to meet accepted standards of practice. **Compliance:** Substantial. **Current recommendation**: Continue current practice.

6. Pharmacy Services		
	Each State hospital shall provide adequate and appropriate pharmacy services consistent with generally accepted professional standards of care. Each State hospital shall develop and implement policies and procedures that require:	**Methodology:** Interviewed: Ronald O'Brien, PharmD, Acting Pharmacy Services Manager Reviewed: 1. Random sample of recommendations made by pharmacists regarding new psychotropic medication orders 2. ASH self-assessment monitoring data 3. The chart of one individual (AD)
F.6.a	Upon the prescription of a new medication, pharmacists to conduct reviews of each individual's medication regimen and, as appropriate, make recommendations to the prescribing physician about possible drug-to-drug interactions, side effects, and need for laboratory work and testing; and	**Current findings on previous recommendations:** **Recommendations 1-3, April 2008:** • Continue to monitor this requirement. • Provide data analysis to provide comparisons with the previous review period and to identify and address any patterns in the areas of concern by the pharmacists. • Ensure that pharmacists' recommendations address all areas of concern, including, but not be limited to, food-drug interactions and drug allergies. **Findings:** ASH presented data regarding the recommendations made since the last review. Although the average total number of recommendations per month has declined somewhat from that reported during the last review (251), the range of recommendations has improved. The following is a summary of the data: 1. Drug-drug interactions 31 2. Side effects 46 3. Need for laboratory testing 10

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<tr><td>4.</td><td>Dose adjustment</td><td>79</td></tr>
<tr><td>5.</td><td>Indications</td><td>4</td></tr>
<tr><td>6.</td><td>Contraindications</td><td>1</td></tr>
<tr><td>7.</td><td>Need for continued treatment</td><td>13</td></tr>
<tr><td>8.</td><td>Others</td><td>24</td></tr>
<tr><td colspan="2">Total number of recommendations*</td><td>210</td></tr>
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*The sum of the recommendations by type differs slightly from the total number of recommendations due to rounding.

The facility's data did not include any data regarding food-drug interactions and/or drug allergies.

Recommendation 4, April 2008:
Ensure that current vacancies in pharmacy staff are filled.

Findings:
Currently, the facility has five vacancies, with eight applicants being processed to fill these positions.

Compliance:
Partial.

Current recommendations:
1. Continue to monitor this requirement.
2. Provide data analysis to provide comparisons with the previous review period and to identify and address any patterns in the areas of concern by the pharmacists.
3. Ensure that current vacancies in pharmacy staff are filled.
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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</td>
<td>Current findings on previous recommendation:</td>
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	record an adequate clinical justification.	**Recommendation, April 2008:** Continue to monitor this requirement. **Findings:** ASH has monitored this requirement and reported that only one recommendation that involved possible drug allergy was not followed by the prescribing physician. In this case (AD), the physician documented an acceptable rationale for not following the recommendation. **Compliance:** Substantial. **Current recommendations**: 1. Continue to monitor this requirement. 2. Provide documentation of follow-up by pharmacist regarding recommendation not accepted by the prescribing physician.

7. General Medical Services		
		Methodology: Interviewed: 1. Douglas Shelton, MD, Chief Physician and Surgeon 2. Emily Luk, MD, Physician and Surgeon 3. Hussein Akhavan, MD, Physician and Surgeon 4. John Cyole, MD, Physician and Surgeon 5. Mathew Steiner, MD, Senior Psychiatrist 6. Susan Everett, Health and Safety Officer 7. Thomas Cahill, MD, Physician and Surgeon 8. Willard Towle, MD, Physician and Surgeon Reviewed: 1. The charts of the following 11 individuals who were transferred to an outside medical facility or the Infirmary (at unit 1) during this review period: AL, BU, CC, CW, DS, GT, HC, MW, RH, RS and TC 2. DMH's Special Order 136, Provision of Medical Care to Individuals (draft) 3. ASH General Medical Care Policies and Procedures, August 16, 2008 4. ASH Critique of Medical Emergency Drill on September 9, 2008 5. The revised DMH History and Physical Form template 6. DMH Medical Surgical Progress Notes Audit Form 7. DMH Medical Surgical Progress Notes Audit Form Instructions 8. ASH Medical Surgical Progress Notes summary audit data (April to August 2008) 9. DMH Integration of Medical Conditions into the WRP Audit Form. 10. DMH Integration of Medical Conditions into the WRP Audit Form Instructions 11. ASH Integration of Medical Conditions into the WRP Audit summary data (April to August 2008) 12. DMH Medical Transfer Audit Form. 13. DMH Medical Transfer Audit Form Instructions

		14. ASH Medical Transfer Audit summary data (March to August 2008) 15. DMH Diabetes Mellitus Audit Form 16. DMH Diabetes Mellitus Audit Form Instructions 17. ASH Diabetes Mellitus Audit summary data (March to August 2008) 18. DMH Asthma/COPD Audit Form 19. DMH Asthma/COPD Audit Form Instructions 20. ASH Asthma/COPD Audit summary data (March to August 2008) 21. DMH Hypertension Audit Form 22. DMH Hypertension Audit Form Instructions 23. ASH Hypertension Audit summary data (March to August 2008) 24. DMH Dyslipidemia Audit Form 25. DMH Dyslipidemia Audit Form Instructions 26. ASH Dyslipidemia Audit summary data (March to August 2008) 27. ASH data regarding availability of outside records upon individuals' return from hospitalization/outside consultations (September 2007 to February 2008)
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:** **Recommendations 1 and 2, April 2008:** • Finalize revisions of the Medical Policies and Procedures and submit an outline of these revisions aligned with the ten areas of deficiencies reported previously by this monitor, with supporting documents. • Implement the revised medical Policies and Procedures and report the effective date of implementation for each specific Policy/Procedure. **Findings:** ASH has implemented this recommendation. The facility approved its General Medical Policies and Procedures on August 16, 2008. The

		revisions adequately addressed the deficiencies cited by this monitor as follows: 1. Timeliness and documentation requirements of initial assessments: The ASH General Medical Care Policies and Procedures (Page 3, Procedures: I., A, B, D.) indicate the following: a. The initial admission assessment form must be completed within 24 hours of admission; b. A complete medical history and physical examination is completed, including referral to on-site specialty clinics and no part of the physical exam may be deferred; c. Any part of the physical exam that is refused is referred to the Program Medical Consultant (PMC), who must make at least three attempts at one-week intervals to complete the examination; d. If the individual continues to refuse after three attempts, the psychiatrist will be informed to address in the WRPC. 2. Timeliness and documentation requirements regarding medical attention to changes in the status of individuals: The General Medical Care Policies and Procedures (Page 4, II, B, and Pages 6 and 7, Procedures: VI, A, 2 and 3) indicate the following: a. Physicians are required to evaluate all conditions with a face-to-face evaluation. b. Physicians are required to make daily rounds in their assigned units. c. Reassessments are required for all individuals with Axis III diagnosis at least quarterly, with documentation in the progress notes. 3. Requirements for the preventive health screening of individuals: The General Medical Care Policies and Procedures (Page 4, Procedures: I., D. and Page 5, Procedures: III D) set adequate standards for the initial and annual health screening, including vaccinations, sexually transmitted disease (STD) workup, blood-

		borne diseases, rectal prostate exam, PSA, thyroid, baseline EKG, stool for occult blood, colonoscopy and routine labs. 4. Proper physician-nurse communications and physician response with timeframes that reflect the urgency of the condition: The General Medical Care Policies and Procedures (Page 6, Procedures: VI, A) outlines the minimum standards for communication and documentation of evaluation, documentation and follow-up of urgent and emergent medical conditions for nurses, regular physicians and on-call physicians. The RN is required to make the initial assessment and determine the level of urgency and communicate to the physicians. The policies outline adequate time frames for notification and response according to the level of urgency. 5. Emergency medical response system, including drill practice: The General Medical Care Policies and Procedures (Pages 11 through 17, section XI and Page 17, section XII) delineates adequate procedures for response to medical emergencies including the responsibilities of the qualified medical emergency leader and ancillary staff. The procedures also include requirements for the performance of medical emergency drills, including drills by each unit on each shift. 6. Communication of needed data to consultants: The Medical Care Policies and Procedures (Page 10, VIII) outline the process and the required information to provide when requesting a consultation. 7. Timely review and filing of consultations and laboratory reports: The General Medical Care Policies and Procedures (Page 7 and 8: Procedures: VI, 3) outline the requirements for review of consultation reports within two days and documentation of review by means of initials and date. The facility reported that its ASH Nursing Procedure 206.2 requires the filing of all signed medical consultation reports in the medical record within no more than two working days of receipt. 8. Follow-up on consultant's recommendations: The General Medical Care Policies and Procedures (Page 7 and 8: Procedures: VI, 3)

		require that the recommendations of consultants are followed and if they are not to be followed, then a rationale explaining the reasoning for not following the consultant's recommendations must be documented in the PPN. 9. Parameters for physician participation in the WRP process to improve integration of medical and mental health care: The General Medical Care Policies and Procedures (Page 7: Procedures: IV, 3) require the physician to update the Medical Conditions Form (focus 6) to ensure that diagnosis and active medical conditions are always current. The physician is also required to participate in the WRPC as requested by the treating psychiatrist. 10. Proper documentation of changes in the medical status of individuals in the WRP: The General Medical Care Policies and Procedures (pages 4 and 5; Procedures: II, B, 4) indicate that the physician shall perform quarterly reassessments and document in a Quarterly Progress Note the significant changes in the medical status of individuals for integration into the WRP. **Recommendation 3, April 2008:** Ensure proper oversight of medical services to correct this monitor's clinical findings of deficiencies (listed in Other Findings above). **Findings:** ASH presented an adequate plan by medical services to implement this recommendation. **Other findings:** The DMH is in the process of finalizing Special Order 136, Provision of Medical Care to Individuals. The DMH has developed draft revisions of the formats and protocols of nursing assessment and documentation of changes in the physical status of individuals. These revisions contain several process improvements. If properly implemented, the new formats and protocols can facilitate the processes of nursing and

medical attention to changes in the status of individuals.

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:

Episode	Date/time of MD evaluation	Reason for transfer
1.	03/16/08 23:10	Lethargy and unsteady gait
2.	04/14/08 09:20	Diabetic ketoacidosis
3.	04/29/08 19:10	Altered mental status examination
4.	04/30/08 23:00	Neck pain due to attempted hanging
5.	05/16/08 20:20	Diaphoresis, tachycardia and shortness of breath
6.	05/22/08 14:35	Left-sided weakness
7.	05/28/08 09:15	Abdominal pain
8.	05/28/08 15:30	R/O drug overdose
9.	06/28/08 19:45	Urinary tract infection, confusion
10.	07/19/08 09:20	S/P right humerus fracture
11	08/27/08 23:09	Chest pain, dizziness
12.	08/31/08 18:58	R/O gastrointestinal bleeding

The review found general evidence of timely and appropriate care in most charts. In particular, there was evidence of improved documentation of nursing assessments of changes in individuals' physical status in some of the charts that contained the new Change in Condition Forms. However, this monitor found a pattern of process

		deficiencies regarding the delivery of medical services. These deficiencies must be corrected to achieve substantial compliance with this requirement. The following are examples: 1. There was no physician's acceptance note for an individual who was hospitalized due to recurrent neurological problems, including possible cerebrovascular event. 2. In general, the physician acceptance notes following outside hospitalization were inadequate. In particular, these notes failed to document adequate review of the hospital's work-up, factors contributing to the hospitalization and assessment of care needed to reduce future risk for the individuals. Only three charts (CW, HC and MW) included appropriate physician's acceptance notes and this documentation was provided by the same physician. 3. There was no documentation by nursing regarding the initial assessment of an individual who had developed diaphoresis, tachycardia and shortness of breath while in the auditorium area. The hospital work-up of this individual's status was limited by the lack of good history regarding the events during this episode. 4. The documentation of PRN administration of a medication that appeared to have precipitated a delirium in one individual was inaccurate. 5. In general, the initial assessment of individuals suffering from delirium was limited to the neurological status and did not adequately address the metabolic variables. 6. There was delayed identification of osteoporosis in an individual despite the individual having a known risk factor (immobility) for almost thirty years. 7. There was evidence of poor follow-up by nursing regarding the risks associated with osteoporosis in an individual who suffered a fracture while experiencing restrictive interventions. 8. There was evidence of incomplete work-up at the regional medical center for an individual who was transferred by ASH with an

		appropriate provisional diagnosis of R/O Drug Overdose. Note that the numbered list above is not intended to correspond to the numbered episodes listed in the table. **Compliance:** Partial. **Current recommendations:** 1. Finalize DMH's Special Order 136, Provision of Medical Care to Individuals (draft). 2. Finalize new formats for nursing assessment and documentation of changes in the status of individuals, and provide training to ensure proper implementation. 3. Ensure proper oversight of medical services to correct this monitor's clinical findings of deficiencies (listed in Other Findings above).
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:** **Recommendation 1, April 2008:** Standardize the monitoring tool regarding the initial admission assessments for use across facilities. **Findings:** The DMH is in the process of finalizing this tool. **Recommendations 2 and 3, April 2008:** • Monitor this requirement based on a 100% sample using the DMH

Admission (Initial) Medical Assessment Audit Form (when completed) and the DMH Surgical Medical Progress Notes Audit Form.

- Provide data analysis that evaluates low compliance and delineates relative improvement (during the reporting period and compared to the last period).

Findings:
The facility's findings and comparative analysis were presented in D.1.c.i.

During this review period, the facility began implementation of the quarterly medical reassessments of individuals with Axis III diagnosis (March 2008). The facility used the DMH Medical Surgical Progress Notes Auditing Form to assess compliance (April to August 2008). The average sample was 9% of all individuals with at least one diagnosis on Axis III. The following is a summary of the data:

1.	*There is a quarterly note that documents reassessment of the individual medical status.*	46%
2.	*Significant conditions for which the individual is at risk for complications are identified.*	97%
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.*	70%

No comparative data were available as implementation began during this review period. In an effort to improve compliance, the facility reported the following corrective actions:

1. Three new physicians have been hired as of September 15, 2008.

		2. A template is being developed for the Quarterly Medical Progress Note. The template provides prompts for required components of the Quarterly Progress Note specific to the diagnosis including Change in Physical Condition, Risk Assessment, Objectives and Interventions. 3. As of September 21, 2008, a PPN and an order for the individual to be placed in the following Medical Sick Call would be written by the on-call physician whenever changes in the individual's physical condition occurred during off-hours. 4. Individual physicians found to be performing below compliance levels have been instructed on the requirements for compliance. **Recommendation 4, April 2008:** Implement corrective actions to address the lack of documentation of follow-up when individuals refuse the examination or parts of the examination. **Findings:** The revised DMH History and Physical Form template was implemented for all admissions on August 4, 2008. This form includes a section addressing follow-up of refused examinations. The form was reviewed with the Family Nurse Practitioners and Physicians to improve compliance. The Department of Medicine has provided instructions to improve compliance, including the following: 1. The provider performing the Admission History and Physical would write an order for follow-up of all refused examinations in Medical Sick Call. 2. The Physicians performing Medical Sick Call on admissions units would review all Admission History and Physical forms from the previous day specifically looking for refused portions of the physical examination. 3. ASH has requested that items be added to the proposed DMH

		Admission Medical Assessment Monitoring Form to audit for any refused examinations. **Compliance:** Partial. **Current recommendations**: 1. Finalize the DMH Initial Medical Assessment standardized monitoring tool and present the data in D.1.c.i. 2. Continue to monitor the quarterly medical reassessments using the DMH Medical Surgical Progress Notes Auditing Form based on a 20% sample. 3. 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.b.ii	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;	**Current findings on previous recommendations:** **Recommendation 1, April 2008:** Standardize the monitoring tools regarding the Medical Emergency Response System and Drills for use across state facilities. **Findings:** The DMH has yet to implement this recommendation. **Recommendation 2, April 2008:** Monitor this requirement using the DMH standardized tools regarding Medical Emergency Response System (when completed), Medical Transfers and Integration of Medical Conditions into the WRP Audit Forms. **Findings:** ASH used the DMH Integration of Medical Conditions into the WRP

Auditing Form to assess compliance (June to August 2008). The average sample was 31% of all individuals with at least one diagnosis on Axis III. The following is a summary of the data:

1.	*All medical conditions listed in Axis III are included on the Medical Conditions form*	53%
2.	*The WRP includes a focus statement, objective and intervention for each medical condition listed on the Medical Conditions form*	62%
3.	*There is an appropriate focus statement for each medical condition or diagnosis*	24%
4.	*There is an appropriate objective for each medical condition or diagnosis*	21%
5.	*There are appropriate intervention(s) for each objective*	4%

Using the same tool, the facility reviewed a 100% sample and provided data regarding the indicator pertaining to the issue of treatment refusal by individuals (April to August 2008). The following is a summary:

6.	*Each state hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to 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*	6%
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.*	0%

No comparative data were available because implementation began

during this review period. To improve compliance, the facility reported the following corrective actions:

1. Clarification to auditors that diagnoses listed as "History of" and "Status Post" surgeries or injuries are not conditions that require objectives and interventions;
2. Follow-up by the Nurse Administrator's office to assist nursing staff in the development of focus statements, objectives and interventions;
3. Interdisciplinary training sessions with physicians, family nurse practitioners and nursing staff; and
4. Central Medical Services (Dental Clinic, Medical-Surgical Clinic, EKG/EEG Department, X-Ray Department, and Outside Appointments) to standardize a method of communicating refusals of appointments, testing, and procedures to the WRPT.

ASH used the DMH Medical Transfer Auditing Form to assess compliance (March to August 2008). The average sample was 100% of the transfers. The following is a summary of the data:

1.	*There is appropriate documentation by the nurse that identifies the symptoms of concern and notification of the physician.*	38%
2.	*There is appropriate and timely response and documentation from the transferring physician meeting the standards of care for the condition being transferred.*	57%
3.	*Sufficient information is provided to the accepting facility in order to ensure continuity of care.*	97%
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 acute medical facility.*	95%
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.*	97%
7.	*The WRP was updated to reflect the individual's current status following hospitalization or emergency room treatment.*	46%

No comparative data were available because implementation began during this review period. The facility's corrective action plan included development of the following items:

1. Specific documentation process for the transfer of individuals to outside facilities for emergency and urgent medical treatment that is not available at the state hospitals;
2. RN Change in Physical Status Note to be included in the Interdisciplinary Notes section to ensure capture of specific documentation by the nurse of symptoms of concern and notification of the physician.
3. A Reference for Assessment and Notification to assist the nursing staff in the identification of changes in conditions and classifications of emergent, urgent and non-urgent levels of urgency; and
4. Interdisciplinary training to include physicians, family nurse practitioners and nursing staff regarding the proper implementation.

Compliance:
Partial.

		Current recommendations: 1. Standardize the monitoring tools regarding the medical emergency response system and drills for use across state facilities. 2. Monitor this requirement using the DMH Medical Transfer Auditing Form and the facility's audit regarding timeliness of consultations off-site based on at least 20% sample. 3. 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.b.iii	define the duties and responsibilities of primary care (non-psychiatric) physicians;	**Current findings on previous recommendation:** **Recommendation, April 2008:** Ensure that the Duty Statement outlines the performance standards and expectations as above. The Duty Statement may refer to the revised policies and procedures. **Findings:** ASH has implemented this recommendation. **Compliance:** Substantial. **Current recommendations**: Continue current practice.
F.7.b.iv	ensure a system of after-hours coverage by primary care physicians with formal psychiatric training (i.e., privileging and proctorship) and psychiatric backup support after hours; and	**Current findings on previous recommendation:** **Recommendation, April 2008:** Continue current practice.

		Findings: ASH has continued to assign a psychiatrist (PMOD) along with a primary care physician (MOD) to provide after-hours coverage on-site. **Compliance:** Substantial. **Current recommendations**: 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:** **Recommendations 1 and 2, April 2008:** • Monitor this requirement based on a 100% sample. • Provide data analysis that evaluates low compliance and delineates relative improvement (during the reporting period and compared to the last period). **Findings:** The facility presented data based on a 100% sample of individuals returning from outside medical treatment (March-August 2008) to assess whether required documents from outside consultants/hospitals have been received within seven days of the individual's return to the facility. The mean compliance rate was 81% compared to 72% during the last review period. The barrier to compliance has been failure by some outside consultants to meet conditions of their contracts. ASH will reportedly contact the contract agency to ensure compliance. **Other findings:** Chart reviews by this monitor (see F.7.a) found improvement in the availability of discharge summaries from outside hospitals compared to the last review period.

		Compliance: Partial. **Current recommendations**: 1. Monitor this requirement based on a 100% sample. 2. Provide data analysis that evaluates low compliance and delineates relative improvement (during the reporting period and compared to the last period).
F.7.c	Each State hospital shall ensure that physicians monitor each individual's health status indicators in accordance with generally accepted professional standards of care, and, whenever appropriate, modify their therapeutic and rehabilitation service plans to address any problematic changes in health status indicators.	**Current findings on previous recommendations:** **Recommendations 1 and 2, April 2008:** • Monitor this requirement using the DMH standardized tools regarding specific medical conditions (diabetes mellitus, dyslipidemia, hypertension and asthma/COPD) in addition to any other instruments that address this requirement (e.g. hepatitis C). • Provide data analysis that evaluates low compliance and delineates relative improvement (during the reporting period and compared to the last period). **Findings:** ASH used the DMH standardized tools to assess compliance regarding the management of diabetes mellitus, hypertension, dyslipidemia and asthma/COPD (April to August 2008). The average samples were 14% (diabetes mellitus), 17% (COPD/asthma), 15% (hypertension) and 27% (dyslipidemia) of individuals diagnosed with these disorders. The following is a summary of the facility's data and corrective actions to improve compliance:

Diabetes Mellitus

1.	*The individual has been evaluated and supporting documentation is completed at least quarterly.*	77%
2.	*HgbA1C was ordered quarterly.*	90%
3.	*The HgbA1C is equal to or less than 7%.*	95%
4.	*Blood sugar is monitored regularly.*	83%
5.	*Urinary micro albumin is monitored annually.*	55%
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.*	61%
8.	*LDL is less than 100mg/dl or there is a plan of care in place to appropriate treat the LDL.*	79%
9.	*Blood pressure is monitored weekly.*	99%
10.	*If blood pressure is greater than 130/80, there is a plan of care in place to appropriately lower the blood pressure.*	50%
11.	*An eye exam by an ophthalmologist/optometrist was completed at least annually.*	77%
12.	*Podiatry care was provided by a podiatrist at least annually.*	84%
13.	*A dietary consultation was considered and the recommendation followed, as applicable.*	84%
14.	*Diabetes is addressed in Focus 6 of the WRP.*	96%
15.	*Focus 6 for Diabetes has appropriate objectives and interventions for this condition.*	90%

Comparative data (for the indicators that were used in the previous tool) showed mixed changes since the last review as follows:

	Previous period	Current period
Mean compliance rate		
1.	54%	77%
3.	88%	83%
4.	41%	55%
5.	93%	61%
6.	61%	79%
7.	13%	50%
8.	79%	77%
9.	88%	84%
10.	94%	84%
11.	54%	77%
12.	88%	83%
13.	41%	55%
Compliance rate in last month of period		
1.	61%	61%
3.	86%	90%
4.	83%	89%
5.	57%	50%
6.	35%	88%
7.	81%	59%
8.	48%	6%
9.	70%	78%
10.	74%	83%
11.	83%	94%
12.	83%	94%
13.	61%	61%

To improve compliance, the facility plans to provide individual physicians found to be performing below compliance levels with

instructions on the requirements for compliance within the next three months.

Asthma/COPD

1.	*The individual has been evaluated and supporting documentation completed at least quarterly.*	64%
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.*	56%
4.	*If the individual is currently a smoker, a smoking cessation program has been discussed and included in the WRP.*	12%
5.	*Asthma or COPD is addressed in focus 6 of the WRP.*	77%
6.	*Focus 6 for Asthma/COPD has appropriate objectives and interventions.*	79%
7.	*The individual has been assessed for a flu vaccination.*	80%
8.	*If the individual has a diagnosis of COPD, a Pneumococcal vaccine has been offered, unless contraindicated.*	38%

Comparative data (for the indicators that were used in the previous tool) showed general improvement, with two exceptions, since the last review as follows:

	Previous period	Current period
Mean compliance rate		
1.	37%	64%
3.	45%	56%

	Previous period	Current period
Mean compliance rate		
4.	19%	12%
5.	81%	77%
6.	49%	79%
7.	70%	80%
8.	37%	64%
Compliance rate in last month of period		
1.	47%	70%
3.	67%	67%
4.	19%	22%
5.	94%	72%
6.	94%	73%
7.	69%	95%
8.	33%	29%

ASH's plan of correction includes the following:

1. The facility will become smoke-free effective November 4, 2008.
2. Individual physicians found to be performing below compliance levels will receive instructions on the requirements for compliance within the next three months.
3. Identify all individuals with asthma/COPD who have not received pneumococcal vaccination and notify physicians to counsel individuals and order vaccination.
4. Notify family nurse practitioners and physicians to screen all admissions regarding need for pneumococcal vaccination (asthma/COPD, CHF, diabetes mellitus and/or other chronic diseases.)

Hypertension

1.	*The individual has been evaluated and supporting documentation completed at least quarterly.*	76%
2.	*Blood pressure is monitored weekly.*	95%
3.	*Blood pressure is less than 140/90 or there is an appropriate plan of care in place to reduce blood pressure.*	90%
4.	*If the individual is 40 or older, aspirin has been ordered unless contraindicated.*	65%
5.	*Hypertension is addressed in Focus 6 of the WRP.*	96%
6.	*Focus 6 for Hypertension has appropriate objectives and interventions.*	96%
7.	*A dietary consult was considered and the recommendation was followed, as applicable.*	93%
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.*	24%
9.	*An exercise program has been initiated.*	8%
10.	*If the individual is currently a smoker, smoking cessation has been discussed and included in the WRP.*	1%

No comparative data were available due to lack of data during the last review. The facility's plan of correction included the following:

1. Cross-reference individuals with hypertension and not receiving on aspirin (over age 40) and notify physicians to discuss the issue with individuals.
2. Provide education to admission providers and instructions to individual physicians found to be performing below compliance levels.

Dyslipidemia

1.	*The individual has been evaluated and supporting documentation completed at least quarterly.*	75%
2.	*A lipid panel was ordered at least quarterly.*	89%
3.	*The HDL level is >40(M) or >50(F) or a plan of care is in place.*	67%
4.	*The LDL level is ≤ or a plan of care is in place.*	89%
5.	*The Triglyceride level is ≤ 200 of a plan of care is in place.*	83%
6.	*Dyslipidemia is addressed in focus 6 of the WRP.*	73%
7.	*Focus 6 for Dyslipidemia has appropriate objectives and interventions for this condition.*	59%
8.	*A dietary consultation was considered and the recommendation followed, as applicable.*	96%
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.*	4%
10.	*An exercise program has been initiated.*	28%
11.	*If non-pharmacological interventions have been ineffective to control Dyslipidemia, medications have been considered or initiated.*	94%

No comparative data were available due to lack of data during the last review.

Compliance:
Partial.

Current recommendations:
1. Monitor specific medical conditions including diabetes mellitus, hypertension, dyslipidemia and asthma/COPD using the

		standardized tools based on at least a 20% sample. 2. Monitor preventive care and care of cardiac disease using NSH indicators. 3. 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:** **Recommendation 1, April 2008:** Utilize the Medical Services EP Performance Improvement Team in the review and analysis of all the medical triggers/key indicators, establishment of any additional indicators of outcomes to the individuals and the medical systems of care and development and implementation of corrective actions. **Findings:** The facility reported that this recommendation will be implemented as part of the new DMH risk management policy and procedure (in process). **Recommendations 2 and 3, April 2008:** • Develop and implement a formalized physician peer review system that utilizes indicators aligned with the standards and expectations outlined in F.7.a. • Identify trends and patterns based on clinical and process outcomes. **Findings:** ASH has yet to implement these recommendations. The facility has reportedly assigned a physician to work closely with the Standards Compliance Department on these tasks. In addition, the Current Peer Review audit tools are being updated to audit for implementation of the

		requirements in the revised Medical Services Policies and Procedures. Finally, the computer software analyzer (Plato) is in the process of developing analysis reports that can be used to identify trends and patterns from the data collected. **Compliance:** Partial. **Current recommendations**: 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. 2. Develop and implement a formalized physician peer review system that utilizes indicators aligned with the standards and expectations outlined in F.7.a. 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:** Interviewed: 1. Belinda Roetker, RN, Standards Compliance 2. Brandi Norico, PHN II 3. Cynthia Davis, Nurse Administrator 4. Gina M. Dusi, PHN II 5. Marlene Espitia, RN, Standards Compliance 6. Rosie Morrison, Health Services Specialist Reviewed: 1. ASH's progress report and data 2. ASH Public Health Supplemental Guidelines for Focus 6/P1 Problems 3. Minutes of the DMH Public Health Committee dated 9/6/07and 3/26/08 4. ASH HSS Committee meeting minutes dated 3/3/08, 3/24/08, 5/5/08, 5/19/08, 6/16/08, 6/23/08, and 9/22/08 5. ASH follow-up instructions for Admission PPDs, Hepatitis C, Immunizations, MRSA, Refused Admitting or Annual Lab or Diagnostic, Annual PPDs, HIV/AIDS, Immunization Refusal, Positive PPD, and Sexually Transmitted Disease 6. Special Order 104.02, HIV/AIDS Prevention and Management 7. ASH Infection Control Committee meeting minutes dated 3/27/08, 4/24/08, 5/22/08, 6/26/08, and 7/31/08 8. ASH Public Health Services Hospital Associated Infection (HAI) Report dated 2/08, 3/08, 4/08, 5/08, 6/08, and 7/08 9. Memos dated 4/3/08, 4/7/08, 5/14/08, 5/19/08, and 7/22/08 regarding issues with TSTs 10. Memo dated 7/25/08 regarding Axis III Diagnoses, General Medical Conditions 11. Memo dated 7/25/08 regarding Focus 6/P-1 Problems and P-20

		Problems 12. Infection Control Performance Improvement/Risk Assessment Third Quarter Report 2007-2008 13. Department of Medicine meeting minutes dated 6/19/08 14. Medical records of the following individuals: AAH, AAR, AB, ADT, AF, AH, AJ, AWS, BLB, BM, CAK, CC, CHM, COH, CP, DAB, DAP, DC, DCT, DGD, DHC, DM, DN, DOM, DRD, ERH, FDB, FDS, FFA, FM, GAV, GHF, GL, GPJ, HGT, HJ, HP, HWB, IAB, ICA, IK, JAC, JAW, JD, JEP, JJF, JJR, JJS, JKA, JLJ, JLS, JOJ, JP, JR, JS, JSA, JT, JW, JWD, JWF, JWO, KAP, KB, KNB, KNS, KT, LBE, LDJ, LJ, LWA, MAG, MC, MD, MG, MM, MMC, MP, OP, PBS, PLS, RA, RAG, RDH, RDL, REP, RGJ, RKD, RL, RLB, RR, RW, SAK, SCB, SCH, SD, SJG, SK, SL, SRT, TC, VE, WC, WKS, WW and WWM
F.8.a	Each State hospital shall establish an effective infection control program that:	**Compliance:** Partial (due to low compliance regarding integration of Infection Control issues into the WRPs).
F.8.a.i	actively collects data regarding infections and communicable diseases;	**Current findings on previous recommendations:** **Recommendation 1, April 2008:** Reconcile inconsistencies between current Infection Control policies/procedures and indicators for monitoring. **Findings:** On June 5, 2008, ASH chaired a telephone conference of the Statewide Public Heath Committee to revise the audit tools. **Recommendation 2, April 2008:** Continue to conduct inter-rater reliability testing until values of 85% or above are achieved.

Findings:
The Hepatitis C tool is the only tool with inter-rater reliability below 85% (83%). ASH reported that this was due to variances in the auditors' interpretations of quality objectives and interventions, which is being addressed. Inter-rater reliability scores for the remaining IC tools range from 85% to 100%

Recommendation 3, April 2008:
Continue to monitor this requirement.

Findings:

Admission PPD
The DMH IC Admission PPD Auditing Form, based on an average sample of 20% of individuals admitted to the hospital with a negative PPD in the review months (March-August 2008), demonstrated the following:

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

F.8.a.ii: Assesses these data for trends:
ASH's compliance score for item 5 is N/A because two-step PPDs are not done at ASH; most newly admitted individuals have recently had a TST done by the transferring facility.

F.8.a.iii: Initiates inquiries regarding problematic trends:
ASH indicated that there were no problematic trends for these items.

F.8.a.iv: Identifies necessary corrective action:
No corrective action was required from ASH's analysis of the data.

F.8.a.v: Monitors to ensure that appropriate remedies are achieved:
ASH will continue to monitor these items for compliance.

A review of the records of 22 individuals admitted during the review period (AAH, AAR, AJ, BLB, DAB, DM, FFA, FM, HWB, JP, JR, JWD, MD, RKD, RLB, RW, SAK, SK, SL, TC, VE and WWM) found that all were in compliance regarding admission PPDs.

Annual PPD
The DMH IC Annual PPD Auditing Form, based on an average sample of 21% of individuals needing an annual PPD during the review months (March-August 2008), demonstrated the following:

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%

F.8.a.ii: Assesses these data for trends:
ASH reported that there were no trends identified.

F.8.a.iii: Initiates inquiries regarding problematic trends:
ASH reported that there were no problematic trends.

F.8.a.iv: Identifies necessary corrective action:
ASH indicated that no corrective action was required.

F.8.a.v: Monitors to ensure that appropriate remedies are achieved:
ASH will continue to monitor these items for compliance.

A review of the records of 20 individuals who needed an annual PPD (ADT, CP, DN, DRD, FDB, GL, IK, JAC, JEP, JLJ, JLS, JW, MC, MM, MMC, OP, RA, SCB, SD and WW) found all to be in compliance.

Hepatitis C
The DMH IC Hepatitis C Auditing Form based on an average sample of 21% of individuals admitted to the hospital who are positive for Hepatitis C in the review month (March-August 2008) demonstrated the following:

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.*	97%
6.	*Appropriate objective is written to include treatment as required by the Hepatitis C Tracking Sheet*	19%
7.	*Appropriate interventions are written to include treatment as required by the Hepatitis C Tracking Sheet, or as required by the WRP Manual*	0%

		F.8.a.ii: Assesses these data for trends: ASH's analysis indicated that compliance for items 1- 5 are at 100%, except in May, when one of the six charts audited did not have a focus opened. In April, May and June 2008, item 6 was above 0% but represented that the Public Health Nurse (PHN) auditors were not clearly defining the parameters of quality objectives. The 0% compliance with item 7 indicates inadequately formulated interventions for Hepatitis C in the WRPs and the content continues to not address appropriate disease progression, treatment or risk factors for transmission. F.8.a.iii: Initiates inquiries regarding problematic trends: The Infection Control (IC) Department, in conjunction with Nursing Services, identified through the auditing process that the objectives and interventions for Hepatitis C were either not initiated or the quality of the content was lacking. F.8.a.iv: Identifies necessary corrective action: To ensure a Focus 6 was opened for Hepatitis C, the individual was placed in sick call and a note was initiated requesting the unit MD to open the focus. Also, the Department of Medicine meeting minutes 6/19/08 verified that the unit physicians were reminded to initiate opening a Focus 6. In addition, Public Health is working with Nursing Services to increase the quality of nursing infection control-related objectives and interventions. Public health supplemental guidelines were developed for the unit nurses to use when developing objectives and interventions for infection control-related topics. F.8.a.v: Monitors to ensure that appropriate remedies are achieved: ASH has initiated having the PHN auditors discuss questionable objectives and interventions prior to rating compliance. ASH is also in the process of developing a multi-department (Nursing Services,

Standards Compliance and Public Health) plan to monitor and improve the quality of Hepatitis C objectives and interventions. An additional staff member assigned to Public Health effective October 14, 2008 should increase the improvement of the quality of objectives and interventions.

A review of the records of 27 individuals who had Hepatitis C (AB, BM, CAK, CC, DHC, DOM, ERH, FDS, GAV, GHF, IAB, JD, JJF, JP, JS, JSA, JWO, KAP, KNB, LBE, LDJ, PBS, RAG, RDH, RDL, REP and RL) found that all had a opened Focus 6 and none had appropriate objectives and interventions in the WRPs. Regarding lab notification to the unit and to the IC Department, all 27 were in compliance. These results are similar to ASH's data.

HIV Positive

The DMH IC HIV Positive Auditing Form, based on a 100% sample of individuals (N=8) who were positive for HIV antibody in the review months (March-August 2008), demonstrated the following:

1.	*Notification by the lab was made to the infection control department identifying the individual with a positive HIV Antibody.*	100%
2.	*Notification was made to the unit housing the individual that he/she has a positive HIV Antibody test.*	75%
3.	*If the individual was admitted with a diagnosis of HIV positive, a referral was made to the appropriate clinic during the admission process.*	88%
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*	100%

	three months for ongoing care and treatment, unless another timeframe is ordered by the physician.	
6.	*A Focus 6 is opened for HIV (unspecified viral illness)*	88%
7.	*Appropriate objective is written to address the progression of the disease.*	50%
8.	*Appropriate interventions are written.*	38%

F.8.a.ii: Assesses these data for trends:
ASH's data analysis demonstrated that in March, items 1 and 2 were N/A due to individuals' known history of HIV, thus a HIV antibody test was not needed on admission. Item 4 was N/A because the individual had a prior history of HIV and was not newly identified at ASH. Also, in the July 2008 data, there was one newly identified HIV antibody-positive individual. Items 2 and 3 were scored 0% since at the time of the audit, the individual had not been informed of his positive antibody status by the Public Health Physician. Consequently, this resulted in the unit not having information about the test result, thus no Focus 6 or interventions and objectives were completed. In addition, in the August 2008 data, item 4 was N/A due to the individual being admitted with a diagnosis of HIV. Items 6 and 7 reflected objectives and interventions that were not initiated or were not of quality content.

F.8.a.iii: Initiates inquiries regarding problematic trends:
See F.8.a.iii for Hepatitis C.

F.8.a.iv: Identifies necessary corrective action:
See F.8.a.iv for Hepatitis C.

F.8.a.v: Monitors to ensure that appropriate remedies are achieved:
ASH will continue to monitor these items for compliance. See F.8.a.v for Hepatitis C.

A review of the records of seven individuals with HIV (BM, CC, JJS,

JWO, KAP, PLS and SCH) found that all had an open Focus 6 but were found in partial compliance due to inadequate WRP objectives and interventions.

Immunizations

The DMH IC Immunization Auditing Form, based on an average sample of 21% of individuals admitted to the hospital during the review months (March-August 2008), demonstrated the following:

1.	*Notification by the lab was made to the Infection Control Department of an individual's immunity status.*	99%
2.	*Notification by the lab was made to the unit housing the individual of his/her immunity status.*	99%
3.	*Immunizations were ordered by the physician within 30 days of receiving notification by the lab.*	99%
4.	*Immunizations were administered by the nurse within 24 hours of the physician order and completed within timeframes.*	99%

F.8.a.ii: Assesses these data for trends:
ASH's analysis indicated that there were no trends identified.

F.8.a.iii: Initiates inquiries regarding problematic trends:
ASH's analysis indicated that there were no trends identified.

F.8.a.iv: Identifies necessary corrective action:
ASH's analysis indicated that there were no trends identified.

F.8.a.v: Monitors to ensure that appropriate remedies are achieved:
ASH will continue to monitor these items for compliance.

A review of the records of 27 individuals regarding immunizations (AB, BM, CAK, CC, DHC, DOM, ERH, FDS, GAV, GHF, IAB, JD, JJF, JP, JS,

JSA, JWO, KAP, KNB, LBE, LDJ, PBS, RAG, RDH, RDL, REP and RL) found that all 27 were in compliance.

Immunization Refusals

The DMH IC Immunization Refusal Auditing Form, based on an average sample of 50% of individuals in the hospital who refused to take their immunizations during the review months (March-August 2008), demonstrated the following:

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).*	9%
3.	*There are appropriate objective(s) developed for the refusal of immunization(s).*	0%
4.	*There are appropriate interventions written for the objective(s) developed for the refusal of immunization(s).*	0%
5.	*The unit notified the Infection Control Department when the individual consented and received the immunization(s).*	N/A

F.8.a.ii: Assesses these data for trends:

ASH's analysis indicated that the data for March through June showed 0% for items 2, 3, and 4 due to immunizations being done in a centralized department at ASH and the lack of a process to notify units when individuals refuse their immunizations. This resulted in the lack of an open focus, objectives and interventions addressing immunization refusals. Individuals who had an open Focus 6 for refusals had been previously audited but had additional refusals. A secondary P-20 problem was initiated but does not require objectives and interventions. In addition, in August 2008, one individual had an

		open Focus 6 for refusal of immunizations. However, at the time of the audit, the team had not yet met to develop objectives and interventions. Also, item 5 had been scored as N/A since all individuals had not consented to get their immunizations due to continued refusals. F.8.a.iii: Initiates inquiries regarding problematic trends: ASH noted that since immunizations are given in a centralized department, a process needs to be implemented to ensure a focus is opened at the point of origin: the Med- Surg Clinic. The PHNs have had meetings with the Public Health Physician addressing this issue. F.8.a.iv: Identifies necessary corrective action: ASH has implemented a process in which individuals without a Focus 6 opened have their names placed in the sick call book, alerting the physician to open a Focus 6 and/or change the P-20 problem to a P-1 that requires objectives and interventions. The PHNs attended the 6/19/08 Department of Medicine meeting as verified by the meeting minutes, addressing the issue of Focus 6/P1 problems vs P-20 problems for refusals. In addition, a memo dated 7/25/08 was sent to the Nurse Administrator regarding Focus 6/P-1 Problems and P-20 Problems. Collaboration with Med Surg Clinic staff has been implemented to develop a process so the Public Health Physician opens a Focus 6 at the time the individual refuses the specific immunization. Also, Public Health is working with Nursing Services regarding the quality of nursing infection control related-objectives and interventions in the WRPs. Supplemental guidelines from PHNs were provided at the HSS meeting on 9/15/08. F.8.a.v: Monitors to ensure that appropriate remedies are achieved: ASH will continue to monitor these items for compliance. A review of the records of 19 individuals who refused immunizations (AF, AWS, CHM, COH, DAP, DRD, ICA, JJR, JKA, KB, KT, LJ, LWA,

MAG, MG, RR, RW, SRT and WKS) found that 18 did not include the refusals in the WRP.

MRSA

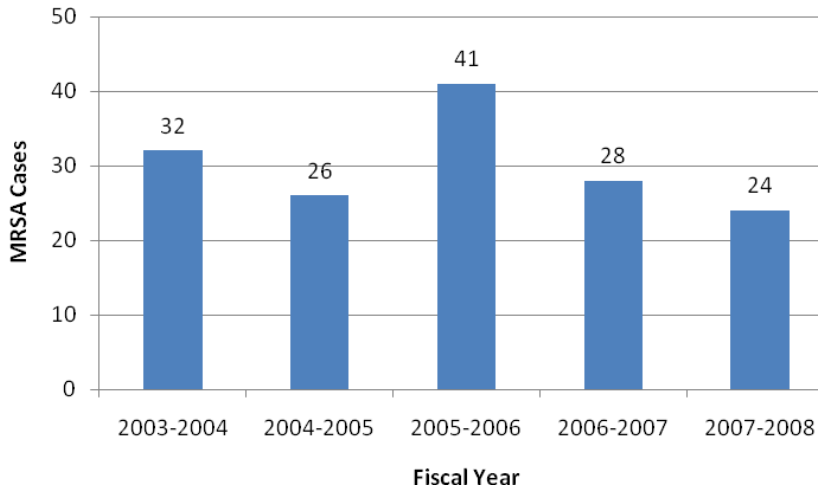
The DMH IC MRSA Auditing Form, based on an average sample of 92% of individuals (N=12) in the hospital who tested positive for MRSA during the review months (March-August 2008), demonstrated the following:

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.*	88%
4.	*The appropriate antibiotic was ordered for treatment of the infection(s).*	90%
5.	*The public health office contacts the unit RN and provides MRSA protocol and guidance for the care of the individual.*	91%
6.	*A Focus 6 is opened for MRSA.*	91%
7.	*Appropriate objective is written to include prevention of spread of infection*	0%
8.	*Appropriate interventions are written to include contact precautions.*	0%

F.8.a.ii: Assesses these data for trends:

ASH's data analysis demonstrated that in March 2008, the two individuals reviewed did not require contact precautions (item 3) as their wounds were healing with no drainage by the time the positive diagnosis was made. Item 3 in April 2008 was 0% due to contact

		precautions not being ordered. Also, some physicians were found to be ordering MRSA precautions instead of contact precautions. ASH only subscribes to contact precautions. In May 2008, there were four MRSA cases. However only three cases were audited due to one individual being discharged prior to the audit. Also, item 3 showed 0% compliance due to the physician(s) not ordering contact precautions or documenting a justification if it was not ordered. Items 5 and 6 showed low compliance due to the PHNs receiving the culture results on 6/3/08 and the individual was discharged on 6/4/08. Item 4 was low due to a case in which no antibiotic was ordered because the site was incised and drained. Overall. WRP objectives and interventions (items 7 and 8) were present, but were of poor quality. ASH also identified the overall trend of MRSA for the facility as of the last day in August 2008 below: • 24 cases of MRSAs for 2007-2008 FY • 28 cases of MRSAs for 2006-2007 FY • 41 cases of MRSAs for 2005-2006 FY • 26 cases of MRSAs for 2004-2005 FY • 32 cases of MRSAs for 2003-2004 FY



F.8.a.iii: Initiates inquiries regarding problematic trends:
The minutes of the 6/19/08 Department of Medicine noted that Communicable Diseases are not consistently listed on the Axis III Diagnosis and Medical Condition form and clarification was needed regarding MRSA and contact precautions. Also see F.8.a.iii under Hepatitis C.

F.8.a.iv: Identifies necessary corrective action:
A memo dated 7/25/08 was sent addressing Axis III Diagnosis, General Medical Conditions. Also see F.8.a.iv under Hepatitis C.

F.8.a.v: Monitors to ensure that appropriate remedies are achieved:
ASH will continue to monitor these items for compliance.

A review of the records of 10 individuals with MRSA (DGD, HJ, JAW, JD, JT, JWF, KNS, REP, SJG and WC) found that two were in compliance with contact precautions ordered (JT and SJG), seven had an opened Focus 6, and none were in compliance due to the lack of

documentation in the WRPs.

Positive PPD

The DMH IC Positive PPD Auditing Form, based on a 100% sample of individuals (N=9) in the hospital who had a positive PPD test during the review months (March-August 2008), demonstrated the following:

1.	*Notification by the unit via a PPD form is sent to Public Health Office for all PPD readings.*	100%
2.	*All positive PPDs received PA and Lateral Chest X-ray.*	100%
3.	*All positive PPDs received an evaluation by the Med-Surg Physician.*	100%
4.	*If active disease is identified, then individual is transferred to medical isolation and appropriate treatment is provided.*	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.*	0%
7.	*If LTBI is present, there are appropriate interventions written to prevent the progression of the disease.*	0%

F.8.a.ii: Assesses these data for trends:

ASH's analysis showed that appropriate objectives and/or intervention were either not initiated or not of quality content.

F.8.a.iii: Initiates inquiries regarding problematic trends:

The PHN attended the 6/19/08 Department of Medicine meeting regarding clarification for Focus 6/P1 problems and P-20 problems. Also see F.8.a.iii under MRSA.

F.8.a.iv: Identifies necessary corrective action:
See F.8.a.iv under Hepatitis C.

F.8.a.v: Monitors to ensure that appropriate remedies are achieved:
ASH will continue to monitor these items for compliance.

A review of the records of nine individuals who had a positive PPD (AH, DC, DCT, GPJ, HGT, HP, JOJ, MP and RGJ) found all in partial compliance due to documentation regarding WRP objectives and interventions.

Refusal of Admitting or Annual Lab Work or Diagnostic Tests
The DMH IC Refused Admitting or Annual Lab Work or Diagnostic Test Audit, based on a 100% sample of individuals (N=13) in the hospital who refused their admission lab work, admission PPD, or annual PPD during the review months (March-August 2008), demonstrated the following:

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*	46%
3.	*There are appropriate objectives written for the lab work or PPD refusal.*	23%
4.	*There are appropriate interventions written for the lab work or PPD refusal.*	15%

F.8.a.ii: Assesses these data for trends:
ASH's data analysis demonstrated that foci were not consistently opened and appropriate objectives and/or interventions were either not initiated or of poor quality.

F.8.a.iii: Initiates inquiries regarding problematic trends:
See F.8.a.iii under MRSA.

F.8.a.iv: Identifies necessary corrective action:
See F.8.a.iv under Positive PPD.

F.8.a.v: Monitors to ensure that appropriate remedies are achieved:
ASH will continue to monitor these items for compliance.

A review of the records of eight individuals who had refused PPDs (DAB, DEB, DST, FA, LWA, MSB, RA and TCA) found that all were in partial compliance due to lack of documentation of an open focus and WRP objectives and interventions.

Sexually Transmitted Diseases
ASH had no individuals who tested positive for an STD during this review period.

1.	*Notification by the lab was made to the Infection Control Department of a positive STD.*	N/A
2.	*Notification by the lab was made to the unit housing the individual that he/she has a STD.*	N/A
3.	*An RPR is ordered during the admission process for each individual.*	N/A
4.	*An HIV antibody test is offered to every individual upon admission.*	N/A
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.*	N/A
8.	*Appropriate objective(s) are written.*	N/A

		9. *Appropriate interventions are written.* N/A F.8.a.ii: Assesses these data for trends: Not applicable. F.8.a.iii: Initiates inquiries regarding problematic trends: Not applicable. F.8.a.iv: Identifies necessary corrective action: Not applicable. F.8.a.v: Monitors to ensure that appropriate remedies are achieved: The facility will continue to monitor these items for compliance. **Other findings:** Although the Admission PPD compliance rates reflect substantial compliance, the IC Department has identified a trend regarding the quality of the TB program due to the increased number of staff administering and reading the admission TSTs. The PHNs have been providing education to the staff and have been reviewing a number of possible interventions to address this concern, including: 1. Implement QuantiFeron; 2. Limit the number of admission program RNs administering the TSTs; 3. Having the program/unit sick call RNs administer the TSTs; and 4. Hire additional Public Health Services staff. **Current recommendation**: Continue to monitor this requirement.
F.8.a.ii	assesses these data for trends;	**Current findings on previous recommendations:**

		Recommendation 1, April 2008: Provide data in a format that demonstrates compliance with this requirement. **Findings:** See F.8.a.i. **Recommendation 2, April 2008:** Continue to monitor this requirement. **Findings:** See F.8.a.i. **Other findings:** A review of ASH's Infection Control Committee meeting minutes, ASH Public Health Services Hospital Associated Infection (HAI) Reports, and the Infection Control Performance Improvement/Risk Assessment Third Quarter Report found that data regarding IC trends are consistently identified. **Compliance:** Substantial. **Current recommendation**: Continue current practice.
F.8.a.iii	initiates inquiries regarding problematic trends;	**Current findings on previous recommendation:** **Recommendation, April 2008:** Same as F.8.a.ii. **Findings:** ASH's IC Committee meeting minutes, Department of Medicine meeting

		minutes, HSS meeting minutes and memos validated that the problematic trends found on the IC audits were being actively addressed by the facility. See F.8.a.i. **Compliance:** Substantial. **Current recommendation**: Continue current practice.
F.8.a.iv	identifies necessary corrective action;	**Current findings on previous recommendations:** **Recommendation 1, April 2008:** Implement a system to monitor and track the implementation of recommendations/corrective actions. **Findings:** ASH uses the IC Committee meeting minutes to monitor and track corrective actions. **Recommendation 2, April 2008:** Continue to monitor this requirement. **Findings:** See F.8.a.i. **Other findings:** This monitor reviewed the following documents: • Minutes of the ASH Infection Control Performance Improvement/Risk Assessment Committee; • The Infection Control Committee; memos regarding TSTs, Axis III Diagnoses, General Medical Conditions and Focus 6/P-1 Problems

		and P-20; • ASH Public Health Services Hospital Associated Infection (HAI) Reports; • Department of Medicine meeting minutes; • ASH Public Health Supplemental Guidelines for Focus 6/P1 Problems; and • ASH follow-up instructions for Admission PPDs, Hepatitis C, Immunizations, MRSA, Refused Admitting or Annual Lab or Diagnostic, Annual PPDs, HIV/AIDS, Immunization Refusal, Positive PPD, and Sexually Transmitted Diseases. These reviews found that corrective actions and recommendations were documented and implemented regarding issues noted in the IC data. **Compliance:** Substantial. **Current recommendation**: Continue current practices.
F.8.a.v	monitors to ensure that appropriate remedies are achieved; and	**Current findings on previous recommendations:** **Recommendation 1, April 2008:** Implement software for Infection Control as planned. **Findings:** ASH's IC Department is in the process of collaborating with IT staff to enhance and/or revise Public Health and Infection Tracking for prototype. **Recommendation 2, April 2008:** Continue to monitor this requirement.

		Findings: According to a number of ASH's meeting minutes addressing IC issues as well as interviews with the IC staff, ASH is actively implementing a number of interventions to increase areas of low compliance. They continue to audit regularly regarding the effectiveness of these interventions. The IC Department has hired a technician to assist the department with IC duties. **Compliance:** Substantial. **Current recommendation**: Continue current practice.
F.8.a.vi	integrates this information into each State hospital's quality assurance review.	**Current findings on previous recommendation:** **Recommendation, April 2008:** Continue to provide data/reports/minutes addressing this requirement. **Findings:** ASH provided a number of reports and minutes of meetings, adequately addressing this recommendation. A review of this supporting documentation found that a number of IC issues have been discussed and plans of action integrated into the different departments and into the facility's Infection Control Performance Improvement/Risk Assessment program. Some of these include: 1. Hospital-wide implementation of Pharmaceutical Waste System; 2. PHN recommendation for medical waste storage; 3. West Nile Alert to Plant Operation staff; 4. PHN recommendation to the RN Assessment Update; 5. PHN recommendation to the Shift Change Prompt Cards; 6. Implemented use of disinfecting towelette for the

		cleaning/disinfecting of resident electric razor bases and beard trimmer bases; 7. Incorporated pharmaceutical waste compliance into monthly Infection Control Committee quality control monitoring; 8. Identification of employee annual health clearance delinquencies and plan to correct; 9. Processes to change the culture of hand hygiene; 10. Infection Control Committee decision to continue testing for legionella species for another six months due to few pneumonia cases; 11. Draft condom policy and product recommendations to Executive Director; and 12. Infection Control Department database is updated with current Hepatitis C clinical laboratory results and clinical judgment is utilized when the Infection Control Department database is reviewed to evaluate the need for continuity of care and immunizations **Compliance:** Substantial. **Current recommendation**: Continue current practice.

9. Dental Services		
	Each State hospital shall provide individuals with adequate, appropriate and timely routine and emergency dental care and treatment, consistent with generally accepted professional standards of care.	**Methodology:** Interviewed: 1. Nolan Nelson, DDS, Chief Dentist Reviewed: 1. ASH's progress report and data 2. Memo dated 10/19/07 regarding After-Hours Dental Emergency Policy 3. Memo dated 9/3/08 regarding Dental Emergency on September 2, 2008 at 1716 hours 4. ASH Department of Medicine Meeting minutes dated September 18, 2008 5. E-mails dated 6/25/08, 9/4/08, 9/8/08, 9/10/08, and 9/15/08 regarding procedure for dental emergencies 6. Dental records of the following 120 individuals: AAH, AB, AD, ADM, AJP, AJR, AK, AP, AS, BB, BER, BRD, BTR, CF, CG, CNG, CSO, CWS, DAH, DCK, DEM, DH, DJB, DJT, DML, DN, DN-2, DP, DRS, DTC, DWH, DWM, EAG, EB, ED, EL, FAO, GAB, GET, GJP, GM, GTS, IS, JAM, JAP, JAW, JBK, JDT, JED, JL, JM, JMH, JOG, JRW, JSS, JTM, JTP, JW, KH, KMS, LAV, LEP, LPR, LRT, MA, MAC, MAH, MAP, MB, MC, MCJ, MCR, MHW, MJA, MKC, MM, MMR, MPR, MS, MSA, MW, MWN, MWW, NAJ, NTN, OAA, OKM, PDD, RA, RDA, RF, RF-2, RH, RJN, RL, RLJ, RMS, RRF, RSW, RSZ, SBZ, SCH, SCK, SGV, SLT, SMB, SP, SRH, SWL, TLW, TM, TP, TR, VE, VLP, WM, WR, WST, WWR and YS
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:** **Recommendation, April 2008:** Continue to monitor this requirement.

		Findings: At the time of this review, ASH has one Chief Dentist, two staff Dentists and three Dental Assistants. ASH's Chief Dentist reported that an office technician would be needed when the new Dental Management software program is implemented. **Compliance:** Substantial. **Current recommendations**: 1. Evaluate the possibility of securing a dental office technician when the Dental Management software program is implemented. 2. Continue current practice.
F.9.b	Each State hospital shall develop and implement policies and procedures that require:	**Compliance:** Substantial.
F.9.b.i	comprehensive and timely provision of dental services;	**Current findings on previous recommendations:** **Recommendation 1, April 2008:** Implement statewide monitoring tools. **Findings:** ASH has implemented the Dental Statewide monitoring tools reflected in this review's data. **Recommendation 2, April 2008:** Continue to monitor this requirement. **Findings:** ASH's data from the DMH Dental Services Audit Form based on an average sample of 62% of individuals scheduled for comprehensive dental exams during the review months (March-August 2008) are

summarized below:

1.a	*Comprehensive dental exam was completed*	99%

Comparable data are not available from last review period.

ASH's data from the DMH Dental Services Audit Form based on an average sample of 51% of individuals who have been hospitalized for 90 days or less during the review months (March-August 2008) are summarized below:

1.b	*If admission examination date was 90 days or less*	99%

No comparative data from the last review period were available.

A review of the records of 20 individuals (AAH, AB, ADM, AJP, BRD, BTR, CNG, CWS, DRS, DWM, EAG, GET, GM, JAP, JDT, JTM, MS, NAJ, RSW and SWL) found that all 20 were timely seen and had a comprehensive dental exam.

ASH's data from the DMH Dental Services Audit Form based on an average sample of 54% of individuals due for annual routine dental examinations during the review months (March-August 2008) are summarized below:

1.c	*Annual date of examination was within anniversary month of admission*	100%

No comparative data from the last review period were available.

A review of annual dental exams for 20 individuals (AD, CF, DJB, DJT, GTS, JRW, JTP, LEP, MAC, MC, MCJ, MJA, MPR, MWW, OKM, RSZ, SCK, SRH, VE and VLP) found that all were seen timely, however, two

individuals refused the exam at the dental appointment (MJA and VLP).

ASH also assessed compliance using the DMH Dental Services Audit Form based on an average sample of 79% of individuals with identified dental problems on admission or annual examination, and a 100% sample of individuals with identified problems during their hospital stay other than on admission or annual examination for March-August 2008. The data are summarized below:

1.d	*Individuals with identified problems on admission or annual examination receive follow-up care, as indicated, in a timely manner*	98%

Comparable data are not available from the last review period.

1.e	*Individuals with identified problems during their hospital stay, other than on admission or annual examination, receive follow-up care, as indicated, in a timely manner*	100%

No comparative data from the last review period were available.

A review of the records of 40 individuals (AAH, AB, AD, ADM, AJP, BRD, BTR, CF, CNG, CWS, DJB, DJT, DRS, DWM, EAG, GET, GM, GTS, JAP, JDT, JRW, JTM, JTP, LEP, MAC, MC, MCJ, MJA, MPR, MS, MWW, NAJ, OKM, RSW, RSZ, SCK, SRH, SWL, VE and VLP) found that all but two individuals received follow-up care; two individuals (MJA and VLP) refused follow-up treatment.

Other findings:
In a discussion with Dr. Nolan Nelson, DDS, Chief Dentist regarding procedures for dealing with after-hours dental emergences, it was noted that four individuals had experienced incidents of dental

		emergencies in which the dentist was not timely notified (EB, MAP, SGV and SRH). A number of e-mails were sent to nursing and medical clarifying the procedure regarding dental emergencies. In addition, the minutes from ASH's Department of Medicine Meeting dated September 18, 2008 verified that clarification of the dental emergency procedure was provided to the medical staff. **Current recommendation**: Continue current practice.
F.9.b.ii	documentation of dental services, including but not limited to, findings, descriptions of any treatment provided, and the plans of care:	**Current findings on previous recommendations:** **Recommendation 1, April 2008:** Evaluate the need for duplication of dental documentation. **Findings:** ASH has added a Dental Tab to the unit's medical records that includes the dental progress notes and a copy of the individual's dental treatment plan. However, it was noted during this review that not all medical records had this tab and a number of medical records did not have the dental information under the new Dental Tab. The implementation of the Dental Management software should eliminate the written duplication of dental progress notes, thus eliminating the inconsistencies contained in the Dental Clinic progress notes and the medical record dental progress notes for the same dental appointment. **Recommendation 2, April 2008:** See F.9.b.i. **Findings:** ASH's data from the DMH Dental Services Audit Form based on an average sample of 72% of individuals scheduled for follow-up dental care during the review months (March-August 2008) are summarized

<table>
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<td></td>
<td>below:
<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>
No comparative data from the last review period were available.

A review of dental documentation for 40 individuals (AAH, AB, AD, ADM, AJP, BRD, BTR, CF, CNG, CWS, DJB, DJT, DRS, DWM, EAG, GET, GM, GTS, JAP, JDT, JRW, JTM, JTP, LEP, MAC, MC, MCJ, MJA, MPR, MS, MWW, NAJ, OKM, RSW, RSZ, SCK, SRH, SWL, VE and VLP) found that all 40 were in compliance.

Current recommendation:
Continue current practice.</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:

Recommendation, April 2008:
See F.9.b.i.

Findings:
ASH's data from the DMH Dental Services Audit Form based on an average sample of 73% of individuals due for annual routine dental examination during the review months (March-August 2008) are summarized below:
<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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<table>
<tr>
<td></td>
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<td>No comparative data from last review period were available.

A review of the records of 40 individuals (AAH, AB, AD, ADM, AJP, BRD, BTR, CF, CNG, CWS, DJB, DJT, DRS, DWM, EAG, GET, GM, GTS, JAP, JDT, JRW, JTM, JTP, LEP, MAC, MC, MCJ, MJA, MPR, MS, MWW, NAJ, OKM, RSW, RSZ, SCK, SRH, SWL, VE and VLP) found that all but two received preventative care; two individuals (MJA and VLP) refused such care.

ASH's data from the DMH Dental Services Audit Form based on a sample of 63% of individuals scheduled for Level I restorative dental care during the review months (March-August 2008) are summarized below:

<table>
<tr><td>3.c</td><td>Restorative care was provided including permanent or temporary restorations (fillings)</td><td>100%</td></tr>
</table>

No comparative data from last review period were available.

A review of the records of 24 individuals (AD, AJR, DAH, DCK, DML, DN, DWH, IS, JL, JOG, JSS, KH, LAV, MC, MKC, MSA, NTN, OAA, RRF, SBZ, TP, TR, WST and YS) found that 18 received restorative care and seven refused restorative care (AJR, DN, DWH, LAV, NTN, TP and WST).

Current recommendation:
Continue current practice.</td>
</tr>
<tr>
<td>F.9.b.iv</td>
<td>tooth extractions be used as a treatment of last resort, which, when performed, shall be justified in a manner subject to clinical review.</td>
<td>Current findings on previous recommendation:

Recommendation, April 2008:
See F.9.b.i.</td>
</tr>
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Findings:
ASH's data from the DMH Dental Services Audit Form based on an average sample of 97% of individuals who had one or more teeth extracted during the review months (March-August 2008) are summarized below:

<table>
<tr><td>4.</td><td>Tooth extractions be used as a treatment of last resort, which, when performed, shall be justified in a manner subject to clinical review.</td><td>97%</td></tr>
</table>

No comparative data from last review period were available.

A review of 38 individuals that had tooth extractions (AP, AS, BER, CSO, DEM, DP, DTC, EAG, FAO, GAB, JAM, JBK, JED, JMH, KMS, LPR, LRT, MA, MAH, MB, MCR, MM, MMR, MW, MWN, RDA, RF, RF, RLJ, RMS, SCH, SLT, SMB, SP, TLW, TM, WM and WWR) found three dental notes in the medical records that were not in compliance regarding clinical justifications documented for extractions (JAM, MB and SCH).

Current recommendation:
Continue current practice.
</td>
</tr>
<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:

Recommendation, April 2008:
Continue current practice.

Findings:
MSH's data from the DMH Dental Services Audit Form based on an average sample of 91% of individuals who received comprehensive dental examination or follow-up dental care during the review months (March-August 2008) are summarized below:
</td>
</tr>
</table>

		5. *Each state hospital shall ensure that dentists demonstrate, in a documented fashion, an accurate understanding of individuals' physical health, medications, allergies and current dental status and complaints.* — 98% No comparative data from last review period were available. A review of the records of 40 individuals (AAH, AB, AD, ADM, AJP, BRD, BTR, CF, CNG, CWS, DJB, DJT, DRS, DWM, EAG, GET, GM, GTS, JAP, JDT, JRW, JTM, JTP, LEP, MAC, MC, MCJ, MJA, MPR, MS, MWW, NAJ, OKM, RSW, RSZ, SCK, SRH, SWL, VE and VLP) found that all were in full compliance with this requirement. **Compliance:** Substantial. **Current recommendation**: Continue current practice.
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:** **Recommendation 1, April 2008:** Present data addressing all elements of this requirement. **Findings:** ASH's data from the DMH Dental Services Audit Form based on a 100% sample of individuals scheduled for dental appointments during the review months (March-August 2008) indicated that transportation and staffing is not a problem at ASH. Refusal of treatment is the major reason for missed appointments. The Dental Department faxes a notice to the individual's unit that he/she fails to keep a scheduled

		dental appointment or refuses treatment. The facility reported that education of the unit staff needs to be instituted to reduce refusals. **Recommendation 2, April 2008:** Develop and implement a system to facilitate compliance for individuals refusing dental appointments. **Findings:** ASH indicated that the current notification of units by the Dental Department regarding refusals has not been effective. No other information was provided regarding this recommendation. **Compliance:** Partial. **Current recommendations**: 1. Develop and implement a system to facilitate compliance for individuals refusing dental appointments. 2. Continue to monitor this requirement.
F.9.e	Each State hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to overcome individual's refusals to participate in dental appointments.	**Current findings on previous recommendations:** **Recommendation 1, April 2008:** Develop and implement a system to facilitate compliance for individuals refusing dental appointments. **Findings:** ASH's data from the DMH Integration of Medical Conditions into WRP Audit Form based on an average sample of 54% of individuals scheduled for but refusing dental procedure(s) during the review months (March-August 2008) indicated the following: 7. *Each state hospital shall ensure that interdisciplinary*

	teams review, assess, and develop strategies to overcome individual's refusals to participate in dental appointments	
7.a	*Refusals are documented in the Present Status section of the Case Formulation in the individual's WRP*	7%
7.b	*When a pattern of refusal is evident or there is potential for adverse outcome, there are objectives and interventions dealing with the refusal in the individual's WRP.*	0%

No comparative data were available.

ASH indicated that the current notification of units by the Dental Department regarding refusals has not been effective and that training for each unit will be instituted to attempt to reduce dental refusals. Other barriers to compliance reported by ASH included the issue of mentally ill individuals understanding the benefits of dental care, fear of the dentist, and that many individuals prefer to smoke rather than to attend their dental appointment.

A review of 20 individuals who refused dental treatments (AK, AP, BB, CG, DH, DRS, ED, EL, GJP, JAW, JM, JW, KH, MHW, PDD, RA, RH, RJN, RL and WR) found that none had refusals addressed in their WRPs.

Compliance:
Noncompliance.

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.	Specific judgments regarding the quality of documentation, as well as progress towards substantial EP compliance and remaining deficiencies, are contained in the discipline-specific subsections of Sections D and F, as well as in Sections E and H. Please refer to these sections for findings (including compliance) and recommendations pertaining to documentation

H. Restraints, Seclusion, and PRN and Stat Medication		
H		**Summary of Progress:** 1. ASH implemented the DMH statewide Seclusion/Restraint monitoring tool in March 2008. 2. ASH has achieved substantial compliance regarding restraint or seclusion not being used as part of a behavioral intervention. 3. The sample size for restraint, seclusion, PRN and Stat data consistently exceeds the required 20%. 4. ASH's training efforts regarding the documentation for seclusion and restraint has resulted in improved compliance in this area.
H	Each State hospital shall ensure that restraints, seclusion, psychiatric PRN medications, and Stat medications are used consistent with generally accepted professional standards of care.	**Methodology:** <u>Interviewed</u>: 1. Charlie Joslin, Clinical Administrator 2. Cynthia Davis, Nurse Administrator 3. Donna Nelson, Standards Compliance Director 4. Jon DeMorales, Executive Director 5. Judith Boyer, Standards Compliance 6. Marlene Espitia, RN, Standards Compliance 7. Moira Leyva, DMH 8. Robert S. Knapp, Medical Director 9. Stan Wilt, RN Central Nursing Services <u>Reviewed</u>: 1. ASH's progress report and data 2. Report from Ad Hoc Committee on Preventing Violence dated 5/28/08 3. Updated Tables from 5/28/08 Report on Violence 4. ASH Prone Stabilization and/or Prone Transportation report 5. Individual Restraint Use Report 6. AD #518, Restraint or Seclusion dated September 23, 2008

		7. Memos dated 8/12/08 and 9/2/08 regarding orders addressing release criteria for seclusion/restraints 8. Memo form for absence of specific release criteria in a restraint or seclusion order sent to physicians 9. NP 307.0.1, Documentation of Medication and Treatments dated 7/7/08 10. ASH Medication Certification and Recertification Objectives 11. PRN/Stat Documentation Card 12. Memo dated 9/18/08 regarding Stat or "Now" Medications from the Chief Psychiatrist to the Department of Psychiatry 13. Memo dated 10/14/08 regarding PRN and Stat use compliance from the Chief Psychiatrist to the Department of Psychiatry 14. ASH WRPT Level 1 Trigger Review form 15. Medical records of the following 80 individuals: AAA, AAM, AB, ABP, AC, AJ, AS, AW, AWB, BG, BKR, BO, BS, CC, CG, CNG, CV, CW, DAB, DJ, DMS, DR, DU, EAM, EC, ECD, ED, EEC, EMH, EV, FG, FT, GEG, GG, GP, HE, HJS, JA, JED, JEP, JFD, JJS, JL, JM, JS, KC, MAP, MCJ, MCR, MG, MM, MR,NB, NC, PP, RAL, RCD, REM, RLC, RLY, RM, RMG, RNG, RY, SAJ, SB, SMB, SNA, SPD, SW, TH, TJC, TLC, TLG, TS, TW, VJJ, VT, WM, WST and WT
H.1	Each State hospital shall revise, as appropriate, and implement policies and procedures regarding the use of seclusion, restraints, psychiatric PRN medications, and Stat Medications consistent with generally accepted professional standards of care. In particular, the policies and procedures shall expressly prohibit the use of prone restraints, prone containment and prone transportation and shall list the types of restraints that are acceptable for use.	**Current findings on previous recommendations:** **Recommendation 1, April 2008:** Ensure that all policies/procedures prohibit the use of fading regarding seclusion and restraints. **Findings:** ASH appropriately revised AD #518 on 9/23/08 to include the prohibiting of "fading restraints." Also, prohibiting "Fade Restraint" was added to the Restraint and Seclusion documentation class on 7/2/08 and to the PMAB class on 8/13/08. In addition, training was provided to the psychiatrists on 7/15/08 regarding exit criteria for

		seclusion and restraints contained in physicians' orders. Also, ASH has implemented a follow-up system to notify psychiatrists of noncompliance regarding documentation of release criteria in physician orders. **Recommendation 2, April 2008:** Identify any individuals who have been placed in prone restraints, prone containment and/or a prone position for transportation for each review period. **Findings:** A report of individuals who were placed in prone positions was provided by Standards Compliance at ASH, validating that this data is now being collected. **Recommendations 3 and 4, April 2008:** • Provide appropriate data for this requirement. • Continue to monitor this requirement. **Findings:** ASH implemented the DMH Seclusion/Restraint Audit on 3/1/08. In addition, the ASH Ad Hoc Committee on Prevention of Violence completed a comprehensive report dated 5/28/08 regarding short-term and long-range actions to reduce inpatient violence. On 10/3/08, a follow-up report (Updated Tables from May 28, 2008 Report on Violence) was generated reviewing the effects of initiatives implemented to reduce violence. The Enhanced Prevention and Management of Aggressive Behavior for Supervisors training was also updated to incorporate skill building in early interventions techniques. **Other findings:** ASH's Prone Stabilization and/or Prone Transportation report indicated that there were 38 incidents of prone stabilization and 19 incidents of prone stabilization and transportation during March-

		August 2008 for 51 individuals. A review of 30 individuals involved in either prone stabilization and/or prone stabilization and transportation (AAM, AC, AW, BKR, BS, CC, CNG, CV, DU, ECD, ED, GEG, JFD, JJS, JL, KC, MCR, MR, NB, NC, RCD, REM, RLC, RM, RMG, RNG, SMB, SNA, TLC and TLG) found that overall, the documentation of the incident was not specific regarding behaviors warranting prone stabilization and/or transportation. In addition, the documentation in the IDNs did not consistently describe the transporting of the individual as being in a prone position. A number of the IDNs noted that "handcuffs" were applied, indicating that the facility's security department was applying these devices. In a discussion with ASH's administrative staff, it was agreed that prone transportation is prohibited without exception. In addition, the facility agreed to provide training to its security staff to ensure that all policies and procedures regarding restraint and seclusion are followed. The facility agreed to continue to monitor any episodes of prone stabilization/transportation and to require specific documentation from physicians and staff regarding individuals who may demonstrate "calm" but continue to pose imminent danger warranting restrictive measures/devices. **Compliance:** Partial. **Current recommendations**: 1. Continue to collect and review episodes of prone stabilization/ transportation. 2. Ensure that security staff is trained and follows the facility's policies and procedures regarding restraint and seclusion. 3. Continue to monitor this requirement.
H.2	Each State hospital shall ensure that restraints and seclusion:	**Compliance:** Partial.

H.2.a	are used in a documented manner and only when individuals pose an imminent danger to self or others and after a hierarchy of less restrictive measures has been considered in a clinically justifiable manner or exhausted;	**Current findings on previous recommendation:** **Recommendation, April 2008:** Continue to monitor this requirement using the DMH monitoring tools. **Findings:** The facility reported data from the DMH Restraint Audit based on a 98% sample of restraint episodes for March-August 2008. The table below summarizes ASH's data:

2.	*Restraints and seclusion are used in a documented manner.*	
2.a	*The IDN described specific behavior that was imminently dangerous to self or others, and*	96%
2.b	*The Physician's Order described specific behavior that was imminently dangerous to self or others.*	80%
3.	*Restraints and seclusion are used only when the individual posed an imminent danger to self or others.*	
3.a	*The justification for restraints or seclusion was to prevent harm to self or to others, and*	99%
3.b	*Did not include prevention of harm from others.*	99%
4.	*Restraints and seclusion are used after a hierarchy of less-restrictive measures has been considered in a clinically justifiable manner or exhausted.*	
4.a	*The IDN described specific, less-restrictive interventions that were tried prior to the use of restraints or seclusion, or there is clinical justification when less-restrictive interventions were not used.*	68%
4.b	*The IDN described the individual's specific response to each intervention used, or there is clinical justification when less- restrictive interventions were not used.*	61%

ASH reported that overall, there was a decrease in compliance due to the implementation of a more sensitive auditing tool with specific sub-items. Comparison data was not available due to the initiation of the DMH Seclusion/Restraint Audit tool on 3/1/08.

ASH identified barriers to compliance with this requirement to be the lack of physician documentation of specific behaviors and the lack of documentation of a hierarchy of less restrictive measures tried. Training was provided for the psychiatrists regarding exit criteria for seclusion and restraints contained in physicians' orders. Also, a system was developed to notify psychiatrists of noncompliance with documentation of release criteria in orders. In addition, a trainer reviews the daily log to identify areas of low compliance and provides one-on-one training regarding documentation requirements.

A review of 55 incidents of restraints for 13 individuals (AB, AJ, AWB, DJ, ECD, EEC, EV, GEG, JA, JED, MAP, RAL and WT) found that the overall documentation regarding specific behaviors prior to the use of restraints has improved since the last review. The documentation for 46 incidents described behaviors that indicated that the use of restraints was in response to behaviors that demonstrated an imminent danger to self or others. The physician orders for 38 incidents included specific behaviors and 28 incidents included the use of less restrictive measures.

The facility reported data from the DMH Seclusion Audit based on an average sample of 98% of seclusion events for March-August 2008. The table below summarizes ASH's data:

2.	*Restraints and seclusion are used in a documented manner.*	
2.a	*The IDN described specific behavior that was*	93%

	imminently dangerous to self or others, and	
2.b	*The Physician's Order described specific behavior that was imminently dangerous to self or others.*	80%
3.	*Restraints and seclusion are used only when the individual posed an imminent danger to self or others.*	
3.a	*The justification for restraints or seclusion was to prevent harm to self or to others, and*	96%
3.b	*Did not include prevention of harm from others.*	96%
4.	*Restraints and seclusion are used after a hierarchy of less-restrictive measures has been considered in a clinically justifiable manner or exhausted.*	
4.a	*The IDN described specific, less-restrictive interventions that were tried prior to the use of restraints or seclusion, or there is clinical justification when less-restrictive interventions were not used.*	68%
4.b	*The IDN described the individual's specific response to each intervention used, or there is clinical justification when less- restrictive interventions were not used.*	61%

ASH reported that the barriers to compliance and plans of correction are the same as described for the restraint data.

A review of 15 incidents of seclusion for 12 individuals (DJ, EC, GEG, HE, HJS, MG, RAL, RM, RY, SAJ, SB and WT) found that the documentation for 13 incidents described specific behaviors indicating the seclusion was in response to behaviors that demonstrated an imminent danger to self or others. The physician orders for 12 incidents included specific behaviors and 8 of the incidents included documentation regarding the use of less restrictive measures.

		Current recommendation: 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:** **Recommendation, April 2008:** Continue to monitor this requirement. **Findings:** The facility reported data from the DMH Restraint Audit based on an average sample of 98% of restraint episodes for March-August 2008. The table below summarizes ASH's data:

5.	*Restraints and seclusion are not used in the absence of, or as an alternative to, active treatment.*	
5.a	*There is a Focus of Hospitalization that targets the behavior that required the individuals to be placed in restraints or seclusion, and*	84%
5.b	*A linked objective, and*	82%
5.c	*A linked intervention (any formal group, individual therapy, or behavioral intervention) for the target behavior that required the individual to be placed in restraints or seclusion.*	76%
6.	*Restraints and seclusion are not used as punishment.*	
6.a	*The staff did not use restraints or seclusion in an abusive manner.*	97%
6.b	*The staff did not keep the individual in restraints or seclusion even when the individual was calm.*	88%
6.c	*The staff did not use restraints or seclusion in a manner to show a power differential that exists between staff and the individual.*	97%
6.d	*The staff did not use restraints or seclusion as coercion.*	98%

7.	*Restraints and seclusion are not used for the convenience of staff.*	
7.a	*Staff used and documented the use of information in the Seclusion and Restraint Preference and Family Notification Form (MSH 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.*	61%

ASH reported that the barrier to compliance for item 5 is due to the fact that most of the restraint and seclusion episodes take place on the admission units where the WRPs have not yet been finalized. Regarding item 6, staff continues to document that the individual was calm or sleeping and still remained in restraint. Regarding item 7, ASH noted that the facility's compliance is high if the item asks if restraints are used as a convenience. However, compliance is low since the item's sub-question asks only if preferences were used and documented. ASH indicated that to increase compliance, they would use data from audits completed after the full WRP has been finalized. See H.2.a.

A review of 55 incidents of restraints for 13 individuals (AB, AJ, AWB, DJ, ECD, EEC, EV, GEG, JA, JED, MAP, RAL and WT) found documentation in the WRP addressing behaviors, objectives and interventions in 10 incidents. Documentation in 42 out of 55 incidents indicated that the individual was released when calm.

The facility reported the following data from the DMH Seclusion Audit based on an average sample of 98% of seclusion episodes for March-August 2008. The table below summarizes ASH's data:

5.	*Restraints and seclusion are not used in the absence of, or as an alternative to, active treatment.*	

5.a	*There is a Focus of Hospitalization that targets the behavior that required the individuals to be placed in restraints or seclusion, and*	85%
5.b	*A linked objective, and*	84%
5.c	*A linked intervention (any formal group, individual therapy, or behavioral intervention) for the target behavior that required the individual to be placed in restraints or seclusion.*	76%
6.	*Restraints and seclusion are not used as punishment.*	
6.a	*The staff did not use restraints or seclusion in an abusive manner.*	97%
6.b	*The staff did not keep the individual in restraints or seclusion even when the individual was calm.*	79%
6.c	*The staff did not use restraints or seclusion in a manner to show a power differential that exists between staff and the individual.*	97%
6.d	*The staff did not use restraints or seclusion as coercion.*	98%
7.	*Restraints and seclusion are not used for the convenience of staff.*	
7.a	*Staff used and documented the use of information in the Seclusion and Restraint Preference and Family Notification Form (MSH 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.*	61%

ASH's barriers and corrective action plans are noted above.

A review of 15 incidents of seclusion for 12 individuals (DJ, EC, GEG, HE, HJS, MG, RAL, RM, RY, SAJ, SB and WT) found documentation in the WRP addressing behaviors, objectives and interventions in nine incidents. Documentation in 10 out of 15 incidents indicated that the

<table>
<tr><td></td><td></td><td>individual was released when calm.

Current recommendation:
Continue to monitor this requirement.</td></tr>
<tr><td>H.2.c</td><td>are not used as part of a behavioral intervention; and</td><td>Current findings on previous recommendation:

Recommendation, April 2008:
Continue to monitor this requirement.

Findings:
The facility reported data from the DMH Psychology Services Monitoring Audit based on a 100% sample of new or revised Behavior Guidelines and PBS Plans implemented in the review month (March-August 2008). The table below summarizes ASH's data:

<table>
<tr><td>8.</td><td>Behavioral interventions, which include Positive Behavior Support Plans, are based on a positive behavior support model, and do not include the use of aversive or punishment contingencies.</td><td></td></tr>
<tr><td>8.a</td><td>The Behavior Guidelines and PBS Plans meet the criteria on the DMH PBS Plan Monitoring Form, and</td><td>100%</td></tr>
<tr><td>8.b</td><td>The Behavior Guidelines and PBS Plans do not include any aversive or punishment contingencies.</td><td>100%</td></tr>
</table>

ASH had 100% compliance with this requirement in the last review period as well.

A review of PBS plans and Behavioral Guidelines for 12 individuals (AAA, AB, BG, CC, DMS, EAM, EMH, GG, MG, RY, SW and WT) found that restraint or seclusion were not included in any of the reviewed plans/guidelines.</td></tr>
</table>

		Current recommendation: Continue current practice.
H.2.d	are terminated as soon as the individual is no longer an imminent danger to self or others.	**Current findings on previous recommendations:** **Recommendation 1, April 2008:** Provide supporting data for Recommendations 1 and 2. **Findings:** See H.1. **Recommendation 2, April 2008:** Continue to monitor this requirement. **Findings:** The facility reported the following data from the DMH Restraint Audit based on an average sample of 98% of restraint episodes for March-August 2008:

9.	*Restraints and seclusion are terminated as soon as the individual is no longer an imminent danger to self or others.*	
9.a	*The individual was released from restraints or seclusion as soon as the violent or dangerous behavior that created the emergency was no longer displayed or met the release criteria on the restraints or seclusion order.*	85%
9.b	*The individual did not continue to be in restraints or seclusion after remaining calm for 15 minutes.*	84%
9.c	*The individual did not continue to be in restraints or seclusion because he/she was unable to contract for safety.*	93%

9.d	*The individual did not continue to be in restraints or seclusion because he/she was unable to agree to cease using offensive language.*	94%
9.e	*The individual did not continue to be in restraints or seclusion because he/she did not cease making verbal threats.*	94%
9.f	*The individual did not continue to be in restraints or seclusion because he/she was not able to say he/she recognizes what behavior prompted the restraints or seclusion episode.*	83%
9.g	*The individual did not continue to be in restraints or seclusion because he/she was unable to say he/she is sorry for his/her actions.*	95%

ASH reported that barriers to compliance include staff charting the two-hour note as an observation note covering the past behavior only and staff continuing to use the word "calm" as an affective description of the patients' body language. To increase compliance with this requirement, ASH reported that the restraint and seclusion documentation class is emphasizing that the two-hour IDN note is a re-assessment to determine if the use of restraints is still warranted. In addition, the class continues to stress the description of "calm." Also, starting in October 2008 the auditors alert the Restraint and Seclusion trainer to the specific units that need additional training.

The facility reported the following data from the DMH Seclusion Audit based on a 98% sample of seclusion episodes for March-August 2008:

9.	*Restraints and seclusion are terminated as soon as the individual is no longer an imminent danger to self or others.*	
9.a	*The individual was released from restraints or seclusion as soon as the violent or dangerous*	78%

		behavior that created the emergency was no longer displayed or met the release criteria on the restraints or seclusion order.
		9.b *The individual did not continue to be in restraints or seclusion after remaining calm for 15 minutes.* 75%
		9.c *The individual did not continue to be in restraints or seclusion because he/she was unable to contract for safety.* 93%
		9.d *The individual did not continue to be in restraints or seclusion because he/she was unable to agree to cease using offensive language.* 95%
		9.e *The individual did not continue to be in restraints or seclusion because he/she did not cease making verbal threats.* 97%
		9.f *The individual did not continue to be in restraints or seclusion because he/she was not able to say he/she recognizes what behavior prompted the restraints or seclusion episode.* 94%
		9.g *The individual did not continue to be in restraints or seclusion because he/she was unable to say he/she is sorry for his/her actions.* 97%
		Barriers and plan of correction are noted above. See H.2.b for reviewer's findings. **Current recommendation**: Continue to monitor this requirement.
H.3	Each State hospital shall comply with 42 C.F.R. § 483.360(f), requiring assessments by a physician or licensed clinical professional of any individual placed in seclusion or restraints within one hour.	**Current findings on previous recommendation:** **Recommendation, April 2008:** Continue to monitor this requirement.

	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.	**Findings:** The facility reported the following data from the DMH Restraint Audit based on a 98% sample of restraint episodes for March-August 2008:

10.	*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.*	
10.a	*The order was obtained within 15 minutes from the initiation of restraints or seclusion.*	85%
10.b	*The RN conducted an assessment within 15 minutes of the initiation of restraints or seclusion, and documented in the IDN.*	77%
10.c	*The Physician conducted a face-to-face evaluation of the individual in restraints or seclusion within one hour from the initiation of restraints or seclusion and documented in the Physician's Progress Note.*	75%

ASH indicated that the barrier to compliance with this requirement was that the RNs' and psychiatrists' notes are timed when written and are thus not an indication of when the assessment was completed. To increase compliance, the time of the actual assessment will be included in the note starting in November 2008.

A review of 55 incidents of restraints for 13 individuals (AB, AJ, AWB, DJ, ECD, EEC, EV, GEG, JA, JED, MAP, RAL and WT) found that orders were obtained within 15 minutes in 48 episodes; the RN conducted a timely assessment in 43 episodes; and the physician conducted a timely face-to-face evaluation in 41 episodes.

ASH reported the following data based on the DMH Restraint Audit

based on a 98% sample of seclusion episodes for March-August 2008:

10.	*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.*	
10.a	*The order was obtained within 15 minutes from the initiation of restraints or seclusion.*	87%
10.b	*The RN conducted an assessment within 15 minutes of the initiation of restraints or seclusion, and documented in the IDN.*	60%
10.c	*The Physician conducted a face-to-face evaluation of the individual in restraints or seclusion within one hour from the initiation of restraints or seclusion and documented in the Physician's Progress Note.*	76%

Barriers and plan of correction are noted above.

A review of 15 incidents of seclusion for 12 individuals (DJ, EC, GEG, HE, HJS, MG, RAL, RM, RY, SAJ, SB and WT) found that orders were obtained within 15 minutes in 12 episodes; the RN conducted a timely assessment, in 8 episodes; and the physician conducted a timely face-to-face evaluation in 10 episodes.

No data was provided regarding competency-based training on the administration of seclusion and restraints.

Compliance:
Partial.

Current recommendations:
1. Provide data regarding competency-based training for seclusion and

		restraints. 2. Continue to monitor this requirement.
H.4	Each State hospital shall ensure the accuracy of data regarding the use of restraints, seclusion, psychiatric PRN medications, or Stat medications.	**Current findings on previous recommendation:** **Recommendation, April 2008:** Continue to monitor this requirement. **Findings:** Although ASH reported that the facility continues to audit restraint and seclusion use via the DMH Restraint and Seclusion audit form and the ASH SIR audit form and by comparing the audit PRN/Stat data against the Medication Administration Record nightly, ASH did not present any data regarding the effectiveness of these processes. Based on a discussion with the Standards Compliance Director, this data will be presented for the next review. **Compliance:** Partial. **Current recommendation**: Provide data regarding this requirement.
H.5	Each State hospital shall revise, as appropriate, and implement policies and procedures to require the review within three business days of individuals' therapeutic and rehabilitation service plans for any individuals placed in seclusion or restraints more than three times in any four-week period, and modification of therapeutic and rehabilitation service plans, as appropriate.	**Current findings on previous recommendation:** **Recommendation, April 2008:** Continue to monitor this requirement. **Findings:** ASH reported the following data from the DMH Restraint Audit based on a 97% sample of individuals who have been in seclusion and/or restraint four or more times in 30 days during the March-August 2008 period:

13.	*Required to 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*	
13.a	*The review was held within 3 business days for any individual who had 4 or more episodes of Seclusion or Restraints within the last 30 days*	46%
13.b	*The Present Status in the Case Formulation section of the WRP documented that a review of the incident(s) was done*	51%
13.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*	45%

ASH reported that the barrier to compliance for this requirement was that the WRPTs had not yet been trained on the required documentation in response to a triggered event. ASH reported that it plans to include this requirement in the mentoring training and to continue to address this in the Enhanced Trigger Review Committee.

A review of the records of 11 individuals who met the trigger criteria for restraints/seclusion during the review period (ABP, AJ, BO, CG, CW, EV, GEG, JEP, RLY, SMB and SPD) found that none were in compliance with the all of the required items for this requirement.

Compliance:
Partial.

		Current recommendations: 1. Provide training to WRPTs regarding this requirement. 2. Continue to monitor this requirement.
H.6	Each State hospital shall develop and implement policies and procedures consistent with generally accepted professional standards of care governing the use of psychiatric PRN medication and Stat medication, requiring that:	**Compliance:** 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 recommendations:** **Recommendation 1, April 2008:** Ensure that documentation for PRN and Stat medication in the IDNs is in alignment with generally accepted standards of nursing practice. **Findings:** In response to this recommendation, Nursing Policy 307.0.1 was revised to include an outline regarding the documentation of PRN and Stat medications. In addition, this is also included in the Medication Certification Class and the Restraint and Seclusion documentation class. **Recommendation 2, April 2008:** Continue to monitor this requirement. **Findings:** See F.3.a.ii for ASH's data and this monitor's findings. **Current recommendations**: Continue to monitor this requirement.

H.6.b	PRN medications, other than for analgesia, are prescribed for specified and individualized behaviors.	**Current findings on previous recommendation:** **Recommendation, April 2008:** Continue to monitor this requirement. **Findings:** The facility reported the following data from the DMH Psychiatry Monthly PPN Audit based on a 24% average sample of individuals with a Length of Stay equal to or greater than 90 days (March-August 2008). The table below summarizes ASH's data: 7. *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* — 35% ASH's analysis showed that the compliance rate increased from 22% in February 2008 to 33% in August 2008. ASH reported that the barrier to compliance was related to the increased number of new psychiatrists and a lack of understanding of the PRN and Stat requirements. To increase compliance, memos have been issued to the Department of Psychiatry regarding PRN and Stat requirements. In addition, all psychiatrists now have access to the PRN/Stat module of WaRMSS that will allow access to this information. ASH indicated that this cell will be monitored by the senior psychiatrists to identify problems timely and provide corrective actions, A review of the records of 24 individuals who had PRN or Stat orders (AS, DAB, DR, ED, EV, FG, FT, GP, HE, JM, JS, MCJ, MM, PP, SW, TH, TJC, TS, TW, VJJ, VT, WM, WST and WT) found that seven had documentation demonstrating compliance with this requirement.

		Current recommendation: Continue to monitor this requirement.
H.6.c	PRN medications are appropriately time limited.	**Current findings on previous recommendation:** **Recommendation, April 2008:** Implement monitoring for this requirement. **Findings:** ASH's progress report indicated that since January 2008, psychiatric PRNs are time-limited to 14 days and the pharmacy will only fill orders for 14 days unless a new order is received. A review of 50 PRN orders for 12 individuals (AS, DR, FT, GP, JM, JS, PP, SW, TS, VT, WM and WST) found that all were appropriately time-limited (14 days). **Current recommendation**: Continue current practice.
H.6.d	nursing staff assess the individual within one hour of the administration of the psychiatric PRN medication and Stat medication and documents the individual's response.	**Current findings on previous recommendation:** **Recommendation, April 2008:** Continue to monitor this requirement. **Findings:** See F.3.a.iii for ASH's data and this monitor's findings. **Compliance:** Partial. **Current recommendation**: Continue to monitor this requirement.

H.6.e	A psychiatrist conducts a face-to-face assessment of the individual within 24 hours of the administration of a Stat medication. The assessment shall address reason for Stat administration, individual's response, and, as appropriate, adjustment of current treatment and/or diagnosis.	**Current findings on previous recommendation:** **Recommendation, April 2008:** Same as in D.1.f, F.1.b and H.6.a. **Findings:** Same as in D.1.f, F.1.b and H.6.a. **Current recommendations**: Same as in D.1.f, F.1.b and H.6.a.
H.7	Each State hospital shall ensure that all staff whose responsibilities include the implementation or assessment of seclusion, restraints, psychiatric PRN medications, or Stat medications successfully complete competency-based training regarding implementation of all such policies and the use of less restrictive interventions.	**Current findings on previous recommendation:** **Recommendation, April 2008:** Continue current practice regarding this requirement. **Findings:** See F.3.h.i and F.3.h.ii for training data and this monitor's findings. **Compliance:** Substantial. **Current recommendation**: See F.3.h.i.
H.8	Each State hospital shall:	**Compliance:** Not applicable.
H.8.a	develop and implement a plan to reduce the use of side rails as restraints in a systematic and gradual way to ensure individuals' safety; and	**Current findings on previous recommendation:** **Recommendation, April 2008:** Continue to monitor this requirement.

		Findings: There was no use of side rails at ASH during this review period. **Current recommendation**: Continue to monitor this requirement.
H.8.b	ensure that, as to individuals who need side rails, their therapeutic and rehabilitation service plans expressly address the use of side rails, including identification of the medical symptoms that 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 recommendations:** **Recommendations 1 and 2, April 2008:** • Ensure adequate documentation regarding the use of side rails. • Continue to monitor this requirement. **Findings:** See H.8.a. **Current recommendation**: Continue to monitor this requirement.

I. Protection from Harm		
I	Each State hospital shall provide the individuals it serves with a safe and humane environment and ensure that these individuals are protected from harm.	**Summary of Progress:** 1. The preliminary investigations conducted by the hospital police and reviewed by this monitor evidenced competent and timely gathering of initial facts of an incident and presented them in a clearly written report. 2. The quality of investigations completed by the Office of Special Investigations has improved. These investigations clearly state whether the named staff member in an abuse/neglect allegation was removed from contact with individuals. 3. The facility's review of each SIR for accuracy and completeness has yielded positive results. Additionally, the vast majority of SIRs were completed within the time frames required. 4. ASH has initiated an independent review of a sample of OSI investigations by the Hospital Administrator using the Investigation Compliance Monitoring form. 5. The facility's Incident Management Review Committee has revised its procedures, members are receiving materials for review prior to the meeting and the entire investigation is available to the committee during its meeting. The IMRC is reviewing Headquarters Reportable Briefs as well as investigations. 6. The facility has identified problems with the reports produced by the DPS Records Management System and is working with the vendor to remedy the situation. 7. The facility continues to ensure that staff members clear criminal background checks and acknowledge in writing their responsibilities as mandated reports of dependent adult abuse and to take disciplinary measures when staff members fail to report allegations of abuse/neglect. 8. The facility reports that in November 2008, it will pilot a Task Tracker database for tracking implementation of corrective actions/interventions identified by the WRPT, the Enhanced

		Trigger Review Committee and the Incident Management Review Committee. 9. The Ad Hoc Committee on Violence has produced reports useful to the facility in its efforts to reduce violence. These reports address the frequency of assault incidents in the one-year period 10/2007—9/2008, pattern location and time of assaults and identify individuals with high incidence of assaults. Furthermore, the Committee has forwarded recommendations to the Quality Council based on its findings, some of which have been implemented.
1. Incident Management		
I.1	Each State hospital shall develop and implement across all settings, including school settings, an integrated incident management system that is consistent with generally accepted professional standards of care.	**Methodology:** Interviewed: 1. D. Fennell, MD, Medical Staff 2. D.K. Landrum, Hospital Administrative Resident II 3. D.W. Landrum, Hospital Police Lieutenant 4. D. Nelson, Director of Standards Compliance 5. E. Dawson, Acting Assistant Hospital Administrator 6. L. Holt, Chief of Police 7. L. Persons, Hospital Administrator 8. M. Espitia, RN, Standards Compliance 9. M. Hughes, Chair, Ad Hoc Violence Committee Reviewed: 1. Seventeen Special Investigator Investigations 2. Incident listings produced by SIR database and the DPS Record Management System 3. Incident Management Review Committee meeting minutes 4. Clinical records of eight individuals for signed rights notification forms 5. Specific aspects of the personnel and training records of 12 staff members

		6. Minutes of the Interdisciplinary Mortality Review Committee 7. Minutes of the Medical Mortality Review Committee 8. October 2008 Report of the Ad Hoc Committee on Violence 9. Eight Headquarters Reportable Briefs <u>Observed</u>: Incident Management Review Committee meeting
I.1.a	Each State hospital shall review, revise, as appropriate, and implement incident management policies, procedures and practices that are consistent with generally accepted professional standards of care. Such policies, procedures and practices shall require:	**Compliance:** Partial.
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 recommendations:** **Recommendation 1, April 2008:** Continue current practice of being alert to failure to report incidents in a timely manner and make the appropriate referrals. **Findings:** See finding below. **Recommendation 2, April 2008:** Determine the appropriate response for the failure to report an allegation of staff misconduct and ensure action is taken in each instance. **Findings:** The facility has not identified a minimum response when a staff member fails to report an allegation of staff misconduct in a timely fashion. The facility reports that all sustained cases of failure to

		report are forwarded to HR for appropriate action, determined on a case-by-case basis. This response implies that some action would be taken in each instance of failure to report. The facility is taking disciplinary action in relation to two staff members who failed to report an allegation of neglect (6/20/08) along with other policy violations. See I.1.c. **Current recommendation**: Continue current practice of identifying in investigations a staff member's failure to report an allegation of staff misconduct and taking appropriate action.
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 recommendation:** **Recommendation, April 2008:** Continue the current practice of having the Incident Management Review Committee review the HQ Reportable Briefs with particular attention to the identification of contributing factors. **Findings:** The IMRC continues to review HQ Reportable briefs at its meetings, as documented in its minutes and as occurred during the meeting this monitor attended. **Other findings:** See I.1.b.iv.4 regarding the misidentification of some incidents. Review of the quality of eight Headquarters Reportable briefs yielded mixed findings. All eight HQ briefs involved incidents that occurred more than 60 business days earlier. Thus, the briefs should have been finalized, but were not. Several of the briefs evidenced thoughtful consideration of precipitating events and corrective measures in response to the incident:

		• The brief related to the assault between two individuals occurring on 7/1/08 documented a review of the staffing at the time of the incident and staff interviews that determined that there had been no prior incidents between the two. • The brief related to the incident of self-harm by DJ on 7/7/08 noted that the behavioral guidelines for DJ had proved ineffective and PBS was called in to develop a behavioral support plan. In contrast, several briefs failed to demonstrate a comprehensive review of the incident: • In the HQ brief related to RS's fall caused by water leaking from a toilet that resulted in non-displaced fractures of two fingers, there is no mention of if, or when, the leak had been reported and whether failure to report the leak or failure to respond to the work request in a timely manner contributed to the incident. The fall occurred on 8/5/08 and the leak was repaired on 8/20/08. • The brief related to the 7/19/08 allegation that staff deliberately allowed JT to be assaulted by another individual provided no information about where staff were and what they were doing at the time of the incident. The brief simply asserted that the assault was not witnessed. • The HQ brief that addressed the neglect allegation made on behalf of DS (incident date: 7/18/08) stated that DPH Licensing and Certification had found that the facility had failed to conduct thorough and ongoing assessments of DS while he was in full restraints and thereby failed to identify in a timely manner a right humeral diaphyseal fracture (date of DPH report: 8/29/08). The HQ brief stated that a plan of correction was formulated and implemented and accepted by CDPH. It did not address why the facility had not identified the neglect in its own review of the incident and what measures it was taking to address this problem.

		Current recommendations: 1. Complete HQ Reportable briefs within the 60 business days allotted. 2. Ensure that the briefs address the issues inherent in the type of incident, e.g., neglect allegations focus on the actions of relevant staff members. 3. Ensure that incidents that receive an administrative (OSI) investigation are identified and referenced using the revised SIR definitions.
I.1.a.iii	mechanisms to ensure that, when serious incidents such as allegations of abuse, neglect, and/or serious injury occur, staff take immediate and appropriate action to protect the individuals involved, including removing alleged perpetrators from direct contact with the involved individuals pending the outcome of the facility's investigation;	**Current findings on previous recommendation:** **Recommendation, April 2008:** Implement plans to record the IMRC's review of the decisions to remove staff members during an investigation in the minutes of the meetings. **Findings:** Most of the investigations reviewed clearly documented whether the named staff member in an allegation of abuse/neglect was removed from contact with the individual. The decision was based on whether, in the judgment of the police lieutenant and HR Director, the staff member represented a risk to health and safety of the individual(s). The IMRC reports that it will include documentation of its review of these matters in its minutes. **Other findings:** The HQ Reportable briefs reviewed clearly documented the immediate actions taken to protect the individual (1:1, transfer of one individual to another unit) and addressed treatment of any injuries or medical issues.

		Current recommendations: 1. Implement plans to record the IMRC's review of the decisions to remove staff members during an investigation in the meeting minutes. 2. Continue current practice of clearly documenting in HQ briefs actions taken to protect individuals and attend to their physical needs immediately after an incident.
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:** **Recommendation, April 2008:** Continue efforts to ensure that staff members attend annual abuse/neglect training when they are due. **Findings:** The facility reported that as of August 2008, 90% of the staff was current in annual Abuse/Neglect training. This is consistent with this monitor's findings in reviewing the training for 12 staff members in various positions. Each of those staff members had received Abuse/Neglect training within the last 12 months. The training history of the non-clinical mall trainers/facilitators provided by the facility revealed that 9 of 21 had not received abuse and neglect training within the last year. **Current recommendation**: Continue efforts to ensure that staff members receive Abuse/Neglect training each year. Pay particular attention to non-clinical mall providers whose rate of non-compliance is inconsistent with the facility's overall training figures.
I.1.a.v	notification of all staff when commencing employment and adequate training thereafter	**Current findings on previous recommendation:**

	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;	**Recommendation, April 2008:** Determine the appropriate facility response when a staff member fails to report staff misconduct in a timely manner and ensure that action is taken and documented. **Findings:** See I.1.a.i. **Other findings:** The personnel records of 12 staff members contained documentation that each had signed mandatory reporter forms on or prior to their date of hire. **Current recommendation**: Continue current practice.
I.1.a.vi	mechanisms to inform individuals and their conservators how to identify and report suspected abuse or neglect;	**Current findings on previous recommendations:** **Recommendation 1, April 2008:** Determine the most appropriate forum for sponsoring a discussion with individuals of the revised definitions of abuse/neglect and other rights guaranteed them. **Findings:** The facility reports that the Patient Rights Advocate and the Chair of the Ad Hoc Committee on Violence are willing to make a presentation to the Hospital Advisory Council. This presentation will reportedly be scheduled soon. **Recommendation 2, April 2008:** Include in the discussion the expectation that the rights will be reviewed with them at their annual review and they will be requested to sign the acknowledgement form.

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Findings:
See above.

Other findings:
Review of the clinical records of eight individuals on the units toured found that half had signed the rights notification within the last 12 months.

<table>
<tr><th>Individual</th><th>Most recent rights notification signing</th></tr>
<tr><td>AP</td><td>8/20/08</td></tr>
<tr><td>DP</td><td>8/27/08</td></tr>
<tr><td>FT</td><td>4/8/04</td></tr>
<tr><td>JN</td><td>Not in record</td></tr>
<tr><td>MA</td><td>5/28/08</td></tr>
<tr><td>RR</td><td>5/29/07</td></tr>
<tr><td>SF</td><td>9/4/08</td></tr>
<tr><td>WB</td><td>8/29/07</td></tr>
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Current recommendation:
Continue with plans to discuss with the HAC the reasons why rights will be reviewed annually with individuals and they will be asked to sign the notification form.

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<td>I.1.a.vii</td>
<td>posting in each living unit and day program site a brief and easily understood statement of individuals' rights, including information about how to pursue such rights and how to report violations of such rights;</td>
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Current findings on previous recommendation:

Recommendation, April 2008:
Determine the best forum for an invitation to the PRA to discuss the complaint process with members of the HAC who have questions/concerns.

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		Findings: The facility reports it will continue an open invitation to the PRA to participate in HAC meetings. **Other findings:** In all units toured, a rights poster was on the wall in a common area and contained the name and phone number of the Patient Rights Advocates. This is consistent with the facility's data. **Current recommendation:** 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:** **Recommendation 1, April 2008:** Review SIRs for timeliness, completeness and accuracy and provide training/guidance to staff who repeatedly make errors. **Findings:** Review of the SIR listing of incidents for May and June 2008 found discrepancies in the coding of the involvement of individuals in suicide threat incidents and incidents involving aggressive acts to self. Examples include the following: • Seven suicide threat incidents in which the individual was coded as involved; • Nine suicide threat incidents in which the individual was coded as aggressor. In most Aggressive Act to Self incidents, the individual was coded as the aggressor, however, in the 6/11/08 incident the individual was coded "involved." To put these findings in perspective, these problems represent a small number of incidents when compared with the

		approximately 585 incidents in the SIR listing for the period reviewed. This strongly suggests that the facility is reviewing SIRs closely. **Recommendation 2, April 2008:** Ensure the completion of Investigation Compliance Monitoring Forms and the aggregation of data from a sizeable sample of the forms, particularly for Special Investigator investigations where the numbers are small. **Findings:** The facility increased the number of Investigation Compliance Monitoring Forms completed each month beginning in June 2008. **Other findings:** Several investigations reviewed documented that the offense under review was reported/discussed with the District Attorney's office. These included the allegation of sexual contact between two individuals occurring on 7/31/08, the allegation of sexual assault occurring on 6/7/08, the allegation of physical abuse made on 6/23/08, and the allegation of falsifying records (8/1/08). **Current recommendation**: Continue current practice of reviewing SIRs for completeness and accuracy, being mindful of the need to code the involvement of an individual in a suicide threat incident consistently.
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	**Current findings on previous recommendation:** **Recommendation, April 2008:** Continue current practice of questioning individuals who change their mind about making an allegation or pursuing criminal charges. **Findings:**

	because of an employee's failure to report an incident in an appropriate or timely manner.	Events in which individuals changed their minds about making allegations or criminal charges did not surface during this review. **Current recommendation**: Continue current practice.
I.1.b	Each State hospital shall review, revise, as appropriate, and implement policies and procedures to ensure the timely and thorough performance of investigations, consistent with generally accepted professional standards of care. Such policies and procedures shall:	**Compliance:** Partial.
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 recommendations:** **Recommendation 1, April 2008:** In collaboration with DMH Headquarters and the other facilities, develop a mortality review system that meets the intent and requirements of SO 205.05. **Findings:** The facility reports that in January 2008, it implemented mortality review procedures that comply with SO 205.05; however, further refinements in the process are necessary. Review of the minutes of the Mortality Interdisciplinary Review Committee for 2008 reveal that the final MIRC meeting, which should convene after the independent death review by DMH, has not yet been held for any of the 2008 deaths. The MIRC has not yet identified any recommendations for improving the quality of care to individuals in the facility. MIRC minutes of the September 4, 2008 meeting state that there will be no independent review of the death of LA (8/20/08) because he died outside the facility. This death warrants an independent review.

		The Medical Mortality Review Committee minutes for 2008 (March, April and June), which covered the deaths of nine of individuals (some of whom died in 2007), found the care "acceptable " in seven instances, "exemplary" in one instance and the remaining death was not medically related. There were no recommendations forthcoming from the Medical Mortality Review Committee minutes reviewed. **Recommendation 2, April 2008:** Ensure the review of the death of RH (date of death: May 9, 2007) is completed. **Findings:** The facility reports that the Medical Mortality Review Committee completed the review of RH's death at the April 24, 2008 meeting. **Recommendation 3, April 2008:** Improve the quality of deficient nursing death reviews. **Findings:** The nursing death reviews of six individuals as reported in the MIRC minutes found incomplete nursing documentation in one case and no other problems in nursing care provided to the other five individuals. **Other findings:** The death investigations reviewed that were completed by Special Investigators conclude with a broad statement that is beyond the scope of the investigation: "It is my opinion that [LC] received proper care and treatment for his terminal illness," and "It is my opinion that [LA] and [JN] received proper treatment while housed at ASH." All of the investigations also concluded that there was no evidence of abuse or neglect in the deaths of these individuals. A determination by an investigator on whether abuse/neglect occurred based on the evidence available at the time is appropriate. A determination by an investigator

		regarding the quality of care and treatment is not, as he/she does not have the qualifications (in medicine or psychiatry) to make such a determination. Opinions regarding quality of care and treatment rendered by Subject Matter Experts that are included in the report should be clearly identified as the opinion of the Subject Matter Expert(s). There is reason to question the statement in the minutes of three Mortality Interdisciplinary Review Committee (MIRC) meetings that state "the [Medical] Mortality Review Committee minutes were reviewed by the Chair." This statement was made in the 2/6/08 minutes related to the death of the JB. The Mortality Review Committee, per its minutes, did not convene to review JB's death until 3/27/08. The statement also appears in the MIRC minutes of 3/20/08 related to the death of JN. This death was not reviewed by the Mortality Review Committee until 4/24/08. No review by the Mortality Review Committee had been completed on the death of DM (2/17/08), but the minutes of the 2/29/08 MIRC meeting again state the minutes had been reviewed by the Chair. This practice has the potential to seriously undermine the ability of the MIRC review to identify systemic policy and procedural issues related to areas of concern arising from a review by the Mortality Review Committee. **Current recommendations**: 1. Revise the death investigations completed by OSI to eliminate conclusions that are beyond the scope of the investigation. 2. Report accurately any areas of concern that were identified in the Nursing Death Review and the Medical Mortality Review to the MIRC. 3. Conduct final MIRC reviews when the report of the independent DMH has been received. 4. Request an independent review of the death of LA (8/20/08).

I.1.b.ii	ensure that only the State Hospital staff who have successfully completed competency-based training on the conduct of investigations be allowed to conduct investigations of allegations of petty theft and all other unusual incidents;	**Current findings on previous recommendation:** **Recommendation, April 2008:** Revise the monitoring data to identify the number of investigations and monitoring forms reviewed by staff not associated with the DPS each month. **Findings:** This recommendation has recently been implemented, but the implementation does not advance the objective of identifying differences in the outcomes of the internal and external reviews. In August2008, the hospital administrator reviewed four investigations. In July and August, a Hospital Administrative Resident reviewed a total of 39 investigations completed by the OSI or DPS. The data from the hospital administrator's review, the HAR review, and the DPS/OSI's own review cannot be compared because one cannot determine which of the investigations were reviewed by both the DPS/OSI and one or both of the independent parties. The DPS/OSI review found that 100% of the 77 investigations were correctly scored using the Investigation Compliance Monitoring form. The hospital administrator reported that all of the four investigations she reviewed were correctly scored, and the HAR reported that 34 of the 39 investigations reviewed were correctly scored. **Other findings:** All allegations of staff and individual wrongdoing are investigated either by the Office of Special Investigations or Criminal Investigators in the hospital police department—all of whom have had investigation training.

		Current recommendation: Determine how to present data or provide a narrative statement so that the reader can learn where the findings of the independent review differ from the internal review completed by the Chief of Police.
I.1.b.iii	investigations required by paragraph I.1.b.i, (above) provide for the safeguarding of evidence;	**Current findings on previous recommendation:** **Recommendation, April 2008:** Continue current practice. **Findings:** This monitor saw no evidence in the investigations reviewed of a failure to safeguard evidence. **Current recommendation**: Continue current practice.
I.1.b.iv	investigations required by paragraph I.1.b.i, (above) require the development and implementation of standardized procedures 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:** **Recommendation, April 2008:** Require updates on at least a semi-monthly basis on tasks that appear to be taking too long to complete. **Findings:** The facility reports that issues are tracked by Standards Compliance or the Incident Management Review Committee on a bi-weekly basis. The IMRC uses a task tracking sheet to review timeliness and completion. **Other findings:** As suggested in the cells in this section, the OSI investigations and the preliminary investigations are meeting many of the requirements of the Enhancement Plan. Problems in timeliness—completion within 30

		business days and the conduct of interviews near the time of the incident—remain. **Current recommendation**: Take measures to improve the timeliness of interviews and of closing OSI investigations.
I.1.b.iv.1	investigations commence within 24 hours or sooner, if necessary, of the incident being reported	**Current findings on previous recommendations:** **Recommendation 1, April 2008:** Complete the transfer of preliminary investigations from the hospital police to the Office of Special Investigation as expeditiously as possible to facilitate the timely assignment and initiation of interviews. **Findings:** This recommendation has been successfully implemented. The preliminary investigation reports reviewed were completed within 24 hours and contained sufficient information in a clearly written report to allow the full investigation to proceed. See also I.1.b.iv.3(v). **Recommendation 2, April 2008:** Ensure that the preliminary investigation clearly identifies attempts to identify all possible witnesses and documents the number of staff on the unit at the time of the incident. **Findings:** Several investigations reviewed made specific reference to attempts to identify possible witnesses. These include asking the alleged victim in the 6/7/08 allegation of sexual assault if anyone else could have seen or heard the assault, looking for staff and individuals in the dayroom on 6/23/08 when an individual made an allegation of physical abuse, and the interview of all individuals who were supposed to be in a Mall group where falsified records were submitted.

		Current recommendation: Continue current practice.
I.1.b.iv. 2	investigations be completed within 30 business days of the incident being reported, except that investigations where material evidence is unavailable to the investigator, despite best efforts, may be completed within 5 business days of its availability;	**Current findings on previous recommendation:** **Recommendation, April 2008:** Continue to work on the timely assignment of cases to Special Investigators, timely interviews, and closure with 30 business days. **Findings:** Forty-six percent of the DPS/OSI investigations were completed within 30 business days in the period March through August 2008, according to facility data. **Other findings:** Timely completion of investigations in the sample reviewed was significantly better than the facility rate cited above. Fourteen of 18 investigations reviewed (78%) were completed within 30 business days. Review of the listing of cases produced by the DPS Records Management System indicates that as of September 24, one case opened in May and one opened in June remained open, as well as six cases opened in July and 10 cases opened in August. **Current recommendation**: Continue work on concluding OSI investigations within the generous 30 business day limit set in the EP.
I.1.b.iv. 3	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	**Current findings on previous recommendation:** **Recommendation, April 2008:** Ensure that areas of concern are clearly identified in the investigation reports and the recommendation for referral to the appropriate body

	its conclusion. The report shall set forth explicitly and separately:	for further review and discussion is made. **Findings:** All investigations reviewed where there was a question of criminal activity were referred to the Office of the District Attorney. In the administrative investigations where there was evidence of staff misconduct, the investigation was referred to the Executive Director and Clinical Administrator, the Incident Management Review Committee, and the facility's Human Resource Department. The review of the incident for clinical and programmatic recommendations is the responsibility of the Incident Management Review Committee. **Current recommendation**: Continue current practice.
I.1.b.iv. 3(i)	each allegation of wrongdoing investigated;	**Current findings on previous recommendation:** **Recommendation, April 2008:** Review SIRs and SOC 341s for completeness and accuracy. **Findings:** See findings in I.1.a.viii. **Other findings:** Two investigation reports reviewed involved several areas of alleged misconduct by several different staff members. In the reports, each staff member and each allegation was investigated and the findings were clearly delineated. See the investigation of the allegation of neglect (6/20/08) and of staff misconduct reported on 5/5/08. **Current recommendation**: Continue current practice.

I.1.b.iv. 3(ii)	the name(s) of all witnesses;	**Current findings on previous recommendation:** **Recommendation, April 2008:** Begin and conclude interviews as quickly as possible to gather recent memory information. **Findings:** See I.1.b.iv.3(v). **Current recommendation:** Ensure that all investigation reports clearly document attempts to identify all possible witnesses. This includes determining the identity of staff members and individuals present when an incident occurred, so that all possible witnesses can be interviewed.
I.1.b.iv. 3(iii)	the name(s) of all alleged victims and perpetrators;	**Current findings on previous recommendation:** **Recommendation, April 2008:** Determine how to provide investigators access to accurate information regarding the incident history of individuals and staff members as required by the EP. **Findings:** The facility has determined that it will not give investigators access to information about a staff member's incident history. Rather, the incident history of staff members will be reviewed by the Incident Management Review Committee at its meeting. This plan, however, is contingent on the success of the work to ensure the accuracy of Records Management System. **Other findings:** All investigation reports reviewed clearly identified the name of the alleged victim and perpetrator.

		Current recommendations: 1. Continue to implement plans to work with the vendor of the Records Management System to ensure the accuracy of the data and the reports produced by the system. 2. Implement plans to review the incident history of individuals and staff members at the IMRC meeting when accurate information is available.
I.1.b.iv. 3(iv)	the names of all persons interviewed during the investigation;	**Current findings on previous recommendation:** **Recommendation, April 2008:** Continue current OSI practice of documenting attempts to find additional witnesses among staff and individuals. Ensure DPS preliminary investigations also document these attempts as well as the number of staff present on the unit at the time of the incident. **Findings:** In the investigations reviewed, this monitor found no instances in which one would reasonably assume that the event had been witnessed by persons who were not interviewed. **Other findings:** All investigation reports reviewed clearly identified the names of all persons interviewed and the dates of the interviews. **Current recommendation**: Continue current practice of attempting to find all witnesses to an incident—individuals and staff members—and document these efforts in the investigation reports.
I.1.b.iv. 3(v)	a summary of each interview;	**Current findings on previous recommendations:**

		Recommendation 1, April 2008: State in investigation reports the number of staff who were present at the time of an incident, so that the reader can be assured that all relevant staff were interviewed. **Findings:** The preliminary investigations reviewed did not document the number of staff members present when an incident occurred. The facility reports that beginning in September 2008, the review of investigations will include looking to ensure that DPS clearly identifies all possible witnesses and the number of staff on duty. **Recommendation 2, April 2008:** Seek additional information when confronted with conflicting reports of an incident. **Findings:** There were no instances in the investigations reviewed in which conflicting information was not dealt with reasonably in the conclusion section of the report. **Other findings:** The reliability of information obtained during interviews is compromised, in some investigations, by the lack of a face-to-face interview or the substantial lapse between the event and the interview. For example, in the allegation of neglect reported by TH on 6/10/08, one of the two named staff members was not interviewed in the OSI investigation until 8/15 and could not recall the events in question. In the allegation of staff misconduct (incident date: 5/2/08), the named staff member was interviewed in the OSI investigation a month later on 6/19/08. Telephone interviews were conducted of the two staff witnesses to the physical abuse allegation reported by GP on 7/10/08. Similarly, a staff witness in the incident involving HE on 5/25/08 was

		interviewed by phone on 7/10/08. **Current recommendations**: 1. Limit telephone interviews to those situations in which a face-to-face interview is impossible or would significantly retard the timeliness of the investigation. 2. Conduct OSI interviews as near to the event as possible.
I.1.b.iv. 3(vi)	a list of all documents reviewed during the investigation;	**Current findings on previous recommendations:** **Recommendation 1, April 2008:** Continue current practice of reviewing and referencing relevant documents. **Findings:** Investigations completed by the Office of Special Investigations continue to reference documents reviewed. For example, in the investigation of the allegation of sexual abuse reported by ES on 6/3/08, the investigator reviewed the main sally port logs to ensure that staff were not returning to the secure area after the close of their shifts. **Recommendation 2, April 2008:** Begin the production of incident trend and pattern data for review by the Incident Management Review Committee as quickly as possible. This information should also be shared with other bodies working on the Violence Abatement Project. **Findings:** In October 208, the Ad Hoc Committee on Violence produced a report on assault incidents in the last year that compared data for the six months prior to the establishment of the committee in April 2008 and the most recent six months. See I.1.d.iv and I.1.d.v, and I.2.b.ii for a

		fuller discussion. **Current recommendation**: Document review of incident trend and pattern data in the minutes of the Incident Management Review Committee.
I.1.b.iv. 3(vii)	all sources of evidence considered, including previous investigations and their results, involving the alleged victim(s) and perpetrator(s);	**Current findings on previous recommendation:** **Recommendation, April 2008:** Develop a reliable method for permitting investigators to conduct and document in the investigation reports a review of the incident history of individuals and named staff members during investigations of allegations of staff misconduct. **Findings:** The facility reports that it is not permitting investigators to review the incident history of individuals or named staff members lest this information color the current investigation. This is consistent with this monitor's findings; none of the investigations reviewed contained documentation of the incident histories of the persons involved. **Other findings:** The facility is entering into discussions with the Records Management System vendor to ensure that the reports it will produce are accurate. These will include reports of the incident history of staff members named in an incident. This information will be available at the Incident Management Review Committee meeting when the incident is discussed. **Current recommendations**: 1. Continue talks with the Records Management System vendor so that the RMS is capable of producing accurate incident history reports on named staff members as well as individuals. 2. Ensure that the IMRC minutes document that the incident history

		of individuals and personnel file of staff members was reviewed at the meeting. [This is not a recommendation to cite the incident history, but rather to cite that the incident history was discussed and any conclusions drawn/recommendations made.]
I.1.b.iv. 3(viii)	the investigator's findings, including findings related to the substantiation of the allegations as well as findings about staff's adherence to programmatic requirements; and	**Current findings on previous recommendation:** **Recommendation, April 2008:** Continue current practice of identifying, during investigations of allegations of abuse and neglect, violations of Administrative Directives and Special Orders related to staff conduct. **Findings:** In the investigation of staff misconduct (date of incident: 5/2/08), the investigator found that the named staff member had not engaged in abusive or neglectful behavior, but had violated ASH guidelines for staff conduct. The investigation was forwarded to Human Resources and members of the facility administration for review. **Current recommendation**: Continue current practice.
I.1.b.iv. 3(ix)	the investigator's reasons for his/her conclusions, including a summary indicating how potentially conflicting evidence was reconciled; and	**Current findings on previous recommendation:** **Recommendation, April 2008:** Work with the vendor to determine how best to correct this problem [of the Records Management System being able to accommodate only a single determination, as described in the previous report]. In the meantime, match the determination with the allegation shown on the RMS reports. **Findings:** Work with the Records Management System vendor continues. As of

		August 1, the RMS is able to match the determination to the allegation, according to the facility. **Other findings:** See also I.1.b.iv.3(v). **Current recommendation**: Continue current practice of documenting the rationale for reconciling conflicting information.
I.1.b.iv.4	staff supervising investigations review the written report, together with any other relevant documentation, to ensure that the investigation is thorough and complete and that the report is accurate, complete, and coherent. Any deficiencies or areas of further inquiry in the investigation and/or report shall be addressed promptly. As necessary, staff responsible for investigations shall be provided with additional training and/or technical assistance to ensure the completion of investigations and investigation reports consistent with generally accepted professional standards of care.	**Current findings on previous recommendation:** **Recommendation, April 2008:** Continue current practice of investigators requesting clinical expert and other assistance when needed. **Findings:** In the investigation of the allegation of physical abuse reported by GP on 7/10/08, which charged that GP was choked during a restraint, the investigator consulted with a Prevention and Management of Assaultive Behavior trainer. **Other findings:** The Investigation Compliance Monitoring form is completed by the Chief of Police at the conclusion of the investigation. Several of these forms incorrectly identified sexual activity between individuals as sexual abuse. See, for example, the allegation of sexual assault of RZ by SM on 6/7/08 and the sexual incident involving MM and MB on 6/8/08. **Current recommendation**: Ensure that all administrative (OSI) investigations and materials referencing them use the revised SIR 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:** **Recommendation 1, April 2008:** Ensure that appropriate remedial actions are taken when a staff member fails to report an incident in a timely manner. **Findings:** Two staff members failed to report an allegation of neglect (incident date: 6/20/08) in a timely manner and engaged in other misconduct. Adverse action is pending for both staff members. **Recommendation 2, April 2008:** Pursue the avenues identified for reducing peer-to-peer violence. **Findings:** See I.1.d.iv. **Other findings:** Review of the personnel actions taken in relation to staff members who had been found to have engaged in misconduct in the investigations reviewed revealed that action was taken or is pending as follows: • An adverse action is pending against the three staff members involved in the 6/20/08 allegation of neglect. • Counseling is pending for the staff member in the sustained verbal abuse allegation reported on 6/6/08. • The contract of a staff member accused of falsifying records was terminated. The "pending" status of the actions related to the June incidents cited suggests that the facility needs to look at the timeliness of its HR actions.

		In no investigation reviewed was a staff member found to have been engaged in misconduct and no action taken or pending. The work of investigators is defined by the facility as limited to fact-finding and referral to the appropriate bodies for the identification of programmatic and disciplinary action. The Incident Management Review Committee is the forum for identifying programmatic/systemic corrective actions and for ensuring that disciplinary actions are underway when they are necessary. The IMRC at ASH is backlogged and investigations are not being reviewed in a timely manner. For example, the sustained allegation of verbal abuse (date of incident: 6/2/08; date investigation closed: 7/29/08) had not yet been reviewed by October 23, 2008. Presently, the IMRC is reviewing a summary of the investigation prepared by the police lieutenant. The full investigation is available to the committee during the meeting. At the meeting held during this monitor's visit, the summaries of two incidents under review did not provide sufficient information to the IMRC members. See the summary provided to the IMRC for the 6/18/08 allegation of neglect of HE, which only tangentially addresses the neglect allegation. Also, the summary of the investigation of the alleged abuse of JT (made on 7/20/08) simply stated the allegation that staff allowed JT to be assaulted and the conclusion that the allegation was unfounded. No supporting findings were presented in the summary. The IMRC is presently reviewing only the investigations of sustained allegations. It is, however, reviewing the Headquarters Reportable Briefs for all incidents. The IMRC would be well served to review all investigations completed by OSI because programmatic issues arise not only in sustained investigations. In every allegation of abuse/neglect, someone has perceived that something has gone wrong. This presents the opportunity to examine the circumstances of the incident to

		determine if there are lessons to be learned. **Compliance:** Partial. **Current recommendations**: 1. Review the process whereby counseling and other disciplinary actions are implemented with the goal of improving timeliness. 2. Review all investigations completed by OSI in the IMRC, regardless of the determination. 3. Improve the timeliness of the review of investigations by IMRC. 4. Ensure that summaries provide sufficient and focused information to the members of the committee or alternately require IMRC members to review the investigation report prior to the meeting.
I.1.d	Each State hospital shall have a system to allow the tracking and trending of investigation results. Trends shall be tracked by at least the following categories:	**Compliance:** Partial.
I.1.d.i	type of incident;	**Current findings on previous recommendations:** **Recommendation 1, April 2008:** Clarify the business rules for the codes identifying the roles of staff and individuals in incidents entered into the Record Management System. Provide training as needed to avoid future problems. **Findings:** The facility has provided new written definitions for the terms to be used in DPS and OSI investigations in identifying the roles of individuals and staff members, as well as definitions of the terms used for determinations (unfounded, not sustained, exonerated). The new definition of the role of victim raises a potential problem, however, since it is not consistent with the codes used on the SIRs to indicate

		the roles of individuals and staff members nor consistent with Special Order 227.08: Special Incident Reports. All alleged victims are identified as such on SIRs. Under the new definitions, the term "victim" will only be used in DPS criminal investigations (not OSI investigations). Instead, when someone alleges he has been abused, he will not be referred to as the victim, but as the "complainant" in the OSI investigation. There is no role designation of "complainant" on the SIR or in the Special Order. Consequently, in reports generated by the two databases, the same individual will have two different role designations. This may lead to inconsistencies that will have to be reviewed and reconciled by a staff member. The facility will also be adding "exonerated" as a possible determination. "Exonerated" is defined by the facility as "the incident described by the complainant did occur but the actions by the subject employee were appropriate and were within policy." The staff member completing an SIR, guided by the revised SIR definitions, must identify the type of incident (there are seven SIR types of abuse/neglect allegations). The purpose of the OSI investigation is to determine whether or not the preponderance of evidence supports the allegation of abuse, using the revised SIR definitions. With this in mind, it is highly questionable that the new "exonerated" determination will provide any clarity in abuse investigations; more likely it will complicate what is presently a straightforward determination. **Recommendation 2, April 2008:** Review past data entered by police officers into the Record Management System and correct errors. Closely review the data as close to the time it is entered as possible. **Findings:** The facility reports that it cannot change any erroneous information in the Records Management System as the change could be problematic

		should the case be prosecuted. The facility reports it is reviewing the accuracy of data as it is entered. **Current recommendations**: 1. Reconsider the change in the use of the term "victim" that limits it to only criminal investigations. 2. Reconsider the use of the "exonerated" determination.
I.1.d.ii	staff involved and staff present;	**Current findings on previous recommendation:** **Recommendation, April 2008:** See recommendations in I.1.d.i. **Findings:** See findings in I.1.d.i. **Other findings:** The DPS Record Management System contains information about the involvement of staff members in each incident in which a staff member played a role (alleged aggressor, reporting party, witness, etc.). This information is not available in the SIR database, which contains no staff members' names. The SIR database will not include this information until the statewide Incident Management System is in place in early summer 2009. **Current recommendations**: 1. Continue efforts to ensure the Record Management System will produce accurate reports by working with the vendor as necessary. 2. Continue work on the statewide incident information system.
I.1.d.iii	individuals directly and indirectly involved;	**Current findings on previous recommendations:**

		Recommendation 1, April 2008: See I.1.d.i. **Findings:** See findings in I.1.d.i and I.1.d.ii. **Recommendation 2, April 2008:** Ensure SIR database and Record Management System are in agreement before running trending and pattern data from either. **Findings:** See the chart in the cell below for examples of discrepancies between the two databases. **Other findings:** It is difficult to compare the two incident databases since there is no common numbering system and neither system consistently references the number assigned to the same incident by the other system. **Current recommendation:** Periodically compare a sample of incident listings from each database for the same period of time and determine if the reports are consistent. If they are not, determine the source of the problem and take appropriate action.
I.1.d.iv	location of incident;	**Current findings on previous recommendations:** **Recommendation 1, April 2008:** Clean the Records Management System, ensure it and the SIR database are in agreement and start running reports. **Findings:** A comparison of the listings of incidents produced by the SIR database

and the incident history of ten individuals produced by the Records Management System (RMS) for the months of May and June 2008 revealed discrepancies in half of the incidents. The discrepancies could be caused by the RMS failing to provide a complete listing of all the incidents in which the individual was involved that had been entered. Alternately, it may be that there were allegations made that were not investigated by OSI and hence not entered into the RMS or the incidents were investigated but not entered into the RMS.

Individual	SIR incident date	SIR incident abuse type	Listed on RMS individual history report
AJ	5/13/08	Physical	Yes
BG	5/22/08	Physical	No
DT	5/10/08	Verbal	Yes
GP	6/14/08	Physical	No
JT	5/21/08	Physical	No
LB	5/6/08	Physical	Yes
LH	6/24/08	Physical	Yes
MR	6/26/08	Physical	No
TF	5/19/08	Sexual	Yes
TH	6/18/08	Psychological	No

Recommendation 2, April 2008:
After review by the appropriate bodies, distribute the aggregate data reports widely and distribute the repeat victim and aggressor reports to the appropriate WRPTs with a request for review and response.

Findings:
The October2008 report by the Ad Hoc Committee on Violence identified the frequency with which individuals were aggressors in an assault incident in the period April through September2008. In addition to the number of discrete assaults per named individual, the

		report provides the rate of SIR assaults per 100 patient days. The data reports the severity of injury for staff members only, not for peers who were victims. The data cites WT as having been involved with the most assaults on staff and KT with the most assaults on peers. While the October report does not look at repeat victims, the aggressor data suggests that some individuals must be targeting the same persons multiple times. For example, SB is cited as having been the aggressor against three staff members and one peer in 18 assault incidents during the review period. **Other findings:** Data from the Ad Hoc Committee on Violence indicates that Program 1 had the highest number of assaults during the period October 2007 through September 2008. Facility-wide, in the same time period, the day hall and the hallway were the scene of most of the incidents of assault. **Current recommendations**: 1. Determine why the SIR database and the incident history of specific individuals in the Records Management System are not reconcilable and take appropriate actions to correct the problem. 2. In addition to identifying repeat aggressors, look at repeat victims also.
I.1.d.v	date and time of incident;	**Current findings on previous recommendation:** **Recommendation, April 2008:** See I.1.d.iv. **Findings:** See findings above.

		Other findings: All investigations reviewed clearly identified the date and time of the incident (when this was known) and the date and circumstances under which it was reported. The Ad Hoc Committee on Violence data indicates that in the period October 2007 through September 2008, most of the incidents of assault (53%) occurred on the PM shift. The night shift was the quietest with 2% of the assault incidents. The hours 5:00 PM to 7:00 PM on both weekdays and weekends saw the most assaults occur. It would be useful to know how many of these incidents occurred waiting in the hallway for dinner. (See location data for assault incidents in the cell above.) **Current recommendations**: 1. Ensure the accuracy of the RMS and reconcile it on a regular basis with the SIR database. 2. Study the relationship (if any) between the dinnertime incidence of assaults and the data showing a high number of assaults occurring in the hallway. Consider measures to reduce the likelihood of these incidents, should a relationship exist.
I.1.d.vi	cause(s) of incident; and	**Current findings on previous recommendation:** **Recommendation, April 2008:** Encourage staff members to complete the analysis section of the HQ briefs identifying contributing factors. **Findings:** See I.1.a.ii.

		Current recommendation: Empower the IMRC to look critically at the section of the HQ brief that deals with contributing factors and look back at the investigation to gain insight as necessary.
I.1.d.vii	outcome of investigation.	**Current findings on previous recommendation:** **Recommendation, April 2008:** Hand-tabulate determination data until the related problems in the DPS Records Management System are addressed by the vendor. **Findings:** The problem that led to the above recommendation has been rectified. The RMS is capable of producing a report of incidents that includes the disposition. The listing of investigations produced by the DPS Records Management System for this tour did not provide information on the determination. It cited three variables: investigation open, investigation closed or the District Attorney's disposition (submitted to DA or rejected by DA). See also I.1.d.i for a discussion of the use of the "exonerated" disposition. **Current recommendation**: Reconsider the use of the disposition term "exonerated."
I.1.e	Each State hospital shall ensure that before permitting a staff person to work directly with any individual, each State hospital shall investigate the criminal history and other relevant background factors of that staff person, whether full-time or part-time, temporary or permanent, or a person who volunteers on a regular basis. Facility staff shall directly supervise volunteers for whom an investigation has not been completed when they are	**Current findings on previous recommendation:** **Recommendation, April 2008:** Continue the practice of documenting decisions regarding removing staff members involved in incidents from direct contact with individuals and initiate review of these decisions in the Incident Management Review Committee.

	working directly with individuals living at the facility. The facility shall ensure that a staff person or volunteer may not interact with individuals at each State hospital in instances where the investigation indicates that the staff person or volunteer may pose a risk of harm to such individuals.	**Findings:** The decision whether to remove staff members involved in incidents was documented in the investigation reports reviewed. This documentation included reference to consultation with Human Resources. The decisions made did not appear unreasonable. The Incident Management Review Committee reviews this determination (but often many weeks or even months after the incident) and will consistently note this review in its minutes. **Other findings:** Personnel information on 12 staff members revealed that all cleared the criminal background check on or prior to their dates of hire. This is consistent with the facility's data. **Compliance:** Substantial. **Current recommendation:** Continue current practice.

2. Performance Improvement		
I.2	Each State hospital shall develop, revise as appropriate, and implement performance improvement mechanisms that enable it to comply fully with this Plan, to detect timely and adequately problems with the provision of protections, treatment, rehabilitation, services and supports, and to ensure that appropriate corrective steps are implemented. Each State hospital shall establish a risk management process to improve the identification of individuals at risk and the provision of timely interventions and other corrective actions commensurate with the level of risk. The performance improvement mechanisms shall be consistent with generally accepted professional standards of care and shall include:	**Methodology:** Interviewed: 1. C. Williams, Standards Compliance 2. D. Nelson, Standards Compliance Director 3. J. Gruver, Information Technology 4. L. Persons, Hospital Administrator 5. M. Espitia, Standards Compliance 6. M. Hughes, Chair, Ad Hoc Committee on Violence 7. S. Joslin, Standards Compliance Reviewed: 1. October2008 report by Ad Hoc Committee on Violence 2. July 2008 memo from the Chair of the Ad Hoc Committee on Violence to the Quality Council regarding Performance Improvement Recommendations 3. June 6, 2008 memo from Executive Director to DMH on Violence Reduction Initiatives 4. Aggregate trigger data 5. WRPT response forms for a number of trigger alerts 6. Clinical records of 12 individuals for evidence of WRPT implementation of its response to a trigger 7. Minutes of the Enhanced Trigger Review Committee
I.2.a	Mechanisms for the proper and timely identification of high-risk situations of an immediate nature as well as long-term systemic problems. These mechanisms shall include, but not be limited to:	**Compliance:** Partial.
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:**

		Recommendation, April 2008: Add timeliness as a consideration in the review of SIRs and SOC341s. **Findings:** This recommendation was implemented. The facility reports that in the period March through August 2008, 95% of the SIRs were completed within the prescribed time limits. No data was provided for the timeliness of SOC 341s, which are reportedly audited by the Office of Special Investigations. **Other findings:** See I.1.d.iv for a discussion of the facility's work on identifying individuals repeatedly involved in incidents of aggression and other characteristics of assault incidents. See also I.2.c for discussion of recommendations resulting from a review of these data. **Current recommendation:** Continue the work of the Ad Hoc Committee on Violence and track implementation of its recommendations that have been accepted by the Quality Council.
I.2.a.ii	establishment of triggers and thresholds that address different levels of risk, as set forth in Appendix A; and	**Current findings on previous recommendations:** **Recommendation 1, April 2008:** Continue the multidisciplinary review of triggers to identify appropriate responses and to track the individual's progress after implementation. **Findings:** The practice of having the psychiatrist and at least two other members of the WRPT participate in a review occasioned by a trigger is a trigger response expectation.

		Recommendation 2, April 2008: Continue the work of identifying the risk factors specific to each individual in a single, easily accessible document. **Findings:** This recommendation can be fully implemented when the Risk Management Special Order is finalized. **Current recommendation:** Finalize and 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:** **Recommendation, April 2008:** Reconsider the recommendation to separate trigger data for abuse/neglect allegations from sexual contact data. **Findings:** The recommendation to remove sexual contact data from the count of allegations of abuse/neglect has been implemented. **Other findings:** See also I.1.d.iv. **Current recommendation:** Continue the work of the Ad Hoc Committee on Violence, promulgate its findings widely and monitor the effective implementation of its recommendations that have been accepted by the Quality Council.
I.2.b	Mechanisms for timely interventions and other corrective actions by teams and disciplines to prevent or minimize risk of harm to individuals. These mechanisms shall include, but not be limited to:	**Compliance:** Partial.

I.2.b.i	a hierarchy of interventions by clinical teams that correspond to triggers and thresholds;	**Current findings on previous recommendation:** **Recommendation, April 2008:** Continue to raise the visibility of the need for timely, documented and effective responses to triggers. **Findings:** See I.2.b.iv. **Other findings:** The Special Order establishing a Risk Management System based on a hierarchy of interventions has been drafted and will be finalized shortly. The Special Order will include attention to the treatment needs of repeat victims. **Current recommendation**: Finalize the Risk Management Special Order and begin implementation.
I.2.b.ii	timely corrective actions by teams and/or disciplines to address systemic trends and patterns;	**Current findings on previous recommendation:** **Recommendation, April 2008:** Continue analysis and discussion of methods for addressing aggression by individuals. Discuss the issue with the Hospital Advisory Council as well. **Findings:** The Ad Hoc Committee on Violence began its work in April 2008. The committee produced a report comparing levels of aggression for the six-month period prior to the establishment of the committee (10/07 through 3/08) and the six-month period since the committee's establishment (4/08 through 9/2008). In each of four categories (verbal and physical aggression to staff and verbal and physical aggression to peers), the data showed a decrease in incidents during

		the latter period. Nonetheless, the total number of assaults on peers and staff in October 2007 and September 2008 are very close, having come down from highs in December 2007 and March 2008. Injuries to both staff and individuals decreased in August and September 2008, perhaps as the beginning of a downward trend. Data graphing the use of restraint/seclusion after the implementation of behavior guidelines indicates that the implementation introduced a trend showing decreased use of the restrictive interventions. **Other findings:** See also I.2.b.iv. **Current recommendation**: Advance the work of the Ad Hoc Committee on Violence and circulate its findings widely within the hospital community.
I.2.b.iii	formalized systems for the notification of teams and needed disciplines to support appropriate interventions and other corrective actions;	**Current findings on previous recommendation:** **Recommendation, April 2008:** Include a review for staff of the types of incidents that require an SIR as part of the efforts to reduce violence at the facility. **Findings:** The facility reports that in August and September2008, a number of training sessions were held to address changes in the Administrative Level 1 and Level 2 reviews of SIRs and the addition of the Psychology Review to the SIR review. Beginning in September, the SIR audit protocol was revised to reflect these additions, according to the facility. **Other findings:** The facility continues to implement an effective system for alerting

		WRPTs when an individual has reached a trigger. **Current recommendation**: Continue current practice.
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 recommendation:** **Recommendation, April 2008:** Continue to encourage documentation in the individual's clinical record of the WRPs response to the trigger and monitor for the same. **Findings:** The facility reports that in the period March through August 2008, 55% of the teams responded to the report of a Level 1 trigger in a timely manner. The percentage of timely responses equaled or exceeded 60% in March, June and August 2008. The facility further reported that over the same review period, there was documented evidence of the implementation of the interventions identified in the WRPT's responses in 54% of the WRPs reviewed. Compliance exceeded 60% in March and August 2008. **Other findings:** Review of 12 randomly selected interventions cited in the WRPTs' responses to a Level 1 trigger or recommended by the Enhanced Trigger Committee review revealed that three had not been completed and documented.

Individual	Intervention	Approx. date of trigger	Implementation documented?
AB	Med change	8/08	Yes
CR	1:1 initiated	7/08	Yes
CC	1:1 initiated	8/08	No

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<tr><td>CG</td><td>PBS consult</td><td>8/08</td><td>Yes (9/2/08)</td></tr>
<tr><td>TS</td><td>Med change</td><td>8/08</td><td>Yes</td></tr>
<tr><td>HE</td><td>Discussion with indiv.</td><td>8/08</td><td>Yes</td></tr>
<tr><td>SB</td><td>Psychology consult</td><td>7/08</td><td>Yes</td></tr>
<tr><td>JR</td><td>Update risk factors to include shunt</td><td>6/08</td><td>Yes</td></tr>
<tr><td>CM</td><td>Add head banging to risk factors</td><td>6/08</td><td>Yes</td></tr>
<tr><td>AT</td><td>Add head banging and seizures to risk factors</td><td>6/08</td><td>Yes</td></tr>
<tr><td>KJ</td><td>Update diagnosis to include special ed</td><td>6/08</td><td>No</td></tr>
<tr><td>JG</td><td>Update WRP to address sepsis and treatment/ susceptibility</td><td>6/08</td><td>No</td></tr>
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Current recommendations:
1. Prepare for implementation of the Risk Management System as described in the Special Order being finalized.
2. Continue monitoring the implementation of responses by the WRPTs and recommendations of the Enhanced Trigger Review Committee and provide feedback to the teams.
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<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 recommendations:

Recommendation 1, April 2008:
Continue the use of a multidisciplinary review process directed at both the WRPT's response to a trigger and the individual's response to the intervention.

Findings:
The practice of having the psychiatrist and at least two other members of the WRPT participate in a review occasioned by a trigger has been is
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		a trigger response expectation. **Recommendation 2, April 2008:** Implement plans to increase monitoring to ensure that WRPTs are responding in a timely manner to triggers through such measures as requiring a copy of the portion of the WRP addressing the trigger in the WRPT's reply. **Findings:** The facility reports that in November 2008, it will pilot a Task Tracker database for tracking implementation of corrective actions/ interventions identified by the WRPT, the Enhanced Trigger Review Committee and the Incident Management Review Committee. This should greatly ease the work of tracking interventions and corrective actions and reduce the likelihood of losing track of any. **Other findings:** See also I.2.b.iv. **Current recommendation**: Continue with plans to implement the Task Tracker database.
I.2.c	Utilize, on an ongoing basis, appropriate performance improvement mechanisms to assess and address the facility's compliance with its identified service goals.	**Current findings on previous recommendations:** **Recommendation 1, April 2008:** Implement and monitor the effectiveness of the Violence Abatement measures. **Findings:** See I.2.b.ii. Review of implementation of five recommendations made by the Ad Hoc Violence Committee or the Executive Director in his June 2008 memo

to DMH revealed the following:

Recommendation	Resolution
Form a workgroup to develop guidelines and a proposal for retooling the Therapeutic Community Meeting and incorporating it into the Mall structure.	A pilot will be targeted for November 2008.
Add red lenses to flashlights used during night rounds.	All units visited had operable flashlights with red lenses.
Institute new procedures for nighttime observation rounds.	Staff member reported that doors are not opened during bedroom rounds and the flashlights are shown through the window in the door to observe the occupant. It is impossible for a staff person under 5′ 4″ to see into the bedroom. Thus, problems remain in completing nighttime rounds and will continue until the bedroom doors are replaced with doors with vertical windows that permit a clearer view inside. Installation of these doors is set to begin in January 2009.
Form a workgroup of nursing staff and supervisors to drill down into the 7-10 PM hours for	This workgroup was formed in mid-October.

highest levels of violence and make recommendations for improvement.		
Use SIR data to identify each month the unit with the lowest rate of violent incidents and reward the unit with prize money to spend.	In October the initiative was implemented and three units were given $25 deposited into their party fund.	

Recommendation 2, April 2008:
Correct the problems in the DPS Record Management System so that individuals who are repeatedly aggressive or victimized can be accurately identified and treated.

Findings:
The facility continues to work with the vendor of the DPS Records Management System to ensure that the reports produced by the RMS are accurate and complete.

Other findings:
See also the finding in I.1.d.iv that discusses facility data on repeat aggressors.

Compliance:
Partial.

Current recommendations:
1. Identify repeat victims as well as repeat aggressors and monitor implementation of interventions to address victimization.
2. Continue to identify measures to reduce violence and monitor implementation.

3. Environmental Conditions		
I.3	Each State hospital shall develop and implement a system to review regularly all units and areas of the hospital to which individuals being served have access to identify any potential environmental safety hazards and to develop and implement a plan to remedy any identified issues, consistent with generally accepted professional standards of care. Such a system shall require that:	**Methodology:** Interviewed: 1. L. Euler, Acting Chief of Plant Operations 2. S. Everett, Health and Safety Officer 3. Staff members acting as tour guides on their units Reviewed: 1. AD #512: Suicide/Self Harm Prevention 2. Minutes of the Suicide Prevention Committee (July 2008) 3. Health and Safety Department September report on environmental improvements 4. Suicide Prevention Compliance Reports for March—August 2008. 5. Look-behind documents on suicide attempts produced by Health and Safety Department 6. Training materials for incontinence treatment audits 7. Clinical records of selected individuals with the problem of incontinence and selected individuals involved in sexual contact incidents Toured: Units 9, 11, 22, 29 and 30
I.3.a	Potential suicide hazards are identified and prioritized for systematic corrective action, and such action is implemented on a priority basis as promptly as feasible;	**Current findings on previous recommendations:** **Recommendation 1, April 2008:** Explain and demonstrate to inspectors the multiple suicide hazards in bathrooms including, but not limited to, stall partitions. **Findings:** This recommendation was implemented and training was provided. Review of the Suicide Prevention Compliance Report for March through

August 2008shows mixed findings as shown below.

	Number of relevant bathrooms inspected	Number of bathrooms found noncompliant with suicide prevention
March	3	3
April	8	0
May	11	7
June	6	6
July	11	7
August	9	5

Since no bathrooms on residential units have been remodeled to remove the stall partition suicide hazard, continued vigilance in inspecting these areas and keeping the risks in mind is essential.

Recommendation 2, April 2008:
Review the appropriateness of the restraint use as response to the incidents of self-harm.

Findings:
The facility reports that 19% of incidents of self-harm resulted in the individual being placed in restraints. Each of these incidents was reviewed using a three-tiered process, and the use of restraints was found to be appropriate in each case, according to the facility.

Recommendation 3, April 2008:
Provide individuals with personal storage space as quickly as possible.

Findings:
The facility is working to provide individuals with storage space. Bedside storage units have been purchased and are at the facility

		waiting to be distributed. Placement in the units cannot proceed until small mesh screens are placed over vents, lest the storage units be used as a perch to make it possible to thread a ligature through the present vents. [A suicide attempt using a ligature threaded through the vent prompted these considerations.] This monitor has cautioned other facilities repeatedly about vents above toilets or otherwise positioned where furniture can be moved into place under them. **Other findings:** The absence of personal storage space is contributing to the poor environmental conditions observed in the bedrooms on the five units toured. The quick unit environmental tours that are supposed to occur daily are not achieving their objectives on the units visited. The sponsor system, which is designed in part to assist individuals in caring for themselves and their personal space, is also not functioning well on the units visited. Specific environmental problems observed included the following: Unit 9: Four bedrooms—one bathroom trash can overflowing, several cups of juice (one moldy) and one cup of coffee on the floor, two beds with very dirty linen. Unit 11: Five bedrooms—clothes, dirty food containers and cups, three bags of popcorn (under one bed), linens and personal hygiene supplies on the floor, one bed with very dirty linen. Unit 22: Four bedrooms—garbage, clothes, three empty plastic bags (suicide hazard) and food on the floor, several beds with insufficient or very dirty linen, one unemptied urinal. Unit 29: Three bedrooms—cigarette butts (many) and ashes, a leaking garbage paper bag, a bag of old lunches, clothes, linen and garbage on the floor, a urine-filled urinal, and dirty or no linens on several beds.

		Unit 30: Four bedrooms—clothes, cigarettes, linens and dirt/dust on the floor. Several beds with either no sheets, blanket or pillow. The facility is reviewing alternatives to the present toilet stall partitions. Possible changes include doors that extend to the ceiling or the use of curtains. The facility finalized AD #512 effective September 23, 2008 addressing Suicide/Self Harm Prevention. It addresses general considerations, assessment of risk of self-harm, and interventions. It specifically requires that no suicide threat, gesture or talk shall be ignored and that any time a suicidal individual is placed into any form of restraint or seclusion, 1:1 observation must be maintained. The Health and Safety Department Environmental Improvements report cites the removal of all lockers in side rooms and dorms and the repositioning of toilet paper holders as suicide prevention efforts that have been completed. In process/plan development are the replacement of slatted vents, the lowering of electrical outlets for CPAP machines to one foot off the floor, and the remodeling of the toilet stall partitions. The look-behind report completed by the Health and Safety Department following a suicide attempt in the period March—August reveals that 11 of 12 attempts included the use of ligature (torn sheets, pillowcases, t-shirts). All individuals were provided enhanced supervision and other interventions. [Trigger data for the same period cites 14 suicide attempts.] Shower room hooks had been replaced by plastic discs in the several areas inspected. In other units, the shower room hooks had been removed, and the plastic discs were expected soon. All units inspected

		had red-lens flashlights for making nighttime rounds. **Compliance:** Partial. **Current recommendations**: 1. Undertake a thorough review of the factors that contributed to the very poor condition of individuals' personal space and take appropriate measures to correct the problems. 2. Continue with the plan to replace the vents that are in places where they pose a suicide hazard. 3. Monitor the Suicide Prevention Compliance data to ensure that inspectors continue to recognize the suicide hazards in bathrooms. 4. DMH should alert all of the facilities to the suicide hazard posed by the air vents when they are in places where they are accessible by standing on furniture or fixtures. 5. Include in the look-behind review of suicide attempts the location where the event occurred, e.g., bathroom stall, seclusion room.
I.3.b	All areas of the hospital that are occupied by individuals being served have adequate temperature control and deviations shall be promptly corrected;	**Current findings on previous recommendation:** **Recommendation, April 2008:** Continue current practice. **Findings:** All areas of the facility toured were maintained at a comfortable temperature. **Other findings:** When extremely high temperatures were expected in May, the Health and Safety Office sent an alert to all units requesting that they record and report the temperature on the unit and in the dining area around noon and again around dinnertime. With the exception of four units, all

		others complied with the request. The temperature logs showed one unit (34) with temperatures consistently above 80; all other units were in the 70s most of the one-week period. Temperature logs were completed for the months of July and August and revealed that no dayroom temperature was above 80 and most were between 70 and 74 degrees. In August, the warmest dayroom was 82 degrees on two days. Most dayroom temperatures were in the 70s. Temperatures on the units were moderate during this monitor's tours. **Compliance:** Substantial. **Current recommendation**: 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:** **Recommendation, April 2008:** Continue to monitor the care provided to individuals with incontinence problems and provide feedback to the WRPTs. **Findings:** According to the minutes of the September HSS Committee meeting, the incontinence audit form and guidelines were distributed and discussed. The facility provided no data on its own audit of the treatment provided to individuals who are incontinent. **Other findings:** This monitor's review of the clinical records of eight individuals identified as having the problem of incontinence found that six of the eight had an incontinence objective in Focus 6, and the records of four

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<td>of those individuals provided evidence of implementation of the interventions specified.

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<tr><th>Individual</th><th>Objectives and interventions in Focus 6</th><th>Evidence of implementation of interventions</th></tr>
<tr><td>AG</td><td>Yes</td><td>Yes</td></tr>
<tr><td>CH</td><td>Yes</td><td>No</td></tr>
<tr><td>JR</td><td>No</td><td></td></tr>
<tr><td>KG</td><td>Yes</td><td>Yes</td></tr>
<tr><td>LJ</td><td>Yes</td><td>Yes</td></tr>
<tr><td>MH</td><td>Yes</td><td>Yes</td></tr>
<tr><td>OP</td><td>Yes</td><td>No</td></tr>
<tr><td>RD</td><td>No</td><td></td></tr>
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Compliance:
Partial.

Current recommendation:
Monitor the treatment provided to individuals with the problem of incontinence using the monitoring tool, provide feedback to the WRPTs, and report this data in the next progress report.</td>
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<td>I.3.d</td>
<td>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</td>
<td>**Current findings on previous recommendation:**

Recommendation, April 2008:
Provide data on the review of the sexual contact incident response monitoring using a standard monitoring form.

Findings:
The facility did not provide any documentation addressing its review of sexual contact incidents.</td>
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		Other findings: Review of the clinical records of six individuals allegedly involved in a sexual incident revealed that each received attention from a physician. Counseling, sometimes but not always limited to advising that the activity was prohibited, was documented in the records of five of the individuals. • DB (7/5/08): Seen by physician, counseled that the activity is not permitted at ASH, no mention of incident in psychiatrist's monthly note. • CG (7/5/08): Seen by physician, counseled. No reference in Psych Tech weekly note. • MM and MB (6/8/08) both counseled and both seen by physician. • SM (6/7/08): Counseled by both physician and Psych Tech. • VG (7/31/08): Psych Tech note and physician note. **Compliance:** Partial. **Current recommendation:** Request the sexual incident audit form from the other facilities and use it to monitor the facility's response to a sample of 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:** **Recommendation, April 2008:** Ensure that non-clinical Mall training providers complete the required training package. **Findings:** The facility's data indicates that non-clinical Mall providers have been trained in PMAB, Abuse/Neglect, By Choice, Mall Overview, Group Facilitation and Learning Strategies sometime between very late 2005

		to those scheduled for some training in November 2008. See also I.1.a.iv. **Compliance:** Partial. **Current recommendation**: Ensure that non-clinical Mall providers are current with those trainings that are conducted periodically (annually, bi-annually).

J. First Amendment and Due Process		
J		**Summary of Progress:** 1. Members of the HAC acknowledge that the members of the facility's leadership regularly attend meetings and are responsive to the questions and concerns of the members. 2. Some HAC officers and others participate in hospital committees where they are able to present the perspective of the individuals. In other instances, the HAC officers and others are members of committees working on the same issue as a parallel staff committee. Individuals report there is substantive communication between the committees. 3. The HAC continues to identify its concerns/priorities, present them as proposals for discussion and review and follow the facility's response.
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:** Participated : Officers' and Chairmen's Meeting of the Hospital Advisory Council Reviewed: Report of results of ASH Individual Survey
J		**Current findings on previous recommendations:** **Recommendation 1, April 2008:** Seriously reconsider the decision to remove copies of the EP from the library. Conduct a Q&A session on the EP at a Hospital Advisory Council meeting, if the individuals are agreeable to this. **Findings:** The facility reports that as of 8/14/08, copies of the Enhancement

Plan have been available in the library. This was confirmed by an individual providing me a tour of the library.

Recommendation 2, April 2008:
Communicate the concerns expressed by the HAC to the Patients' Right Advocate and facilitate a response.

Findings:
The facility provided no information regarding this recommendation. Problems related to the operation of the office of the PRA did not surface during this review.

Recommendation 3, April 2008:
Install bedroom door locks that will keep personal items safe as quickly as possible.

Findings:
The facility reports that it will begin replacing bedroom doors with locks that will allow individuals to lock their rooms from the inside in January 2009. These doors will have a staff override.

Other findings:
Review of selected items on the ASH Individual Survey for the period March—August 2008 yielded the following results:

Item	% positive response
Feel safe?	78%
Treated with respect?	86%
Environment clean and safe?	80%
Helped to meet W&R goals?	84%
Your rights have been explained to you?	78%
Grievance process works ?	64%
If you see A/N, can you report it?	82%

Able to communicate freely with family, attorney or advocate?	79%

In August, 72% of the responses to the question asking if the grievance system worked were positive. In the prior months, positive responses to this question averaged 63%.

During the meeting of the Officers and Chairmen of the Hospital Advisory Council, the individuals acknowledged that they sit on various hospital committees or on parallel committees. The individuals reported effective communication between staff and individual parallel committees dealing with the same or related topics, e.g. By Choice committees. The individuals further acknowledged that representatives of administration are present at their meetings on a regular basis and listen and respond to their questions and concerns. Some members expressed anxiety about the prospect of the facility going smoke-free in November, but were reminded by others of all of the preparatory work that had been done.

Two agenda items that were important to many of the participants were the proposal to have the library open evenings and weekends and advocacy for increasing the $12.50 monthly stipend.

Compliance:
Partial.

Current recommendation:
Survey individuals to determine the reasons for the perception that the grievance procedure at the facility is not effective. If the problems are within the facility's purview, take corrective action. If they are not, document the results of the survey that demonstrate this finding.