REPORT 4

METROPOLITAN STATE HOSPITAL

March 10-14, 2008

THE HUMAN POTENTIAL CONSULTING GROUP
ALEXANDRIA, VIRGINIA

NOTE

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

The Court Monitor is not in any way responsible for the services provided at Metropolitan 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 Metropolitan State Hospital. All decisions regarding the facility, its clinical and administrative operations and the individuals it serves are made independently from the Court Monitor.

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Introduction

A. Background Information

The evaluation team, consisting of Court Monitor (Mohamed El-Sabaawi, MD) and four expert consultants (Vicki Lund, PhD, MSN, ARNP; Ramasamy Manikam, PhD; Elizabeth Chura, MSRN; and Monica Jackman, OTR/L) visited Metropolitan State Hospital (MSH) from March 10 to 14, 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 (C1, C2, D1 through D.7, E, F1 through F 10, G, H., I and J);
2. Current findings focused on the requirements in each action step of the EP; this includes, as appropriate, the facility's internal monitoring data and the evaluators' monitoring data;
3. Compliance status in terms of the EP; and
4. Recommendations.

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

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

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

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

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

C. Statistical Reporting

The following statistical abbreviations used in the report are defined as follows:

Abbreviation	Definition
N	Total target population
n	Sample of target population reviewed/monitored
%S	Sample size; sample of target population reviewed/monitored (n) divided by total target population (N) and multiplied by 100
%C	Compliance rate (unless otherwise noted)

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. Note that MSH often calculates averages over time by summing the number of instances of compliance found over the period audited and dividing that number by a sum of "n" for each month in the period; this may give a slightly different result than an average of the compliance rates generated in each month but is a valid approach.

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

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

   a. The key indicator data are an essential ingredient of a culture of performance improvement. While they are provided to the Court Monitor as required by the EP, the primary users of the data should be the clinical and administrative leadership and management of the facility.

b. MSH reports data on all key indicators and has sufficient longitudinal data for the data to provide insight into trends and patterns.
c. Several important positive trends are illustrated by the data provided as of March 2008, including:
   i. The use of restraint as a behavioral intervention has declined nearly continuously since June 2006, when data was first reported.
   ii. Medications variances have fallen across a range of variance categories.
   iii. MSH appears to be "holding the line" in terms of some practices/trigger categories such as the use of combined pharmacotherapy, incidence and management of diabetes mellitus and weight changes, for which February seemed to generate healthier results than other months.
d. At the same time, the data reveals patterns that should be noted, even though they are not necessarily indicative of poor practices in and of themselves:
   i. There was an increase in the number of individuals diagnosed with fractures in the first calendar quarter. (The increase in diagnoses does not seem to tie to the number of NEW diagnoses of fracture.)
   ii. There was an unexpected death in the facility in seven of the past ten months ending in March 2008.
e. It is the monitor's recommendation that the DMH undertake an analysis of each facility's key indicator data on a quarterly basis. The resulting analysis should be reviewed by the State with their Chief CRIPA Consultant. The outcome of this review should be that the hospitals: (a) use the same statewide definitions for all key indicators; (b) standardize their data collection and data analysis methodologies, (b) improve their services, and (c) use the data for future policy decisions. The DMH Chief CRIPA Consultant should update the monitor on these efforts following each review. It is critical that the key indicator data are valid and reliable, and used to enhance the mental health services provided throughout the DMH system.

2. Monitoring, mentoring and self-evaluation

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

a. MSH has strengthened the structure and functions of its WRP training program. Most importantly, the facility initiated processes of clinical mentors assigned to each WRP to provide ongoing observations and mentoring and a formalized system of feedback to the WRPT utilizing and integrating the facility's monitoring data.
b. The facility's self-monitoring data generally had integrity, were reasonably well organized and the data presented were relevant to requirements of the EP.

c. The facility's self-monitoring data regarding the process and content of Wellness and Recovery Planning (Sections C.1 and C.2) were based on the DMH standardized tools. As mentioned in previous reports, these tools contain indicators and operational instructions that are consistent with EP requirements.
d. The DMH has streamlined and standardized most of the tools used for disciplinary assessments and services. The newly approved tools contain appropriate operational instructions and are well-aligned with requirements of the EP.
e. MSH has improved the sampling methodology during this review period, including a review of up to a 100% sample in some areas (e.g. court assessments). However, further work is needed to ensure acceptable samples of appropriately defined target populations across the board.
f. MSH began to provide data analysis that delineates areas of relative improvement in sub-items of each requirement of the EP when the overall rates were calculated by evaluating compliance with multiple nested requirements. The facility provided adequate plans of correction to improve compliance in most sections of the EP.
g. MSH has to improve the analysis of its self-assessment data. For example, this analysis must explain areas of discrepancy among the data that address similar requirements of the EP (C.2) and between intensive case analysis data and data regarding outcomes of ADRs (F.1).
h. All facilities must ensure that discipline chiefs and senior executives review the monitoring data on a monthly basis at the facility level and that results of these reviews are used to enhance service delivery within each hospital. As mentioned in earlier reports by this monitor, the monitoring data across hospitals should be reviewed quarterly by the State with its Chief CRIPA Consultant so that the aggregate data can be used to enhance the mental health services provided throughout the DMH system.
i. The DMH has yet to ensure that the tools and data collection are automated.

3. Implementation of the EP

a. Overall, MSH has developed most of the structures and processes that are required for implementation of the EP. At this juncture, the facility needs to focus its efforts on using the EP processes and monitoring data to refine the quality of clinical services to the individuals.
b. MSH has achieved substantial compliance with EP requirement regarding the case loads of WRPT members on the long-term units.
c. MSH has made progress in the following areas:
    i. The process of WRP reviews during the WRPCs;
    ii. The formulation of stages of change, objectives and interventions in some WRPs;
    iii. The process and content of initial Psychiatric Assessments (within 24 hours of admission);
    iv. The process and content of Court Reports for individuals admitted under PC 1026 and 1370;

v. Timeliness and content of the Psychological Assessments;
vi. Timeliness and content of the 7-day Social Work and 30-day Psychosocial Assessments;
vii. Implementation of the newly developed Admission and Integrated Nursing Assessments;
viii. Implementation of the newly developed Rehabilitation Assessments (in the psychosocial domain);
ix. The processes of reporting and analysis of adverse drug reactions (ADRs) and medication variances;
x. The process and content of intensive case analysis of ADRs;
xi. The process of functional analysis of behavior and the participation of the PBS team in functions of the WRPT;
xii. The frequency of seclusion and/or restraints of individuals;
xiii. The reliability of self-monitoring data regarding the Infection Control Service;
xiv. The documentation of dental services;
xv. The identification of individuals who have reached behavioral triggers;
xvi. The quality of investigations of abuse/neglect/exploitation of individuals; and
xvii. The cleanliness of the environment of care.

d. MSH has maintained quality improvements in nutritional assessments and services.
e. MSH has yet to make progress in achieving appropriate linkage between interventions provided at the PSR Mall and objectives outlined in the WRP.
f. MSH has to ensure that the Psychiatric Reassessments provide a more concise, individualized and meaningful review of clinical data.
g. MSH needs to implement the newly developed medical policies, procedures and standardized monitoring instruments to ensure correction of process deficiencies in the delivery of medical services.
h. The DMH needs to finalize efforts to automate the processes of assessments and WRPs.
i. 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.
j. Functional outcomes of the current structural changes have yet to be identified and implemented to guide further implementation.
k. 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. Mall hours: The number of hours of Psychosocial Rehabilitation Mall (PSR) services (i.e., group facilitation or individual therapy) provided by the various disciplines, administrative staff, and others is currently minimal. The following table provides the minimum average number of hours of mall services that DMH facilities should provide:

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: Groups 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: Groups 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: Groups 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: Groups 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: Groups 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.

ii. **Progress notes**: MSH has begun to implement a requirement for providers of mall groups and individual therapy to complete and make available to each individual's Wellness and Recovery Planning Team (WRPT) the DMH-approved PSR Mall Facilitator Monthly Progress Note prior to regularly scheduled WRPCs. Without the information in the monthly progress notes, the WRPT has almost no basis for revising an individual's objectives and interventions. This is not aligned with the requirements as stated in the DMH WRP Manual. All hospitals must fully implement the PSR Mall Facilitator Monthly Progress Note in their PSR Malls for all groups and individual therapies.

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

The cognitive screening protocol will also provide information for the WRPT psychologist to determine whether a referral

to the DCAT and/or neuropsychological service is required. 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.

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

v. **Virtual PSR Mall**: Those facilities that 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 MSH staffing table below shows the staffing pattern at the hospital as of January 31, 2008. These data were provided by the facility. The table shows that there continues to be shortages of staff in several key areas: senior psychiatrists, senior psychologists, pharmacy personnel, social workers, rehabilitation therapists and nursing staff (registered nurses and psychiatric technicians). MSH has made progress in recruitment of staff psychiatrists since the last review, but more work is needed to fill all required positions.

Metropolitan State Hospital Vacancy Totals as of January 31, 2008

Identified Clinical Positions	Established Positions 07/08 F.Y.	Caseload Allocations	Filled Positions	Vacancies	Vacancy Rate
Assistant Coordinator of Nursing Services	5.00	5.00	4.00	1.00	20.00%
Assistant Director of Dietetics	2.00	2.00	2.00	0.00	0.00%
Audiologist I	0.00	0.00	0.00	0.00	0.00%
Chief Dentist	0.00	0.00	0.00	0.00	0.00%
Chief Physician & Surgeon	0.00	0.00	0.00	0.00	0.00%

Metropolitan State Hospital Vacancy Totals
as of January 31, 2008

Identified Clinical Positions	Established Positions 07/08 F.Y.	Caseload Allocations	Filled Positions	Vacancies	Vacancy Rate
Chief, Central Program Services	1.00	1.00	1.00	0.00	0.00%
Chief Psychologist	1.00	1.00	1.00	0.00	0.00%
Clinical Dietician/Pre-Reg. Clin. Dietician	8.00	8.00	8.00	0.00	0.00%
Clinical Laboratory Technologist	5.00	5.00	4.00	1.00	20.00%
Clinical Social Worker	54.80	47.25	38.50	8.75	18.52%
Coordinator of Nursing Services	1.00	1.00	1.00	0.00	0.00%
Coordinator of Volunteer Services	1.00	1.00	1.00	0.00	0.00%
Dental Assistant	2.00	2.00	2.00	0.00	0.00%
Dentist	2.00	2.00	2.00	0.00	0.00%
Dietetic Technician	2.00	2.00	2.00	0.00	0.00%
E.E.G. Technician	1.00	1.00	1.00	0.00	0.00%
Food Service Technician I and II	82.00	82.00	67.50	14.50	17.68%
Hospital Police Lieutenant	2.00	2.00	2.00	0.00	0.00%
Hospital Police Sergeant	6.00	6.00	5.00	1.00	16.67%
Hospital Police Officer	53.00	53.00	47.00	6.00	11.32%
Hospital Worker	6.00	6.00	5.00	1.00	16.67%
Health Record Technician I	26.00	26.00	20.00	6.00	23.08%
Health Record Techn II Sp	6.00	6.00	6.00	0.00	0.00%
Health Record Techn II Sup	3.00	3.00	2.00	1.00	33.33%
Health Record Techn III	2.00	2.00	2.00	0.00	0.00%
Health Services Specialist	34.00	34.00	27.00	7.00	20.59%
Institution Artist Facilitator	1.00	1.00	0.00	1.00	100.00%

Metropolitan State Hospital Vacancy Totals as of January 31, 2008					
Identified Clinical Positions	**Established Positions 07/08 F.Y.**	**Caseload Allocations**	**Filled Positions**	**Vacancies**	**Vacancy Rate**
Licensed Vocational Nurse	47.00	44.00	44.00	0.00	0.00%
Medical Technical Assistant	0.00	0.00	0.00	0.00	0.00%
Medical Transcriber	4.00	4.00	2.00	2.00	50.00%
Medical Transcriber Sup	0.00	0.00	0.00	0.00	0.00%
Sr Medical Transcriber	0.00	0.00	0.00	0.00	0.00%
Nurse Instructor	4.00	4.00	4.00	0.00	0.00%
Nurse Practitioner	1.00	1.00	1.00	0.00	0.00%
Nursing Coordinator	6.00	6.00	6.00	0.00	0.00%
Office Technician	42.50	42.50	36.00	6.50	15.29%
Pathologist	0.00	0.00	0.00	0.00	0.00%
Pharmacist I	18.60	18.60	14.60	4.00	21.51%
Pharmacist II	2.00	2.00	2.00	0.00	0.00%
Pharmacy Services Manager	1.00	1.00	1.00	0.00	0.00%
Pharmacy Technician	13.60	13.60	11.00	2.60	19.12%
Physician & Surgeon (includes 1 Prog. Dir. - Medical)	20.20	20.20	19.00	1.20	5.94%
Podiatrist	1.00	1.00	1.00	0.00	0.00%
Pre-licensed Pharmacist	0.00	0.00	0.00	0.00	0.00%
Pre-licensed Psychiatric Technician	0.00	0.00	0.00	0.00	0.00%
Program Assistant	7.00	7.00	6.00	1.00	14.29%
Program Consultant (RT, PSW)	2.00	2.00	1.00	1.00	50.00%
Program Director	6.00	6.00	6.00	0.00	0.00%
Psychiatric Nursing Education Director	1.00	1.00	1.00	0.00	0.00%

Metropolitan State Hospital Vacancy Totals
as of January 31, 2008

Identified Clinical Positions	Established Positions 07/08 F.Y.	Caseload Allocations	Filled Positions	Vacancies	Vacancy Rate
Psychiatric Technician *	351.60	244.19	259.00	-14.81	-6.06%
Psychiatric Technician Trainee*	0.00	0.00	0.00	0.00	0.00%
Psychiatric Technician Assistant*	52.00	52.00	45.00	7.00	13.46%
Psychiatric Technician Instructor	1.00	1.00	1.00	0.00	0.00%
Psychologist-HF, (Safety)	45.30	36.91	33.00	3.91	10.59%
Public Health Nurse II/I	2.00	2.00	2.00	0.00	0.00%
Radiologic Technologist	1.00	1.00	1.00	0.00	0.00%
Registered Nurse *	181.00	195.57	143.00	52.57	26.88%
Reg. Nurse Pre Registered	0.00	0.00	0.00	0.00	0.00%
Rehabilitation Therapist	51.00	43.25	36.60	6.65	15.38%
Special Investigator	1.00	1.00	1.00	0.00	0.00%
Special Investigator, Senior	3.10	3.10	3.00	0.10	3.23%
Speech Pathologist I	0.00	0.00	0.00	0.00	0.00%
Sr. Psychiatrist	11.50	11.50	6.00	5.50	47.83%
Sr. Psychologist (Spvr and Spec)	10.00	10.00	4.00	6.00	60.00%
Sr. Psych Tech(Safety)	53.00	45.00	42.00	3.00	6.67%
Sr. Radiologic Technologist (Specialist)	1.00	1.00	1.00	0.00	0.00%
Sr. Voc. Rehab. Counselor/Voc. Rehab. Counselor	0.00	0.00	0.00	0.00	0.00%
Staff Psychiatrist	50.00	39.57	42.90	-3.33	-8.42%
Supervising Psychiatric Social Worker	0.00	0.00	0.00	0.00	0.00%
Supervising Registered Nurse	9.00	9.00	7.00	2.00	22.22%
Supervising Rehabilitation Therapist	0.00	0.00	0.00	0.00	0.00%

Metropolitan State Hospital Vacancy Totals as of January 31, 2008					
Identified Clinical Positions	**Established Positions 07/08 F.Y.**	**Caseload Allocations**	**Filled Positions**	**Vacancies**	**Vacancy Rate**
Teacher-Adult Educ./Vocational Instructor	9.40	9.40	7.00	2.40	25.53%
Teaching Assistant	10.00	0.00	0.00	0.00	0.00%
Unit Supervisor	21.00	21.00	15.00	6.00	28.57%
Vocational Services Instructor	2.00	2.00	1.00	1.00	50.00%

In order to meet the Enhancement Plan requirements, the overall numbers of nursing staff must increase and the skill mix must be expanded. The facility needs sufficient numbers of direct service nursing staff to provide a minimum of 5.5 nursing care hours per patient day (NCHPPD) on all units. If any individual on the unit is on 1:1 observation, an additional staff member should be added to each shift for the period of time an individual is on 1:1 observation, and this additional staff member would not be counted in the overall NCHPPD.

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

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

Finally, while MSH is not as affected as other facilities, 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.

F. Next Steps

1. The Court Monitor's team is scheduled to tour Metropolitan State Hospital September 8 to 12, 2008.for a follow-up evaluation.
2. The Court Monitor's team is scheduled to reevaluate Atascadero State Hospital April 21 to 25, 2008.
3. All compliance reports should be reviewed and utilized, as applicable, by all facilities to guide implementation efforts regardless of the schedule of facility-specific assessments.

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. MSH has improved the process of WRP reviews during the WRPCs. 2. MSH has achieved substantial compliance with the requirement regarding case loads of WRPT core members on the long-term units. 3. MSH has strengthened the WRP training programs, including the establishment of clinical mentorship for each WRPT and formalizing a system of feedback to the teams utilizing team-specific monitoring data. 4. MSH has maintained substantial compliance with the timeliness of WRP reviews within 24 hours and seven days after admission. 5. MSH has made some progress in the formulation of stages of change, objectives and interventions in some WRPs. 6. MSH began to conduct analysis of its monitoring data to address progress on sub-items of multiple nested requirements.
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. Nady Hanna, MD, Medical Staff President 2. Bala Gulasekaram, MD, Chief of Psychiatry 3. Kenneth Layman, Treatment Enhancement Coordinator <u>Reviewed</u>: 1. WRP Mentor Training Database 2. WRP Mentor Roles and Responsibilities 3. WRP Mentoring Assignments 4. Outline of training for WRP Master Trainers on February 29, 2008 5. Phase II WRP Team Member Training Database

		6. WRP Training Record for Team Members by 95% (or above) 7. Outline of MSH Engagement Module PowerPoint Presentation 8. MSH Team Leader Supportive Actions 9. WRP Update Training: Addressing Discharge Planning 10. DMH WRP Clinical Chart Auditing Form 11. DMH WRP Clinical Chart Auditing Form Instructions 12. MSH WRP Clinical Chart Auditing summary data (August 2007 to January 2008) 13. DMH Psychiatry Team Leadership Monitoring Form 14. DMH Psychiatry Team Leadership Monitoring Form Instructions 15. MSH Psychiatry Team Leadership Monitoring summary data (August 2007 to January 2008) 16. DMH WRP Process Observation Monitoring Form 17. DMH WRP Process Observation Monitoring Form Instructions 18. MSH WRP Process Observation Monitoring summary data (August 2007 to January 2008) 19. DMH Admission Psychiatric Assessment Auditing Form 20. DMH Admission Psychiatric Assessment Auditing Form Instructions 21. DMH Integrated Assessment: Psychiatry Section Auditing Form 22. DMH Integrated Assessment: Psychiatry Section Auditing Form Instructions 23. DMH Psychiatric Progress Notes Auditing Form 24. DMH Psychiatric Progress Notes Auditing Form Instructions 25. DMH Integrated Assessment: Psychology Section Auditing Form 26. DMH Integrated Assessment: Psychology Section Auditing Form Instructions 27. DMH Physician Inter-Unit Transfer Note Auditing Form 28. DMH Physician Inter-Unit Transfer Note Auditing Form Instructions 29. DMH 30-Day Psychosocial Assessment Auditing Form 30. DMH 30-Day Psychosocial Assessment Auditing Form Instructions 31. DMH Integrated Assessment: Nursing Section Form 32. DMH Integrated Assessment: Nursing Section Instructions

		33. DMH Integrated Assessment: Social Work Auditing Form 34. DMH Integrated Assessment: Social Work Auditing Form Instructions 35. MSH data regarding vacancies in clinical classifications 36. MSH data regarding attendance by core WRPT members at WRPCs 37. MSH data regarding case loads of core WRPT members on admission and long-term services <u>Observed</u>: 1. WRPC (Program II unit 412) for quarterly review of CL 2. WRPC (Program V, unit 403) for annual review of REW 3. WRPC (Program V, unit 411) for monthly review of JB 4. WRPC (Program III, unit 407) for quarterly review of JP 5. WRPC (Program V, unit 405) for quarterly review of DAMB 6. WRPC (Program III, unit 407) for monthly review of RAM 7. WRPC (Program III, unit 401) for review of JF
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:** **Recommendation 1, August 2007:** Ensure that senior clinicians from all core disciplines provide ongoing feedback and mentoring to WRPTs to correct the deficiencies identified above. **Findings:** Since the last review, MSH has designed and implemented a senior clinical mentoring process. Senior clinicians from the classifications of Psychiatry, Psychology, Social Work, Rehabilitation, Registered Nurses and Psychiatric Technicians were identified and trained by the WRP master trainers. The trainers included the President of the Medical staff and the discipline chiefs of Psychiatry, Psychology, Social Work, Rehabilitation and Treatment Enhancement. This training was provided on January 8, 11, 22 and 24 and February 14, 2008 for a total of 17

		hours. The training included didactic and experiential components and a variety of written instructional materials on roles, responsibilities and knowledge requirements as well as follow-up on specific recommendations from the monitor's reports. Since the last review, 41 senior clinicians from all core disciplines have been assigned to mentor and/or co-mentor all teams in the facility. Since late January 2008, the mentors have been assigned to meet with their teams weekly to improve teams' performance on the process and content of WRP. **Recommendation 2, August 2007:** Increase training sessions provided to WRP trainers (Phases II and III). **Findings:** MSH has increased training for WRP master trainers during this reporting period. The trainers have met to discuss WRP issues to increase knowledge and consistency of training presentations for the WRPTs. In addition, the DMH Chief CRIPA Consultant provided training to the WRP trainers on February 29, 2008. **Recommendations 3 and 5, August 2007:** • Provide clear documentation of WRP training sessions provided to the trainers and to the WRPTs. • Continue new employee WRP training (for non-nursing disciplines). **Findings:** Since the last review, MSH has provided the following training programs to its WRPTs: 1. Presentations by the master trainers on September 24 and 27, October 11 and November 15, 2007 for a total of 32 hours. The curriculum included the following: a) Previously designed modules (engagement, diagnosis and case

		formulation, discharge planning, foci and objectives, and interventions and mall integration); b) A new PowerPoint presentation regarding engagement of individuals; c) New written examples and suggestions for writing objectives and interventions; and d) A new discharge planning component focusing on the continuity of discharge planning within sections of the WRP 2. Additional three sessions of updates (two hours each) by the master trainers; 3. Clinical mentorship by WRP mentors as described above. This included a review and update on EP requirements for WRP process and documentation; 4. Use of approved WRP knowledge assessment test to measure competency and catch-up testing (see next recommendation); and 5. Use of new feedback system from master trainers and mentors to the WRPTs. This system consists of the following components: a) A memorandum and a graph are provided to each team regarding team-specific WRP Process Observation data; b) Team-specific data concerning engagement is shared with the team leaders via hard copy mail; c) Team-specific data is provided to mentors to share with their teams (effective January 2008). **Recommendations 4, August 2007:** Provide documentation of WRP competencies of WRPTs. **Findings:** Since the last review, MSH has increased its competency threshold from 80% to 95% based on successful completion of the WRP Knowledge Assessment Post-Test. The following table outlines the percentages of WRPT staff who obtained a WRP knowledge assessment test score of 95% or above. The data showed that these percentages

have increased from an average of 25% to 96% during this reporting period. Some of the staff included in this table obtained the required score after being re-tested.

	Aug	Sep	Oct	Nov	Dec	Jan
MDs	28	67	77	95	95	95
PhDs	32	61	89	83	83	100
SWs	42	73	91	94	94	94
RTs	30	64	76	88	88	97
RNs	15	46	59	92	92	97
PTs	4	39	51	65	85	95
Mean	25	58	74	86	90	96

Other findings:
The monitor attended six WRPCs. In general, the meetings showed progress in the overall process of the team meetings. The following are examples of areas of progress:

1. All meetings started on time.
2. The team psychiatrists assumed leadership of all meetings attended.
3. All meetings included the required core members of the WRPT.
4. The teams presented a summary of the assessment data and reviewed risk factors prior to the individual's arrival.
5. The team members were respectful of the individuals and made an effort to elicit their input.
6. The teams reviewed the diagnosis, objectives and interventions with the individual.
7. In general, the teams updated the life goals and strengths during the meeting.
8. The teams made an effort to review the individual's attendance (and participation) at the assigned groups.
9. In general, the teams reviewed the By Choice participation and

		point allocation with the individual. However, the meetings showed the following process deficiencies: 1. The posters on the walls of the treatment teams included the wrong sequence of tasks. 2. In some meetings, the teams and individuals were unable to review the projected print of the WRPs because of its small size. 3. The teams did not consistently identify key questions/issues to be discussed with the individual. 4. The updates of the present status did not consistently include the required elements, including the individual's input. 5. There was no mechanism to conduct data-based review of the individuals' progress in Mall groups. 6. The teams did not consistently revise/update the case formulation, foci, objectives and interventions. 7. The reviews of diagnosis, foci, objectives and interventions were not consistently informed by the assessments/ consultations and the case formulation. 8. The reviews of the discharge criteria were either generic or did not occur, and the teams did not consistently discuss with the individual progress needed to meet each criterion. The above deficiencies must be corrected to achieve substantial compliance with EP requirements regarding the WRP process. **Compliance:** Partial. **Current recommendations**: 1. Provide a summary outline of all WRP training and mentoring provided to the WRPTs during the reporting period. 2. Provide documentation of WRP competencies of WRPTs.

<table>
<tr>
<td>C.1.b</td>
<td>Be led by a clinical professional who is involved in the care of the individual.</td>
<td>
Current findings on previous recommendations:

Recommendation 1, August 2007:
Ensure that senior clinicians from all core disciplines provide ongoing feedback and mentoring to WRPTs. (Also applicable to C.1.c through C.1.f).

Findings:
Same as Findings for Recommendation 1 in C.1.a.

Recommendations 2 and 3, August 2007:
• Continue to monitor the presence and participation by team leaders in the WRPCs.
• Standardize the process of monitoring of the presence and participation by team leaders across facilities.

Findings:
The DMH has developed and implemented two standardized tools for monitoring the presence and participation of team leaders. MSH implemented these tools to assess compliance.

Using the DMH WRP Observation Monitoring Form, the facility reviewed variable samples for each type of conference. The following table outlines the average sample size and corresponding mean compliance rate for each type of WRPC (August 2007 to January 2008):
<table>
<tr><th>WRPC</th><th>%S</th><th>%C</th></tr>
<tr><td>7-Day</td><td>8%</td><td>93%</td></tr>
<tr><td>14-Day</td><td>28%</td><td>96%</td></tr>
<tr><td>Monthly</td><td>14%</td><td>96%</td></tr>
<tr><td>Quarterly</td><td>15%</td><td>96%</td></tr>
<tr><td>Annual</td><td>14%</td><td>94%</td></tr>
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</table>

To assess the participation of the team leaders, the facility used the DMH Psychiatry Team Leadership Monitoring Form (August 2007 to January 2008). The average sample was 85% of the target (two audits per program per month). The following are the monitoring indicators and corresponding mean compliance rates:

1.	*Psychiatrist was present.*	100%
2.	*Psychiatrist elicited the participation of all disciplines.*	100%
3.	*Psychiatrist ensured the (integration of) assessments from other disciplines into the case formulation.*	92%
4.	*Psychiatrist ensured the "Present Status" section in the Case Formulation was updated.*	98%
5.	*Psychiatrist ensured that the interventions were linked to the measurable objectives.*	62%
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.*	75%

Compliance:
Partial.

Current recommendations:
1. Monitor this requirement using 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).

<table>
<tr>
<td>C.1.c</td>
<td>Function in an interdisciplinary fashion.</td>
<td>
Current findings on previous recommendation:

Recommendation 1, August 2007:
Ensure that senior clinicians from all core disciplines provide ongoing feedback and mentoring to WRPTs.

Findings:
Same as Findings for Recommendation 1 in C.1.a.

Recommendation 2, August 2007:
Monitor this requirement based on at least a 20% sample.

Findings:
MSH used the DMH WRP Observation Monitoring Form (7-Day, 14-Day, Monthly, Quarterly and Annual) to assess compliance (August, 2007 to January 2008). The average sample sizes were outlined in C.1.b. The data did not include monitoring done during September 2007 due to a very small sample during that period. The following table shows the mean compliance rates for each type of conference:
<table>
<tr><th>WRPC</th><th>%C</th></tr>
<tr><td>7-Day</td><td>21%</td></tr>
<tr><td>14-Day</td><td>43%</td></tr>
<tr><td>Monthly</td><td>20%</td></tr>
<tr><td>Quarterly</td><td>13%</td></tr>
<tr><td>Annual</td><td>28%</td></tr>
</table>

The facility conducted data analysis that showed improvement from August 2007 to January 2008 in sub-items related to this requirement. The following is a summary of this monitor's interpretation of the data:
</td>
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<table>
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<td>
<table>
<tr><td>1.</td><td>The team reviews and updates the WRPC Task Tracking Form</td><td></td></tr>
<tr><td></td><td>14-Day WRPC</td><td>From 60% to 89%</td></tr>
<tr><td></td><td>Monthly WRPC</td><td>From 61% to 83%</td></tr>
<tr><td></td><td>Annual WRPC</td><td>From 67% to 75%</td></tr>
<tr><td>2.</td><td>Team members present assessments/ consultations as listed in the Task Tracking Form</td><td></td></tr>
<tr><td></td><td>14-Day WRPC</td><td>From 60% to 100%</td></tr>
<tr><td></td><td>Monthly WRPC</td><td>From 44%to 60%</td></tr>
<tr><td></td><td>Annual WRPC</td><td>From 48% to 80%</td></tr>
<tr><td>3.</td><td>Team presents By Choice data</td><td></td></tr>
<tr><td></td><td>Quarterly WRPC</td><td>From 60% to 85%</td></tr>
<tr><td>4.</td><td>Team discusses medical conditions</td><td></td></tr>
<tr><td></td><td>Quarterly WRPC</td><td>From 60% to 96%</td></tr>
</table>

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

Recommendation 1, August 2007:
Ensure that senior clinicians from all core disciplines provide ongoing feedback and mentoring to WRPTs.</td>
</tr>
</table>

		Findings: Same as Findings for Recommendation 1 in C.1.a. **Recommendation 2, August 2007:** Continue to survey the views of team members regarding the role of psychiatrists as team leaders. **Findings:** This recommendation is no longer needed because the new DMH Psychiatry Team Leadership Monitoring Form adequately addresses the requirement (see C.1.b). **Recommendation 3, August 2007:** Present data from the Clinical Chart Auditing Form regarding this requirement. **Findings:** MSH used the DMH Clinical Chart Auditing Form that was recently standardized. Based on this process, the facility reviewed an average sample of 20% and found a mean compliance rate of 43%. The data showed relative improvement in this item from August 2007 (5%) to January 2008 (64%). **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).

C.1.e	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.	**Current findings on previous recommendations:** **Recommendation 1, August 2007:** Ensure that senior clinicians from all core disciplines provide ongoing feedback and mentoring to WRPTs. **Findings:** Same as Findings for Recommendation 1 in C.1.a. **Recommendation 2, August 2007:** Finalize efforts to streamline and standardize monitoring instruments that address quality of all disciplinary assessments. **Findings:** The DMH has implemented this recommendation except for tools that address the Admission Medical Assessment and the Rehabilitation Assessment. The finalized tools are accompanied by operational instructions that align with EP requirements. The following is a list of these tools: 1. DMH Admission Psychiatric Assessment Auditing Form 2. DMH Integrated Psychiatric Assessment Auditing Form 3. DMH Physician Inter-Unit Transfer Note Auditing Form 4. DMH Psychology Assessment Auditing Form 5. DMH Discharge Planning and Community Integration Auditing Form 6. DMH Nursing Assessment Monitoring Form 7. DMH Nutritional Assessment Auditing Form 8. DMH Social Work Assessment Auditing Form. **Recommendation 3, August 2007:** Continue to monitor this requirement using process observation.

Findings:
MSH used the WRP observation process described in C.1.c. The following table outlines the mean compliance rate for each type of WRPC:

WRPC	**%C**
7-Day	21%
14-Day	34%
Monthly	16%
Quarterly	14%
Annual	15%

The facility conducted data analysis that showed relative improvement (August 2007 compared to January 2008) in a variety of sub-items. The following is a summary of this monitor's interpretation of the data:

1.	*Team members present relevant and appropriate content for the assessment*	
	14-Day WRPC	From 30% to 59%
	Annual WRPC	From 13% to 43%
2.	*Team reviews outcomes, including By Choice Allocation*	
	14-Day WRPC	From 60% to 90%
	Annual WRPC	From 14% to 71%
3.	*Team reviews outcomes, including medical conditions*	
	14-Day WRPC	From 60% to 100%
4.	*Team members present assessments/consultations as listed on the Task Tracking Form*	
	Quarterly WRPC	From 47% to 64%

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<tr><td>5.</td><td>Team discusses Mall Facilitator Progress Note</td><td></td></tr>
<tr><td></td><td>Quarterly WRPC</td><td>From 45% to 65%</td></tr>
<tr><td>6.</td><td>Team reviews alerts and risks</td><td></td></tr>
<tr><td></td><td>Quarterly WRPC</td><td>From 45% to 100%</td></tr>
<tr><td>7.</td><td>Team reviews outcomes, including MOSES data</td><td></td></tr>
<tr><td></td><td>Annual WRPC</td><td>From 17% to 86%</td></tr>
</table>

Recommendation 4, August 2007:
Expedite recruitment and training to improve compliance.

Findings:
MSH's data showed that Psychology and Social Work vacancy rates have significantly decreased since the last review. On July 31, 2007, these vacancies were 12.2 and 14.0 positions and on January 31, 2008 had decreased to 4.9 and 8.45 respectively. The Psychiatry department has not had any vacancies since the last review.

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).
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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</td>
<td>Current findings on previous recommendations:</td>
</tr>
</table>

those results for diagnosis, therapy and rehabilitation by no later than the next review.

Recommendation 1, August 2007:
Ensure that senior clinicians from all core disciplines provide ongoing feedback and mentoring to WRPTs.

Findings:
Same as Findings for Recommendation 1 in C.1.a.

Recommendation 2, August 2007:
Continue to monitor this requirement using process observation.

Findings:
MSH used the previously described WRP observation process. The following table outlines the mean compliance rate for each type of WRPC:

WRPC	%C
7-Day	29%
14-Day	38%
Monthly	19%
Quarterly	22%
Annual	22%

Data analysis by MSH showed relative improvement in compliance with this requirement (14-Day WRPC) from 22% (August 2007) to 40% (January 2008).

Recommendation 3, August 2007:
Expedite recruitment and training to improve compliance.

Findings:
Same as Findings for Recommendation 4 in C.1.e.

<table>
<tr><td></td><td></td><td>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).</td></tr>
<tr><td>C.1.g</td><td>Be responsible for the scheduling and coordination of assessments and team meetings, the drafting of integrated treatment plans, and the scheduling and coordination of necessary progress reviews.</td><td>Current findings on previous recommendation:

Recommendation, August 2007:
Expedite recruitment efforts.

Findings:
Same as Findings for Recommendation 4 in C.1.e.

Other Findings:
Using the previously described WRP observation process, the facility assessed its compliance with this requirement (August 2007 to January 2008). The following table outlines the mean compliance rate for each type of WRPC:

<table>
<tr><th>WRPC</th><th>%C</th></tr>
<tr><td>7-Day</td><td>64%</td></tr>
<tr><td>14-Day</td><td>81%</td></tr>
<tr><td>Monthly</td><td>65%</td></tr>
<tr><td>Quarterly</td><td>69%</td></tr>
<tr><td>Annual</td><td>48%</td></tr>
</table>

Data analysis by MSH showed relative improvement in compliance with this requirement (August 2007 to January 2008) from 70% to 90% (14-</td></tr>
</table>

		Day WRPC) and 14% to 57% (Annual WRPC). Review of data related to sub-items showed improvement in the team's identification of a recorder from 95% to 100% (Quarterly WRPC). **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.h	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.	**Current findings on previous recommendations:** **Recommendation 1, August 2007:** Continue current efforts to improve attendance by core members. **Findings:** Since the last review, MSH has increased administrative oversight of attendance by core members. The oversight now includes weekly spot-checks of RN and PT presence, review of WRP signature pages by program managers and submission by program directors or designees to the facility's Clinical Administrator of weekly attendance reports. **Recommendation 2, August 2007:** Continue to monitor this requirement and ensure a sample size of at least 20%. **Findings:** MSH provided process observation data regarding attendance by core members. The data are based on an average sample of 15% of the

<table>
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<td>WRPCs that were held during the reporting month. The following table outlines the data:

<table>
<tr><td></td><td>Aug</td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Mean</td></tr>
<tr><td>MDs</td><td>89</td><td>95</td><td>96</td><td>91</td><td>87</td><td>94</td><td>92</td></tr>
<tr><td>PhDs</td><td>59</td><td>55</td><td>74</td><td>64</td><td>69</td><td>79</td><td>66</td></tr>
<tr><td>SWs</td><td>90</td><td>86</td><td>92</td><td>90</td><td>85</td><td>90</td><td>89</td></tr>
<tr><td>RTs</td><td>79</td><td>69</td><td>78</td><td>79</td><td>65</td><td>69</td><td>73</td></tr>
<tr><td>RNs</td><td>98</td><td>98</td><td>99</td><td>98</td><td>99</td><td>97</td><td>98</td></tr>
<tr><td>PTs</td><td>76</td><td>79</td><td>86</td><td>80</td><td>71</td><td>68</td><td>76</td></tr>
<tr><td>Mean</td><td>82</td><td>80</td><td>88</td><td>84</td><td>79</td><td>83</td><td>83</td></tr>
</table>

Data analysis showed that the sample size has increased from 9% in July 2007 to 16% in January 2008, that the mean compliance for all disciplines has increased from 72% (July 2007) to 83% (January 2008) and that increased recruitment of psychologists have resulted in significant increase in attendance by this discipline.

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).</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</td>
<td>**Current findings on previous recommendation:**

Recommendations 1 and 2, August 2007:
- Expedite recruitment efforts for all core disciplines.</td>
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time.

- Resolve barriers related to recruitment of psychologists and social workers.

Findings:
Same as Findings for Recommendation 4 in C.1.e.

Other findings:
The facility presented data regarding the case loads of core members on the admission and long-term units. The following tables outline the data:

Admissions WRPTs (expected ratios 1:15)							
	Aug	Sep	Oct	Nov	Dec	Jan	Mean
MDs	16.9	16.8	16.8	16.4	15.8	15.1	16.3
PhDs	21.5	20.2	19.8	18.2	17.1	16.6	19.0
SWs	21.0	21.1	20.2	18.2	17.7	16.5	19.1
RTs	16.3	16.4	15.8	17.2	16.5	15.8	16.3
RNs	16.2	16.4	15.3	16.9	16.5	15.4	16.1
PTs	15.4	15.8	15.1	16.2	15.8	15.3	15.6
Mean	17.9	17.8	17.2	17.2	16.6	15.8	17.1

Long-Term WRPTs (average expected ratios 1:25)							
	Aug	Sep	Oct	Nov	Dec	Jan	Mean
MDs	20.7	21.4	20.6	20.9	20.4	19.7	20.6
PhDs	23.9	23.6	24.4	24.1	24.0	24.0	24.0
SWs	25.2	25.0	24.7	24.4	24.3	22.2	24.1
RTs	21.9	21.0	21.4	21.2	21.6	19.4	21.1
RNs	23.5	23.9	24.0	23.0	23.0	23.1	23.4
PTs	24.2	23.1	22.4	22.4	21.1	23.0	22.7
Mean	23.2	22.6	22.9	22.7	22.4	21.9	22.6

The data showed that the long-term disciplines are now all under the

		expected ratio of 1:25. The Admission disciplines are at or near expected ratio of 1:15. The facility's analysis of the admission teams' data noted the following positive trends (August 2007 to January 2008): 1. The mean case loads for all disciplines have decreased from 1:17.9 to 1:15.8. 2. The Social Work case loads have improved from 1:21 to 1:16.5. 3. The Psychology case loads have improved from 1:21.5 to 1:16.6. In addition, compared to the mean for the last review period, the mean case load has improved from 19.6 to 19.0 for psychology. **Compliance:** Partial. **Current recommendations**: 1. Continue current practice on the long-term units. 2. Continue efforts to achieve compliance on the admission units. 3. Provide data regarding case loads on both the admission and long-term units.
C.1.j	Not include staff that is not verifiably competent in the development and implementation of interdisciplinary wellness and recovery plans.	**Current findings on previous recommendation:** **Recommendation, August 2007:** Same as in C.1.a through C.1.f. **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:** <u>Interviewed</u>: 1. Individuals PZ, RK and SM 2. Abilio Hernandez, MD, Psychiatrist 3. Albert Olmors, PT 4. Alex Callanta, RN, Supervisor 5. Alonzo Webb, PT 6. Ana Peeks, PsyD, Psychologist 7. Andrea Cirota, CTRS, Rehabilitation Therapy Supervisor 8. Andrea Zaug, RT 9. Asha Vij, Occupational Therapist 10. Ashvind Singh, PhD, Psychologist 11. Barbara Rodriguez, RNA (Restorative Nursing Assistant) 12. Barbara Yau, LCSW, Social Work 13. Brian Hough, PhD, Senior Psychologist 14. Cynthia Lusch, Clinical Administrator 15. Dalisay Quines, PT 16. Dawn Lyons, Dance Movement Therapist 17. Debra Hughs, Unit Supervisor 18. Don Pieratt, PT, BY CHOICE Coordinator, Program V 19. Doug Strosnider, Mall Director 20. Edwin Poon, PhD, Psychologist 21. Edward Tongwa, SPT 22. Emily Dukesherer, Recreation Therapist 23. Eric McMullen, PT 24. Estelita Perreras, RN 25. Eugenio Danganam, PTA 26. Gretchen Hunt, BY CHOICE Coordinator 27. Jack McClary, Supervisor of Vocational Services 28. Jamie Critie, Mall Coordinator Program 6 29. Jeff Bookman, PT

		30. Jocelyn Agtarap, RN, Supervisor 31. John Lush, Program Director 32. John Pyle, PT 33. Josephine Salumbides, PT 34. Julia Hastings, Physical Therapist 35. Karen Chong, Program Director 36. Kenneth Layman, Treatment Enhancement Coordinator 37. Linda Gross, RN, Nurse Coordinator 38. Linda Scott, PA 39. Lisa Rimland, MT-BC, WRP Trainer 40. Lolly Doyle, LCSW, Social Work 41. Luz Abayata, RN 42. Lydia Greico, PT 43. Mari Cobb, Chief of Rehabilitation Therapy Services 44. Marion Paclibar, Physical Therapist 45. Marsha Jordan-Woods, Recreation Therapist 46. Mary Lou, Assistant Chief, Central Program Services 47. Michael Barsom, MD, Medical Director 48. Moheb Beshey, MD, Psychiatrist 49. Nady Hanna, MD, Medical Staff President 50. Purvi Shahpatel, LCSW 51. Rebecca McClary, Program Assistant 52. Richard Hartley, PhD, Psychologist 53. Roudabeh Rahbar, PhD, Substance Recovery Coordinator 54. Sean Johnson, Assistant BY CHOICE Coordinator 55. Sharon Nevins, Executive Director 56. Shirin Karimi, LCSW, Chief of Social Work 57. Silas Santiago Gomez, PT 58. Socorro Sanchez, PT 59. Stacy Weeks, PhD, Psychologist 60. Stelita Perreras, RN 61. Stephens Scottirae, LCSW, Social Work 62. Steve Yang, PsyD, Psychologist

		63. Steven Jones, PT 64. Swati Roy, PhD, Chief of Psychology, Co-Chair of BCC 65. Tommy Phillips JR., Unit Supervisor <u>Reviewed</u>: 1. The charts of the following 179 individuals: AA, AB, ABJ, ABW, AC, AE, ADJ, AFC, AJH, ALL, AMA, APT, ARF, BAM, BEA, BF, BG, BJ, BM, BR, BRB, BT, BU, CA, CAZ, CC, CDH, CEM, CG, CJ, CL, CLP, CM, CP, CR, CW, CWL, DEL, DG, DLG, DLH, DLJ, DLL, DLT, DP, DPM, DT, DTP, DY, EB, EC, EK, EL, ELN, EM, ETJ, EWK, FJ, FM, FMK, GB, GCA, GCR, GP, GR, GS, HAS, HL, JA, JAM, JAN, JB, JC, JCT, JD, JDS, JFK, JG, JHT, JJ, JLB, JM, JM-2, JMS, JQ, JR, JRB, JS, JSA, JWG, KB, KLL, KLM, KMA, KMO, KO, KR, KRS, KS, LB, LEW, LI, LLD, LP, LVL, MAM, MAO, MC, MCA, MCL, MEB, MG, ML, MM, MOS, MP, MS, NA, NEJ, OBJ, OJB, OJV, OLM, OS, PB, PC, PD, PDF, PGB, PS, PT, PW, PZ, RA, RAL, RB, RBG, RD, REG, RES, RF, RFC, RG, RH, RHL, RJD, RK, RLM, RLS, RM, RMT, RR, RS, RTL, RV, RW, SB, SE, SH, SJ, SL, SM, SMA, SMN, SO, SP, SS, TAN, TB, THE, TP, TS, VMR, VP, VTM, WH, WJM, WO and WRP 2. DMH WRP Clinical Chart Auditing Form 3. DMH WRP Clinical Chart Auditing Form Instructions 4. MSH WRP Clinical Chart Auditing summary data (August 2007 to January 2008) 5. DMH WRP Process Observation Monitoring Form 6. DMH WRP Process Observation Monitoring Form Instructions 7. MSH WRP Process Observation Monitoring summary data (August 2007 to January 2008) 8. DMH WRP Chart Auditing Form 9. DMH WRP Chart Auditing Form Instructions 10. MSH WRP Chart Auditing summary data (August 2007 to January 2008) 11. DMH Mall Alignment Monitoring Form Instructions 12. MSH Mall Alignment summary data (October to January 2008)

		13. MSH data regarding compliance with Mall progress notes 14. DMH WRP Substance Abuse Audit Form 15. DMH WRP Substance Abuse Audit Form Instructions 16. MSH WRP Substance Abuse Audit summary data (August 2007 to January 2008) 17. AD #3465, Clinical Matters Special Cases: Assessment of Students, English Learners 18. Basic Group Leadership Lesson Plan 19. Basic Group Leadership Pre-/Post-Test 20. BY CHOICE Individual Satisfaction Survey 21. BY CHOICE Training Log (August 2007 – January 2008) 22. Case Formulation Help List 23. Case Formulation Training Module 24. Education and Training Policy Manual 25. Enhancing Motivation for Change (EMCIT) training overview 26. Enhancing Motivation for Change (EMCIT) training record 27. Enrichment Activity Summary 28. Family Therapy Assessment Tool 29. Family Therapy Assessment Tool Instructions 30. Individual Educational Plans 31. Individual Enrichment Activity participation Hours List 32. Individual Mall Hours Summary 33. In-Service Training Activity Attendance Sheet 34. List Credentialing/Privileging for Substance Abuse 35. List of individuals who received Occupational, Physical, and/or Speech Therapy direct treatment from August 2007-January 2008 36. List of individuals with cognitive disorders 37. List of individuals with substance disorders 38. List of individuals under DCAT services 39. List of individuals with a diagnosis of cognitive functioning disorder 40. List of individuals with high Body Mass Index 41. List of individuals with high seclusion, restraints, and psychiatric PRN or Stat medication

		42. List of new enrichment activities 43. List of scheduled exercise groups 44. List of scheduled vs. canceled/missed appointments 45. List of trained and competent Substance Recovery curriculum providers 46. List verifying staff competency for specific Mall groups 47. Mall curriculum and lesson plans 48. Mall provider list 49. Motivational Enhancement Knowledge Assessment 50. MSH Duty Statement, Substance Abuse Treatment Coordinator 51. MSH Engagement Module, Outline of PowerPoint Presentation 52. MSH Objectives and Interventions Examples 53. MSH Objectives Worksheet Exercise 54. MSH Strengths Survey 55. MSH Substance Recovery Group Provider Monitoring Form 56. Program III Spring 2008 PSR Alignment Plan 57. Psycho-education assessments 58. Psychosocial Enrichment Activity List 59. Substance Recovery Training Assessment 60. Substance Recovery Pre/Post-Test 61. Summary of Enrichment Data (Hours Scheduled/Provided) 62. Summary of Missed Appointments 63. Therapeutic milieu outcome measures 64. Weekly group activity schedule 65. WRP Training Database 66. WRPT Time Analysis Form 67. WRPT Time Analysis data (February 2008) <u>Observed</u>: 1. WRPC (Program II unit 412) for quarterly review of CL 2. WRPC (Program V, unit 403) for annual review of REW 3. WRPC (Program V, unit 411) for monthly review of JB 4. WRPC (Program III, unit 407) for quarterly review of JP

		5. WRPC (Program V, unit 405) for quarterly review of DAMB 6. WRPC (Program III, unit 407) for monthly review of RAM 7. WRPC (Program III, unit 401) for review of JF 8. PSR Mall Service: Motivational Room, Program V 9. PSR Mall Service: Mindfulness, Program II 10. PSR Mall Service: Community Integration, Program III 11. PSR Mall Service: Mock Trial, Program III
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, August 2007:** Increase WRP training sessions and provide ongoing feedback and mentoring to the teams regarding the process of engaging the individual in providing substantive input. **Findings:** Same as in C.1.a. **Recommendation 2, August 2007:** Correct factors related to low compliance with this requirement. **Findings:** MSH has developed and implemented a system of ongoing feedback to WRPTs pertaining to the process of WRP, including the engagement of individuals in their WRPs (October 2007). This system was described in C.1.a. 1. A memorandum and a graph are provided to each team regarding team-specific WRP Process Observation data. 2. Team-specific data concerning engagement is shared with the team leaders via hard copy mail. 3. Team-specific data is provided to mentors to share with their teams (effective January 2008).

Other findings:
MSH used the DMH WRP Process Observation Monitoring Form. The following table outlines the average sample and corresponding mean compliance rates for each type of WRPC (August 2007 to January 2008):

WRPC	%S	%C
7-Day	8%	53%
14-Day	28%	48%
Monthly	14%	44%
Quarterly	15%	53%
Annual	14%	36%

The facility conducted data analysis showing the following positive trends during this reporting period (compliance rates in August 2007 vs. January 2008):

1. 14-Day WRPC:
   a. New objectives are developed when old ones have been achieved (from 67% to 100%).
   b. The team reviews By Choice data (from 67% to 75%).
   c. The team updates the plan when the individual identifies cultural preferences (from 63% to 100%).
2. Annual WRPC:
   a. The team asks the individual for input (from 50% to 60%).
   b. New objectives are developed when old ones have been achieved (from 43% to 100%).
   c. The team reviews By Choice data (from 50% to 71%).
   d. The team updates the plan when the individual identifies cultural preferences (from 0% to 50%).

		Compliance: Partial. **Current recommendations**: 1. Continue current training and mentoring regarding engagement of individuals. 2. Monitor this requirement using process observation based on 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).
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 and 2, August 2007:** • Continue implementation of the A-WRP within 24 hours of the admission. • Continue monitoring to ensure that A-WRPs are completed within 24 hours of all admissions. **Findings:** MSH used the DMH Chart Audit Form to assess compliance. The facility reviewed an average sample of 24% of all WRP reviews that were due each month (August 2007 to January 2008). The mean compliance rate was 100%. **Other findings:** This monitor reviewed the charts of 10 individuals who have been admitted during this reporting period (AMA, BT, DG, DLJ, JWG, LLD,

		PDF, PS, RMT and SB). The review found compliance in all charts except one (JWG). **Compliance:** Substantial. **Current recommendations**: Continue current practice, including self-monitoring.
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 and 2, August 2007:** • Continue implementation of the A-WRP within seven days of the admission. • Continue monitoring to ensure that A-WRPs are completed within seven days of all admissions, based on at least a 20% sample. **Findings:** Using the DMH Chart Audit Form, the facility reported a mean compliance rate of 95% with this requirement. The average sample was 13% of the 7-day WRPs due for the month (August 2007 to January 2008). **Other findings:** Chart reviews by this monitor found compliance in all cases (AMA, BT, DG, DLJ, JWG, LLD, PDF, PS, RMT and SB). **Compliance:** Substantial. **Current recommendations**: Continue current practice, including self-monitoring.

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, August 2007:** Continue monitoring to ensure that all WRP reviews are completed within the required timeframes, based on at least a 20% sample. **Findings:** MSH used the DMH Chart Audit Form and reviewed an average sample of 17% of all WRPs due for the month (August 2007 to January 2008). The mean compliance rate was 12%. The facility has assessed the factors contributing to lack of progress on this item. The main barriers involved the inability of the WRPTs to follow the established schedules, insufficient time scheduled for the teams to complete the required tasks in each WRPC and the required dates for the reviews occasionally falling on a holiday or weekend. MSH is in the process of conducting time analysis to identify how much time each team needs and a comparison of time needed with scheduled time on the team's weekly calendar. The facility plans to train the unit supervisors, who schedule the team meetings, to ensure more effective scheduling. **Other findings:** Reviews by this monitor found compliance in six charts (AMA, DLJ, JWG, PDF, PS and SB) and non-compliance in four (BT, DG, LLD and RMT). **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). 3. Implement corrective actions to improve compliance.
C.2.c	Treatment rehabilitation and enrichment services are goal-directed, individualized, and informed by a thorough knowledge of the individual's psychiatric, medical, and psychosocial history and previous response to such services;	**Current findings on previous recommendations:** **Recommendation 1, August 2007:** Continue monitoring using the DMH Clinical Chart Auditing Form, based on at least a 20% sample. **Findings:** MSH used the DMH Clinical Chart Audit Form to assess compliance. Reviewing an average sample of 15% of the quarterly WRP reviews, the facility reported a mean compliance rate of 72% (August 2007 to January 2008). This is an improvement from the mean compliance rate of 56% reported as of July 2007. **Recommendation 2, August 2007:** Increase training of WRPTs and provide ongoing feedback and mentoring, to ensure that: a. The case formulation includes appropriate review and analysis of assessments to identify the individual's needs in the psychiatric, medical and psychosocial domains, and b. Foci of hospitalization address all identified needs of the individual in the above domains. **Findings:** Same as in C.1.a. **Other findings:** The monitor reviewed the charts of ten individuals diagnosed with a variety of cognitive disorders (ABW, CC, JM, KMO, KR, PB, PDF, PW,

		RTL and TP) and five individuals diagnosed with seizure disorders (AE, ETJ, JM-2, JMS, MCA and PB). This review found some improvement in the documentation of foci, objectives and interventions for a few individuals suffering from cognitive impairments. An example is found in the chart of an individual diagnosed with Dementia Due to General Medical Condition and Alcohol-Induced Persisting Dementia (CC). The review also found some general improvement in the documentation of interventions designed to teach individuals suffering from seizure disorders about their conditions, treatments and the side effects of treatment. Despite these areas of improvement, this monitor found a persisting pattern of 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: a) The WRP includes diagnoses that are irreconcilable, such as Dementia Due to General Medical Condition and Borderline Intellectual Functioning (RTL). b) The WRPs do not include foci, objectives and/or interventions to address diagnoses of Dementia Due to Head Injury (PDF), Dementia Due to General Medical Condition, Mixed Expressive Language Disorder and Borderline Intellectual Functioning (RTL), Mild Mental Retardation (TP and KR) and Cognitive Disorder, NOS (PB). c) The WRPs do not include current and adequate measures/ consultations to assess, determine the etiology of and/or finalize the diagnosis of Dementia, NOS (JM) and Cognitive Disorder, NOS (ABW and PB), although these diagnoses involve impairments that are central to the reason for hospitalization. d) The WRP does not include an intervention to assess/minimize the risks of long-term treatment with clonazepam for an individual suffering from Borderline Intellectual Functioning

		and Polysubstance Dependence (PW) e) The WRP includes interventions that do not appear to align with the level of functioning of individuals diagnosed with Mental Retardation (TP and KR). f) In general, the present status sections of the WRPs do not address the current status of these individuals' cognitive dysfunction. 2) Individuals diagnosed with seizure disorders: a) The WRPs do not include a specific diagnosis regarding the type of seizure disorder in all the charts reviewed. b) The WRPs include objectives that are not attainable for the individuals, focusing on being free from seizure activity or side effects of treatment (AE, PB and JMS) or phrased as an intervention by staff (MCA). c) The interventions do not specify the current anticonvulsant medication regimen (AE) or what the staff will do to assist the individual in achieving appropriate objectives (JM-2, MCA and PB). d) The present status section of the WRPs does not address the status of the individual's seizure activity during the previous interval (AE, JM-2, MCA, PB and JMS). e) The WRPs do not include objectives/ interventions to assess the risks of treatment with older anticonvulsant medications and to minimize its impact on the individual's behavior and cognitive status. Examples include individuals receiving phenytoin (AE, JM-2, MCA and PB) or a combination of phenytoin and clonazepam (AE). Some of these individuals also suffer from documented cognitive impairments, which increase the risk of these treatments. Examples include Mild Mental Retardation (JM-2) and Borderline Intellectual Functioning (EJ).

		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 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, August 2007:** Increase case formulation training and ensure that the training includes clinical case examples, ongoing feedback and mentoring by senior clinicians. **Findings:** Same as in C.1.a. **Recommendation 2, August 2007:** Continue to monitor this requirement using the Clinical Chart Auditing Form and ensure a 20% sample of the target population.

		Findings: Using the DMH Clinical Chart Audit Form, MSH reviewed an average sample of 19% of the quarterly reviews and reported a mean compliance a rate of 46% (August 2007 to January 2008). The mean compliance rates for requirements in C.2.d.ii to C.2.d.vi are listed for each corresponding cell below. Data analysis showed that compliance with this requirement has increased from 49% in July 2007 to 72% in January 2008. **Other findings:** Chart reviews and WRPCs attended by this monitor indicate that MSH has made some progress in the following areas: 1. A draft of the case formulation is prepared prior to the meeting. 2. The teams review the draft during the meeting. 3. The case formulations are generally completed in the 6-p format. 4. The content of the present status section of the formulation is, in general, more comprehensive. 5. The pertinent history is, in general, more inclusive of needed information. 6. In general, substance abuse is addressed as a precipitating and a perpetuating factor. However, the content of most of the formulations shows that the facility has to make further progress regarding the following: 1) The present status section of the WRP does not include sufficient review and analysis of important clinical events that require modifications in WRP interventions. The most significant deficiencies involve needed information in the reviews of: a) Use of restrictive interventions; b) Clinical progress regarding a variety of disorders and high-risk

		behaviors; and c) Clinical progress towards individualized discharge criteria. 2) More work is needed to improve the linkages within different components of the formulations and between the material in the case formulations and other key components of the WRP (e.g. foci of hospitalization, life goals, objectives and interventions). These deficiencies must be corrected in order to achieve substantial compliance with this requirement. **Current recommendations**: 1. Continue training on the Case Formulation Module to all WRPTs and ensure that the training includes clinical case examples. 2. Monitor this requirement using the Clinical Chart Auditing Form 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.d.ii	include a review of: pertinent history; predisposing, precipitating and perpetuating factors; previous treatment history, and present status;	MSH reported a mean compliance rate of 22%. Data analysis showed that compliance has improved from 11% (August 2007) to 19% (January 2008).
C.2.d.iii	consider biomedical, psychosocial, and psychoeducational factors, as clinically appropriate, for each category in § [III.B.4.b] above;	MSH reported a mean compliance rate of 39%. The data showed improvement from 11% (August 2007) to 65% (January 2008).
C.2.d.iv	consider such factors as age, gender, culture, treatment adherence, and medication issues that may affect the outcomes of treatment and rehabilitation interventions;	MSH reported a mean compliance rate of 46%. Data analysis showed an increase from 11% (August 2007) to 80% (January 2008) during this reporting period and from 55% (July 2007) to 80% (January 2008) compared to the last review period.

C.2.d.v	support the diagnosis by diagnostic formulation, differential diagnosis and Diagnostics and Statistical Manual DSM-IV-TR (or the most current edition) checklists; and	MSH reported a mean compliance rate of 39%. Data analysis showed an increase from 16% (August 2007) to 46% (January 2008) during this reporting period and from 25% (July 2007) to 46% (January 2008) compared to the last review period.
C.2.d.vi	enable the interdisciplinary team to reach sound determinations about each individual's treatment, rehabilitation, enrichment and wellness needs, the type of setting to which the individual should be discharged, and the changes that will be necessary to achieve discharge.	MSH reported a mean compliance rate of 27% and attributed low compliance to the lack of enrichment focus, revisions based on changes in the functional status of individuals and strengths-based objectives/interventions. The facility reported that clinical mentors have been trained regarding corrective actions and that an example document showing how to utilize an individual's strengths in interventions was added to the training program during this reporting period.
C.2.e	The therapeutic and rehabilitation service plan specifies the individual's focus of hospitalization (goals), assessed needs (objectives), and how the staff will assist the individual to achieve his or her goals/objectives (interventions);	**Current findings on previous recommendation:** **Recommendation, August 2007:** 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:** Psychosocial Rehabilitation Therapists have revised the Integrated Assessment-Rehabilitation Therapy Section tool and instructions to include assessment recommendations in the form of focus, objectives, and interventions. Due to recent implementation, no facility data was available for the August 2007-January 2008 review period. Instructions for focused Rehabilitation Therapy assessments are currently in the process of being revised to reflect WRP language, including recommendations for focus, objectives, and interventions, and thus no data facility data was available for review.

		Review of a sample of RIAT Pilot assessments from October 2007-December 2007 and IA-RTS assessments in January 2008 found that 55% of corresponding WRP documents contained Rehabilitation Therapy foci, 50% contained WRP inclusion of objectives and 60% contained WRP inclusion of interventions. A review of records of individuals with Occupational, Physical, and/or Speech Therapy assessments/consultations during the August 2007-January 2008 review period found that 13% of corresponding WRP documents contained Occupational, Physical, and/or Speech Therapy foci, 4% contained WRP inclusion of objectives and 17% contained WRP inclusion of interventions. A review of records of individuals participating in Rehabilitation Therapist-led PSR Mall groups found that 29% had WRP documentation of focus, 6% had WRP documentation of objectives and 24% had WRP documentation of interventions. A review of records of individuals receiving direct Occupational, Physical, and Speech Therapy found that 45% had WRP documentation of focus, 32% had WRP documentation of objectives and 41% had WRP documentation of interventions. A review of a sample of Nutrition Care assessments completed across assessment sub-types found that 87% of corresponding WRP documents contained Nutrition Care foci and 72% contained WRP inclusion of objectives and interventions. According to facility report of audit data (n of 266) for August 2007-January 2008, 85% of corresponding WRP documents contained Nutrition Care foci and 68% contained WRP inclusion of objectives and interventions.

		Compliance: Partial. **Current recommendations**: Same as in C.2.c, C.2.f, C.2.g and C.2.o.
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:** **Recommendation 1, August 2007:** Increase training sessions regarding objectives and interventions, and provide ongoing feedback and mentoring by senior clinicians. **Findings:** Same as in C.1.a. **Recommendations 2 and 3, August 2007:** • Continue to monitor this requirement based on at least a 20% sample. • Continue to assess factors related to low compliance and provide corrective actions. **Findings:** Using the Clinical Chart Audit Form, MSH reviewed an average sample

		of 17% of the WRPs due each month (August 2007 to January 2008). The facility reported a mean compliance rate of 2%, but did not provide an analysis to address the conflict between this rating and the much higher rate reported in C.2.c. MSH also used the DMH WRP Process Observation Form to assess compliance. The facility reviewed an average sample of 14% of the WRPs that were due each month (August 2007 to January 2008) and reported a mean compliance rate of 51%. The facility reported that the main barrier to higher compliance involved two sub-items related to the proper formulation of the stages of change and the strengths-based interventions. It was noted that the teams were able to identify the strengths of the individuals during the team process, but did not consistently incorporate them into the written interventions. The plan of correction focused on further WRP training and mentoring of the teams, including the use of written examples regarding correct alignment of stages of change with objectives/interventions and utilization of strengths in the interventions. **Other findings:** This monitor reviewed the charts of six individuals who have been admitted to the facility during this review period (BT, JWG, KLL, MAM, PB and PD). The review found partial compliance in four charts (BT, JWG, MAM and PB), compliance in one (KLL) and non-compliance in one (PD). **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). 3. Implement corrective actions to improve compliance.
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, August 2007:** Same as above. **Findings:** MSH used the above-mentioned chart audits to assess compliance. The facility reported a mean compliance rate of 2% and attributed low compliance to the lack of recreational/leisure groups for the enrichment focus and skills training groups on the Mall. MSH's plan of correction included the previously described training program. In addition, the facility reported that a training document was developed (October 2007) by Rehabilitation Therapy to assist the teams in the proper identification and inclusion of focus 10 leisure interventions. **Other findings:** Chart reviews by this monitor found compliance in five charts (BT, JWG, MAM, PB and PD) and non-compliance in one (KLL). **Compliance:** Partial. **Current recommendations**: Same as above.
C.2.f.iii	write the objectives in behavioral, observable, and/or measurable terms;	**Current findings on previous recommendation:**

		Recommendation, August 2007: Same as above. **Findings:** The facility reported a mean compliance rate of 2% and offered the previously described training program as corrective action plan. This program includes written examples to assist WRPTs in compliance. **Other findings:** This monitor's reviews found partial compliance in five charts (BT, JWG, MAM, PB and PD) and compliance in one (KLL). **Compliance:** Partial. **Current recommendations**: Same as above.
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, August 2007:** Same as above. **Findings:** MSH reported a mean compliance rate of 7% and reported the previously described corrective action plan to address the stages of change. **Other findings:** Chart reviews by this monitor found partial compliance in four charts (BT, JWG, MAM and PB), compliance in one (KLL) and non-compliance in one (PD). The chart of KLL included the best example of proper identification of all the stages of change and their alignment with the

		objectives and interventions since these reviews began. **Compliance:** Partial. **Current recommendations**: Same as above.
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, August 2007:** Same as above. **Findings:** The facility's mean compliance rate was 1%. The plan of correction was based on the previously mentioned training program, including written examples. **Other findings:** This monitor reviewed six charts and found partial compliance in three (BT, JWG and PB), compliance in two (KLL and PD) and non-compliance in one (MAM). **Compliance:** Partial. **Current recommendations**: Same as above.
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:** **Recommendations 1 and 2, August 2007:** • Correct factors related to inadequate scheduling by the WRPTs,

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

inaccurate reporting of hours scheduled on the WRP, disconnection between WRP and My Activity Plan and Participation (MAPP) data and inadequate participation by individuals.

- Continue to monitor hours of active treatment (scheduled and attended).

Findings:
MSH reported that WRP training has addressed scheduling and the disconnection between the WRP and the Mall schedule.

The following table summarizes the facility's MAPP data regarding the number of individuals in each category of hours scheduled and attended:

	Aug	Sep	Oct	Nov	Dec	Jan	Mean
0-5	147	180	126	128	147	161	148
6-10	249	287	283	230	208	266	253
11-15	193	102	238	203	221	192	191
16-19	114	112	42	129	87	43	87
20+	10	7	9	10	9	8	8

The facility did not provide an analysis of its data compared to the last review period. However, the facility presented a plan of correction that includes the following:

1. At the end of each month, Information Technology has produced a report that produces the hospital-wide weekly data as above.
2. Each WRPT will be able to address weekly Mall hours, scheduled and actual, with each individual at the WRPC. Mentors and Program managers will work with WRPTs to ensure 20+hour scheduling.
3. Motivation rooms have been established in all Programs. Staff trained in motivational enhancement are using these skills to improve adherence.

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Other findings:
This monitor reviewed six charts (BT, JWG, KLL, MAM, PB and PD) to determine the documentation of active treatment hours listed on the most recent WRP. The corresponding MAPP data regarding hours scheduled and attended were also reviewed.

<table>
<tr><td></td><td>WRP scheduled</td><td>MAPP scheduled</td><td>MAPP attended</td></tr>
<tr><td>BT</td><td>10</td><td>19</td><td>16</td></tr>
<tr><td>JWG</td><td>9</td><td>20</td><td>15</td></tr>
<tr><td>KLL</td><td>11</td><td>18</td><td>6</td></tr>
<tr><td>MAM</td><td>Unspecified</td><td>20</td><td>1</td></tr>
<tr><td>PB</td><td>12</td><td>20</td><td>19</td></tr>
<tr><td>PD</td><td>8</td><td>23</td><td>16</td></tr>
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The monitor's reviews found that the facility has yet to correct the discrepancy between WRP and APP data and to ensure that individuals receive the required hours of active treatment.

Compliance:
Partial.

Current recommendations:
1. Monitor hours of active treatment (scheduled and attended).
2. Correct factors related to inadequate scheduling by the WRPTs, inaccurate reporting of hours scheduled on the WRP, disconnection between WRP and MAPP data and inadequate participation by individuals.

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<td>C.2.f.vii</td>
<td>maximize, consistent with the individual's treatment needs and legal status, opportunities for treatment, programming, schooling, and</td>
<td>**Current findings on previous recommendations:**</td>
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	other activities in the most appropriate integrated, non-institutional settings, as clinically appropriate; and	**Recommendations 1 and 2, August 2007:** • Continue to monitor this requirement using at least a 20% sample. • Continue to assess factors related to lack of programs and provide corrective actions. **Findings:** MSH used the DMH Chart Auditing Form as mentioned previously. The facility reported a mean compliance rate of 4%. The facility's plan of correction is focused on community learning activities rather than providing actual programs in the community. **Other findings:** This monitor reviewed six charts of individuals who have been admitted under civil commitments (CL, KMO, KRS, OS, RS and SH). The reviews found compliance in one chart (RS) and non-compliance in five (CL, KMO, KRS, OS and SH). **Compliance:** Partial. **Current recommendations**: 1. Monitor this requirement using 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. Ensure that plans of correction are focused on the actual delivery of programs in the community.
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	**Current findings on previous recommendations:** **Recommendation 1, August 2007:** Provide documentation of current mechanisms used to improve linkage, and report on progress made in this area.

	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.	**Findings:** MSH provided an outline of current mechanisms. The following is a summary: 1. WRP training addresses scheduling of Mall groups and the disconnection between the WRP and the individual's Mall schedule. 2. A team notebook is provided to all WRPTs. It contains Mall spreadsheets and other documents as necessary to send and receive group requests. 3. The completed Mall facilitators' progress notes assist the WRPTs in aligning the WRP with data regarding Mall group attendance. 4. Clinical mentors address the quality of linkage. The facility used the DMH Mall Alignment Monitoring Form to assess compliance (October 2007 to January 2008). Reviewing an average sample of 81% (N=20 charts per month), MSH reported a mean compliance rate of 38%. **Recommendations 2 and 3, August 2007:** • Ensure implementation of electronic progress notes by all Mall and individual therapy providers. • Ensure that WRPTs integrate data from the Mall progress notes in the review and modification, as needed of the WRPs. **Findings:** MSH reported that a plan to implement a hospital-wide system to ensure that progress notes are available to WRPTs for review was implemented in October 2007. The clinical disciplines and Mall coordinators have been trained on the progress reporting process. The facility has conducted monthly audits of implementation of the progress notes ensure that they are completed by providers. Managers are reviewing compliance data and following up with Mall facilitators who have not completed progress notes. In addition, the facility

reported that some Malls are using an electronic system for the progress notes and that two programs have developed a system to utilize automation in linking WRP objectives to progress notes via WaRMSS.

The facility presented data showing that the total Mall progress notes completed have increased from 352 in August 2007 to 3699 in January 2008. The following table shows the compliance rates with Mall progress notes for each program:

Program	%C
I	73
II	95
III	21
V	77
VI	54

Other findings:
Reviews by this monitor found compliance in three charts (BT, JWG and PB) and partial compliance in three (KLL, MAM and PD).

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. Improve compliance with the completion of Mall progress 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:** **Recommendation 1, August 2007:** Increase training sessions to WRPTs, including ongoing feedback and mentoring by senior clinicians, to ensure that foci and objectives are reviewed and revised and that new interventions are developed and implemented as clinically needed. **Findings:** Same as in C.1.a. **Recommendations 2 and 3, August 2007:** • Monitor this requirement using both process observation and chart auditing, based on at least a 20% sample. • Provide 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:** MSH used the DMH Chart Audit Form to assess compliance. Reviewing an average sample of 19% of all WRP reviews due each month, the facility reported a mean compliance rate of 24% (August 2007 to January 2008). The compliance rate has increased from 8% in July 2007 to 36% in January 2008.

		The facility also used the DMH Process Observation Monitoring Form and reviewed an average sample of 10% of all WRPs due each month (August 2007 to January 2008). The mean compliance rate was 57%. Compliance with this criterion has decreased between August 2007 (71%) and January 2008 (51%). The facility assessed the main barrier to be that staff are often not reviewing and/or incorporating data from the WRP attachment into the WRP. The plan of correction includes the previously described WRP training program and ongoing training on WaRMSS (regarding proper use of the WRP attachment form). This monitor found non-compliance in four charts (JWG, KLL, PB and PD), compliance in one (BT) and partial compliance in one (MAM). In addition, six percent of records for individuals participating in Rehabilitation Therapist-led PSR Mall groups contained WRP documentation of revision of focus, objectives, and/or interventions according to individualized needs. Twenty-four percent of records for individuals receiving direct Occupational, Physical, and Speech Therapy contained WRP documentation of revision focus, objectives, and/or interventions according to individualized needs. **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). 3. 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.
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, August 2007:** Implement corrective actions to improve and ensure compliance, in particular: 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:** MSH has implemented this recommendation. This requirement was reportedly included in the training provided to clinical WRP Mentors on January 11, 2008. In addition, AD #3306, effective October 22, 2007, outlined the following under Section 3.4.3.6: *For any individual placed in seclusion or restraint for more than three times in any four-week period, the individual's Wellness and Recovery Planning Team will review the plan within three business days and modify the plan as clinically appropriate*. The facility requires that this review must be documented in the individual's medical record. **Recommendation 2, August 2007:** Continue to monitor this requirement using at least a 20% sample. **Findings:** MSH used the DMH Clinical Chart Audit Form and reviewed an average sample of 5% of all WRPs due each month (August 2007 to January 2008). The mean compliance rate was 2%. The facility reported the same barrier and plan of correction that was described in C.2.g.i. The facility also used the DMH WRP Process Observation Monitoring

		Form and reviewed an average sample of 11% of all WRP reviews each month (August 2007 to January 2008). The mean compliance rate was 64%. The facility's assessment of the main factor in low compliance is not aligned with this requirement. **Recommendation 3, August 2007:** Revise current monitoring tool to include individuals whose functional status has improved. **Findings:** The DMH WRP Process Observation Monitoring Form addresses this recommendation. **Other findings:** This monitor reviewed the charts of seven individuals who have experienced the use of seclusion and/or restraints during this reporting period (CG, DLH, DLT, JLB, KR, RFC and WO). Only two charts contained adequate documentation of the use of these interventions in the WRPs (CG and KR) and one (WO) included incomplete documentation. None of the charts included documentation in the WRP of the circumstances that led to the use and/or modifications of treatment/rehabilitation as a result of this use. **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.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:** **Recommendation 1, August 2007:** Same as in C.2.g.i. **Findings:** Same as in C.2.g.i. **Recommendation 2, August 2007:** Increase training sessions to WRPTs, including ongoing feedback and mentoring by senior clinicians, to ensure that barriers related to discharge are addressed using appropriate foci, objectives and interventions. **Findings:** Same as in C.1.a. **Other findings:** This monitor reviewed the charts of six individuals (BT, JWG, KLL, MAM, PB and PD). Only one chart (MAM) included individualized criteria. The documentation of the team's discussion of progress towards discharge was found in three charts (JWG, MAM and PB). **Compliance:** Partial. **Current recommendations**: 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	**Current findings on previous recommendations:**

	specified in the therapeutic and rehabilitation service plan.	**Recommendation 1, August 2007:** Same as in C.2.g.i. **Findings:** Same as in C.2.g.i. **Recommendation 2, August 2007:** Same as in C.2.f.viii. **Findings:** Same as in C.2.f.viii. **Other findings:** Chart reviews by this monitor found that the Mall progress notes were documented in all cases (BT, JWG, KLL, MAM, PB and PD), but in two charts (BT and PD) the notes did not include meaningful comments to inform the WRP reviews. The WRPTs incorporated the review of Mall progress notes into the WRPs in only two charts (JWG and PB). **Compliance:** Partial. **Current recommendations**: 1. Same as in C.2.g.i. 2. Same as in C.2.f.viii.
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 recommendation:** **Recommendation, August 2007:** Ensure that all PBS plans are trained to certification across environments before implementation.

		Findings: This monitor's documentation review of MSH's staff training/ certification of PBS plans found that staff was trained to competency. However, according to MSH's data, the mean compliance rate for consistent implementation of the plans is only 69%. MSH should review the reasons for the low compliance rate and resolve the barriers to consistent implementation and full compliance. Otherwise, it is difficult, if not impossible, to identify the reasons for worsening/no change in the in the target behaviors. **Compliance:** Partial. **Current recommendations**: Ensure that all PBS plans are trained to certification across environments before implementation.
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 and 2, August 2007:** • All discipline-specific assessments should include a section that states the implications of the assessment for rehabilitation activities. • The WRPT should integrate these assessments and prioritize the individual's assessed needs. **Findings:** This monitor's review of discipline-specific assessment templates found that Nursing, Rehabilitation Therapy, Social Work, Psychology,

		Psychiatry, and Nutrition assessments include the section requiring the statement on the implications of the assessments for rehabilitation activities. This monitor reviewed seven Integrated Assessments (BR, FJ, JG, JRB, PGB, RAL and SP). The information in four of them (BR, JG, JRB and SP) was incorporated into the individuals' WRPs and utilized in the objectives, interventions, and discharge criteria sections. The information in the remaining three (FJ, PGB and RAL) did not fully incorporate the information and/or use the information in the objectives/interventions sections. In a few Integrated Assessments, (RAL and MO), the information in the implication sections was not very informative. **Recommendation 3, August 2007:** The WRPT should select all available group and individual therapies that will meet the needs of the individual and then allow the individual to choose from these interventions. **Findings:** MSH used item #2 (*Is based on the individual's assessed needs and is directed toward increasing the individual's ability to engage in more independent life functions*) from the DMH WRP Mall Alignment Monitoring Form to address this recommendation, reporting 48% compliance. This monitor interviewed a number of WRPT members and individuals. Information gathered from these interviews revealed that WRPTs discuss group selection with the individuals based on the group names rather than with the understanding of what goals/objectives are addressed in the groups. According to the Mall Director, WRPTs lacked a number of groups aimed at improving independent life functioning. In one case (PZ), the individual was removed from a group he was co-

		facilitating because, according to documentation in the Present Status section of his WRP, he failed to get prior permission from the WRPT. The WRPT then moved him to another similar group but at a lower stage of change. This individual has already attended these groups at another facility. Issues in other areas, or past history, should not influence the individual's participation and performance in the PSR Mall groups. **Recommendation 4, August 2007:** Ensure that group leaders are consistent and enduring for specific groups. **Findings:** MSH's response to this recommendation is, "Group leader assignments continue from quarter to quarter, and Mall Coordinators work closely with Program Management to address staff absences and accountability issues." This monitor's review of Mall schedules, interviews with individuals, and interview with substitute (stand-in) facilitators found that while facilitators continue to be assigned to the same groups, the same cannot be said for their consistent attendance to facilitate their groups. A number of staff reported to this monitor that for certain groups (for example, Community Integration), the facilitator frequently fails to show up. **Recommendation 5, August 2007:** Provide Motivational Interviewing, Narrative Therapy and other cognitive behavioral interventions to individuals who refuse to attend groups as specified in their WRPs. **Findings:** MSH's criterion to intervene is seven consecutive absences in Mall groups. MSH does not appear to have a proper system to track and monitor poor attendance in groups. For example, Mall notes are not

		consistently written to inform WRPTs about individuals' participation. In other cases, individuals sit in on groups not assigned to them. This monitor's visit with a number of Mall groups found poor attendance in a number of them, but the facilitators were not aware of where the individuals were. In one Mall area, twelve individuals who did not belong to the group were sitting in the area. This monitor visited the Motivational room a number of times. Each time, there were as many as 9 to 14 individuals in the room. A check into their progress notes found that many were frequent visitors to the room. The staff monitoring the room did not know or were not able to do any kind of meaningful assessment/therapy with the individuals. **Other findings:** According to reviews of records of individuals participating in Rehabilitation Therapist-led PSR Mall groups, 41% of PSR Mall group objectives and interventions were aligned with assessment findings regarding individual needs and strengths. Review of records for individuals receiving direct Occupational, Physical, and Speech Therapy found that 100% of treatment activities were aligned with assessment findings of individual needs. **Current recommendations**: 1. The WRPT should select all available group and individual therapies that meet the needs of the individual and then allow the individual to choose from these interventions. 2. Ensure that group leaders are consistent and enduring for specific groups. 3. Provide Motivational Interviewing, Narrative Therapy and other cognitive behavioral interventions to individuals who refuse to attend groups as specified in their WRPs.
C.2.i.ii	Has documented objectives, measurable outcomes, and standardized methodology	**Current findings on previous recommendations:**

		Recommendation, August 2007: Ensure that each objective is directly linked to a relevant focus of hospitalization. **Findings:** MSH used item # 3 (*Has documented objectives, measurable outcomes, and standardized methodology*) from the Mall Alignment Monitoring tool to address this recommendation, reporting 20% compliance. This monitor reviewed eight charts (ABJ, JA, JC, JRB, KLM, OJB, OLM and RHL). The objectives in six of the WRPs were properly linked to their foci of hospitalization (ABJ, JRB, KLM, OJB, OLM and RHL), and in two of them (JA and JC) one or more of the objectives were not directly linked to the foci of hospitalization. **Current recommendations**: Ensure that each objective is directly linked to a relevant focus of hospitalization.
C.2.i.iii	Is aligned with the individual's objectives that are identified in the individual's Wellness and Recovery Plan	**Current findings on previous recommendations:** **Recommendation 1, August 2007:** Ensure that WRPTs write objectives in behavioral, observable, and/or measurable terms. **Findings:** This monitor reviewed the 13 charts (ADJ, DLL, JA, JB, JC, JFK, JR, KLM, OJB, OJV, OLM, RF and RHL). Eight of the WRPs in the charts (ADJ, DLL, JA, JB, JR, KLM, OJB and RHL) had the objectives written in observable/measurable terms. The remaining five (JC, JFK, OJV, OLM and RF) had one or more objectives that were not written in observable/measurable terms.

		Recommendation 2-3, August 2007: • Ensure that all therapies and rehabilitation services provided in the malls are aligned with the assessed needs of the individuals. • When assigning Mall groups, the WRPT members should use the Mall Catalogue so that the groups they recommend are aligned with the individual's needs, stage of change and cognitive level. **Findings:** This monitor reviewed 12 charts. (ADJ, DLL, JA, JB, JC, JFK, JR, KLM, OJB, OLM, RF and RH). Seven of the WRPs in the charts (ADJ, DLL, JFK, JR, KLM, OLM and RF) referenced therapies and rehabilitation services aligned with the assessed needs of the individuals. Five of the WRPs (JA, JB, JC, OJB and RH) had one or more groups missing/ mismatched with the individuals' needs. This monitor's interviews with the Mall Director and WRPT leaders confirmed that Mall Catalogues are available to the WRPTs for use when selecting groups for individuals. The WRPTs use the assessments (integrated assessments and focused assessments) to determine the individual's needs and utilize the information to align the groups with the individual's needs, stage of change, and cognitive level. Individuals' cognitive levels are screened during the Integrated Assessment: Psychology Section. According to the Mall Director, the Curriculum Committees also conduct needs assessments to adjust the Mall offerings. **Current recommendations**: 1. Ensure that WRPTs write objectives in behavioral, observable, and/or measurable terms. 2. Ensure that all therapies and rehabilitation services provided in the malls are aligned with the assessed needs of the individuals.

C.2.i.iv	utilizes the individual's strengths, preferences, and interests;	**Current findings on previous recommendations:** **Recommendation 1, August 2007:** Ensure that group facilitators and individual therapists use the Individual Strengths Survey. **Findings:** This monitor found in interviews with WRPT members and the Mall Director that the WRPTs are aware of and familiar with the Individual Strength Surveys and use the Surveys to identify individuals' strengths. According to the Mall Director, copies of the Individual Strength Surveys are placed in the Mall offices and made available to the WRPTs in each unit conference room. **Recommendation 2, August 2007:** Ensure that the individual's strengths, preferences, and interests are clearly specified in the interventions in the individual's WRP in accordance with the DMH WRP manual and that the facilitators are aware of these. **Findings:** MSH audited 30 charts over the last six months, using item #3 (*Utilizes the individual's strengths, preferences, and interests*) from the DMH Mall Alignment Monitoring Tool to address this recommendation, reporting 33% compliance. This monitor reviewed 13 charts (ADJ, DLL, JA, JB, JC, JFK, JR, KLM, OBJ, OJB, OLM, RF and RH). Four of the WRPs in the charts (ADJ, DLL, JA and OBJ) had the individual's strengths, preferences, and/or interests specified in the intervention sections of the WRP. The remaining nine (JB, JC, JFK, JR, KLM, OJB, OLM, RF and RH) did not have strengths, preferences, and/or interests identified in one or more of the interventions. The facilitators interviewed by this monitor were

		familiar with the strengths, preferences, and interests of individuals attending their groups. However, many of them came to know this through speaking with the individuals or by looking up the individuals' WRPs. **Current recommendations**: 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 and that the facilitators are aware of these.
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, August 2007:** Undertake clinical case formulation as a team rather than by assigning the task to a team member or to non-team members. **Findings:** This monitor reviewed nine charts (ADJ, DLL, JA, JB, JFK, JR, KLM, RF and RHL). Seven of the WRPs in the charts (ADJ, DLL, JA, JB, JR, KLM and RHL) contained documentation (quotations, identification of staff by name and/or identification of the discipline involved) that the case formulation was undertaken as a team. The remaining two (JFK and RF) did not have such evidence. **Recommendation 2, August 2007:** Include the individual's vulnerabilities in the case formulation under predisposing, precipitating, and perpetuating factors. **Findings:** This monitor reviewed ten charts (DLL, JA, JC, JFK, JR, KLM, OJV, OLM, RF and RHL). Seven of the WRPs in these charts (JC, JFK, JR, KLM, OLM, RF and RHL) documented the individual's vulnerabilities in

		the case formulation under the 6-Ps and the remaining three (DLL, JA and OJV) did not. **Recommendation 3, August 2007:** Update the Present Status section of the individual's WRP to reflect the current status of these vulnerabilities. **Findings:** This monitor reviewed five charts (ADJ, JA, KLM, OLM and RHL). Two of the WRPs in these charts (JA and OLM) documented the change in the individual's vulnerabilities and three of them (ADJ, KLM and RHL) did not. **Recommendation 4-5, August 2007:** • Use the staged model of substance abuse training for group facilitators. • Use the staged model of substance abuse manual for delivering rehabilitation services to individuals with substance abuse issues. **Findings:** According to Roudabeh Rahbar, PhD, Substance Recovery Coordinator, MSH continues to use the staged model of substance abuse training for group facilitators, and is using the staged model of substance abuse manual for delivering rehabilitation services to individuals with substance abuse issues. This monitor's documentation review (training log, pre-/post test) found that MSH has trained 15 facilitators at stages 1 and 2 (the same as reported in August 27, 2007) in the last six months, and all training participants achieved competency (scores ranged between 85% and 92%). Documentation also showed that MSH offered between 36 and 40 Substance Abuse groups across the Programs in the last six months.

		Recommendation 6, August 2007: Provide groups regarding the purpose of Wellness Recovery Action Plan (WRAP) to all individuals in order to preempt relapse. **Findings:** According to the Mall Director, MSH has purchased WRAP material in both English and Spanish. The Mall Director has provided training to Social Work staff on WRAP. Documentation showed that MSH offered between 16 and 25 WRAP groups in the last six months. MSH also used item #6 (*Focuses on the individual's vulnerabilities to mental illness, substance abuse, and readmission due to relapse, where appropriate*) from the DMH Mall Alignment Monitoring Form to address this recommendation, reporting 16% compliance. **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 section of the individual's WRP to reflect the current status of these vulnerabilities. 4. Use the staged model of substance abuse training for group facilitators. 5. Use the staged model of substance abuse manual for delivering rehabilitation services to individuals with substance abuse issues. 6. Provide groups regarding the purpose of Wellness Recovery Action Plan (WRAP) 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:** **Recommendations 1 and 2, August 2007:** • PSR Mall groups should address the assessed cognitive levels of the

		individuals participating in the group. • Psychologists should assess all individuals suspected of cognitive disorders, mental retardation and developmental disabilities and other conditions that may adversely impact an individual's cognitive status. **Findings:** According to the Mall Director, an Excel spreadsheet with individuals' cognitive levels was distributed to Mall Coordinators and Program Directors in February 2008. It appears that the persons most in need of this information are the Mall facilitators; MSH should try to distribute the Excel spreadsheets to them. MSH audited 152 groups over the last six months and found that only 25 of these groups addressed cognitive levels when providing services to individuals in their groups. A number of groups this monitor observed (Mindfulness, Community Interaction) included individuals across a wide range of cognitive levels as well as physical and medical diagnoses. This monitor did not observe differences in the written material/handouts or verbal instructions to indicate that the facilitators were addressing the specific cognitive levels of the individuals in their groups. This monitor's review of documentation and interviews with the Psychology staff and DCAT members found that cognitive levels of individuals are assessed by psychologist examiners during the Integrated Assessments, during Psychology Focused Assessments, and by DCAT members. The individuals' cognitive levels determined from these evaluations are made available to the WRPTs, who then use the information to assign individuals to groups/services. However, the process of assignment of individuals for services according to their cognitive levels is ineffective in many cases due to the lack of multiple levels for a large numbers of Mall groups.

		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 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, August 2007:** • 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:** This monitor's review of PSR Mall monthly progress notes found that MSH has implemented the Mall Monthly Progress Notes facility-wide. According to the Mall Director, the system is automated via the WaRMSS in Programs V and VI. The other programs continue to use the paper system. According to the Mall Director, Mall Progress Notes are not written consistently and when notes are written, they are not always filed timely for use by the WRPTs. Also, Mall notes are not always reviewed and incorporated into the Present Status sections of the individuals' WRPs. MSH audited the Mall Monthly Progress Notes, reporting a compliance

		rate of 73% in Program 1, 95% in Program II, 21% in Program III, 77% in Program IV and 54% in Program VI. This monitor reviewed nine charts (ADJ, JA, JFK, JR, KLM, OJV, OLM, RF and RHL). All nine charts included progress notes. However, none of them included all of the required monthly Mall Progress Notes. Only three of the progress notes (JR, KLM and OLM) were integrated into the Present Status sections of the individuals' WRPs. In addition, a number of discrepancies were found between the progress notes and the WRPs. For example, the Mall groups from which the Mall Progress Notes came from were not identified in the intervention sections of the individuals' WRPs (JA, KLM, OJV, RF and RHL). **Other findings:** A review of records of individuals participating in Rehabilitation Therapist-led PSR Mall groups found that 55% had evidence of Mall Facilitator Monthly Progress notes and 47% of progress notes were completed appropriately. According to facility audit data (internal Rehabilitation Therapy Mall Facilitator Monthly Progress note monitoring) for a sample of records reviewed, 71% had evidence of Mall Facilitator Monthly Progress notes and 24% of progress notes were completed appropriately. A review of records for individuals receiving direct Occupational, Physical, and Speech Therapy found that 100% of records contained documentation of progress, and 8% of records contained documentation of progress in the WRP. **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 state holidays;	**Current findings on previous recommendations:** **Recommendations 1 and 2, August 2007:** • Provide PSR Mall groups as required by the EP, five days a week, for a minimum of four hours a day (i.e. two hours in the morning and two hours in the afternoon each weekday), for each individual or two hours a day when the individual is in school, except days falling on State holidays. • Mandate that all staff at MSH, other than those who attend to emergency medical needs of individuals, will provide services at the PSR Mall. This includes clinical, administrative and support staff. **Findings:** This monitor's review of documentation (Mall schedules and WRPs) and interview with the Mall Director found that three of the five Malls at MSH meet the elements in this recommendation. The remaining two Malls operate for three hours in the morning and one hour in the afternoon. According to the Mall Director, all Malls will operate for two hours in the morning and two hours in the afternoon, meeting EP criteria, as of Spring 2008. According to the Mall Director, all clinical staff has been directed to schedule and provide the minimum number of PSR Mall service hours per week. Furthermore, the ED has also directed all administrative and support staff to provide a minimum of one hour of PSR Mall service per

		week. **Recommendations 3 and 4, August 2007:** • Provide groups as needed by the individuals and written in the individuals' WRPs. • Add new groups as the needs are identified in new/revised WRPs. **Findings:** According to the Mall Director, the Curriculum Committee is reviewing Mall groups, individuals' cognitive levels and objectives, and Mall course material to determine the need for additional Mall groups. The Mall Director also indicated that WRPT members have been reminded to make requests for new groups where needed and appropriate forms have been made available to the team members. This monitor's documentation review (Group/Activity Request Form) found that 15 forms have been submitted to the Mall Director in the last six months. Eight of the requests were for new groups (Coping with Writing, Writing for Publication, Vietnamese Mock Trial, Horticulture, Paint Crew, Plumbing Crew, Cognitive Rehabilitation and Mental Health Education). Six of the remaining seven requests were to drop existing groups and one was to change the room. **Current recommendations**: 1. Provide PSR Mall groups as required by the EP, five days a week, for a minimum of four hours a day (i.e. two hours in the morning and two hours in the afternoon each weekday), for each individual or two hours a day when the individual is in school, except days falling on State holidays. 2. Provide groups as needed by the individuals and written in the individuals' WRPs. 3. Add new groups as the needs are identified in new/revised WRPs.

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<td>C.2.i.ix</td>
<td>is provided to individuals in bed-bound status in a manner and for a period that is commensurate with their medical status;</td>
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Current findings on previous recommendation:

Recommendation, August 2007:
Continue with the implementation of the curriculum for bed-bound individuals.

Findings:
MSH has continued to provide services to bed-bound individuals. The table below showing the number of bed-bound individuals per month (N), the number of individuals audited (n), the hours scheduled for services (Scheduled), and the hours of individual participation (Actual) is a summary of the facility's data.

<table>
<tr><td></td><td>Aug</td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td></tr>
<tr><td>N</td><td>3</td><td>2</td><td>1</td><td>2</td><td>1</td><td>1</td></tr>
<tr><td>n</td><td>3</td><td>2</td><td>1</td><td>2</td><td>1</td><td>1</td></tr>
<tr><td>%S</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td></tr>
<tr><td>Scheduled</td><td>39</td><td>53</td><td>44</td><td>29</td><td>27</td><td>57</td></tr>
<tr><td>Actual</td><td>27</td><td>19</td><td>17</td><td>26</td><td>12</td><td>26</td></tr>
</table>

This monitor's documentation review (WRPs, progress notes and schedules) and interview with the Mall Director found that MSH has continued to provide services to its bed-bound individuals. This monitor visited units 418, 419, and 420 where bed-bound individuals are served. None of the individuals in these units were bed-bound. All individuals were out and about at the time of this monitor's visit, many in wheelchairs.

Current recommendations:
Continue current practice.

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<td>C.2.i.x</td>
<td>routinely takes place as scheduled;</td>
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Current findings on previous recommendations:

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		Recommendations 1 and 2, August 2007: • Implement a more focused Mall program that is regularly scheduled, implemented, and provided within the individual's cognitive, medical, physical and functional status. • Ensure that Mall groups and individual therapies are cancelled rarely, if ever. **Findings:** MSH's Mall organization and course offerings do not fully address the individuals' cognitive, medical, physical, and functional status as it relates to participation in Mall groups. MSH only recently developed an Excel spreadsheet with the cognitive levels of individuals and distributed it to Mall coordinators and Program Directors. The Mall Director indicated that in many cases, WRPTs do not have a sufficient array of groups to assign individuals to based on their needs. The Mall Director has presented WPRTs with "New Mall Group Request Forms," which are not being used by WRPTs. This monitor's review of MSH's data on Mall group cancellations found that a total of 183 Mall groups were cancelled over the last six months. According to the Mall Director, restroom remodeling, repair in the New Horizons Program, death of a staff member and a large number of individuals afflicted with gastroenteritis caused some of the Mall group cancellations. This monitor's interview with Mall facilitators and unit staff also found that a number of groups often get combined into one; in a few situations, facilitators use stand-ins and in other cases, facilitators get credit when the group concerned actually was conducted by substitute staff. The Mall Director and the Central Program Service Coordinator are aware of these situations and have indicated that they will problem-solve to ensure that the MAPP data is accurate and valid.

Recommendation 3, March 2007:
Ensure that all disciplines facilitate a specified minimum number of hours of mall groups.

Findings:
The tables below are summaries of the facility's data showing the hours of services per week provided by each discipline.

Acute Services							
Disc. (req. hrs)	Aug	Sep	Oct	Nov	Dec	Jan	Mean
Psychiatry (4)	1.7	1.4	1.6	1.6	.8	.9	1.3
Psychology (5)	6.2	3.3	3.9	5.4	4.5	5.3	4.8
Social Work (5)	4.7	3.7	5.0	5.8	4.0	5.7	4.8
RT (7)	9.7	5.4	6.7	9.1	8.2	10.8	8.3

Long-Term Services							
Disc. (req. hrs)	Aug	Sep	Oct	Nov	Dec	Jan	Mean
Psychiatry (8)	2.2	1.4	2.2	2.6	2.6	2.6	2.3
Psychology (10)	3.7	2.8	3.8	5.8	5.6	5.8	4.6
SW (10)	6.7	3.9	4.8	6.2	5.6	6.1	5.6
RT (15)	9.7	7.3	8.0	9.3	9.8	9.8	9.0

Nursing							
Discipline	Aug	Sep	Oct	Nov	Dec	Jan	Mean
RN/LVN	1.4	1.5	1.6	2.1	1.5	1.1	1.5
Psych Tech	1.5	1.2	1.3	1.8	1.5	1.3	1.4

As seen in the tables above, except for the Acute Care Rehabilitation Therapists, none of the disciplines are providing their required hours in a consistent manner.

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Recommendation 4, August 2007:
Ensure that administrators and support staff facilitate a minimum of one Mall group per week.

Findings:
MSH audited the number of hours of PSR Mall services provided by the Administrative and Support staff. The table below showing the average hours of services provided by the disciplines per month, reporting mean hours of services of 0.6 hrs (administrative staff) and 3.4 hrs (support staff) is a summary of the facility's data.

<table>
<tr><td>Discipline</td><td>Aug</td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Mean</td></tr>
<tr><td>Administrative</td><td>0.6</td><td>0.4</td><td>0.5</td><td>0.8</td><td>0.6</td><td>0.6</td><td>0.6</td></tr>
<tr><td>Support</td><td>3.7</td><td>2.0</td><td>3.7</td><td>3.6</td><td>5.3</td><td>2.2</td><td>3.4</td></tr>
</table>

As the data in the table above show, the administrative staff are not meeting the minimum required hours of PSR Mall service.

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.

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<td>C.2.i.xi</td>
<td>includes, in the evenings and weekends, additional activities that enhance the individual's quality of life; and</td>
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Current findings on previous recommendations:

Recommendation 1, August 2007:
Plan and organize these activities such that there is minimal

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		interruption, individuals are reinforced to participate regularly in these activities, as much as possible eliminate competing activities that act as a barrier for individuals to participate in such activities. **Findings:** This monitor interviewed the Mall Director, who reported that scheduling of medical appointments for individuals, court appointments, mealtimes, showers, and implementing more than one activity on the same schedule are issues that need to be rectified to remove competing activities that act as barriers to individuals' participation in activities. MSH has set up a good structure for planning and implementing these activities. MSH has established Enrichment Coordinators for each Program, along with instructions and monitoring forms. The items in the monitoring forms address reinforcing individual participation in group activities if there are interruptions and competing activities during the group activities. **Recommendation 2, August 2007:** Increase the number of hours of enrichment activities per individual provided in the evenings and weekends. **Findings:** This monitor's review of MSH's documentation on this recommendation found no change in the hours of enrichment activities provided in the evenings and weekends. The table below showing the hours of activities scheduled per individual per month, and the number of hours of activities offered per individual per month is a summary of the facility's data.

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<tr><td></td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Mean</td></tr>
<tr><td>Average scheduled hours</td><td>25.4</td><td>25.4</td><td>26.3</td><td>21.4</td><td>24.6</td></tr>
<tr><td>Average provided hours</td><td>8.8</td><td>7.8</td><td>9.5</td><td>11.5</td><td>9.4</td></tr>
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The table above shows that the activities scheduled per individual per month from October 2007 and January 2008 ranged from 21.4 hours to 26.3 hours, for a mean of 24.6 hours. The hours of service provided ranged between 7.8 hours and 11.5 hours, for a mean of 9.4 hours. MSH previous report (August 2007) showed that scheduled activities ranged between 18 hours and 33 hours per week (for July 2007) for a mean of 25 hours of activity per week.

Current recommendations:
1. Plan and organize these activities such that there is minimal interruption, individuals are reinforced to participate regularly in these activities, as much as possible eliminate competing activities that act as a barrier for individuals to participate in such activities.
2. Increase the number of hours of enrichment activities per individual provided in the evenings and weekends.
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<td>C.2.i.xii</td>
<td>is consistently reinforced by staff on the therapeutic milieu, including living units.</td>
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Current findings on previous recommendations:

Recommendation 1, August 2007:
Ensure that all WRPs have therapeutic milieu interventions clearly specified in the intervention sections.

Findings:
This monitor reviewed nine charts (ADJ, DLL, JA, JB, JFK, JR, OLM, RF and RH). Three of the WRPs in the charts (JR, OLM and RF) had specified milieu interventions in the intervention sections. The remaining six (ADJ, DLL, JA, JB, JFK and RH) did not include milieu interventions in the intervention sections.
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Recommendation 2, August 2007:
Ensure that unit staff know what the individuals are learning in the malls and individual therapies and reinforce their learning in all settings.

Findings:
MSH used item #12 (*Staff is observed discussing mall activities with individuals)* from the Therapeutic Milieu Observation Monitoring Form to address this recommendation, reporting 36% compliance. The table below showing the number of units in the facility (N), the number of 30-minute observations conducted in each unit per month (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

	Aug	Sep	Oct	Nov	Dc	Jan	Mean
N	18	18	18	18	18	18	
n	8	11	16	5	7	4	
%S	44	61	89	28	39	22	
%C #12	38	36	50	60	29	0	36

This monitor's observation of staff engaged in Mall activities, enrichment activities and WRPCs found that staff engaged individuals in the activities and reinforced individuals appropriately and frequently. This monitor did not observe many interactions between staff and individuals in the units. One contributing factor for the low staff performance is the lack of specification of milieu interventions in the intervention sections of the individuals' WRPs. This monitor anticipates improvement in staff performance in the units when MSH fully implements the system-wide Positive Support Plan.

Current recommendations:
1. Ensure that all WRPs have therapeutic milieu interventions clearly

		specified in the intervention sections. 2. Ensure that unit staff know what the individuals are learning in the malls and individual therapies and reinforce their learning in all settings.
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, August 2007:** • Establish group exercises and recreational activities for all individuals. • Provide training to Mall facilitators to conduct the activities appropriately. **Findings:** MSH audited the number of exercise and recreational groups per month. The table below showing the number of exercise and recreational groups per month is a summary of the facility's data.

Mall	Aug	Sep	Oct	Nov	Dec	Jan	Mean
DB 404, Prog. I	12	12	4	4	4	4	7
Outward B, Prog. II	12	12	8	8	8	12	10
Bridge Recov. Prog. III	53	53	55	55	55	62	56
New Horizon, Prog. V	27	27	27	27	27	33	28
Inspiration Isl. Prog. VI	17	17	19	19	19	7	16
Total	121	121	113	113	113	118	

MSH has trained 200 Mall facilitators (September 2007 and January 2008). According to MSH's data, all facilitators met competency standards, with scores ranging from 86% to 100%.

Recommendations 3 and 4, August 2007:

- Track and review participation of individuals in scheduled group exercise and recreational activities.
- Implement corrective action if participation is low.

Findings:

This monitor interviewed the Mall Director, who reported that the WaRMSS MAPP allows for better tracking of individuals in their group activities. This monitor's document review found an increase of seven exercise groups in Program III. The table below showing the BMI categories, the number of individuals participating per category each month (N), and the percentage of individuals participating each month (%C) is a summary of the facility's data.

BMI LEVEL	Aug	Sep	Oct	Nov	Dec	Jan
BMI change <25 to 25 - 29.9	N= 177 %C=62	N= 183 %C= 64	N= 183 %C=59	N= 201 %C=57	N= 207 %C=57	N= 184 %C= 63
Body Mass Index (BMI) between 30 and 34.5 (Obesity-Grade I)	N= 96 %C=61	N= 102 %C=65	N= 91 %C=58	N= 101 %C=61	N= 100 %C=59	N= 88 %C=68
Body Mass Index (BMI) between 35 and 39.9 (Obesity-Grade II)	N= 31 %C=53	N= 30 %C=58	N= 35 %C=55	N= 47 %C=51	N= 50 %C=50	N= 35 %C=65

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<tr><td>Body Mass Index (BMI) of 40 or above (Obesity-Grade III)</td><td>N= 20
%C=59</td><td>N= 17
%C=56</td><td>N= 12
%C=61</td><td>N= 18
%C=59</td><td>N= 17
%C=61</td><td>N= 20
%C=64</td></tr>
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As seen in the table above, participation of individuals with high BMIs in recreational/exercise groups ranged between 50% and 68%. Participation in the previous report (data was reported for only one month) ranged between 52%-75%. According to the Mall Director, WRPTs are to utilize progress notes and attendance reports to implement corrective actions for individuals whose attendance is low.

Compliance:
Partial.

Current recommendations:
1. Track and review participation of individuals in scheduled group exercise and recreational activities.
2. Implement corrective action if participation is low.
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<td>C.2.k</td>
<td>Individuals who have an assessed need for family therapy services receive such services in their primary language, as feasible, consistent with generally accepted professional standards of care and that these services, and their effectiveness for addressing the indicated problem, are comprehensively documented in each individual's chart.</td>
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Current findings on previous recommendations:

Recommendation 1 and 2, August 2007:
• Conduct a needs assessment with individuals and/or their families.
• Ensure that family therapy needs are fulfilled.

Findings:
MSH has developed and implemented a Family Therapy Assessment tool to assess families in need of therapy/education. According to the Chief of Social Work, MSH has implemented a pilot program to assess the needs of families for therapy/education in Program II, and the assessments will continue until completion in all Programs. Additionally,
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		the Chief of Social Work reported that two family therapy/support groups are underway with seven individuals and their families. **Compliance:** Partial. **Current recommendations:** Complete the needs assessments for all individuals and provide needed services as indicated by the needs assessment.
C.2.l	Each individual's therapeutic and rehabilitation service plan identifies general medical diagnoses, the treatments to be employed, the related symptoms to be monitored by nursing staff (i.e., registered nurses ["RNs"], licensed vocational nurses ["LVNs"] and psychiatric technicians) and the means and frequency by which such staff shall monitor such symptoms, consistent with generally accepted professional standards of care.	**Current findings on previous recommendation:** **Recommendation 1, August 2007:** Provide training regarding the elements of this requirement. **Findings:** MSH's progress report indicated that the WRP training sessions include a presentation that focuses on the elements of this requirement. In addition, newly hired nursing staff receive WRP training in nursing orientation, and the psychiatric nursing training and nursing update training also address this requirement. **Recommendation 2, August 2007:** Continue to monitor this requirement. **Findings:** MSH's data from the Medical Conditions Monitoring Form audit, based on a 20% mean sample of Nursing Medical Conditions Focus 6 Audits completed each month (August 2007 to January 2008), indicated the following mean compliance score for each listed item: 1. *Each of the open medical conditions listed on the Medical Conditions list are identified in the WRP* — 47%

		under Focus 6.	
		2.	*Does the WRP identify the general medical diagnosis?*	92%
		3.	*Does the WRP identify the treatment to be employed for this condition?*	71%
		4.	*Does the WRP identify the related symptoms to be monitored by nursing staff?*	43%
		5.	*Does the WRP identify by what means staff will monitor these symptoms?*	60%
		6.	*Does the WRP identify by what frequency staff will monitor these symptoms?*	28%
		7.	*Are staff to perform these interventions are identified by title?*	16%
		8.	*Medical Consultant was present during the WRP.*	6%
		9.	*Each medical condition listed in the Axis III is identified in the Medical Conditions List and in the WRP under Focus 6*	61%
		10.	*All changes in medical status of the Individual are incorporated in the WRP*	68%
		11.	*Each Focus 6 has a corresponding objective and active and /or therapeutic milieu intervention*	56%
		(See F.3.c for review of WRPs.) **Compliance:** Partial. **Current recommendations**: Continue to monitor this requirement.	
C.2.m	The children and adolescents it serves receive, consistent with generally accepted professional standards of care:	**Compliance:** Full.	

C.2.m.i	Therapy relating to traumatic family and other traumatic experiences, as clinically indicated; and	**Current findings on previous recommendation:** **Recommendation, August 2007:** Ensure that children and adolescents with traumatic family and other traumatic experiences receive appropriate and timely assessment and treatment services. **Findings:** The Allen Young School Program at MSH closed effective February 15, 2008. MSH has transferred all its children and adolescents to other settings except for one adolescent (SM) still in the facility. MSH has conducted a complete and thorough assessment of the individual and her family to determine necessary services, including the skills and supports the individual needs for the next placement. This monitor's documentation review on SM (IEP, PBS plan, Progress Report) found a well-developed IEP and well-written and implemented PBS plan (frequency data was collected both for behavior and academic work).
C.2.m.ii	reasonable, clinically appropriate opportunities to involve their families in treatment and treatment decisions.	**Current findings on previous recommendations:** **Recommendation 1-4, August 2007:** • Continue to monitor children and families' needs. • Communicate relevant information to appropriate persons and the WRPT. • Actively expand the opportunities for these individuals and their families to receive appropriate services. • Collect outcome and satisfaction data. **Findings:** This monitor interviewed the staff involved in the care of SM. According to the information in SM's WRP and provided by staff, SM's family is not in a position to accept and receive any family therapy/services at this time, because the mother recently had a baby.

		Staff involved in SM's care actively communicate with her family and with staff at her anticipated placement. Data analysis showed high variability in SM's learning and behavioral responses. However, her behaviors have shown improvement in the last two months. According to the staff, now that SM is the only individual in the setting she gets all the positive attention whereas previously other adolescents picked on her, agitating her and increasing her maladaptive behaviors. Now that she is by herself, she is calm and cooperative for the most part. This monitor observed SM in her unit. She was calmly watching television. She agreed to speak with this monitor and gave brief responses to a few questions asked of her. She was able to recall her routine for the day and the next activity she had to attend to. She made fleeting eye contact. She actively engaged with staff.
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, August 2007:** Monitor the implementation of the policy and procedure to ensure correction of the deficiencies identified in C.2.o below. **Findings:** MSH used the DMH WRP Substance Abuse Audit Form to assess compliance. The data are presented in section C.2.o. **Compliance:** Partial. **Current recommendations**: Same as in C.2.o.
C.2.o	Individuals who require treatment for substance abuse are provided appropriate therapeutic and	**Current findings on previous recommendations:**

	rehabilitation services consistent with generally accepted professional standards of care.	**Recommendation 1, August 2007:** Strengthen administrative oversight to the SR program. **Findings:** MSH has hired Roudabeh Rahbar, PsyD as Substance Abuse Coordinator during this period. Dr. Rahbar has an adequate plan to strengthen the administrative oversight. The following are the main components: 1. Implement appropriate evidence-based training of MSH staff to facilitate Substance Recovery groups based upon Velasquez, et al, and SAMHSA recommendations; 2. Identify a core of certified Substance Abuse trainers to train group facilitators; 3. Provide the appropriate number of staged Substance Recovery groups for individuals with Substance Abuse diagnosis; 4. Utilize current system of cognitive screenings in Integrated Psychological Assessments to provide appropriate level of Substance Recovery group treatment in mall; 5. Provide training and mentoring to WRPT staff to identify appropriate stages of change for the individuals in their WRPs. **Recommendation 2, August 2007:** Refine process and clinical outcomes to correct deficiencies identified above. **Findings:** The facility has refined its process and clinical outcomes as follows: 1. Process outcomes: a. Number of individuals screened for substance abuse per month; b. Number of individuals with positive screens who have received

		substance abuse assessment as evidenced by chart audits; c. Number of individuals with substance abuse who have Focus 5 (Substance Abuse) staged, with at least one objective and one intervention currently linked to their stage of change; d. Number of SR providers trained in the SR curriculum and exhibit an appropriate level of competency in this area; and e. Number of SR groups currently being provided. 2. Clinical outcome: the individuals are making progress throughout the stages of change as evidenced by self assessment questionnaire as well as pre and post-tests that are administered in the beginning of group cycle and at the conclusion. The outcome measures are appropriate to assess effectiveness of substance recovery services. **Recommendation 3, August 2007:** Provide pre- and post-testing to assess learning of individuals in all SR programs. **Findings:** Since last review, MSH has provided training on the implementation of pre and post-testing for individuals to all Substance Abuse curriculum trained staff. The Pre and post-tests have been made available and are located in the curriculum material. The planned implementation is April 1, 2008. **Recommendation 4, August 2007:** Provide documentation of all current training programs of SR. The data must: a) Provide an outline of each program; b) Identify who is training who and for what purpose; c) Explain how all programs are aligned with the facility's current stage-specific training manuals, and the two publications by

		SAMHSA; and d) Document results of competency-based training of SR providers and link the results with the programs provided. **Findings:** MSH has implemented this recommendation. Since the last review, training has been conducted by Abilio Hernandez, MD, Denise Nicks, MS and Cozette Moysa, RPh. These individuals are employed by MSH and have appropriate credentials in substance abuse. The purpose of the training was to orient and educate SR group facilitators on the evidenced based and staged SR curriculum. The facility plans to assess the competency level of staff trained through a post-test. This training is not intended to produce certified chemical dependency counselors. There are currently 87 mall facilitators trained on Phase I of the substance recovery curriculum. Out of the 87 staff trained, there are 23 that are currently group providers. There are currently three Substance Recovery group providers that need training in the current curriculum and are scheduled to receive training in the next Mall break in March 2008. The training consists of the following components: 1. Overview: goals and objectives of training, SR groups, outcome measures, areas in need of improvement as outlined by the court monitor's report, the Mall curriculum and post-tests of staff to measure competency and evaluations. 2. Transtheoretical model of stages of change (Velasquez et al): drugs of abuse, definitions and addictions patterns and symptoms, characteristics of each stage, treatment and interventions of each stage, behavioral processes of change, and example vignettes of stages of addiction. 3. SAMHSA TIP 35: a. Co-occurring disorders, precipitating factors of addiction

and vulnerabilities of Substance Abuse;

b. Motivational Interviewing in relation to substance recovery treatment;

c. Enhancing Motivation for Change In-Service Training (EMCIT).

Recommendation 5, August 2007:
Monitor this requirement using the Clinical Chart Auditing Form (not the Chart Auditing Form) and the Substance Recovery Assessment and Treatment Recovery Auditing Form, based on at least a 20% sample of the total number of individuals diagnosed with substance use disorders.

Findings:
MSH used the DMH Clinical Chart Audit Form to assess compliance. The data are based on an average sample of 14% of the WRP reviews due each month (August 2007 to January 2008). The following is an outline of the monitoring indicators and corresponding mean compliance rates:

1.	*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.*	70%
2.	*When substance abuse is diagnosed on Axis I, it is documented in Focus 5 and there is at least one objective and intervention.*	47%

The facility also used the DMH WRP Substance Abuse Audit Form and reviewed an average sample of 71% (August 2007 to January 2008). The following is an outline of the monitoring indicators and corresponding mean compliance rates:

1.	*Substance abuse is integrated into the case formulation and discussed in the present status.*	61%
2.	*There is an appropriate Focus statement listed under Focus 5.*	84%
3.	*There is at least one objective related to each of the individual's stages of change.*	77%
4.	*There are interventions that are appropriately linked to the active objectives.*	69%
5.	*The active treatment for substance abuse that is specified in the WRP is aligned with the individual's Mall schedule.*	55%
6.	*The discharge criteria related to substance abuse are individualized and written in behavioral, observable and/or measurable terms.*	15%

Other findings:
During this reporting period, MSH has provided an average of 36 substance recovery groups to individuals in all five Malls.

This monitor reviewed the charts of six individuals diagnosed with substance use disorders (MAM, BT, KLL, JWG, PB and DLH). The reviewed showed some improvement since the last review. The following pattern was noted:

1. Substance abuse was listed as a diagnosis on the WRP in all cases except one (MAM).
2. All charts included objective(s) and interventions related to substance abuse.
3. The objectives and interventions were properly linked to the ages of change in one chart (KLL) and the linkage was partial in three charts (JWG, MAM and PB).

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

Current recommendations:
1. Implement process and clinical outcome measures regarding substance recovery services, including pre- and post-testing of individuals.
2. Provide outcome data regarding substance recovery services.
3. Provide results of competency-based training of SR providers.
4. Monitor this requirement using Clinical Chart and Substance Abuse Audit Forms based on at least a 20% sample.
5. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the past period).</td>
</tr>
<tr>
<td>C.2.p</td>
<td>Group facilitators and therapists providing therapeutic and rehabilitation services (in groups or individual therapy) are verifiably competent regarding selection and implementation of appropriate approaches and interventions to address therapeutic and rehabilitation services objectives, are verifiably competent in monitoring individuals' responses to therapy and rehabilitation, and receive regular, competent supervision.</td>
<td>Current findings on previous recommendation:

Recommendation, August 2007:
Monitor the competency of group facilitators and therapists in providing rehabilitation services, and specify what the training entailed, the total target population, the sample reviewed, and how competency was measured.

Findings:
MSH audited Rehabilitation Therapists using the Group Facilitator Monitoring tool. The table below showing the total number of Mall facilitators per month (N), the number of facilitators observed (n) and the percentage of competency achieved (%C) is a summary of the facility's data.
<table>
<tr><td></td><td>Aug</td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Mean</td></tr>
<tr><td>N</td><td>627</td><td>571</td><td>583</td><td>569</td><td>558</td><td>638</td><td></td></tr>
<tr><td>n</td><td>3</td><td>2</td><td>12</td><td>3</td><td>3</td><td>3</td><td></td></tr>
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<td>
<table>
<tr><td>%S</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td></td></tr>
<tr><td>%C</td><td>94</td><td>70</td><td>84</td><td>86</td><td>72</td><td>92</td><td>84</td></tr>
</table>

MSH should continue to evaluate providers from all disciplines.

Compliance:
Partial.

Current recommendations:
Monitor the competency of all group facilitators and therapists in providing rehabilitation services, and specify what the training entailed, the total target population, the sample reviewed, and how competency was measured.
</td>
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<tr>
<td>C.2.q</td>
<td>Group facilitators and therapists providing therapeutic and rehabilitation services in the field of substance abuse should be certified substance abuse counselors.</td>
<td>
Current findings on previous recommendations:

Recommendation 1-3, August 2007:
• Ensure that all group facilitators complete the substance abuse training curriculum as per MSH training curriculum.
• Clarify and streamline staff competency criteria to ensure their alignment with the current training curriculum.
• Ensure that training includes all of the five stages of change.

Findings:
This monitor's review of MSH's training documentation and interview of staff confirmed that MSH continues to train substance abuse group facilitators. The table below shows the number of staff trained (N) in the pre-contemplation and contemplation stages each month and the competency level achieved (through a post-test) by the staff (%C) undergoing training.
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<table>
<tr><td></td><td>Sep</td><td>Oct</td><td>Dec</td><td>Mean</td></tr>
<tr><td>N</td><td>4</td><td>8</td><td>3</td><td>5</td></tr>
<tr><td>% Competency</td><td>85</td><td>92</td><td>92</td><td>90</td></tr>
</table>

Recommendation 4, August 2007:
Establish a review system to evaluate the quality of services provided by these trained facilitators.

Findings:
MSH has established a system to evaluate the quality of services provided by the trained Substance Abuse group facilitators. The system involves auditing 20% of the Substance Abuse and the Substance Recovery groups each month. The Substance Abuse coordinator then analyzes the data obtained from the audits to identify deficiencies in the training and the competency of facilitators, and follow ups with remedial training and mentoring to improve the quality of service provided by these trained facilitators.

Compliance:
Partial.

Current recommendations:
1. Ensure that all group facilitators complete the substance abuse training curriculum as per MSH training curriculum.
2. Clarify and streamline staff competency criteria to ensure their alignment with the current training curriculum.
3. Ensure that training includes all of the five stages of change.
4. Implement the review system and show data derived from the remedial training.
</td>
</tr>
<tr>
<td>C.2.r</td>
<td>Transportation and staffing issues do not preclude individuals from attending appointments.</td>
<td>Current findings on previous recommendations:</td>
</tr>
</table>

Recommendation 1 and 2, August 2007:

- Review reasons for cancellations and assess and correct factors contributing to such events.
- Assess why individuals refuse medical appointments and find ways to resolve their concerns.

Findings:

MSH used items #1 to #3 from the Missed Appointments Monitoring tool to evaluate the percentage of missed appointments in the last six months, reporting 21% of total appointments missed. Of the missed appointments, 95% were missed due to refusals and 5% were missed due to individuals not making themselves available. The table below with its monitoring indicators showing the number of appointments scheduled per month (N), the number of appointments completed per month (n), the percentage of appointments completed (%C), and the number of appointments missed for each reason is a summary of the facility's data.

	Aug	Sep	Oct	Nov	Dec	Jan	Mean
N	1471	1314	1474	1383	1297	1470	
n	1145	1041	1119	1059	1031	1209	
%C	78	79	76	77	79	82	79
#1: Individual refused	284	221	303	288	250	234	263
#2: Individual not available	14	21	20	10	8	9	14
#3: Staffing-related	0	0	2	0	0	0	0

The table above shows that a total of 1,580 appointments were missed over the last six months due to individuals refusing to attend their scheduled appointments, a total of 82 missed appointments due to non-availability of the individuals, and only 2 missed appointments were

		staffing related. Refusals by individuals to keep their scheduled appointments are high. Data on the reasons for refusals included individuals not wanting to miss smoking breaks, not wanting to miss free time activities, not wanting to miss Mall groups, and not wanting to lose BY CHOICE points. According to the Treatment Enhancement Coordinator, MSH is monitoring cancellations through the use of a tracking sheet. The tracking sheet containing the names of those individuals who have missed three scheduled appointments is given to Unit Supervisors and Nursing Coordinators so that the WRPTs can address the issues with the individual. Additional steps MSH has taken include involvement of the Individual Council, and awarding BY CHOICE points as incentives to motivate individuals to keep their scheduled appointments. **Recommendation 3, August 2007:** Complete and implement the Medical Scheduler. **Findings:** MSH has yet to implement the Medical Scheduler. According to Ken Laymen, Treatment Enhancement Coordinator, the WaRMSS Medical Scheduler application is pending approval from the DMH. **Compliance:** Partial. **Current recommendations**: 1. Review reasons for cancellations and assess and correct factors contributing to such events. 2. Complete and implement the Medical Scheduler.

C.2.s	Adequate oversight to treatment, rehabilitation and enrichment groups is provided to ensure that individuals are assigned to groups that are appropriate to their assessed needs, that groups are provided consistently and with appropriate frequency, and that issues particularly relevant for this population, including the use of psychotropic medications and substance abuse, are appropriately addressed, consistent with generally accepted professional standards of care.	**Current findings on previous recommendations:** **Recommendation 1, August 2007:** Ensure that individuals' cognitive levels, needs, and strengths are utilized when considering groups assignments. **Findings:** This monitor's review of documentation (Integrated Assessments: Psychology section and DCAT assessments) and interview with the Chief of Psychology found that WRPTs are aware of individuals' cognitive levels. However, assignment of individuals to groups based on cognitive levels is still poor because Mall groups do not offer multiple versions to address different cognitive levels. Strengths are not used to assign individuals to groups because in many instances, strengths are not indicated in the intervention sections of the WRP. **Recommendation 2, August 2007:** Ensure that providers and facilitators are knowledgeable, competent, and motivated to translate course content to individuals' needs to maximize learning. **Findings:** MSH has audited Rehabilitation Therapists and Substance Abuse Providers facilitating Mall groups to establish their knowledge, competency, and motivation in conducting the groups. MSH has not done the same for all Mall group facilitators, across disciplines. **Recommendation 3, August 2007:** Develop and implement monitoring systems that address all of the required elements. **Findings:** MSH used item #10 from the DMH WRP Clinical Chart Auditing Form

to address this recommendation, reporting 59% compliance. The table below with its monitoring indicator showing the number of quarterly WRPs per month (N), the number of chart audits conducted per month (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

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.

	Aug	Sep	Oct	Nov	Dec	Jan	Mean
N	161	156	162	157	119	169	
n	17	24	41	25	18	31	
%S	11	15	25	16	15	18	
%C #10	53	54	42	72	78	58	59

Compliance:
Partial.

Current recommendations:
1. Ensure that individuals' cognitive levels, needs, and strengths are utilized when considering groups assignments.
2. Ensure that providers and facilitators are knowledgeable, competent, and motivated to translate course content to individuals' needs to maximize learning.
3. Develop and implement monitoring systems that address all of the required elements.

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:** **Recommendation 1, August 2007:** Continue to develop and implement monitoring tools to ensure the process outcomes of treatment and/or rehabilitation services. **Findings:** MSH has decided to use the Mall Facilitator Monitoring form to address the process outcomes of treatment and/or rehabilitation services. **Recommendation 2, August 2007:** Develop and implement monitoring tools to ensure positive clinical outcomes of treatment and/or rehabilitation services. **Findings:** MSH has yet to develop and implement monitoring tools to ensure positive clinical outcomes of treatment and/or rehabilitation services. The Mall Curriculum Committee has the task of developing and implementing this tool. **Recommendation 3, August 2007:** Develop and implement monitoring tools to ensure that Mall activities are properly linked to the foci, objectives and interventions specified in the WRP. **Findings:** MSH used item #11 from the DMH WRP Clinical chart Auditing Form to address this recommendation, reporting 11% compliance. The table below with this monitoring indicator showing the number of quarterly WRPs per month (N), the number of charts audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

Treatment, rehabilitation and enrichment services are monitored appropriately against rational, operationally-defined target variables and revised as appropriate in light of significant development, and the individual's progress, or lack thereof.

	Aug	Sep	Oct	Nov	Dec	Jan	Mean
N	161	156	162	157	119	169	
n	19	26	41	34	23	31	
%S	12	17	25	22	19	18	
%C -#11	5	15	12	18	9	7	11

This monitor reviewed eight charts (AFC, DTP, JJ, KS, PC, SB, SL and THE). Two of the WRPs in the charts (SL and THE) were properly linked with the foci, objectives, interventions, and the Mall activities. The remaining six (AFC, DTP, JJ, KS, PC and SB) had one or more discrepancies among the Mall activities and the foci, objectives and interventions. For example, one of KS' discharge criteria related to self-injurious behavior, but there was no focus, objective, or intervention for the behavior or an appropriate Mall group; PC has an objective that has no bearing on his groups ("Paul will apply his group participation to his discharge planning").

Compliance:
Partial.

Current recommendations:
1. Continue to develop and implement monitoring tools to ensure the process outcomes of treatment and/or rehabilitation services.
2. Develop and implement monitoring tools to ensure positive clinical outcomes of treatment and/or rehabilitation services.
3. 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:** **Recommendation 1, August 2007:** Increase the number of Mall groups that are provided to address this requirement, based on needs assessment. **Findings:** MSH has yet to implement this recommendation. The facility's report indicated that on average, 20 groups were provided during this review period (August 2007 to January 2008). This represents a decrease from the last review, at which time an average of 24 groups were provided. MSH did not provide an explanation for this drop in compliance. A plan of correction was presented at the request of this monitor and involves the use of data from psychological assessments regarding the cognitive level of Mall populations to ensure that groups are aligned with the individuals' levels of functioning. The facility plans to identify the appropriate number of additional groups and utilize existing resources for implementation. **Recommendation 2, August 2007:** Provide data to identify number of groups and discipline of providers. **Findings:** The facility provided data showing that the mean number of all Wellness and Recovery Mall groups during this reporting period was 20. The groups were facilitated by representatives of the disciplines of Psychiatry, Psychology, Rehabilitation Therapy, and Clinical Social Worker. In addition, a Nurse Practitioner participated in this task. **Recommendation 3, August 2007:** Continue to monitor implementation of this requirement, and ensure at

		least a 20% sample size. **Findings:** The facility provided data from the WRP process observation audit (August 2007 to January 2008). Based on an average sample of 14% of all WRP reviews, the facility reported that on average, 81% of the individuals received a copy of their WRPs. This represents an improvement in compliance compared to the last reporting period. **Compliance:** Partial. **Current recommendations**: 1. Increase the number of Mall groups that are provided to address this requirement, based on needs assessment. 2. Provide an analysis of low compliance and implement corrective action. 3. Provide data to identify number of groups and discipline of providers. 4. Continue to monitor implementation of this requirement and ensure at least a 20% sample size.
C.2.v	Staff educates individuals about their medications, the expected results, and the potential common and/or serious side effects of medications, and staff regularly asks individuals about common and/or serious side effects they may experience.	**Current findings on previous recommendations:** **Recommendation 1, August 2007:** Increase the number of Mall groups that are provided to address this requirement, based on needs assessment. **Findings:** MSH provided approximately 30 groups during this reporting period, a significant decrease from 61 groups reported for the last review period. The facility explained that this decline was due to a change in the definition of Medication Education groups. During the previous

		review period, the facility had included "Symptom Management" groups as Medication Education groups if the content included teaching about medications. After a review of the content in August 2007, the facility decided that these groups no longer qualified as Medication Education groups. **Recommendation 2, August 2007:** Provide data to identify number of groups and discipline of providers. **Findings:** MSH reported that the providers consisted of 19 psychiatrists, three registered nurses, two social workers, one pharmacist and one psychologist. **Compliance:** Partial. **Current recommendations**: 1. Increase the number of Mall groups that are provided to address this requirement, based on needs assessment. 2. Provide an analysis of low compliance and implement a plan of correction.
C.2.w	Interdisciplinary teams review, assess, and develop positive clinical strategies to overcome individual's barriers to participation in therapeutic and rehabilitation services.	**Current findings on previous recommendations:** **Recommendation 1, August 2007:** Track non-adherence to WRPs and WRPTs' responses to notifications. **Findings:** MSH tracks WRP non-adherence as part of the key indicators, but the facility has yet to implement a system of trigger notifications and tracking of follow-up by the WRPTs.

		Recommendation 2, August 2007: Assess other barriers to individuals' participation in their WRPs and provide corrective actions to all identified barriers. **Findings:** Since the last review, MSH has assessed the barriers to participation and found those barriers to include Mall group scheduling, some staff members' lack of skills in motivational enhancement techniques, and the perception by some individuals that their assigned groups do not meet their needs. The facility is in the process of implementing a plan of correction to address Mall scheduling, training in motivational enhancement techniques (see next recommendation) and provision of groups that align with individuals' cognitive levels. **Recommendation 3, August 2007:** Provide training to the WRPTs to ensure implementation of: a) Appropriate individual therapy to individuals non-adherence to WRP in the Key Indicator; and b) Clinical strategies to help individuals achieve readiness to engage in group activities. **Findings:** Since the last review period, MSH has provided three training sessions of eight hours each to WRPT members using the Enhancing Motivation for Change In-Service Training EMCIT TIP-35 curriculum. Training was divided in three phases and provided by Denise Nicks, the former Substance Recovery Coordinator. Competency testing was given to Phase III attendees who had completed the training. **Compliance:** Partial.

		Current recommendations: 1. Implement a system of trigger notifications and tracking of response by the WRPTs. 2. Continue training to the WRPTs to ensure implementation of: a. Appropriate individual therapy to individuals non-adherence to WRP in the Key Indicator; and b. Clinical strategies to help individuals achieve readiness to engage in group activities.

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:** **Psychiatric Assessments and Diagnoses** 1. MSH has improved the format and quality of the Initial Admission Psychiatric Assessments. 2. MSH has made progress in the finalization of diagnoses listed as Not Otherwise Specified (NOS), as clinically appropriate. 3. The DMH has standardized all monitoring instruments for this section, with the exception of the Admission Medical Assessment. 4. MSH has improved its methodology in self-monitoring by utilizing the DMH standardized instruments. **Psychological Assessments** 1. MSH has made significant progress in completing Integrated Assessments: Psychology Section (IAPs) for all individuals in the facility; MSH has completed most of the IAP reviews/re-evaluations for individuals admitted before June 1, 2006 2. MSH has made significant improvement in ensuring that diagnostic uncertainties are backed up by additional testing. **Nursing Assessments** 1. MSH has implemented the Statewide Nursing Admission and Integrated Assessments. 2. MSH has implemented a mentoring program for the nursing admission assessments and has added an additional Registered Nurse to the admissions unit to assist with the admission assessments. 3. The Nursing Department at MSH has earnestly embraced the Wellness and Recovery philosophy.

		Rehabilitation Therapy Assessments 1. The Integrated Assessment-Rehabilitation Therapy Services (IA-RTS) admission assessment has been revised and implemented to ensure that assessments include clinical observations and structured activities and are multi-disciplinary in nature. 2. Drafts of focused assessments for Occupational, Speech and Physical Therapy and Vocational Rehabilitation have been developed and are pending finalization and implementation. 3. Integrated Assessment- Rehabilitation Therapy Section and focused assessment tools appear to meet EP requirements. **Nutrition Assessments** 1. Compliance with Nutrition Care Assessment sub-types continues to improve. 2. The current system for Nutrition Assessments and monitoring appears to meet generally accepted standards of care. **Social History Assessments** 1. MSH has aligned all Social Work assessments and monitoring tools with the EP. 2. MSH has improved the timeliness and quality of the Integrated Assessment: Social Work section, and the 30-day Social History assessments. **Court Assessments** 1. MSH has revised AD #0206, The Forensic Review Panel, to codify the practice of FRP review of all court reports. The FRP reviewed 100% of all court reports during the interval. 2. The minutes of the FRP meetings adequately document the proceedings.

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:** <u>Interviewed</u>: 1. Michael Barsom, MD, Medical Director 2. Nady Hanna, MD, Medical Staff President 3. Bala Gulasekaram, MD, Chief of Psychiatry <u>Reviewed</u>: 1. The charts of the following 42 individuals : ABW, AJG, AMA, BJL, BRS, BT, CG, DAMB, DE, DFM, DG, DLJ, HO, IER, JC, JL, JLB, JLM, JM, JNU, JV, JWG, LLD, MAM, MC, MH, MJ, MLC, MML, NB, NV, PB, PDF, PS, PW, RAL, RH, RJA, RMT, RRF, SB and TM 2. MSH revised template for the Admission Psychiatric Assessment 3. MSH proposed system for risk assessment during the first 24 hours of admission 4. MSH instructions regarding completion of the Psychiatric Integrated Assessment 5. MSH revised template for Physician Performance Data 6. Database regarding current individuals with "No Diagnosis" listed on Axis I 7. Medical Care Policy and Procedure (revised) 8. MSH Medical Admission Assessment Monitoring Form 9. MSH Medical Admission Assessment Monitoring summary data (August 2007 to January 2008) 10. DMH Admission Psychiatric Assessment Auditing Form 11. DMH Admission Psychiatric Assessment Auditing Form Instructions 12. MSH Admission Psychiatric Assessment Auditing summary data (August 2007 to January 2008) 13. DMH Integrated Assessment: Psychiatry Section Auditing Form 14. DMH Integrated Assessment: Psychiatry Section Auditing Form Instructions 15. MSH Integrated Assessment: Psychiatry Section Auditing summary

		data (August 2007 to January 2008) 16. DMH Monthly Psychiatric Progress Notes Auditing Form 17. DMH Monthly Psychiatric Progress Notes Auditing Form Instructions 18. DMH Weekly Psychiatric Progress notes Auditing Form 19. DMH Weekly Psychiatric Progress notes Auditing Form Instructions 20. MSH Psychiatric Progress Notes Auditing summary data (August 2007 to January 2008) 21. DMH Physician Inter Unit Transfer Note Auditing Form 22. DMH Physician Inter Unit Transfer Note Auditing Form Instructions 23. MSH Physician Inter Unit Transfer Auditing summary data (August 2007 to January 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:** **Recommendation 1, August 2007:** Finalize statewide efforts to consolidate and standardize monitoring instruments regarding psychiatric assessments and address the monitor's comments listed above. **Findings:** The DMH has developed and finalized the indicators and operational instructions for the following instruments: 1. DMH Admission Psychiatric Assessment Auditing Form; 2. DMH Integrated Assessment: Psychiatry Section Auditing Form; and 3. DMH Physician Inter Unit Transfer Note Auditing Form The DMH has yet to finalize a standardized tool regarding the Admission Medical Assessment.

Recommendation 2, August 2007:
Continue to monitor this requirement and ensure samples of 20% of the total target populations.

Findings:
MSH used the DMH Admission Psychiatric Assessment Audit Form and reviewed an average sample of 92% (August 2007 to January 2008). The following outlines the indicators and mean compliance rates:
…

1.	*Admission diagnosis Axis I-V are addressed.*	90%
2.	*The DSM diagnosis is consistent with history and presentation.*	84%

Using the DMH Integrated Assessment: Psychiatry Section Auditing Form, the facility reviewed an average sample of 75% (August 2007 to January 2008). The following are the indicators and corresponding mean compliance rates:

1.	*Statements from the individual are included, if available.*	75%
2.	*Diagnosis and medications given at previous facility are included.*	36%
3.	*Diagnostic formulation*	68%
4.	*Differential diagnosis*	71%
5.	*Current psychiatric diagnosis*	90%

MSH reported that the lower compliance on item#2 (*diagnosis and medications given at previous facility are included)* is due to the fact that the facility has a significant number of individuals under PC 4011.6 who are admitted directly from jails where minimal assessment and/or treatment had been initiated. The facility had initiated contacts with the sending facilities to improve continuity of care.

		The facility has recognized a recent pattern of low compliance in completing the Mini-Mental State Examination (MMSE) for individuals with cognitive disorders. To address this issue, MSH has developed and implemented a new system as of March 2008. This system requires an MMSE at least quarterly for all individuals who have or are at risk for cognitive impairment. The system establishes a set schedule for MMSE in specific months (March, June, September, December) regardless of date of admission. MSH did not present its data from progress notes auditing related to diagnostic accuracy indicators. **Recommendation 3, August 2007:** Provide ongoing feedback and monitoring by senior psychiatrists to correct the deficiencies outlined by this monitor (D.1.c.i through D.1.c.iii). **Findings:** MSH reported that the senior psychiatrists have provided slide presentations of the data (graphs) to the medical staff in several meetings of the medical staff and the Department of Psychiatry Executive Committee. **Other findings:** Chart reviews by this monitor found that the psychiatric diagnoses were, in general, stated in terminology that is consistent with the current version of DSM. The facility has made progress in the quality of information in the initial admission psychiatric assessments necessary to ensure diagnostic accuracy. However, some deficiencies remain in both the admission and integrated psychiatric assessments (see D.1.c.ii and D.1.c.iii) that 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 20%. 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 recommendation:** **Recommendation, August 2007:** Continue current practice. **Findings:** The facility has continued its practice. As of February 1, 2008, 100% of the 51 psychiatrists employed by MSH (including two forensic psychiatry fellows) have successfully completed at least three years of psychiatry residency training in a residency program that is accredited by the Accreditation Counsel for Graduate Medical Education (ACGME). Currently, 24 of the 51 psychiatrists are certified by the American Board of Psychiatry and Neurology (ABPN). **Compliance:** Full compliance.

		Current recommendations: Continue current practice and encourage all psychiatrists to obtain board certification.
D.1.b.ii	Are verifiably competent (as defined by privileging at initial appointment and thereafter by reprivileging for continued appointment) in performing psychiatric assessments consistent with each State Hospital's standard diagnostic protocols.	**Current findings on previous recommendation:** **Recommendation, August 2007:** Utilize the data from the Physician Quality Profiles in the processes of reprivileging and performance improvement of the medical staff. **Findings:** MSH began implementation of this recommendation and has used data from its newly developed Physician Performance Quality profile in the process of reprivileging of the medical staff (psychiatry). Since the inception of the Quality Profile, the facility has reviewed the performance of 31 physicians. **Compliance:** Partial. **Current recommendations**: Utilize the data from the Physician Quality Profiles in the processes of reprivileging of all medical staff and initiate performance improvement, as needed, to address identified trends/patterns.
D.1.c	Each State hospital shall ensure that:	Please see sub-cells for compliance findings.
D.1.c.i	Within 24 hours of an individual's admission to each State hospital, the individual receives an Admission Medical Assessment that includes:	**Current findings on previous recommendations:** **Recommendation 1, August 2007:** Implement the revised Medical Care Policy and Procedure regarding deferrals and refusals of the physical examination or parts of the

		examination. **Findings:** MSH has implemented this recommendation. The revised Medical Care Policy and Procedure incorporates the recommendation (pages 2 and 3). **Recommendation 2, August 2007:** Continue to monitor this requirement, and include deferrals and refusals of the examination and follow up (as per revised Medical Services Medical Care Policy and Procedures). **Findings:** MSH used the current MSH Medical Admission Assessment Monitoring Form to assess compliance (the DMH has yet to finalize a standardized tool). The facility reviewed an average sample of 92% (August 2007 to January 2008) and the mean compliance rate for this requirement was 99%. Compliance rates for the requirements in D.1.c.i.1 to D.1.c.i.5 are reported in each corresponding cell below. The facility did not provide an analysis of the low compliance rate in D.1.c.i.5. **Other findings:** This monitor reviewed the charts of 10 individuals who were admitted during this reporting period (AMA, BT, DG, DLJ, JWG, LLD, PDF, PS, RMT and SB). The review found compliance with the timeliness of the assessment in all cases. Regarding the content of the assessment, the main deficiency continues to be lack of documentation of follow-up when individuals refuse genital/rectal examination (PDF) or deferral of the rectal examination without reason (DG). **Compliance:** Partial.

		Current recommendations: 1. 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. 2. Provide data analysis that evaluates and delineates areas of low compliance and relative improvement (during the reporting period and compared to the last period). 3. Finalize the DMH Initial Medical Examination Auditing Form and Instructions for use across facilities.
D.1.c.i.1	a review of systems;	99%.
D.1.c.i.2	medical history;	99%.
D.1.c.i.3	physical examination;	99%.
D.1.c.i.4	diagnostic impressions; and	No data (pending implementation of the DMH Initial Medical Assessment standardized tool).
D.1.c.i.5	management of acute medical conditions	77%.
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, August 2007:** Ensure that mental status examinations are completed on all admission psychiatric assessments. An adequate narrative must be entered whenever indicated to complete the section titled "elaborate on positive mental status examination." **Findings:** MSH has updated its format for the Admission Psychiatric Assessment to include a space for elaboration on any positive finding in the mental

		status examination. **Recommendation 2, August 2007:** Ensure documentation of a provisional plan of care upon the completion of the initial psychiatric examination. **Findings:** The update of the assessment format also included a provisional plan of care that adequately addresses the following: 1. Management of identified target symptoms; 2. Management of identified risks; 3. Consultations, if applicable; and 4. Pharmacological consent issues. In addition, MSH has initiated a draft suicide risk assessment scale to be part of the initial assessment as a screening tool during the first 24 hours of hospitalization. The tool is derived from generally accepted literature. However, the design of this instrument provides equal weight to multiple variables and non-modifiable factors regardless of their relative significance in determining suicide risk. **Recommendation 3, August 2007:** Monitor this requirement based on a review of a 100% sample. **Findings:** MSH used the DMH Admission Psychiatric Assessment and reviewed an average sample of 92%, reporting a mean compliance rate of 99% with this requirement. The compliance rates for the requirements in D.1.c.ii.2 to D.1.c.ii.6 are listed in each corresponding cell below along with relevant data analysis. The indicators are listed only if they represented sub-components of the requirement.

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Other findings:
This monitor reviewed the previously identified 10 charts. The review found improved documentation of the plan of care for individuals who were admitted after implementation of the revised format for the assessment in November 2008. Overall, there is evidence of improvement in the quality of these assessments. However, deficiencies are still noted in the documentation of an adequate narrative to assess positive findings such as auditory hallucinations (RMT) and delusional thinking (DG, DLG and JWG). In addition, the chart of BT did not include an assessment of mood/affect (despite documented history of suicide attempt two years ago) and there was no documentation of a cognitive examination in the charts of JWG and RMT.

Compliance:
Partial.

Current recommendations:
1. Finalize and implement a risk assessment tool for use during the first 24 hours of admission that aligns with the instructions regarding risk factors in the integrated psychiatric assessment.
2. Continue to monitor the Admission Psychiatric Assessment 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).

</td>
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<tr>
<td>D.1.c.ii.1</td>
<td>psychiatric history, including a review of presenting symptoms;</td>
<td>

<table>
<tr><td>1.</td><td>History of present illness</td><td>81%</td></tr>
<tr><td>2.</td><td>Psychiatric history</td><td>65%</td></tr>
</table>

Data analysis showed improvement in compliance with both indicators from August 2007 to January 2008.

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</table>

D.1.c.ii.2	complete mental status examination;	95%.
D.1.c.ii.3	admission diagnoses;	90%.
D.1.c.ii.4	completed AIMS;	96%.
D.1.c.ii.5	laboratory tests ordered; and	98%
D.1.c.ii.6	consultations ordered.	96%
	plan of care	<table><tr><td>1.</td><td>Regular psychotropic medications with rationale</td><td>61%</td></tr><tr><td>2.</td><td>Special precautions to address risk factors, as indicated</td><td>90%</td></tr></table> The data showed a trend of increasing compliance scores since November 2007. The facility attributed this to the assignment of a board-certified psychiatrist to the Admission Suite in September 2007.
D.1.c.iii	within 7 days (60/72 hrs) of an individual's admission to each State hospital, the individual receives an Integrated Psychiatric Assessment that includes:	**Current findings on previous recommendations:** **Recommendation 1, August 2007:** Provide ongoing feedback and mentoring by senior psychiatrists to ensure that the integrated assessments correct the deficiencies outlined by this monitor. **Findings:** Same as Findings for Recommendation 3 in D.1.a. **Recommendation 2, August 2007:** Monitor this requirement based on a review of a 100% sample.

		Findings: The facility provided monitoring data based on the DMH Integrated Assessment: Psychiatry Section Audit Form (August 2007 to January 2008). The average sample size was 75%. The facility reported mean compliance rate of 54% with this requirement. The compliance rates with the requirements in D.1.c.iii.1 to D.1.c.iii. 10 are listed for each corresponding cell below along with relevant data analysis. The indicators are listed only if they represented sub-components of the requirement. **Other findings:** This monitor reviewed the charts of 11 individuals (AMA, BT, DG, DJJ, JWG, LLD, MJ, PDF, PS, RMT and SB). The review found that MSH has yet to make significant improvement in the quality of integrated assessments. The facility's monitoring data from the new DMH standardized tool and operational instructions and the current system of feedback by senior psychiatrists should facilitate efforts to improve compliance. The following are some examples of the deficiencies that must be corrected to achieve substantial compliance: 1. The assessment did not include information regarding substance use history, psychosocial history and family history, apparently due to the individual's status at the time of the assessment. However, there was no documentation of subsequent attempts to obtain needed information (PS). 2. The assessment did not include a review of suicidal ideations/ intent/plan (DLJ). 3. The diagnostic formulation was inadequate (DLJ and MJ). 4. The assessment did not include differential diagnosis although it was clinically indicated (DLJ and MJ). 5. The strengths formulation was absent (MJ) or based on generic characteristics (BT, DG, PDF and RMT). 6. The cognitive examination was incomplete and inadequate (JWG and

<table>
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<td></td>
<td></td>
<td>MJ).
7. The MMSE was not completed although it was indicated (SB).
8. The assessment of insight and judgment was generic (AMA, BT, JWG and MJ).
9. The assessment did not include a plan to manage identified risks (DLJ).
10. The assessment did not include a psychopharmacological plan of care (JWG).

Compliance:
Partial.

Current recommendations:
1. Implement the operational instructions regarding the assessment of risk factors in the integrated assessments and standardize this process in all facilities.
2. Continue to monitor the Integrated Psychiatric Assessment 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).</td>
</tr>
<tr>
<td>D.1.c.iii.
1</td>
<td>psychiatric history, including a review of present and past history;</td>
<td>
<table>
<tr><td>1.</td><td>Identifying data including legal status</td><td>74%</td></tr>
<tr><td>2.</td><td>Statements from the individual, if available</td><td>75%</td></tr>
<tr><td>3.</td><td>Chief complaint</td><td>96%</td></tr>
<tr><td>4.</td><td>Diagnosis and medications given at previous facility</td><td>36%</td></tr>
<tr><td>5.</td><td>Effectiveness of medications from previous facility</td><td>41%</td></tr>
<tr><td>6.</td><td>Past psychiatric history is documented including a review of pertinent physical exam status.</td><td>67%</td></tr>
</table>

The facility is attempting to improve compliance with sub-items 4, 5 and 6 through contacts with the referring facilities (for individuals</td>
</tr>
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<table>
<tr><td></td><td></td><td>admitted under PC 4011.6).</td></tr>
<tr><td>D.1.c.iii.
2</td><td>psychosocial history;</td><td><table>
<tr><td>1.</td><td>Developmental history</td><td>87%</td></tr>
<tr><td>2.</td><td>Family history</td><td>84%</td></tr>
</table></td></tr>
<tr><td>D.1.c.iii.
3</td><td>mental status examination;</td><td><table>
<tr><td>1.</td><td>Attitude/cooperation</td><td>95%</td></tr>
<tr><td>2.</td><td>General appearance</td><td>90%</td></tr>
<tr><td>3.</td><td>Motor activity</td><td>87%</td></tr>
<tr><td>4.</td><td>Speech</td><td>80%</td></tr>
<tr><td>5.</td><td>Mood/affect</td><td>87%</td></tr>
<tr><td>6.</td><td>Thought process/content</td><td>80%</td></tr>
<tr><td>7.</td><td>Perceptual alterations</td><td>89%</td></tr>
<tr><td>8.</td><td>Fund of general knowledge</td><td>63%</td></tr>
<tr><td>9.</td><td>Abstraction ability</td><td>60%</td></tr>
<tr><td>10.</td><td>Judgment</td><td>41%</td></tr>
<tr><td>11.</td><td>Insight</td><td>49%</td></tr>
<tr><td>12.</td><td>MMSE if indicated</td><td>75%</td></tr>
</table>MSH has provided operational instructions to the medical staff to improve compliance with sub-items 10 and 11.</td></tr>
<tr><td>D.1.c.iii.
4</td><td>strengths;</td><td>87%.</td></tr>
<tr><td>D.1.c.iii.
5</td><td>psychiatric risk factors;</td><td><table>
<tr><td>1.</td><td>Addresses history of suicide attempts</td><td>76%</td></tr>
<tr><td>2.</td><td>Addresses current clinical symptoms, including suicidal ideation/threats/plans to harm self</td><td>77%</td></tr>
<tr><td>3.</td><td>Risk factors for seclusion/restraint addressed</td><td>65%</td></tr>
</table></td></tr>
</table>

<table>
<tr><td></td><td></td><td>
<table>
<tr><td>4.</td><td>Risk of aggression/fire setting/elopement/etc. addressed</td><td>69%</td></tr>
<tr><td>5.</td><td>Risk for victimization</td><td>No data</td></tr>
</table>

In an effort to improve compliance, MSH has provided instructions to the medical staff to include specific factors unique to the individual that indicate that the examining physician has considered the impact of these factors in assessing the overall risks. In addition, the facility instructed its staff to conduct a demographic risk assessment and assessment of psychosocial losses for all individuals regardless of the current suicidal status. These instructions adequately address this requirement.
</td></tr>
<tr><td>D.1.c.iii.6</td><td>diagnostic formulation;</td><td>68%.

The facility's data showed a trend of improvement in compliance during this review period (August 2007 to January 2008).</td></tr>
<tr><td>D.1.c.iii.7</td><td>differential diagnosis;</td><td>60%.

MSH has provided operational instructions to the medical staff to improve compliance.</td></tr>
<tr><td>D.1.c.iii.8</td><td>current psychiatric diagnoses;</td><td>90%.</td></tr>
<tr><td>D.1.c.iii.9</td><td>psychopharmacology treatment plan; and</td><td>
<table>
<tr><td>1.</td><td>Target symptoms</td><td>33%</td></tr>
<tr><td>2.</td><td>Specific medications to be used</td><td>46%</td></tr>
<tr><td>3.</td><td>Dosage titration schedules, if indicated</td><td>46%</td></tr>
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		<table><tr><td>4.</td><td>*Rationale for anticholinergics, benzodiazepines, polypharmacy, and new generation antipsychotics in at-risk population if indicated*</td><td>39%</td></tr><tr><td>5.</td><td>*Medication consent issues*</td><td>52%</td></tr></table> The use of the DMH standardized instrument has allowed the facility to provide data on the above sub-items for the first time.
D.1.c.iii.10	management of identified risks.	62%. MSH did not provide information regarding efforts to improve compliance.
D.1.d	Each State hospital shall ensure that:	Please see sub-cells for compliance findings.
D.1.d.i	Clinically justifiable diagnoses are provided for each individual, and all diagnoses that cannot be clinically justified for an individual are discontinued no later than the next review;	**Current findings on previous recommendations:** **Recommendation 1, August 2007:** Continue medical education programs to improve diagnostic accuracy, including assessment of cognitive and other neuropsychiatric disorders. **Findings:** MSH provided documentation of a variety of medical education programs that addressed diagnostic accuracy, but the facility has yet to provide documentation of programs specific to the assessment of cognitive and neuropsychiatric disorders. **Recommendation 2, August 2007:** Same as in C.1.a. **Findings:** Same as in C.1.a.

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Other findings:
This monitor reviewed the charts of six individuals who have received diagnoses listed as NOS continuously for more than two months during this reporting period. The review found that the facility has made further progress in finalizing these diagnoses. However, more work is needed to ensure adequate documentation of the individuals' impairments and/or alignment of the diagnostic information in the current WRP with the most recent psychiatric progress notes The following is the list of the charts reviewed:
<table>
<tr><th>Initials</th><th>Diagnosis</th></tr>
<tr><td>ABW</td><td>Cognitive Disorder, NOS</td></tr>
<tr><td>IER</td><td>Eating Disorder, NOS (discontinued in February 2008)</td></tr>
<tr><td>JM</td><td>Dementia, NOS</td></tr>
<tr><td>JNU</td><td>Psychotic Disorder, NOS</td></tr>
<tr><td>PB</td><td>Psychotic Disorder, NOS and Cognitive Disorder NOS (both diagnoses were finalized in February 2008)</td></tr>
<tr><td>RJA</td><td>R/O Alcohol-Induced Dementia and Cognitive Disorder NOS</td></tr>
</table>
Compliance:
Partial.

Current recommendations:
Continue medical education programs to improve diagnostic accuracy, including assessment of cognitive and other neuropsychiatric disorders.
</td>
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<tr>
<td>D.1.d.ii</td>
<td>The documented justification of the diagnoses is in accord with the criteria contained in the most current DSM (as per DSM-IV-TR</td>
<td>Current findings on previous recommendation:</td>
</tr>
</table>

	Checklist);	**Recommendation, August 2007:** Same as D.1.a. **Findings:** Same as D.1.a. **Other findings:** Same as D.1.a. **Compliance:** Partial. **Current recommendations**: Same as D.1.a.
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, August 2007:** Same as D.1.d.i. **Findings:** Same as D.1.d.i. **Other findings:** Same as D.1.d.i. **Compliance:** Partial. **Current recommendations**: Same as D.1.d.i.

D.1.d.iv	"no diagnosis" is clinically justified and documented.	**Current findings on previous recommendation:** **Recommendation, August 2007:** Continue current practice. **Findings:** MSH has continued its practice. According to HIMD records, there are no individuals with "no diagnosis" listed on Axis I (as of March 3, 2008). **Compliance:** Substantial. **Current recommendations**: Continue current practice.
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 recommendation:** **Recommendations 1 and 2, August 2007:** • Monitor the frequency of weekly and monthly documentation as required by the EP, based on at least a 20% sample. • Assess and correct factors related to low compliance. **Findings:** MSH used the DMH Monthly Physician Progress Notes (PPN) Audit Form to assess compliance (August 2007 to January 2008). Based on an average sample size of 31%, the facility reported a compliance rate of 58% regarding the requirement for monthly notes on the long-term units. Since September 2007, MSH has developed the capacity to segregate data regarding timeliness of the Weekly Physician Progress Notes from Monthly Physician Progress Notes. Although the segregated data were not provided, the facility acknowledged a pattern of low compliance with this requirement. According to the facility's

		report, contributing factors included a newly implemented requirement that all PPNs must be either dictated or typed. Consequently, the dictation system was backlogged and there was excessive delay in the timeliness of PPNs. To address this deficiency, MSH has evaluated several electronic or voice-recognition document systems and a pilot project is currently underway in one program. **Other findings:** This monitor reviewed the charts of seven individuals to assess compliance with the requirement for weekly notes on the admissions units. The review found noncompliance in four charts (DG, DLJ, PDF and PS), compliance in two (JWG and SB) and partial compliance in one (BT). **Compliance:** Partial. **Current recommendations**: 1. Continue to monitor this requirement and provide separate data for weekly and monthly notes. 2. Implement corrective actions to improve compliance.
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, August 2007:** Provide ongoing feedback and mentoring by senior psychiatrists to ensure that the psychiatric reassessments correct the deficiencies outlined by this monitor. **Findings:** MSH currently has an adequate structure for the provision of oversight by senior psychiatrists. The system includes weekly meetings between the senior psychiatrists and the Chief of Psychiatry to review

		current practice patterns and identify corrective actions, as needed. **Recommendation 2, August 2007:** Monitor this requirement based on a review of at least a 20% sample. **Findings:** MSH used the DMH Monthly PPN (Psychiatry) Monitoring Form to assess compliance (August 2007 to January 2008). The use of this form has allowed the facility to consolidate all monitoring data for this cell. The average sample size was 14%. The mean compliance data and monitoring indicators, as needed, are presented for each sub-cell below. **Recommendation 3, August 2007:** 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:** MSH has yet to implement this recommendation. **Other findings:** This monitor reviewed the charts of 13 individuals (AMA, BT, DG, DLJ, JL, JLM, JWG, LLD, MJ, PDF, PS, RMT and SB) and found that the facility has maintained some progress in the documentation of psychiatric reassessments in the monthly notes. However, some charts included evidence of unacceptable delinquencies in the documentation of weekly (DG, DLJ, PDF and PS) and monthly (JL and JLM) psychiatric reassessments. In addition, further work is needed to ensure that the documentation of interval history provides meaningful information regarding important developments during the interval. Furthermore, the documentation of benefits and risks of current treatment continues to be focused mostly on a generic review of potential side

		effects and benefits without relevance to the current status of the individual. This monitor also reviewed the charts of five individuals who have experienced the use of seclusion and/or restraints during this reporting period (CG, HO, JLB, MC and RH). The purpose of this review was to assess the appropriateness of the use of PRN medications prior to seclusion and/or restraints. This review is also relevant to the requirement in D.1.f.vi. The review found that only one chart (JLB) contained evidence of appropriate use and documentation of this use. In general, the main deficiencies included the use of PRNs for generic indications and the lack of documentation in the psychiatric reassessments of the appropriateness and efficacy of the PRN regimen and of timely adjustment of regular treatment following the repeated use of PRN medications. **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). 3. 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.
D.1.f.i	significant developments in the individual's clinical status and of appropriate psychiatric follow up;	1. *Subjective complaints are documented.* 89% 2. *Identified target symptoms are documented.* 86%

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<tr><td>3.</td><td>Participation in treatment is documented.</td><td>86%</td></tr>
<tr><td>4.</td><td>Progress towards objective in the Wellness and Recovery Plan.</td><td>76%</td></tr>
<tr><td>5.</td><td>The mental status is documented.</td><td>86%</td></tr>
<tr><td>6.</td><td>The individual's legal status and any change in legal status, if applicable, is documented.</td><td>84%</td></tr>
<tr><td>7.</td><td>Current status of medical problems and treatment are documented.</td><td>78%</td></tr>
<tr><td>8.</td><td>Relevant lab data and consults are documented.*</td><td>80% and 78%</td></tr>
</table>
The facility's data analysis showed improvement in compliance on most sub-items in December 2007 and January 2008.
</td></tr>
<tr><td>D.1.f.ii</td><td>Timely and justifiable updates of diagnosis and treatment, as clinically appropriate;</td><td>79%.</td></tr>
<tr><td>D.1.f.iii</td><td>Analyses of risks and benefits of chosen treatment interventions;</td><td>62%.

The facility's report did not address low compliance with this item</td></tr>
<tr><td>D.1.f.iv</td><td>Assessment of, and attention to, high-risk behaviors (e.g., assaults, self-harm, falls) including appropriate and timely monitoring of individuals and interventions to reduce risks;</td><td>80%.

The facility's data analysis showed improvement in compliance on most sub-items in December 2007 and January 2008.</td></tr>
<tr><td>D.1.f.v</td><td>Responses to and side effects of prescribed medications, with particular attention to risks associated with the use of benzodiazepines, anticholinergic medications, polypharmacy (use of multiple drugs to address the same condition), and conventional and atypical antipsychotic medications;</td><td>
<table>
<tr><td>1.</td><td>Rationale for current psychopharmacology plan including analysis of risks and benefits</td><td>62%</td></tr>
<tr><td>2.</td><td>Monitoring of side effects</td><td>78%</td></tr>
<tr><td>3.</td><td>AIMS is completed.</td><td>68%</td></tr>
<tr><td>4.</td><td>Response to pharmacologic treatment is documented.</td><td>76%</td></tr>
</table>
</td></tr>
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		MSH has recognized a recent pattern of decreased compliance in completing AIMS for individuals with involuntary motor movements. To address this issue and simplify tracking, MSH has developed and implemented a new system as of March 2008. This system requires at least quarterly AIMS for all individuals who have or are at risk for involuntary motor movements. The system establishes a set schedule for AIMS on specific months regardless of date of admission.
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	71%. The facility's report did not address low compliance with this item.
D.1.f.vii	Verification in a clinically justifiable manner, that psychiatric and behavioral treatments are properly integrated. The psychiatrist shall review the positive behavior support plan prior to implementation to ensure consistency with psychiatric formulation, document evidence of regular exchange of data or information with psychologists regarding differentiation of learned behaviors and behaviors targeted for psychopharmacological treatments, and document evidence of integration of treatments.	*There is a description in the note of the response to non-pharmacologic treatment* — 68%
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;	**Current findings on previous recommendations:** **Recommendation 1, August 2007:** Provide ongoing feedback and mentoring by senior psychiatrists to ensure that the transfer psychiatric assessments correct the

	psychiatric risk assessment; current barriers to discharge; and anticipated benefits of transfer.	deficiencies outlined by this monitor. **Findings:** Same as Findings for Recommendation 1 in D.1.f. **Recommendation 2, August 2007:** Monitor this requirement based on a review of at least a 20% sample. **Findings:** MSH used the DMH Physician Transfer Summary Monitoring Form to assess compliance (August 2007 to January 2008). The average sample size was 64%. The following is a summary of the monitoring indicators and corresponding mean compliance rates: 1. *Reason for transfer* 72% 2. *Five axis diagnosis* 59% 3. *Psychiatric course of hospitalization* 60% 4. *Medical history and current medical conditions* 56% 5. *Current target symptoms* 61% 6. *Psychiatric risk factors* 58% 7. *Current barriers to discharge* 54% 8. *Anticipated benefits of transfer* 57% MSH presented a corrective action plan to improve compliance. The plan includes the following: 1. Mechanisms to allow for more timely transfers, including a minimum of 48 hours notice prior to transfer and maintaining empty beds on acute/admissions units rather than long-term units; and 2. Feedback to physicians with low compliance. **Recommendation 3, August 2007:** Ensure that individuals who present severe management problems and

require frequent inter-unit transfers receive PBS plans that are adequately designed and implemented prior to transfers.

Findings:
MSH reported that it has a system to address behavioral triggers in order to minimize inter-unit transfers for individuals who present severe management problems. This system includes review of the individual's status in the weekly Trigger Meeting with Program Directors, Department Chiefs and Administrators and referrals for PBS or BCC (Behavioral Consult Committee) evaluation. Recommendations are made during that meeting with follow-up at subsequent meetings. The facility did not present specific information regarding the frequency of these transfers.

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

Individual	Date of transfer
DAMB	02/01/08
DFM	09/20/07
MAM	01/14/08
MH	12/29/07
MLC	02/26/08
RRF	01/23/08

The review found that some assessments included improved delineation of the symptoms targeted for treatment and review of risk status of the individuals (DAMB, DFM and RRF). The transfer assessments of MAM and MLC did not include the required information to ensure continuity of care. There was no transfer assessment in the chart of MH.

		Compliance: Partial. **Current recommendations**: 1. Implement corrective action plan to improve compliance. 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. Ana Peeks, PsyD, Psychologist (A) 2. Ashvind Singh, PhD, Psychologist 3. Edwin Poon, PhD, Senior Psychologist 4. Gretchen Hunt, BY CHOICE Coordinator 5. John Pyle, PTA 6. Karen Chong, Program Director 7. Ken Layman, Treatment Enhancement Coordinator 8. Kirk Hartley, PhD, Senior Psychologist 9. Mary Lou, Assistant Chief, Central Program Services 10. Sean Johnson, Assistant BY CHOICE Coordinator 11. Stacy Weeks, PsyD, Psychologist 12. Steve Yang, PsyD, Psychologist 13. Swati Roy, PhD, Chief of Psychology <u>Reviewed</u>: 1. Charts of the following 70 individuals (AA, AMA, APT, AW, BA, BG, BM, BR, BT, CW, CZ, DG, DLJ, DP, DR, EA, FL, FRP, GJ, IDR, JA, JAM, JAS, JB, JC, JDB, JKE, JN, JNU, JP, JRB, JRP, JS, JT, JW, KDH, KMA, KR, LT, MC, MJ, MM, MO, NA, NC, NO, PBR, PGB, PGD, PN, PW, RAL, RB, RG, RJ, RK, RR, RRG, RT, RW, SD, SG, SH, SM, SN, SP, VP, WH, WL and WP) 2. AD#3465 (Clinical Matters Special Cases: Assessment of Students, English Learners) 3. BCC attendance summary 4. Behavioral guidelines completed in the last six months 5. Completed PBS-BCC checklists 6. Fidelity check data (DG, JG, MC and ML) 7. Functional assessments completed in the last six months 8. Individual Educational Plans

		9. List of completed consultations for educational or other psychological testing 10. List of completed DSM-IV-TR checklists 11. List of individuals 22 years old and younger 12. List of individuals by primary or preferred language other than English 13. List of individuals in need of PBS plans 14. List of individuals not making good progress on PBS plans 15. List of individuals referred to BCC 16. List of individuals undertaking psychological assessments 17. List of individuals x Program x Unit with "rule out", "deferred", "No Diagnosis", and "NOS" diagnosis 18. Monthly fidelity check on implementation of PBS plans 19. Neuropsychological assessments completed in the last six months 20. PBS Plans (DY, MC, ML, PW and TP) 21. Psycho-education assessments 22. Psychological assessments completed in the last six months 23. Staff certification logs (DG, JG, MC and ML) 24. Staff training documentation on PBS plans 25. Structural and functional assessment template 26. Structural assessments completed in the last six months
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	**Current findings on previous recommendations:** **Recommendation, August 2007:** Continue the practice of orienting new staff to the manual. **Findings:** MSH continues to orient new staff to the DMH Psychology Manual. This monitor's interview with the Chief of Psychology, Swati Roy, and review of documentation found that MSH had hired 16 new psychology staff. All 16 were oriented to the DMH Psychology Manual. Orientation was conducted between August 2007 and January 2008.

	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.	**Compliance:** Full. **Current recommendations**: Continue the practice of orienting new staff to the 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 recommendation:** **Recommendation, August 2007:** Complete academic and cognitive assessments of new admissions on a timely basis. **Findings:** MSH used item #1 from the Psychology Assessment Monitoring Form to address this recommendation, reporting 75% compliance. The table below with its monitoring indicator showing the number of new admissions of individuals under 22 years of age per month (N), the number of individuals audited (n), and the percentage of compliance obtained (%C). *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.*

	Aug	Sep	Oct	Nov	Dec	Jan	Mean
N	3	2	1	6	4	4	
n	3	2	1	6	4	4	
%S	100	100	100	100	100	100	
% C	100	100	0	67	75	75	75

This monitor's documentation review found that MSH admitted 20 individuals below 22 years of age in the last six months (August 2007 to January 2008). Timely cognitive and academic assessments were conducted on 15 of them. The remaining five could not be tested due to refusal by the individuals.

MSH also audited the completion of cognitive and academic assessments of all individuals under 22 years of age in the facility, reporting 79% compliance. The table below with its monitoring indicator showing the number of individuals under 22 years of age in the facility (N), the number of individuals audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

Completion of cognitive and academic assessments 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.

	Aug	Sep	Oct	Nov	Dec	Jan	Mean
N	46	39	42	42	45	40	
n	46	39	42	42	45	40	
%S	100	100	100	100	100	100	
% C	70	72	76	76	89	93	79

This monitor reviewed 20 charts (AMA, APT, BG, BM, CZ, DP, EA, IDR, JAM, JAS, JC, JKE, JS, JT, KMA, MJ, RG, SM, SN and WP) of individuals under 22 years of age. The cognitive and educational assessments of six of the individuals (AMA, BG, BM, JC, JS, and MJ) were conducted in a timely manner. The assessments were completed but untimely in eleven charts (CZ, DP, EA, IDR, JAS, JKE, JM, JT, KMA, RG and SM); many delays were because the individuals refused to participate in the assessments or were not stable to attend to the test

		instructions. Three individuals had had comparable assessments conducted within a year prior to admission (APT, SN and WP) and therefore did not need new assessments. **Compliance:** Substantial. **Current recommendations**: Continue to ensure that academic and cognitive assessments of new admissions are completed on a timely basis.
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, August 2007:** Continue current practice. **Findings:** This monitor's interview with the Chief of Psychology and review of credentials of staff conducting psychological assessments found that the staff conducting the assessments was verifiably competent, as evidenced by their qualifications, training received at MSH and fulfillment of MSH's credentialing and certification privileging requirements. **Compliance:** Full. **Current recommendations**: Continue current practice.

D.2.d	Each State hospital shall ensure that all psychological assessments, consistent with generally accepted professional standards of care, shall:	**Compliance:** Substantial.
D.2.d.i	expressly state the clinical question(s) for the assessment;	**Current findings on previous recommendations:** **Recommendation 1, August 2007:** Ensure that all psychological assessments have a statement of the reasons for referral and ensure that the statement is concise and clear. **Findings:** MSH audited 50 focused psychology assessments conducted in the last six months, using item #3 (*All psychological assessments, consistent with generally accepted professional standard of care, shall expressly state the clinical question(s) for the assessment*) from the Psychology Assessment Monitoring Form, to address this recommendation reporting 98% compliance. This monitor reviewed ten focused psychological assessments (AA, FL, JA, JS, KR, LT, MC, PW, RK and SH). The clinical/referral questions in all ten were clear and concise. **Recommendation 2, August 2007:** Ensure that there is continuity among the various sections that address referral questions to appropriate conclusions, recommendations and therapies available at MSH. **Findings:** MSH audited 50 focused psychology assessments conducted in the last six months, using items #3, #4, and #8 from the Psychology Assessment Monitoring Form to address this recommendation,

reporting 98%, 100% and 98% compliance respectively. The table below showing the number of focused psychology assessments conducted in the last six months (N), the number of focused psychology assessments audited (n), and the percentage of compliance obtained for each indicator (%C) is a summary of the facility's data.

#3: *All psychological assessments, consistent with generally accepted professional standard of care, shall expressly state the clinical question(s) for the assessment.*

#4: All psychological assessments, consistent with generally accepted professional standard of care, shall include findings specifically addressing the clinical question(s), but not limited to diagnoses and treatment recommendations.

#8: All psychological assessments, consistent with generally accepted professional standard of care, shall include the implications of the findings for interventions.

	Aug	Sep	Oct	Nov	Dec	Jan	Mean
N	4	9	9	5	5	18	
n	4	9	9	5	5	18	
%S	100	100	100	100	100	100	
% C #3	100	100	100	100	100	94	98
% C #4	100	100	100	100	100	100	100
% C #8	100	100	100	100	100	94	98

This monitor reviewed 11 focused psychological assessments (JA, JDB, JW, LT, MM, RJ, RT, RW, SG, WL and WP). All eleven focused assessments were complete, comprehensive, and the information well-sequenced among the various sections addressing the referral questions to appropriate conclusions, recommendations and therapies available at MSH.

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

Current findings on previous recommendation:

Recommendation, August 2007:
Ensure that all psychological assessments include findings specifically addressing the clinical question(s), but not limited to diagnoses and treatment recommendations.

Findings:
MSH audited 50 focused psychology assessments conducted in the last six months, using item #4 (*All psychological assessments, consistent with generally accepted professional standard of care, shall include findings specifically addressing the clinical question(s), but not limited to diagnoses and treatment recommendations*) from the Psychology Assessment Monitoring Form to address this recommendation, reporting 100% compliance. The table below showing the number of focused psychology assessments conducted in the last six months (N), the number of focused psychology assessments audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

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<tr><td></td><td>Aug</td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Mean</td></tr>
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<tr><td>n</td><td>4</td><td>9</td><td>9</td><td>5</td><td>5</td><td>18</td><td></td></tr>
<tr><td>%S</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td></td></tr>
<tr><td>% C</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td></tr>
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This monitor reviewed ten focused psychology assessments (AA, FL, JA, JS, LT, MC, PW, RK, RT and SH). All ten assessments, in addition to addressing the clinical questions, provided sufficient information to
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<tr><td></td><td></td><td>inform the psychiatric diagnosis, identified the individual's treatment and rehabilitation needs, and suggested interventions that may be considered for inclusion in the individual's WRP.

Current recommendations:
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, August 2007:
Ensure that all psychological assessments specify whether the individual would benefit from individual therapy or group therapy.

Findings:
MSH audited 50 focused psychology assessments conducted in the last six months, using item #5 (All psychological assessments, consistent with generally accepted professional standard of care, shall specify whether the individual would benefit from individual therapy or group therapy in addition to attendance at mall groups) from the Psychology Assessment Monitoring Form to address this recommendation, reporting 100% compliance. The table below showing the number of focused psychology assessments conducted in the last six months (N), the number of focused psychology assessments audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.
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<tr><td></td><td>Aug</td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Mean</td></tr>
<tr><td>N</td><td>4</td><td>9</td><td>9</td><td>5</td><td>5</td><td>18</td><td></td></tr>
<tr><td>n</td><td>4</td><td>9</td><td>9</td><td>5</td><td>5</td><td>18</td><td></td></tr>
<tr><td>%S</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td></td></tr>
<tr><td>% C</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td></tr>
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		This monitor reviewed nine focused psychology assessments (JS, JW, MC, PW, RK, RRG, RT, SH and WL). Seven of them (JW, MC, PW, RK, RRG, RT, and SH) specified whether the individual would benefit from individual therapy or group therapy, and the remaining two (JS and WL) did not. **Current recommendations**: 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, August 2007:** Ensure that assessments are based on current, accurate, and complete data. **Findings:** MSH audited 50 focused psychology assessments conducted in the last six months, using item #6 (*All psychological assessments, consistent with generally accepted professional standard of care, shall be based on current, accurate, and complete data*) from the Psychology Assessment Monitoring Form to address this recommendation, reporting 100% compliance. The table below showing the number of focused psychology assessments conducted in the last six months (N), the number of focused psychology assessments audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

	Aug	Sep	Oct	Nov	Dec	Jan	Mean
N	4	9	9	5	5	18	
n	4	9	9	5	5	18	
%S	100	100	100	100	100	100	
% C #6	100	100	100	100	100	100	100

		This monitor reviewed eight focused psychology assessments (DR, JA, JS, NC, PW, RK, RRG and SH). All eight assessments included the individual's identification information, relevant sources of information, behavioral observations, and statements on the validity of the assessment. **Current recommendations**: Continue current practice.
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, August 2007:** Ensure that all psychological assessments of individuals with maladaptive behaviors determine whether behavioral supports or interventions are warranted or whether a full positive behavior support plan is required. **Findings:** MSH audited 50 focused psychology assessments conducted in the last six months, using item #7 (*All psychological assessments, consistent with generally accepted professional standard of care, shall 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*) from the Psychology Assessment Monitoring Form to address this recommendation, reporting 100% compliance. The table below showing the number of focused psychology assessments conducted in the last six months (N), the number of focused psychology assessments audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

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<tr><td>n</td><td>4</td><td>9</td><td>9</td><td>5</td><td>5</td><td>18</td><td></td></tr>
<tr><td>%S</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td></td></tr>
<tr><td>% C #7</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td></tr>
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This monitor reviewed ten focused psychology assessments (DR, FL, JA, JS, LT, MC, PW, RRG, RT and WL). Nine of them (DR, FL, JA, JS, LT, MC, PW, RRG, RT and WL) included the elements necessary to meet the criteria for this recommendation and one of them (JA) did not.

Current recommendations:
Ensure that all psychological assessments of individuals with maladaptive behaviors determine whether behavioral supports or interventions are warranted or whether a full positive behavior support plan is required.
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<td>D.2.d.vi</td>
<td>include the implications of the findings for interventions;</td>
<td>
Current findings on previous recommendation:

Recommendation, August 2007:
Ensure that all focused psychological assessments include the implications of the findings for interventions, especially psychosocial rehabilitation.

Findings:
MSH audited 50 focused psychology assessments conducted in the last six months, using item #8 (*All psychological assessments, consistent with generally accepted professional standard of care, shall include the implications of the findings for interventions)* from the Psychology Assessment Monitoring Form to address this recommendation, reporting 98% compliance. The table below showing the number of focused psychology assessments conducted in the last six months (N),
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<td>the number of focused psychology assessments audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

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<tr><td></td><td>Aug</td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Mean</td></tr>
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<tr><td>n</td><td>4</td><td>9</td><td>9</td><td>5</td><td>5</td><td>18</td><td></td></tr>
<tr><td>%S</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td></td></tr>
<tr><td>% C #8</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>94</td><td>98</td></tr>
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This monitor reviewed ten focused psychology assessments (FL, JS, JW, LT, MC, PW, RRG, RT, SH and WL). All ten assessments included implications or the findings for interventions.

Current recommendations:
Ensure that all focused psychological assessments include the implications of the findings for interventions, especially psychosocial rehabilitation.</td>
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<tr>
<td>D.2.d.vii</td>
<td>identify any unresolved issues encompassed by the assessment and, where appropriate, specify further observations, records review, interviews, or re-evaluations that should be performed or considered to resolve such issues; and</td>
<td>**Current findings on previous recommendation:**

Recommendation, August 2007:
Ensure that all focused psychological assessments meet this requirement.

Findings:
MSH audited 50 focused psychology assessments conducted in the last six months, using item #9 (*All psychological assessments, consistent with generally accepted professional standard of care, shall identify any unresolved issues en-compassed 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*) from the Psychology Assessment Monitoring Form to</td>
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<td>address this recommendation, reporting 90% compliance. The table below showing the number of focused psychology assessments conducted in the last six months (N), the number of focused psychology assessments audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

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<tr><td></td><td>Aug</td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Mean</td></tr>
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<tr><td>n</td><td>4</td><td>9</td><td>9</td><td>5</td><td>5</td><td>18</td><td></td></tr>
<tr><td>%S</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td></td></tr>
<tr><td>% C #9</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>72</td><td>90</td></tr>
</table>

This monitor reviewed 12 focused psychological assessments (DR, JA, JB, JS, KR, LT, PW, RK, RRG, RT, SH and WL). Eight of them (DR, JA, JB, JS, KR, LT, RRG and SH) indicated whether or not there were unresolved issues and what, if any, steps should be taken to address the unresolved issues. The remaining four (PW, RK, RT and WL) did not.

Current recommendations:
Ensure that all focused psychological assessments meet this requirement.</td>
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<tr>
<td>D.2.d.
viii</td>
<td>Use assessment tools and techniques appropriate for the individuals assessed and in accordance with the American Psychological Association Ethical Standards and Guidelines for testing.</td>
<td>**Current findings on previous recommendations:**

Recommendations 1 and 2, August 2007:

Use assessment tools and techniques appropriate for the individuals assessed and in accordance with the American Psychological Association Ethical Standards and Guidelines for testing.
Abide by the American Psychological Association Ethical Standards and Guidelines for testing.
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Findings:
MSH audited 50 focused psychology assessments conducted in the last six months, using item #10 (*All psychological assessments, consistent with generally accepted professional standard of care, shall use assessment tools and techniques appropriate for the individuals assessed and in accordance with the American Psychological Association Ethical Standards and Guidelines for testing*) from the Psychology Assessment Monitoring Form to address this recommendation, reporting 100% compliance. The table below showing the number of focused psychology assessments conducted in the last six months (N), the number of focused psychology assessments audited (n), and the percentage of compliance obtained for each indicator (%C) is a summary of the facility's data.

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<tr><td></td><td>Aug</td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Mean</td></tr>
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<tr><td>n</td><td>4</td><td>9</td><td>9</td><td>5</td><td>5</td><td>18</td><td></td></tr>
<tr><td>%S</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td></td></tr>
<tr><td>% C #10</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td></tr>
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Findings:
This monitor reviewed seven charts (JDB, JW, LT, MM, RJ, RW and WP). All seven assessments included statements of confidentiality, the instruments used were appropriate for addressing the clinical questions and the instruments were from the DMH Clinical Indicator List of approved instruments.

Current recommendations:
Continue current practice.

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<td>D.2.e</td>
<td>Each State hospital shall ensure that all psychological assessments of all individuals residing at each State hospital who were admitted there</td>
<td>**Current findings on previous recommendation:**</td>
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	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.	**Recommendation, August 2007:** Ensure that all psychological assessments of all individuals residing at MSH admitted before the effective date hereof be reviewed, by qualified clinicians in psychological testing, and revised as needed to meet EP requirements. **Findings:** This monitor's documentation review found that as of August 2007, MSH cared for 379 individuals who were admitted before June 1, 2006. MSH has reviewed 377 of the individuals' Integrated Assessments and approved the existing assessments or conducted new assessments. **Compliance:** Substantial. **Current recommendations**: Continue the review process until all individuals in the facility who were admitted before June 1, 2006 have had their psychological assessments are reviewed and addressed accordingly.
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 recommendation:** **Recommendation, August 2007:** Ensure that integrated psychological assessments are conducted in a timely manner as required. **Findings:** MSH audited Integrated Assessments: Psychology Section conducted over the last six months to address this recommendation, reporting 68% compliance. The table below showing the number of Integrated Assessments: Psychology Section each month (N), the number of Integrated Assessments: Psychology Section audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

	Aug	Sep	Oct	Nov	Dec	Jan	Mean
N	35	19	32	44	58	42	
n	35	19	32	41	57	42	
%S	100	100	100	93	98	100	
% C	60	37	69	61	70	86	68

As the table shows, the percentage of timely completion of the Integrated Assessments increased in December 2007 and January 2008. According to the Chief of Psychology, the increase was due to hiring of psychologists to fill vacancies. In addition, the Psychology Department has implemented a Notification System whereby unit psychologists are notified on the first day when an admission occurs and re-notified on the fourth day to prompt the staff that the assessment is due the next day. According to the Chief of Psychology, at least in one case, the assessment was delayed because the unit psychologist was on medical leave.

This monitor reviewed 20 charts (BR, DG, DLJ, FRP, GJ, JAM, JN, JN,

<table>
<tr><td></td><td></td><td>JP, JRB, KDH, MO, PBR, PGB, PGD, RAL, RRG, SD, SM and SP). All 20 Integrated Assessments: Psychology Section in the charts were conducted in a timely manner.

Current recommendations:
Ensure that integrated psychological assessments are conducted in a timely manner as required.</td></tr>
<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, August 2007:
Ensure that integrated psychological assessments address the nature of the individual's impairments to inform the psychiatric diagnosis.

Findings:
MSH used item #12 (Address the nature of the individual's impairments to inform the psychiatric diagnosis) from the Psychology Assessment Monitoring Form to address this recommendation, reporting 97% compliance. The table below showing the number of Integrated Assessments: Psychology Section conducted in the last six months (N), the number of Integrated Assessments audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

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<tr><td></td><td>Aug</td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Mean</td></tr>
<tr><td>N</td><td>35</td><td>19</td><td>32</td><td>44</td><td>58</td><td>42</td><td></td></tr>
<tr><td>n</td><td>35</td><td>19</td><td>32</td><td>41</td><td>57</td><td>42</td><td></td></tr>
<tr><td>%S</td><td>100</td><td>100</td><td>100</td><td>93*</td><td>98**</td><td>100</td><td></td></tr>
<tr><td>% C #12</td><td>83</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>97</td></tr>
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This monitor reviewed ten charts (BG, BR, JAM, JN, KDH, MO, PGB, RRG, SD and SM). All ten Integrated Assessments in the charts addressed the nature of the individual's impairments to inform the</td></tr>
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<tr><td></td><td></td><td>psychiatric diagnosis.

Current recommendations:
Ensure that integrated psychological assessments address the nature of the individual's impairments to inform the psychiatric diagnosis.</td></tr>
<tr><td>D.2.f.i.2</td><td>provide an accurate evaluation of the individual's psychological functioning to inform the therapeutic and rehabilitation service planning process;</td><td>Current findings on previous recommendation:

Recommendation, August 2007:
Ensure accurate evaluation of psychological functioning that informs that WRPT of the individual's rehabilitation service needs.

Findings:
MSH used item #13 (Provide an accurate evaluation of the individual's psychological functioning to inform the therapeutic and rehab service planning process) from the Psychology Assessment Monitoring Form to address this recommendation, reporting 99% compliance. The table below showing the number of Integrated Assessments: Psychology Section conducted in the last six months (N), the number of Integrated Assessments audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

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<tr><td></td><td>Aug</td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Mean</td></tr>
<tr><td>N</td><td>35</td><td>19</td><td>32</td><td>44</td><td>58</td><td>42</td><td></td></tr>
<tr><td>n</td><td>35</td><td>19</td><td>32</td><td>41</td><td>57</td><td>42</td><td></td></tr>
<tr><td>%S</td><td>100</td><td>100</td><td>100</td><td>93</td><td>98</td><td>100</td><td></td></tr>
<tr><td>% C #13</td><td>95</td><td>95</td><td>100</td><td>100</td><td>100</td><td>100</td><td>99</td></tr>
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This monitor reviewed ten charts (BG, BR, DLJ, JAM, JN, NO, RRG, SD, SM and SP). Seven of the Integrated Assessments: Psychology Section in the charts (BG, BR, DLJ, NO, RRG, SD and SP) provided accurate and sufficient information regarding the individuals' psychological functioning that would be useful to the WRPT in planning</td></tr>
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<tr><td></td><td></td><td>the individual's rehabilitation service needs. The remaining three (JAM, JN and SM) failed to satisfy this requirement.

Current recommendations:
Ensure accurate evaluation of psychological functioning that informs that WRPT of the individual's rehabilitation service needs.</td></tr>
<tr><td>D.2.f.ii</td><td>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</td><td>Current findings on previous recommendation:

Recommendation, August 2007:
Ensure appropriate structural and functional assessments are undertaken by a qualified psychologist when an individual has learned maladaptive behavior.

Findings:
MSH used item #14 (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) from the Psychology Assessment Monitoring Form to address this recommendation, reporting 62% compliance. The table below showing the number of Integrated Assessments: Psychology Section conducted in the last six months (N), the number of Integrated Assessments audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

<table>
<tr><td></td><td>Aug</td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Mean</td></tr>
<tr><td>N</td><td>13</td><td>11</td><td>11</td><td>11</td><td>12</td><td>16</td><td></td></tr>
<tr><td>n</td><td>13</td><td>11</td><td>11</td><td>11</td><td>12</td><td>16</td><td></td></tr>
<tr><td>%S</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td></td></tr>
<tr><td>% C #14</td><td>62</td><td>55</td><td>55</td><td>55</td><td>58</td><td>81</td><td>62</td></tr>
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This monitor's review of the PBS plans audited by MSH is in agreement</td></tr>
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		with the facility's data. According to the Chief of Psychology, structural and functional assessments are conducted as part of the development of a PBS plan. However, some of the structural and functional assessments did not conform to the DMH Psychological Services Monitoring Form. The Psychology staff has corrected many of these structural and functional assessments. The corrected assessments are reflected in the higher percentage of compliance for January 2008. This monitor's documentation review found that MSH currently has 56 active behavioral interventions, 40 of which are Behavioral Guidelines (structural and functional assessments are not conducted for Behavioral Guidelines). According to the Chief of Psychology, thirteen of the 40 Behavioral Guidelines were developed in collaboration with the PBS teams, and the remaining 27 were completed by the WRPT psychologists. The remaining 16 active behavioral interventions are PBS plans, for which structural and functional assessments were conducted. **Current recommendations**: Ensure appropriate structural and functional assessments are undertaken by a qualified psychologist when an individual has learned maladaptive behavior.
D.2.f.iii	additional psychological assessments shall be performed, as appropriate, where clinical information is otherwise insufficient, and to address unresolved clinical or diagnostic questions, including differential diagnosis, "rule-out," "deferred," "no-diagnosis" and "NOS" diagnoses.	**Current findings on previous recommendations:** **Recommendation 1, August 2007:** Ensure that additional psychological assessments are performed, as appropriate, where clinical information is otherwise insufficient, and address unresolved clinical or diagnostic questions, including differential diagnosis, "rule-out," "deferred," "no-diagnosis," and "NOS" diagnoses.

Findings:
MSH used items #16-21 (outlined below) from the Psychology Assessment Monitoring Form to address this recommendation, reporting 69%, 69%, 67%, 67%, 63% and 69% compliance respectively. The table below showing the number of Integrated Assessments: Psychology Section completed each month (N), the number of Integrated Assessments audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

#16: *Additional psychological assessments shall be performed, as appropriate, where clinical information is otherwise insufficient.*

#17: *Additional psychological assessments shall be performed, as appropriate, for diagnostic questions, specifically differential diagnosis.*

#18: *Additional psychological assessments shall be performed, as appropriate, for diagnostic questions specifically "rule-out."*

#19: *Additional psychological assessments shall be performed, as appropriate, for diagnostic questions specifically "deferred."*

#20: *Additional psychological assessments shall be performed, as appropriate, for diagnostic questions specifically "no diagnosis.".*

#21: *Additional psychological assessments shall be performed, as appropriate, for diagnostic questions specifically "NOS diagnosis."*

	Aug	Sep	Oct	Nov	Dec	Jan	Mean
N	35	19	32	44	58	42	
n	35	19	32	41	57	42	
%S	100	100	100	93	98	100	
% C #16	100	47	100	100	100	100	96

% C #17	100	89	100	100	100	100	99
% C #18	100	89	97	95	100	98	97
% C #19	100	89	97	96	95	100	97
% C #20	97	32	100	98	100	100	93
% C #21	100	89	100	100	98	100	99

This monitor reviewed ten charts (AA, AW, BA, BT, CW, JNU, NA, RB, RR and VP) of individuals with diagnostic uncertainties. The diagnostic uncertainties of seven of the individuals (AA, BA, BT, CW, NA, RB and VP) were clarified through further assessments. The remaining three (AW, JNU and RR) did not have proper supporting assessments to justify the diagnostic uncertainties. AW, for example, had a "Cognitive Diagnosis NOS" and further cognitive screening was conducted, but the results were not used to clarify the diagnosis; in the case of RR, the chart noted "Mood Disorder NOS" but noted no behaviors or symptoms characteristic of the diagnosis; in addition, no further testing was conducted or requested.

Current recommendations:
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 use of interpreters in the individual's primary language and dialect, if feasible.	**Current findings on previous recommendations:** **Recommendation 1 and 2, August 2007:** • Ensure that examiners consider cultural aspects when choosing assessment instruments with individuals whose preferred language is not English. • Ensure that psychological assessments are provided in the individual's preferred language using interpreters.

		Findings: This monitor's interview of the Chief of Psychology and the Senior Psychologists confirmed that interpreters are available for testing individuals whose primary language is other than English. A list of interpreters is available from the Communication Department. Psychologists are also free to use the AT&T translation services when there is no interpreter for a particular language. This monitor's review of documentation and interview with the Chief of Psychology and the Senior Psychologists found that 15 of the 190 individuals admitted at MSH indicated their primary/preferred language to be a language other than English. Twelve of these 15 individuals (80%) were assessed in their primary/preferred language. Specific plans for assessing the remaining three in their primary/preferred language have not been developed and/or implemented. . This monitor reviewed six charts (AA, BG, FL, JA, JN, and TM) of individuals whose primary/preferred language was not English. The primary/preferred languages of these six individuals included Spanish (five of them) and Urdu (one of them). Five of them were assessed in their primary/preferred language, and one of them did not have the Integrated Assessment conducted in Spanish (the individual's preferred language); however the individual was transferred to the Spanish-speaking unit. **Compliance:** Partial. **Current recommendations**: Ensure that examiners consider cultural aspects when choosing assessment instruments with individuals whose preferred language is

		not English, and that psychological assessments are provided in the individual's preferred language using interpreters.

3. Nursing Assessments		
		Methodology: Interviewed: 1. Joellyn Arce, Nursing Coordinator 2. Carmen Fayloga, RN, Health Service Specialist 3. Aurora Hendricks, Nurse Administrator 4. Aubri Griffis, Unit Supervisor, Admissions Unit 5. Linda Scott, Program Assistant, Program I 6. Rebecca Schneider, RN, Assistant Coordinator of Nursing Services Reviewed: 1. MSH's progress report and data 2. Training rosters for Recovery 3. WRPC Preparation Form for Registered Nurse (RN), Psychiatric Technician (PT), and Licensed Vocational Nurse (LVN) 4. Nursing Policy/Procedure 101, Nursing Assessment and Plan of Care (revised March 2008) 5. Nursing Assessment Competency Validation tool and instructions 6. Nursing admission/integrated assessments and WRPs for the following 40 individuals: AFA, AMA, BE, BF, BG, BM, CAC, CAZ, CJ, DAC, EWK, FMC, GRS, IRG, JAS, JCS, JF, JLS, KMA, MG, MRW, MSP, MT, PAA, PDF, PV, RBG, REG, RR, SB, SD, SF, SMM, SMV, SR, TS, TW, VMD, WJM and WKB Observed: WRPC (Program III, unit 407) for monthly review of JM
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, August 2007:** Implement the Statewide Nursing Admission Assessment and Integrated Assessment forms. **Findings:** MSH implemented both the Statewide Admission and Integrated Assessments on October 11, 2007. **Recommendation 2, August 2007:** Continue to monitor this requirement. **Findings:** Although MSH included data for these requirements generated from the old Nursing admission and integrated assessments and monitoring instruments for August through October 2007, only data from November 2007 through January 2008 will be addressed since these data represent the new Statewide admission and integrated assessment tools. MSH's data from the Nursing Admission Assessment audit, based on a 94% mean sample of admissions (November, December 2007, and January 2008), indicated 75% mean compliance with the requirement that a description of the presenting conditions was documented. This monitor's review of 40 individuals' admission assessments (AFA, AMA, BE, BF, BG, BM, CAC, CAZ, CJ, DAC, EWK, FMC, GRS, IRG, JAS, JCS, JF, JLS, KMA, MG, MRW, MSP, MT, PAA, PDF, PV, RBG, REG, RR, SB, SD, SF, SMM, SMV, SR, TS, TW, VMD, WJM and WKB) found that seven of the assessments (BG, CJ, JAS, JCS, MG, PAA and TS) did not adequately address the presenting conditions. Rather than including a description of the individual, the review found that the individual

		charges were listed in this section of the assessment. However, overall this monitor found many specific descriptions of the individual, even in cases where he or she refused to answer or were uncooperative. In two cases, current prescribed medications were not completed. Vital signs were documented in all 40 assessments and only one was missing information regarding allergies. In addition, pain, use of assistive devices and activities of daily living were adequately addressed on all the assessments reviewed. Two assessments (AFA and SR) indicated that the physician and dietician should be notified but was not. Although immediate alerts were adequately addressed, the section addressing immediate nursing interventions was not adequately addressed for ten individuals (CJ, GRS, JLS, JS, MSP, RR, SMM, SMV, SR and TS). With continued training and mentoring regarding the admission assessments, MSH should be able to reach substantial compliance in this area. **Other findings:** Based on review of the new Nursing Admission Assessments, there was significant variability in the quality of the assessments. Some staff wrote very little in the Social Skills and Trauma Assessment sections. In addition, information contained in sections regarding Stress/Crisis Triggers, Signals of Distress and Calming Strategies were not integrated into the individuals' WRPs. **Current recommendations**: Continue to monitor this requirement.
D.3.a.ii	current prescribed medications;	This and the following cells contain MSH's data from the Nursing Admission Assessment audit for each associated indicator, based on a mean 94% sample of admissions (November, December 2007, and January 2008):

		98%
D.3.a.iii	vital signs;	99%
D.3.a.iv	allergies;	99%
D.3.a.v	pain;	88%
D.3.a.vi	use of assistive devices;	82%
D.3.a.vii	activities of daily living;	92%
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	89%
D.3.a.ix	conditions needing immediate nursing interventions.	58%
D.3.b	Nursing may use a systems model (e.g., Johnson Behavioral System Model) for the nursing evaluation.	**Current findings on previous recommendations:** **Recommendations 1 and 2, August 2007:** • Continue efforts to integrate Wellness and Recovery into nursing practices. • Continue to monitor this requirement. **Findings:** MSH's data from the Recovery Model Annual Update Competency Report, based on a 100% sample of level of care nursing staff required to attend Hospital Annual Update (N) who passed the competency exam (n), indicated 100% compliance, which was supported by training rosters.

		Compliance: Full. **Current recommendations**: 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 Metropolitan State Hospital shall have graduated from an approved nursing program, shall have passed the NCLEX-RN and shall have a license to practice in the state of California.	**Current findings on previous recommendations:** **Recommendations 1 and 2, August 2007:** • Develop and implement a system to ensure nursing competency regarding assessments for acute illness and injuries. • Continue to monitor this requirement. **Findings:** MSH has initiated a system in which the HSSs and Supervising RNs (SRNs) observe each RN completing an assessment and document findings on the Nursing Assessment Competency Validation Form. MSH's data from the Nursing Assessment Competency Validation Form audit, based on a 20% mean sample of RN assessment competency validation audits (August 2007 to January 2008), indicated the following mean compliance score for each listed item:

1.	*Is the assessment completed within the required time frame, e.g., 24 hours, 7 days, quarterly, or annually?*	98%
2.	*Is the individual's presenting condition assessed and documented?*	99%
3.	*Are all current prescribed medications documented?*	90%
4.	*Are all vital signs complete and documented?*	95%
5.	*Are allergies identified and documented?*	98%
6.	*Is the pain assessment completed per hospital policy?*	97%
7.	*Is the use of assistive devices assessed and documented?*	95%

		8.	*Are activities of daily living assessed and documented?*	99%	
		9.	*Are all identified alerts addressed*	100%	
		10.	*Is there documentation describing conditions needing immediate nursing interventions?*	78%	
		In addition, MSH reported that 100% of the RNs employed had current California licenses. No data was provided for Psychiatric Technicians (PTs) or Licensed Vocational Nurses LVNs). **Compliance:** Substantial. **Current recommendations**: 1. Include data regarding PTs and LVNs in licensing data. 2. Continue to monitor this requirement.			
D.3.d	Each State hospital shall ensure that nursing assessments are undertaken on a timely basis, and in particular, that:	**Compliance:** Partial.			
D.3.d.i	Initial nursing assessments are completed within 24 hours of the individual's admission;	**Current findings on previous recommendations:** **Recommendation, August 2007:** Continue to monitor this requirement. **Findings:** MSH's data from the Nursing Admission Assessment audit, based on a 94% mean sample of admissions (November, December 2007, and January 2008), indicated 100% mean compliance with the requirement that the initial admission nursing assessment was completed with 24 hours.			

		This monitor's review of 40 nursing admission assessments (AFA, AMA, BE, BF, BG, BM, CAC, CAZ, CJ, DAC, EWK, FMC, GRS, IRG, JAS, JCS, JF, JLS, KMA, MG, MRW, MSP, MT, PAA, PDF, PV, RBG, REG, RR, SB, SD, SF, SMM, SMV, SR, TS, TW, VMD, WJM and WKB) found that several assessments did not contain documentation regarding which sections were completed, making it impossible to determine if all were completed within 24 hours. Ensuring that this section contains complete documentation would resolve this issue. However, because of this omission, it was unclear as to how the MSH auditors determined compliance with this element. **Current recommendations**: 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 recommendation:** **Recommendation, August 2007:** Continue to monitor this requirement. **Findings:** MSH's data from the Nursing Admission Assessment audit, based on a 50% mean sample of 7-day assessments (November, December 2007, and January 2008), indicated 39% mean compliance with the requirement that the Integrated Nursing Assessment was completed within seven days of the individual's admission. Based on information gained from MSH's progress report and discussions with Nursing, the low compliance rate for this issue is due to the initiation in October of the new Statewide Integrated Assessments, which are more comprehensive and lengthier than the previous assessments. In January 2008, MSH assigned an extra nurse to the admission unit to assist in the assessment caseload requirements.

		This monitor's review of 40 integrated assessments (AFA, AMA, BE, BF, BG, BM, CAC, CAZ, CJ, DAC, EWK, FMC, GRS, IRG, JAS, JCS, JF, JLS, KMA, MG, MRW, MSP, MT, PAA, PDF, PV, RBG, REG, RR, SB, SD, SF, SMM, SMV, SR, TS, TW, VMD, WJM and WKB) found that there were several assessments that contained inconsistencies regarding the dates documented on the first and last page of the assessments, making it impossible to determine when the assessments were actually completed. **Current recommendations**: 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 1, August 2007:** Ensure that nursing assessments are reviewed as required by the EP. **Findings:** MSH has initiated the CET Team Attendance and Nursing Participation Monitoring Form, adequately addressing this recommendation. **Recommendation 2, August 2007:** Separate data for each element of this requirement. **Findings:** MSH's data has been separated, adequately addressing this recommendation. **Recommendation 3, August 2007:** Continue to monitor this requirement.

		Findings: MSH's data from the WRPC CET Team Attendance and Nursing Participation Monitoring Form audit, based on a 29% mean sample of observed 14-day WRPs (November, December 2007, and January 2008), indicated 94% mean compliance with the requirement that nursing assessments were reviewed. MSH's data from the WRPC CET Team Attendance and Nursing Participation Monitoring Form audit, based on a 12% mean sample of observed monthly WRPs (November, December 2007, and January 2008), indicated 90% mean compliance with the requirement that nursing assessments were reviewed. MSH's data from the WRPC CET Team Attendance and Nursing Participation Monitoring Form audit, based on an 11% mean sample of observed quarterly WRPs (November, December 2007, and January 2008), indicated 88% mean compliance with the requirement that nursing assessments were reviewed. MSH's data from the WRPC CET Team Attendance and Nursing Participation Monitoring Form audit, based on a 10% mean sample of observed annual WRPs (November, December 2007, and January 2008), indicated 73% mean compliance with the requirement that nursing assessments were reviewed. MSH indicated that meetings with the Unit Supervisors and Nursing Coordinators will be increased to twice monthly to discuss data results on WRP requirements and obtain plans of corrective action. In addition, Nursing is working with the senior clinical mentors and the hospital-wide trainers to increase compliance in this area. In the monthly WPR for JM observed by this monitor, the nurse did review the nursing assessment.

		Current recommendations: Continue to monitor this requirement.

4. Rehabilitation Therapy Assessments		
		Methodology: Interviewed: 1. Andrea Cirota, Rehabilitation Therapy Supervisor 2. Asha Vij, Occupational Therapist 3. Jack McClary, Supervisor of Vocational Services 4. Julia Hastings, Physical Therapist 5. Mari Cobb, Chief of Rehabilitation Therapy Services 6. Marion Paclibar, Physical Therapist 7. Rebecca McClary, Program Assistant Reviewed: 1. DMH Rehabilitation Therapy Service Manual draft 2. AD #1052, Rehabilitation Therapy Services 3. Integrated Assessment-Rehabilitation Therapy Section 4. Integrated Assessment-Rehabilitation Therapy Section instructions 5. DMH Rehabilitation Therapy Monitoring Form and Instructions (D4 monitoring tool for admission assessments) 6. DMH Rehabilitation Therapy Monitoring Tool and Instructions (IA-RTS audit) 7. DMH MSH Organizational Chart 8. IA-RTS Competency-Based Training database 9. DMH Rehabilitation Therapy IA-RTS Audit data for October 2007-December 2007 RIAT Pilot assessments and January 2008 IA-RTS assessments 10. 12-week lesson plan for Introduction to Rehabilitation Therapy Services (IA-RTS assessment group) 11. Proposal for a Hospital-Wide Rehabilitation Integrated Assessment Team 12. Rehabilitation Integrated Assessment Team training materials

		13. DMH Vocational Rehabilitation Assessment Tool and Instructions drafts 14. DMH Vocational Rehabilitation Screening Tool draft 15. DMH Vocational Rehabilitation Assessment Monitoring Tool and Instructions drafts 16. DMH Vocational Rehabilitation Assessment Monitoring Form-Supplemental and Instructions drafts 17. Vocational Services Abbreviations, Process and Vocabulary document 18. DMH Occupational Therapy Evaluation/Assessment and Instructions drafts 19. DMH Occupational Therapy Evaluation/Assessment Monitoring Tool and Instructions drafts 20. DMH Speech-Language Focused Assessment and Instructions drafts 21. DMH Speech-Language Focused Assessment Monitoring Tool and Instructions drafts 22. DMH Physical Therapy Focused Assessment and Instructions drafts 23. DMH Physical Therapy Focused Assessment Monitoring Tool and Instructions drafts 24. Duty Statement for Restorative Nursing Technician Program VI 25. DMH Comprehensive Integrated Physical Rehabilitation Therapy Assessment and Instructions drafts 26. DMH Comprehensive Integrated Physical Rehabilitation Therapy Assessment Monitoring Tool and Instructions drafts 27. IA-RTS Inter-rater Agreement Study 28. List of individuals who had October 2007-December 2007 RIAT Pilot assessments and January 2008 IA-RTS assessments 29. Records of the following 23 individuals who had RIAT Pilot assessments from October 2007-December 2007 or IA-RTS assessments in January 2008: AA, AMA, APT, BG, BT, CAZ, CDH, CM, EK, FM, JAM, JQ, JWG, KB, KMA, KO, LVL, MS, PS, RBG, RG,

		VP and VTM 30. List of individuals who had Occupational Therapy assessment/consultation from August 2007-January 2008 31. Records of the following five individuals who had Occupational Therapy assessment/consultation during the August 2007-January 2008 review period: AB, CLP, DLG, NA and SMN 32. List of individuals who had Physical Therapy assessment/consultation from August 2007-January 2008 33. Records for the following seven individuals who had Physical Therapy assessment/consultation during the August 2007-January 2008 review period: ALL, BAM, CW, EM, MEB, RM and TS 34. List of individuals who had Speech Therapy assessment/consultation from August 2007-January 2008 35. Records for the following six individuals who had Speech Therapy assessment/consultation during the August 2007-January 2008 review period: DG, DT, JS, LP, RR and WH 36. List of individuals who had Vocational Rehabilitation assessment from August 2007-January 2008 37. Records for the following 11 individuals who had a Vocational Assessment from August 2007-January 2008: ES, GA, GEK, HAS, JD, JG, JHA, KRS, MCM, RWD and WLD 38. Training roster and competency scores for IA-RTS trainings on 12/20/07 and 1/4/08
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, August 2007:** Revise and implement organizational structure of Rehabilitation Services Department to include Psychosocial Rehabilitation (Music, Dance/Movement, Art, and Recreation Therapy), Physical Rehabilitation (Occupational, Physical, and Speech Therapy), and Vocational Rehabilitation/Industrial Therapy.

		Findings: The Rehabilitation Therapy organizational chart was revised and implemented at MSH in September 2007 and includes all Rehabilitation Therapy disciplines in one integrated department. An exception appears to be the POST team direct link to Rehabilitation Therapy from Medical Services, which, according to facility report, will be complete when a POST supervisor is hired. **Recommendation 2, August 2007:** Revise and implement Rehabilitation Therapy Manual to reflect changes including departmental integration and re-structuring, as well as a description of all Rehabilitation Therapy disciplines, collaboration among disciplines and therapy teams, the departments' unified role in the WRP team process, and discipline-specific responsibilities in the team process. **Findings:** The draft of the statewide Rehabilitation Therapy Manual was developed in November 2007 and 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 POST team, Occupational Therapist, Physical Therapist, Speech Therapist and Industrial Therapist (Vocational Rehabilitation). The manual addresses the Rehabilitation Therapist's role in acting as a liaison to report findings of the POST disciplines and Vocational Rehabilitation Services. Updating of the Manual should continue so as to include focused assessments, instructions, and monitoring tools and instructions as written processes and/or appendix attachments. **Recommendation 3, August 2007:** Revise and implement Integrated Rehabilitation Therapy Assessment and instructions to ensure interdisciplinary assessment by a Psychosocial Rehabilitation Team for all admission assessments, with

		clinical assessment activities and analysis of findings incorporated into the IRTA process. **Findings:** According to facility report, the Rehabilitation Integrated Assessment Team (RIAT) was piloted in Program V at MSH from October – December 2007. The RIAT membership consisted of the following clinicians: recreation therapy, art therapy and music therapy. Each discipline of the RIAT conducted structured group activities during the assessment, using those activities to assess the individual's skill levels in the areas of physical functioning, social functioning and life skills. The data collected was then used to develop a comprehensive assessment. The form MH-C 9043 Integrated Assessment: Rehabilitation Therapy Section (IA-RTS) and instruction tool was approved in December 2007 and was implemented on 1/1/08. The RIAT procedure expanded to hospital-wide implementation on 1/1/08 to correspond with the use of form MH-C 9043. However, while the RIAT process steps appear to meet accepted standards of practice, according to statewide policy, PSR Mall groups may only be used for active treatment, and not for only assessment. In addition, the use of one team of Rehabilitation Therapists to perform all admission IA-RTS assessments and IA-RTS type D.4.d assessments would not allow these therapists to provide PSR Mall hours. (It is a statewide requirement that all Rehabilitation Therapists should provide PSR Mall hours.) It appears that additional Rehabilitation Therapists should share the RIAT assessment caseload to enable all therapists who are performing assessments to also provide PSR Mall groups. This would not require any additional hiring/staffing; it would require a shift in duties from therapists exclusively providing assessment or PSR Mall to all therapists providing both duties. Therefore, current RIAT process conducted outside of Mall hours with more than one team of therapists providing assessments would meet EP requirements of and generally accepted standards of practice, while requiring no additional staffing

		or resources from the state. **Recommendation 4, August 2007:** Develop and implement Rehabilitation Therapy protocols/ instruction sheets for Vocational Rehabilitation, Physical Therapy, Speech Therapy, and Occupational Therapy assessments. **Findings:** Drafts for Vocational Rehabilitation assessment and instructions and Physical, Occupational, Speech Therapy and Comprehensive POST Assessment and instructions have been developed. According to facility report, they will be implemented on 3/1/08. **Recommendation 5, August 2007:** Discontinue the Physical Nutritional Support Team, Comprehensive Assessment for Physical and Nutritional Support, and corresponding procedures. Develop and implement procedure for the provision of two interdisciplinary Physical Rehabilitation teams (POST), each comprised of a Physical, Occupational, and Speech Therapist, to replace the existing Physical Nutritional Support Team. **Findings:** According to facility report, the Physical Nutritional Support Team was discontinued on 9/1/07. The Physical, Occupational, Speech Therapy (POST) team members for one enduring team were identified on 9/1/07, and hiring is in process for the second POST team. The A.D. 1052 procedure for Physical, Occupational and Speech Therapies has been revised and implemented to reflect this system change, as well as pertinent sections of the DMH Rehabilitation Therapy Service manual. **Recommendation 6, August 2007:** Develop and implement Comprehensive Integrated Physical Rehabilitation Assessment to address individual needs and supports

		that include but extend beyond the scope of dysphagia management, and ensure that this assessment is appropriate for use in measuring function and assessing acute and chronic physical rehabilitation needs of individuals within the inpatient Psychiatric Rehabilitation population. **Findings:** The draft of the Comprehensive Integrated Physical Rehabilitation Therapy Assessment (CIPRTA) is under review at the statewide level and pending approval. According to facility report, implementation of the CIPRTA will begin on 3/1/08. **Recommendation 7, August 2007:** Develop and implement a plan to ensure that individuals who would benefit from a Comprehensive Integrated Rehabilitation Assessment are referred for this service by the WRP. **Findings:** A plan to recommend referrals for individuals who have been identified as in need of a Comprehensive Integrated Physical Rehabilitation Therapy assessment based on IA-RTS findings has been developed and implemented on 1/1/08, according to facility report. Individuals are also identified upon admission based on findings of the 24-hour Nursing assessment and IA-RTS. However, there is no formal system in place by which the team can determine when an individual should be referred for this service, for individuals living at MSH who experience a change in functional status that would warrant a referral for a Comprehensive Integrated Physical Rehabilitation Therapy assessment. **Recommendation 8, August 2007:** Develop and implement Comprehensive Integrated Rehabilitation Assessment instructions.

		Findings: A draft of the Comprehensive Integrated Physical Rehabilitation Therapy Assessment (CIPRTA) instruction tool is under review at the statewide level. According to facility report, implementation of the CIPRTA instruction tool will begin on 3/1/08. **Compliance:** Partial. **Current recommendations**: 1. Revise and implement the Department of Mental Health Rehabilitation Therapy Service Manual draft based on changes, new protocols and procedures, and system development. 2. Finalize and implement focused assessment tools and instructions including Physical, Occupational, Speech, Vocational Rehabilitation, and Comprehensive Physical Rehabilitation Therapy assessments, and ensure process/format is consistent with those of the other three state hospitals. 3. Develop and implement a plan to ensure that individuals (both new admissions and individuals residing at MSH) who would benefit from a Comprehensive Physical Rehabilitation Therapy assessment or a Vocational Rehabilitation assessment are referred for this service by the WRPT.
D.4.b	Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:	**Compliance:** Partial.
D.4.b.i	Is accurate and comprehensive as to the individual's functional abilities;	**Current findings on previous recommendations:** **Recommendation 1, August 2007:** Develop and implement monitoring tool(s) for Physical, Occupational,

		and Speech Therapy assessments, Vocational Rehabilitation Assessment, and Comprehensive Integrated Physical Rehabilitation Assessment to ensure that all assessments are timely and provide a thorough assessment of functional ability as opposed to a focus on dysfunction and disability. **Findings:** A draft of MH-C 9044 Rehabilitation Therapy Assessment Monitoring Form and Instructions was developed to monitor D.4 admission (IA-RTS) assessments. The IA-RTS audit tool and instructions were finalized and implemented on 1/1/08, according to facility report. However, the sample size requirement of 100% of admission assessments has not been met. Drafts of audit tools and instructions for PT/OT/ST/POST/Vocational Rehabilitation assessments have been developed but are pending approval and implementation. A D.4 monitoring tool for focused assessments has not yet been developed. **Recommendation 2, August 2007:** Ensure that all individual objectives are functional, meaningful, and measurable. **Findings:** According to facility report, 32 Rehabilitation Therapists have had competency-based WRP training, which includes training on how to write objectives in functional, observable, and measurable terms. The IA-RTS assessment instructions include information related to writing functional, observable and measurable objectives. Facility data on individual objectives will be presented at the next evaluation. Upon review of a sample of IA-RTS admission assessments and objectives for individuals participating in observed PSR Mall groups, it

		was noted that 42% of RT objectives were functional, measurable, and observable. Upon review of a sample of records of individuals receiving direct Occupational Therapy treatment, it was noted that 42% of objectives were functional and 33% were measurable. Upon review of a sample of records of individuals receiving direct Physical Therapy treatment, it was noted that 75% of objectives were functional and 88% were measurable. Upon review of a sample of records of individuals receiving direct Speech Therapy treatment, it was noted that 100% of objectives were functional and 33% were measurable. **Recommendation 3, August 2007:** Establish inter-rater reliability for all audit/monitoring tools prior to implementation. **Findings:** According to facility report, an inter-rater agreement study was completed and an average of 88% inter-rater agreement was noted for IA-RTS assessments. **Other findings:** According to audit data for October-December 2007 RIAT pilot assessments and January 2008 IA-RTS assessments, 24% of assessments were accurate and comprehensive as to the individual's functional abilities. Record review of October-December 2007 RIAT pilot assessments and January 2008 IA-RTS assessments, revealed that 100% of IA-RTS assessments were complete, 70% were comprehensive, and 61% addressed functional abilities.

		No facility audit data was available for Occupational Therapy assessments. Record review of Occupational Therapy Assessments revealed that 100% of Occupational Therapy assessments were complete and addressed functional abilities and 80% were comprehensive. No facility audit data was available for Physical Therapy assessments. Record review of Physical Therapy Assessments revealed that 100% of assessments were complete, comprehensive, and addressed functional abilities. No facility audit data was available for Speech Therapy assessments. Review of Speech Therapy Assessments showed that 100% of assessments were complete, 40% were comprehensive, and 83% addressed functional abilities. No facility audit data was available for Comprehensive Integrated Physical Rehabilitation Assessments, as none were completed during this review period since the assessment tool was not developed. No facility audit data was available for Vocational Rehabilitation assessments. Record review of Vocational Rehabilitation assessments revealed that 100% of assessments were complete, 10% were comprehensive, and 10% addressed functional abilities. No audit data was reported from MSH audits for October-December 2007 RIAT pilot assessments and January 2008 IA-RTS assessments regarding timeliness, as the facility reports that it did not track timeliness, but will begin doing so on 3/1/08. Record review of a sample of IA-RTS admission assessments completed from October-December 2007 showed that 65% of assessments were completed within five days of admission.

		Timeliness of Vocational, Physical, Occupational, and Speech Therapy assessments could not be determined, as no data was provided regarding timeliness by MSH, and upon review of DMH Rehabilitation Therapy Manual and A.D. 1052 it was noted that specific timeframes for Focused Assessments were not listed. Review of drafts of focused assessments and instructions revealed upon referral, Vocational Rehabilitation assessments are to be completed within 30 days, and Occupational, Physical, and Speech Therapy assessments as well as CIPRTA are to be completed within 14 days or as clinically indicated. **Current recommendations**: 1. Develop and implement D4 monitoring tool(s) which report data on Enhancement Plan cells pertaining to all Rehabilitation Therapy assessments (Integrated and Focused) according to DMH format/standards, including timeliness. 2. Finalize and implement focused assessment audit tools. 3. Ensure that all Rehabilitation Services admission and focused assessments are accurate and comprehensive as to the individual's functional abilities.
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, August 2007:** Ensure that all assessments identify the individual's current functional status and the skills and supports needed to facilitate transfer to the next level of care. **Findings:** According to audit data for October-December 2007 pilot admissions assessments and January 2008 IA-RTS assessments, 76% addressed functional status and identified skills and supports needed to transfer to the next level of care.

		Upon record review of IA-RTS assessments from October-December 2007, it was noted that 83% of assessments identified current functional status and 56% of assessments identified skills and supports needed to facilitate transfer to the next level of care. No facility audit data was available for Occupational Therapy assessments. Review of Occupational Therapy assessments revealed that 60% of assessments identified current functional status and 25% of assessments identified skills and supports needed to facilitate transfer to the next level of care. No facility audit data was available for Physical Therapy assessments. Record review of Physical Therapy assessments showed that 100% of assessments identified current functional status and none of the assessments identified skills and supports needed to facilitate transfer to the next level of care. No facility audit data was available for Speech Therapy assessments. Review of Speech Therapy assessments revealed that 83% of assessments identified current functional status, and 33% of assessments identified skills and supports needed to facilitate transfer to the next level of care. No facility audit data was available for Vocational Rehabilitation assessments. Review of Vocational assessments showed that 30% of assessments identified current functional status, and 20% of assessments identified skills and supports needed to facilitate transfer to the next level of care. **Current 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.
D.4.b.iii	Identifies the individual's life goals, strengths, and motivation for engaging in wellness activities.	**Current findings on previous recommendation:** **Recommendation, August 2007:** Ensure that all assessments identify the individual's life goals, strengths, and motivation for engaging in wellness activities **Findings:** According to audit data for October-December 2007 RIAT pilot assessments and January 2008 IA-RTS assessments, 66% of assessments identified individual's life goals, 66% addressed strengths, and 16% identified motivation for engaging in wellness activities. Upon record review of October-December 2007 RIAT pilot assessments and January 2008 IA-RTS assessments, it was noted that 96% of assessments identified individual's life goals, 87% addressed strengths, and 87% identified motivation for engaging in wellness activities. No facility audit data was available for Occupational Therapy assessments. Review of Occupational Therapy assessments revealed that 20% of assessments identified individual's goals, none addressed strengths, and 20% identified motivation for engaging in wellness activities. No facility audit data was available for Physical Therapy assessments. Record review of Physical Therapy assessments showed that 67% identified individual's goals and none addressed strengths or identified the individual's motivation for engaging in wellness activities. No facility audit data was available for Speech Therapy assessments. Review of Speech Therapy assessments revealed that none of the assessments identified individual's goals, addressed strengths or

		identified motivation for engaging in wellness activities. No facility audit data was available for Vocational Rehabilitation assessments. Review of Vocational assessments showed that 33% of assessments identified individual's goals, 30% addressed strengths, and 60% identified motivation for engaging in wellness activities. **Current recommendation**: Ensure that all Rehabilitation Services admission and focused assessments identify the individual's life goals, strengths, and motivation for engaging in wellness activities.
D.4.c	Each State hospital shall ensure that all clinicians responsible for performing or reviewing rehabilitation therapy assessments are verifiably competent in performing the assessments for which they are responsible	**Current findings on previous recommendation:** **Recommendation, August 2007:** Provide competency-based training to all Rehabilitation Services staff regarding changes in departmental procedures, and to appropriate staff regarding developed/revised assessment protocols and instructions on a discipline/team specific basis. **Findings:** According to facility report, 16 Rehab Therapy staff members were trained on the seven-day Rehab Therapy Transfer Review form on 11/21/07, though no data was provided to support this. According to facility report, 15 Rehabilitation Therapy staff were trained and completed competency-based testing on the IA-RTS on 12/20/07 and 14 Rehabilitation Therapy staff were trained and completed competency-based testing on the IA-RTS on 1/4/08; this is verified by review of training rosters and competency-based scores, but upon review it is noted that only 13 out of 29 trainees attained at least 90% (substantial) compliance. A system for trend analysis of IA-RTS audit findings and resultant

		mentoring has been initiated, and this is confirmed by review of mentoring logs. Competency-based training regarding all focused assessments has not yet been completed as these tools have not yet been developed. **Compliance:** Partial. **Current recommendations**: 1. Ensure that individuals who are performing assessments (admission and focused) have received competency-based training regarding these assessments, and have achieved competency per protocol. 2. Establish inter-rater agreement prior to the implementation of Rehabilitation Therapy focused assessment audit tools. 3. 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. 4. 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 recommendations:** **Recommendation 1, August 2007:** Revise, pilot, and implement revised Integrated Rehabilitation Therapy Assessment. **Findings:** See D.4.a for findings regarding this recommendation.

		Recommendation 2, August 2007: Ensure that all individuals admitted to MSH prior to March 1, 2007 receive an Integrated Rehabilitation Therapy Assessment within the next six months. **Findings:** No individuals admitted to MSH prior to June 1, 2006 have received an IA-RTS assessment as this tool has only recently been finalized and implemented. According to facility report, the plan is to administer the IA-RTS to these individuals during the date of each individual's annual assessment in order to complete all D.4.d assessments in the period of one year. **Compliance:** Partial. **Current recommendation**: Ensure that all individuals admitted to MSH prior to June 1, 2006 receive an Integrated Assessment-Rehabilitation Therapy Section Assessment within the next twelve 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. Chris Marshall, Director of Dietetics 2. Portia Salvacion, Assistant Director of Dietetics Reviewed: 1. Nutrition Care Monitoring audit data for August 2007-January 2008 for each assessment type 2. Lists of individuals with Nutrition Care Assessments due from August 2007-January 2008 for each assessment type 3. Records for the following five individuals receiving type a. assessments from August 2007-January 2008: APT, CW, DEL, JS and JS2 4. Records for the following four individuals receiving type c. assessments from August 2007-January 2008: BJ, LB, NA and RB 5. Records for the following four individuals receiving type d. assessments from August 2007-January 2008: CM, MAO, PB and RMT 6. Records for the following five individuals receiving type e. assessments from August 2007-January 2008: ARF, BEA, PD, SB and WJM 7. Records for the following seven individuals receiving type f. assessments from August 2007-January 2008: AE, BF, CA, EWK, FM, REG and RJD 8. Records for the following seven individuals receiving type g. assessments from August 2007-January 2008: CJ, JAN, JCT, JDS, JM, LI and RV 9. Records for the following nine individuals receiving type i. assessments from August 2007-January 2008: CEM, DPM, FMK, JR, LEW, RD, RLS, SS and VMR 10. Records for the following four individuals receiving type j.i

		assessments (random sample across subtypes) from August 2007-January 2008: CR, GS, MOS and SMA 11. Records for the following three individuals receiving type j.ii assessments from August 2007-January 2008: HL, JM and TAN
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, August 2007:** Continue current practice. **Findings:** According to facility report, 14 individuals were scheduled for type a. assessments during the August 2007-January 2008 review period, and 14 records were audited using the Nutrition Care Monitoring Tool. This meets the sample size requirement of 100%. According to Nutrition Assessment audit data for the August 2007-January 2008 review period, 93% of assessments were completed on time, 100% had complete subjective findings, 99% had complete objective findings, 100% had correctly formulated nutrition diagnosis, 77% had individualized and measurable goals and all had appropriate recommendations. A weighted mean of all assessment line items for a total of 97% compliance was reported. Record review of a sample of individuals requiring type a. assessments during the August 2007-January 2008 indicated that 100% of assessments were completed on time and had complete subjective findings, complete objective findings, correctly formulated nutrition diagnosis and appropriate recommendations; 80% had individualized and measurable goals. **Compliance:** Partial.

		Current recommendation: Continue current practice.
D.5.b	For new admissions directly into the medical-surgical unit, a comprehensive Admission Nutrition Assessment will be completed within 3 days of admission.	Not applicable—MSH does not have a medical/surgical unit.
D.5.c	For new admissions directly into the skilled nursing facility unit, a comprehensive Admission Nutrition Assessment will be completed within 7 days of admission.	**Current findings on previous recommendation:** **Recommendation, August 2007:** Continue current practice. **Findings:** According to facility report, eight individuals were scheduled for type c. assessments during the August 2007-January 2008 review period, and eight records were audited using the Nutrition Care Monitoring Tool. This meets the sample size requirement of 100%. According to Nutrition Assessment audit data for the August 2007-January 2008 review period, 100% of assessments were completed on time and had complete subjective and objective findings, a correctly formulated nutrition diagnosis and appropriate recommendations; 75% had individualized and measurable goals. Record review of a sample of individuals requiring type c. assessments during the August 2007-January 2008 indicated that 100% of assessments were completed on time and had complete subjective and objective findings, a correctly formulated nutrition diagnosis, individualized and measurable goals and appropriate recommendations.

		Compliance: Partial. **Current recommendation**: Continue current practice.
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, August 2007:** Continue current practice. **Findings:** According to facility report, 84 individuals were scheduled for type d. assessments during the August 2007-January 2008 review period and 45 records were audited using the Nutrition Care Monitoring Tool. This does not meet the sample size requirement of 100%. According to Nutrition Assessment audit data for the August 2007-January 2008 review period, 100% of assessments were completed on time and had complete subjective findings, correctly formulated nutrition diagnosis and appropriate recommendations; 98% had complete objective findings and 70% had individualized and measurable goals. A weighted mean of all assessment line items for a total of 99% compliance was reported. Record review of a sample of individuals requiring type d. assessments during the August 2007-January 2008 indicated that 100% of assessments were completed on time and had complete subjective and objective findings, a correctly formulated nutrition diagnosis and appropriate recommendations; 75% had individualized and measurable goals.

		Compliance: Partial. **Current recommendation**: Continue current practice.
D.5.e	For new admissions with therapeutic diet orders for medical reasons, a comprehensive Admission Nutrition Assessment will be completed within 7 days of admission.	**Current findings on previous recommendation:** **Recommendation, August 2007:** Continue current practice. **Findings:** According to facility report, 28 individuals were scheduled for type e. assessments during the August 2007-January 2008 review period, and 28 records were audited using the Nutrition Care Monitoring Tool. This meets the sample size requirement of 100%. According to Nutrition Assessment audit data for the August 2007-January 2008 review period, 100% of assessments were completed on time and had complete subjective findings, a correctly formulated nutrition diagnosis and appropriate recommendations; 99% had complete objective findings; and 70% had individualized and measurable goals. A weighted mean of all assessment line items for a total of 99% compliance was reported. Record review of a sample of individuals requiring type e. assessments during the August 2007-January 2008 indicated that 100% of assessments were completed on time and had complete subjective and objective findings, a correctly formulated nutrition diagnosis and appropriate recommendations; 80% had individualized and measurable goals.

		Compliance: Partial. **Current recommendation**: Continue current practice.
D.5.f	For individuals with therapeutic diet orders for medical reason after admission, a comprehensive Admission Nutrition Assessment will be completed within 7 days of the therapeutic diet order but no later than 30 days of admission.	**Current findings on previous recommendation:** **Recommendation, August 2007:** Continue current practice. **Findings:** According to facility report, 16 individuals were scheduled for type f. assessments during the August 2007-January 2008 review period, and 16 records were audited using the Nutrition Care Monitoring Tool. This meets the sample size requirement of 100%. According to Nutrition Assessment audit data for the August 2007-January 2008 review period, 94% of assessments were completed on time, 94% had complete subjective findings, 97% had complete objective findings, 100% had a correctly formulated nutrition diagnosis, 40% had individualized and measurable goals and 94% had appropriate recommendations. A weighted mean of all assessment line items for a total of 96% compliance was reported. Record review of a sample of individuals requiring type f. assessments during the August 2007-January 2008 indicated that 88% of assessments were completed on time; 100% had complete subjective and objective and a correctly formulated nutrition diagnosis; 43% had individualized and measurable goals; and 88% had appropriate recommendations.

		Compliance: Partial. **Current recommendation**: Continue current practice.
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, August 2007:** Continue current practice. **Findings:** According to facility report, 151 individuals were scheduled for type g. assessments during the August 2007-January 2008 review period and 151 records were audited using the Nutrition Care Monitoring Tool. This meets the sample size requirement of 100%. According to Nutrition Assessment audit data for the August 2007-January 2008 review period, 100% of assessments were completed on time and had complete subjective findings and appropriate recommendations; 99% had complete objective findings and a correctly formulated nutrition diagnosis; and 67% had individualized and measurable goals. A weighted mean of all assessment line items for a total of 97% compliance was reported. Record review of a sample of individuals requiring type g. assessments during the August 2007-January 2008 indicated that 100% of assessments were completed on time and had complete subjective and objective findings, a correctly formulated nutrition diagnosis and appropriate recommendations; 71% had individualized and measurable goals.

		Compliance: Partial. **Current recommendation**: Continue current practice.
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, August 2007:** Continue current practice. **Findings:** Upon record review of a sample of all assessment types for assessments completed from August 2007-January 2008, it is noted that that an average (weighted mean) of 100% of Nutrition Care assessments had evidence of a correctly assigned NST level. Facility database for all assessment types for August 2007- January 2008 indicated that an average (weighted mean) of 100% of assessments audited had evidence of a correctly assigned NST level. **Compliance:** Full. **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,	**Current findings on previous recommendation:** **Recommendation, August 2007:** Continue current practice.

	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.	**Findings:** According to facility report, 952 individuals were scheduled for type i. assessments during the August 2007-January 2008 review period, and 333 records were audited using the Nutrition Care Monitoring Tool. This meets (in fact exceeds) the 20% sample size requirement. According to Nutrition Assessment audit data for the August 2007-January 2008 review period, 95% of assessments were completed on time; 83% had complete subjective findings; 97% had complete objective findings; 100% had a correctly formulated nutrition diagnosis and appropriate recommendations; and 93% had individualized and measurable goals. A weighted mean of all assessment line items for a total of 97% compliance was reported. Record review of a sample of individuals requiring type i. assessments during the August 2007-January 2008 indicated that 100% of assessments were completed on time and had complete subjective and objective findings, a correctly formulated nutrition diagnosis, individualized and measurable goals and appropriate recommendations. **Compliance:** Substantial. **Current recommendation**: Continue current practice.
D.5.j.i	Individuals will be reassessed when there is a significant change in condition.	**Current findings on previous recommendations:** **Recommendation, August 2007:** Continue current practice. **Findings:** According to facility report, 11 individuals were scheduled for type j.i

		14 day assessments for the August 2007-January 2008 review period, and 11 records were audited using the Nutrition Care Monitoring Tool. This meets the sample size requirement of 20% or N=n if N is less than 20. It is reported that five individuals received referrals for non-administrative transfers to the SNF unit for the August 2007-January 2008 review period, and five records were audited using the Nutrition Care Monitoring Tool. This meets the sample size requirement of 20% or N=n if N is less than 20. According to Nutrition Assessment audit data for August 2007-January 2008, for j.i 14-day referrals, 91% of assessments were completed on time; 91% had complete subjective findings; 98% had complete pertinent objective findings; 100% had a correctly formulated nutrition diagnosis and appropriate recommendations; and 80% had individualized and measurable goals. A weighted mean of all assessment line items for a total of 95% compliance was reported. According to Nutrition Assessment audit data for August 2007-January 2008, for j.i non-administrative transfer to the SNF unit referrals, 100% of assessments were completed on time and had complete subjective and objective findings, a correctly formulated nutrition diagnosis, individualized and measurable goals and appropriate recommendations. Record review of a sample of individuals receiving type j.i assessments (weighted mean of a sample of the three j.i sub-types) from the review period of August 2007-January 2008 indicated that 100% of assessments were completed on time and had complete subjective and objective findings, a correctly formulated nutrition diagnosis and appropriate recommendations; 50% had individualized and measurable goals.

		Compliance: Partial. **Current recommendation**: Continue current practice.
D.5.j.ii	Every individual will be assessed annually.	**Current findings on previous recommendation:** **Recommendation, August 2007:** Continue current practice. **Findings:** According to facility report, 266 individuals were scheduled for type j.ii assessments during the August 2007-January 2008 review period, and 118 records were audited using the Nutrition Care Monitoring Tool. This meets (in fact exceeds) the 20% sample size requirement. According to Nutrition Assessment audit data for the August 2007-January 2008 review period, 97% of assessments were completed on time; 98% had complete subjective findings; 99% had complete objective findings; 100% had a correctly formulated nutrition diagnosis and appropriate recommendations; and 91% had individualized and measurable goals. A weighted mean of all assessment line items for a total of 99% compliance was reported. Record review of a sample of individuals requiring type e. assessments during the August 2007-January 2008 indicated that 100% of assessments were completed on time and had complete subjective and objective findings, a correctly formulated nutrition diagnosis, individualized and measurable goals and appropriate recommendations. However, while a larger sample of records was requested, only three were available for review, and a determination of substantial

		compliance cannot be made based on this sample size considering N=266. **Compliance:** Partial. **Current recommendation**: Continue current practice.

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:** <u>Interview</u> 1. Cynthia Lusch, Clinical Administrator 2. Donie Yoo, LCSW, Supervising Social Worker 3. Karen Chong, Program Coordinator 4. Ken Layman, Central Program Services Coordinator 5. Maribel Forbes, LCSW, Supervising Social Worker 6. Sharon Nevins, Executive Director 7. Shirin Karimi, LCSW, Chief of Social Work 8. Terry Garcia, LCSW, Supervising Social Worker <u>Reviewed</u>: 1. Charts of the following 38 individuals: AC, AE, AP, BR, CAO, CM, CO, DA, DN, DR, ES, EWK, FM, GJ, GS, HFM, JAW, JH, JL, JM, JR, JRB, JS, KO, KS, LAB, LLD, LMC, MT, PGB, RAL, RJ, RR, SB, SL, SR, SV and VW 2. 30-Day Psychosocial Assessment Instructions 3. 30-Day Psychosocial Assessment 4. Curriculum for Newly Hired Social Work Staff 5. DMH Social History Assessment Audit Form 6. DMH Social History Assessment Monitoring Form 7. Family Therapy Assessment Tool Instructions 8. Family Therapy Assessment Tool 9. MSH 30-Day Assessment Department of Social Work Monitoring Tools 10. MSH Progress Report <u>Observed</u>: 1. WRPC for DAMB, Unit 405, Program V 2. WRPC for JF, Unit 401,Program III 3. WRPC for JP, Unit 407, Program III

		4. PSR Mall Service: Motivational Room, Program V 5. PSR Mall Service: Mindfulness, Program II 6. PSR Mall Service: Community Integration, Program III 7. PSR Mall Service: Mock Trial, Program III
D.6.a	Is, to the extent reasonably possible, accurate, current and comprehensive;	**Current findings on previous recommendations:** **Recommendation 1 and 2, August 2007:** • Implement the 30-day social history reviews. • Align monitoring tools with the EP. **Findings:** This monitor's documentation review and interview of the Chief of Social Work found that MSH has implemented the DMH-approved 30-day social history reviews. This monitor's review of the Social Work audit tools found that the tools are aligned with EP. MSH used items #1-3 from the Social History Integrated Assessment Monitoring Form (*Is to the extent reasonably possible accurate [#1], current [#2], and comprehensive [#3])* to evaluate compliance with the requirements of this cell, reporting 97%, 94%, and 94% compliance respectively. The table below showing the number of Integrated Assessments: Social Work Section completed each month (N), the number of Integrated Assessments audited (n), and the percentage of compliance for each indicator (%C) is a summary of the facility's data:

	Aug	Sep	Oct	Nov	Dec	Jan	Mean
N	28	19	24	29	34	45	
n	10	3	10	12	33	45	
%S	36	16	42	41	97	100	
%C #1	100	100	89	100	94	100	97
%C #2	70	100	100	100	91	100	94
%C #3	90	100	89	100	94	93	94

This monitor reviewed 20 charts (AC, AE, BR, CAO, ES, GJ, GS, JH, JRB, KS, LAB, LLD, LMC, PGB, RR, SB, SL, SR, SV and VW). Eighteen of the Integrated Assessments in the charts (AC, AE, BR, CAO, ES, GJ, GS, JRB, KS, LAB, LLD, LMC, PGB, RR, SB, SL, SR and SV) were present and timely, and two of them were not timely (JH and VW).

MSH also audited the 30-Day Social History Assessments using the same items as above and reported 95%, 93%, and 100% compliance respectively. The table below showing the number of 30-Day Social History Assessments conducted each month (N), the number of 30-Day Social History Assessments audited (n), and the percentage of compliance obtained for each indicator (%C) is a summary of the facility's data:

	Aug	Sep	Oct	Nov	Dec	Jan	Mean
N	36	39	12	17	34	44	
n	6	3	8	3	13	12	
%S	17	8	67	18	38	27	
%C #1	67	100	100	100	100	100	95
%C #2	67	100	88	100	100	100	93
%C #3	100	100	100	100	100	100	100

This monitor reviewed 20 charts (AC, AE, AP, CM, CO, DN, DR, ES, FM, GS, JAW, JL, JM, JS, KO, LAB, LLD, MT, RJ and SL). Fifteen of the 30-Day Social History Assessments were present, timely, accurate, and complete (AC, AP, CM, CO, DN, DR, ES, FM, JAW, JL, JM, JS, LAB, MT and SL), and five of them (AE, GS, KO, LLD, and RJ) were present but untimely.

Compliance:
Substantial.

		Current recommendations: Ensure that the 5-Day Integrated Assessment and the 30-Day Social History Assessment are, to the extent reasonably possible, accurate, current, and comprehensive.
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:** **Recommendation 1 and 2, August 2007:** • Ensure that social workers identify and address the inconsistencies in current assessments. • Monitor factual inconsistencies in social histories. **Findings:** MSH used items #4, #5, and #6 from the Social History Assessment Monitoring Form (described below) to evaluate compliance with the requirements of this cell, reporting 95% compliance for each of the three items. The table below showing the number of 30-Day Social History Assessments conducted each month (N), the number of 30-Day Social History Assessments audited (n), and the percentage of compliance obtained for each indicator (%C) is a summary of the facility's data: *#4: Expressly identifies factual inconsistencies among sources* *#5: Resolves or attempts to resolve inconsistencies* *#6: Explains the rationale for the resolution offered*

	Aug	Sep	Oct	Nov	Dec	Jan	Mean
N	36	39	12	17	34	44	
n	6	3	8	3	13	12	
%S	17	8	67	18	38	27	
%C #4	67	100	100	100	100	100	95
%C #5	67	100	100	100	100	100	95
%C #6	67	100	100	100	100	100	95

		This monitor reviewed eight charts (AP, DA, DR, FM, JAW, JS, MT and RJ). Two of the charts (FM and JAW) did not have the 30-Day Social History assessments. Five of the remaining six 30-Day assessments (AP, DA, DR, MT and RJ) addressed the factual inconsistencies, and one (JS) did not. **Compliance:** Partial. **Current recommendations**: Ensure that factual inconsistencies are addressed in the 30-Day Social History Assessments.
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, August 2007:** Ensure all Social Work Integrated Assessments are completed and available to the WRPT before the seven-day WRPC. **Findings:** MSH used item #7 from the Social History Assessment Monitoring Form (*Is included in the 7-day integrated assessment*) to evaluate compliance with the requirements of this cell, reporting 96% compliance. The table below showing the number of Integrated Assessments conducted each month (N), the number of Integrated Assessments audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data:

	Aug	Sep	Oct	Nov	Dec	Jan	Mean
N	28	19	24	29	34	45	
n	10	3	10	12	33	45	
%S	36	16	42	41	97	100	

%C #7	90	100	100	100	92	95	96

This monitor reviewed 13 charts (AP, DN, FM, JAW, JH, JR, JS, KS, LAB, LMC, MT, RJ and VW). Eleven of the Integrated Assessments were present and timely (AP, DN, FM, JAW, JH, JS, KS, LAB, LMC, MT and RJ), and two (JR and VW) were present but untimely.

Recommendation 2, August 2007:
Ensure that all 30-day social histories are completed and available to the individual's WRPT members by the thirtieth day of admission.

Findings:
MSH used item #8 from the Social History Assessment Monitoring form (*Fully documented by the thirtieth day of the individual's admission*) to evaluate compliance with the requirements of this cell, reporting 80% compliance. The table below with its monitoring indicator showing the number of 30-Day Assessments conducted each month (N), the number of 30-Day Assessments audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data:

	Aug	Sep	Oct	Nov	Dec	Jan	Mean
N	36	39	12	17	34	44	
n	6	3	8	3	13	12	
%S	17	8	67	18	38	27	
%C #8	83	100	38	67	100	92	80

This monitor reviewed 16 charts (AC, AE, AP, CAO, DR, ES, FM, GS, JAW, JL, JS, LLD, MT, RJ, SL and VW). Nine of the assessments were present and timely (AC, AP, CAO, DR, ES, JL, JS, MT and SL), five were present but untimely (AE, GS, LLD, RJ and VW) and two were not found in the charts (FM and JAW).

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

Current recommendations:
Ensure that all 30-day social histories are completed and available to the individual's WRPT members by the thirtieth day of admission.</td></tr>
<tr><td>D.6.d</td><td>Reliably informs the individual's interdisciplinary team about the individual's relevant social factors and educational status.</td><td>Current findings on previous recommendation:

Recommendation, August 2007:
Ensure that social histories reliably inform the individual's WRPT about the individual's relevant social factors and educational status.

Findings:
MSH used items #9 and #10 from the Social History Assessment Monitoring form (Reliably informs the individual's interdisciplinary team about the individual's relevant social factors [#9] and educational status [#10]) to evaluate compliance with the requirements of this cell, reporting 96% compliance for both items. The table below with its monitoring indicators showing the number of Integrated Assessments conducted each month (N), the number of Integrated Assessments audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data:

<table>
<tr><td></td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Mean</td></tr>
<tr><td>N</td><td>24</td><td>29</td><td>34</td><td>45</td><td></td></tr>
<tr><td>n</td><td>10</td><td>12</td><td>33</td><td>45</td><td></td></tr>
<tr><td>%S</td><td>42</td><td>41</td><td>97</td><td>100</td><td></td></tr>
<tr><td>%C #9</td><td>82</td><td>100</td><td>100</td><td>100</td><td>96</td></tr>
<tr><td>%C #10</td><td>100</td><td>92</td><td>91</td><td>100</td><td>96</td></tr>
</table>

MSH also audited the 30-Day Social History Assessments using the same items as above and reported 89% compliance for both items. The</td></tr>
</table>

table below with its monitoring indicators showing the number of 30-Day Assessments conducted each month (N), the number of 30-Day Assessments audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data:

	Aug	Sep	Oct	Nov	Dec	Jan	Mean
N	36	39	12	17	34	44	
n	6	3	8	3	13	12	
%S	17	8	67	18	38	27	
%C #9	100	33	100	100	100	100	89
%C #10	100	33	100	100	100	100	89

This monitor reviewed eight charts (AP, DN, DR, FM, JAW, JS, MT and RJ). Six of the Integrated Assessments in the charts (AP, DN, DR, FM, MT and RJ) addressed the individuals' educational status and social factors, and two (JAW and JS) did not. All eight 30-Day Assessments in the charts identified the individuals' educational status and social factors.

Compliance:
Partial.

Current recommendations:
Ensure that social histories reliably inform the individual's WRPT about the individual's relevant social factors and educational status.

7. Court Assessments		
		Methodology: Interviewed: 1. David Niz, MD, Chair, Forensic Review Panel (FRP) 2. Michael Barsom, MD, Medical Director Reviewed: 1. The charts of the following six individuals who were admitted under PC 1026: ALL, JSP, KAN, OCG, RC and RH 2. The charts of the following six individuals who were admitted under PC 1370: CX, EG, JAA, SR, TP and WL 3. DMH Manual for Preparation of PC 1026 and 1370 Court Reports 4. DMH PC 1026 Court Report Monitoring Form 5. MSH PC 1026 Court Report Monitoring summary data (August 2007 to January 2008) 6. DMH PC 1370 Court Report Monitoring Form 7. MSH PC 1370 Court Report Monitoring summary data (August 2007 to January 2008) 8. AD #0206, The Forensic Review Panel (FRP), effective February 20, 2008 9. Minutes of the FRP meetings from August 2007 to January 2008 10. A sample of written feedback by the FRP to authors of Court Reports
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,	**Compliance:** Partial.

	as clinically indicated:	
D.7.a.i	clinical progress and achievement of stabilization of signs and symptoms of mental illness that were the cause, or contributing factor in the commission of the crime (i.e., instant offense);	**Current findings on previous recommendations:** **Recommendations 1 and 2, August 2007:** • Continue to monitor this requirement. • Address and correct factors related to low compliance. **Findings:** MSH used the DMH PC 1026 Court Report Monitoring Form (August, 2007 to January 2008) to assess compliance. The facility reviewed 100% of 1026 reports. The mean compliance rate for this item was 95%. The mean compliance rates for the requirements in D7.a.ii through D7.a.xi are reported for each corresponding cell below. On January 10, 2008, members of the FRP provided training to the treatment providers to improve compliance with the new court report format and expectations in accordance with the finalized version of the DMH Manual for Preparation of PC 1026 and PC 1370 Court Reports. Data analysis shows some reduction in compliance rates after September 2007, which was attributed by the facility to a change of reviewers and use of more precise and stringent monitoring criteria (based on the DMH manual). The facility reported that any compliance of less than 100% was addressed by feedback given to the authors directly from members of the FRP on an ongoing basis. **Other findings:** This monitor reviewed court reports in the charts of six individuals who have been admitted under PC 1026. All reports were completed during this review period. The review found compliance in four charts (KAN, OCG, RC and RH) and noncompliance in two (ALL and JSP). **Current recommendations:** Continue to monitor this requirement and provide data analysis that

		evaluates low compliance and delineates relative improvement (during the reporting period and compared to the past period).
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, August 2007:** Same as above. **Findings:** The mean compliance rate for this item was 91%. **Other findings:** Chart reviews by this monitor found compliance in five (ALL, JSP, KAN, OCG and RC) and partial compliance in one (RH). **Current recommendations**: Same as above.
D.7.a.iii	understanding of potential for danger and precursors of dangerous/criminal behavior, including instant offense;	**Current findings on previous recommendation:** **Recommendation, August 2007:** Same as above. **Findings:** The mean compliance rate for this item was 93%. **Other findings:** This monitor found compliance in three charts (ALL, KAN and RH, partial compliance in two (OCG and RC) and noncompliance in one (JSP). **Current recommendations**: Same as above.

D.7.a.iv	acceptance of mental illness and understanding of the need for treatment, both psychosocial and biological, and the need to adhere to treatment;	**Current findings on previous recommendation:** **Recommendation, August 2007:** Same as above. **Findings:** The mean compliance rate for this item was 98%. **Other findings:** This monitor found compliance in four charts (JSP, KAN, RC and RH), partial compliance in one (OCG) and noncompliance in one (ALL). **Current recommendations**: Same as above.
D.7.a.v	development of relapse prevention plan (i.e., Personal Wellness Recovery Plan or Wellness Recovery Action Plan) for mental illness symptoms, including the individual's recognition of precursors and warning signs and symptoms and precursors for dangerous acts;	**Current findings on previous recommendation:** **Recommendation, August 2007:** Same as above. **Findings:** The mean compliance rate for this item was 98%. **Other findings:** Chart reviews by this monitor found compliance in five (JSP, KAN, OCG, RC and RH) and partial compliance in one (ALL). **Current recommendations**: Same as above.
D.7.a.vi	willingness to achieve understanding of substance abuse issues and to develop an effective relapse	**Current findings on previous recommendation:**

	prevention plan (as defined above);	**Recommendation, August 2007:** Same as above. **Findings:** The mean compliance rate for this item was 78%. **Other findings:** This monitor found compliance in five (ALL, KAN, OCG, RC and RH) and partial compliance in one (JSP). **Current recommendations**: Same as above.
D.7.a.vii	previous community releases, if the individual has had previous CONREP revocations;	**Current findings on previous recommendation:** **Recommendation, August 2007:** Same as above. **Findings:** The mean compliance rate for this item was 86%. **Other findings:** This monitor found compliance in all three charts (ALL, JSP and OCG) in which this requirement was applicable. **Current recommendations**: 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, August 2007:** Same as above.

		Findings: The mean compliance rate for this item was 82%. **Other findings:** Chart reviews by this monitor found noncompliance in three (KAN, RC RH), compliance in two (JSP and OCG) and partial compliance in one (ALL). **Current recommendations**: 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, August 2007:** Same as above. **Findings:** The mean compliance rate for this item was 54%. **Other findings:** This monitor found partial compliance in four charts (ALL, JSP, KAN and RC), compliance in one (OCG) and noncompliance in one (RH). **Current recommendations**: 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	**Compliance:** Partial.

	assessments. Consistent with the right of an individual accused of a crime to a speedy trial, the focus of the IST hospitalization shall be the stabilization of the symptoms of mental illness so as to enable the individual to understand the legal proceedings and to assist his or her attorney in the preparation of the defense. The forensic reports should include the following:	
D.7.b.i	relevant clinical description of initial presentation, if available, which caused the individual to be deemed incompetent to stand trial by the court;	**Current findings on previous recommendation:** **Recommendation, August 2007:** Same as D.7.a.i (as applicable to PC 1370). **Findings:** MSH reviewed a 100% sample (August 2007 to January 2008) using the DMH PC 1370 Court Report Monitoring Form. The mean compliance rate for this item was 99%. The mean compliance rates for the requirements in D7.b.i through D7.b.iv are reported for each corresponding cell below. The monitoring indicators are listed if they represented components of the requirement. **Other findings:** This monitor reviewed the court reports in the charts of six individuals who have been admitted under PC 1370. All reports were completed during this review period. The review found compliance in three charts (JAA, SR and TP), partial compliance in three (CX, EG and WL). **Current recommendations**: Same as D.7.a.i (as applicable to PC 1370).
D.7.b.ii	clinical description of the individual at the time of admission to the hospital;	**Current findings on previous recommendation:**

<table>
<tr>
<td></td>
<td></td>
<td>Recommendation, August 2007:
Same as above.

Findings:
The mean compliance rate for this item was 93%.

Other findings:
Chart reviews by this monitor found compliance in four (CX, EG, SR and TP), partial compliance in one (WL) and noncompliance in one (JAA).

Current recommendations:
Same as above.</td>
</tr>
<tr>
<td>D.7.b.iii</td>
<td>course of hospital stay, describing any progress or lack of progress, response to treatment, current relevant mental status, and reasoning to support the recommendation; and</td>
<td>Current findings on previous recommendation:

Recommendation, August 2007:
Same as above.

Findings:
<table>
<tr><td>1.</td><td>Describing any progress or lack of progress</td><td>93%</td></tr>
<tr><td>2.</td><td>Response to treatment</td><td>99%</td></tr>
<tr><td>3.</td><td>Current relevant mental status</td><td>96%</td></tr>
<tr><td>4.</td><td>Reasoning to support the recommendation—(a) stability of the symptoms and capacity to cooperate rationally with counsel in the conduct of a defense and (b) individual's understanding of the charge(s) and legal procedure</td><td>97%</td></tr>
</table>
Other findings:
Chart reviews by this monitor found compliance in all cases reviewed (CX, EG, JAA, SR, TP and WL).</td>
</tr>
</table>

		Current recommendations: Same as above.
D.7.b.iv	all self-harm behaviors and relevant medical issues, to inform the courts and the facility where the individual will be housed after discharge.	**Current findings on previous recommendation:** **Recommendation, August 2007:** Same as above. **Findings:** The mean compliance rate for this item was 75%. **Other findings:** This monitor found compliance in five charts (CX, EG, JAA, TP and WL) and partial compliance in one (SR). **Current recommendations**: 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, August 2007:** Revise AD 0206 to include that the FRP shall review the responses by the WRPTs to its feedback and ensure that all court reports are modified as appropriate prior to submission to the courts. **Findings:** MSH has implemented this recommendation in the recent revision of AD #0206, The Forensic Review Panel (FRP), effective February 2008. As mentioned earlier, the FRP currently reviews 100% of the Court Reports (PC 1026 and PC 1370). **Compliance:** Substantial.

		Current recommendations: 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. 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.	**Current findings on previous recommendation:** **Recommendation, August 2007:** Ensure that minutes of the FRP meetings adequately document activities of the panel. **Findings:** MSH has implemented this recommendation. Review of the minutes of the FRP meetings that were held during this reporting period (August 9, October 11, November 9, December 13 and December 20, 2007 and January 10, 2008) found that the facility has used an adequate format to document activities of the panel. **Compliance:** Substantial. **Current recommendations**: Continue current practice.

E. Discharge Planning and Community Integration		
		Summary of Progress: 1. MSH has implemented the Family Therapy Needs Assessment Tool. 2. MSH has implemented Family Therapy Services groups and is currently offering two groups for seven families. 3. MSH has improved its system of tracking and monitoring individuals referred for discharge, and has established steps to communicate with external entities (for example CONREP) to solve problems and discharge individuals expediently.
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. Individuals PZ, RK and SM 2. Barbara Yau, LCSW, Social Work 3. Cynthia Lusch, Clinical Administrator 4. Donie Yoo, LCSW, Supervising Social Worker 5. Karen Chong, Program Coordinator 6. Ken Laymen, Central Programming Services Coordinator 7. Lolly Doyle, LCSW, Social Work 8. Maribel Forbes, LCSW, Supervising Social Worker 9. Purvi Shahpatel, LCSW 10. Sharon Nevins, Executive Director 11. Shirin Karimi, LCSW, Chief of Social Work 12. Stephens Scottirae, LCSW, Social Work 13. Terry Garcia, LCSW, Supervising Social Worker <u>Reviewed</u>: 1. Charts of the following 61 individuals: ABJ, AFC, ALC, AMA, APT, BL, BT, CAO, CM, CO, CW, DA, DP, DTP, DTS, DWN, EA, ES, EZ, FG, JF, JJ, JL, JMI, JRB, JS, KH, KR, KS, LB, LK, LLD, LT, MAO, MC, MCL, MO, MP, MTS, OBJ, OS, PC, PF, PJL, PL, RAL, RB, RF, RH,

		RM, RMP, RMT, RN, RR, SB, SD, SL, TB, THE, TS and YFH 2. DMH WRP Discharge Planning and Community Integration Auditing Form 3. MSH progress report 4. Discharge Planning and Community Integration Audit Tool 5. List of individuals referred for discharge but still in hospital 6. List of individuals needing family education 7. List of individuals providing Mall groups 8. PSR Mall hours of service by discipline <u>Observed</u>: 1. WRPC for DAMB, Unit 405, Program V 2. WRPC for JF, Unit 401,Program III 3. WRPC for JP, Unit 407, Program III 4. PSR Mall Service: Motivational Room, Program V 5. PSR Mall Service: Mindfulness, Program II 6. PSR Mall Service: Community Integration, Program III 7. PSR Mall Service: Mock Trial, Program III
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:	**Current findings on previous recommendations:** **Recommendation 1, August 2007:** Ensure that discharge setting and relevant skills for that setting are developed at the first seven-day WRP. **Findings:** MSH used item #4 (*The skills and supports necessary to live in the setting in which the individual will be placed*) from the MSH WRP Discharge Planning and Community Integration Form to address this recommendation, reporting 30% compliance. The table below with its monitoring indicator showing the number of WRPs due each month (N), the number of WRPs audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

	Nov	Dec	Jan	Mean
N	672	667	678	
n	16	44	53	
%S	3	7	8	
%C #4	33	23	34	30

This monitor reviewed six charts (CW, JS, LK, MO, PL and RR). Two of them (CW and MO) had identified the individual's next placement and skills needed to adjust to the new setting. The remaining four (JS, LK, PL and RR) did not include such information.

Recommendation 2, August 2007:
Ensure appropriate linkage between each discharge criteria, focus of hospitalization and relevant PSR Mall groups or individual therapy (as needed) to achieve that discharge criteria.

Findings:
This monitor reviewed 19 charts (AFC, DA, DTP, EA, JI, JJ, JS, KR, KS, LB, LK, LT, PC, PF, PL, RR, SB, SL and THE). Eleven of the WRPs in the charts (DA, EA, JI, KR, LB, LT, PF, PL, RR, SL and THE) had acceptable linkages among the discharge criteria, foci of hospitalization and PSR Mall groups/individual therapy services; the remaining eight (AFC, DTP, JJ, JS, KS, LK, PC and SB) did not. For example, one intervention for PC has his strength as "attending groups" but there were two objectives that were worded to encourage PC to attend Mall groups; also an objective read, "P will apply his group participation to his discharge planning." In SB's WRP, an objective read, "B will have a complete wellness and recovery plan", but the intervention aligned with the objective read, "Nursing staff will monitor B's medication adherence." The WRP for KS had an element related to self-injurious behavior as part of the discharge plan, but there were no focus, objectives, or interventions for KS to achieve the

		discharge goal. **Recommendation 3, August 2007:** Ensure that the discharge criteria and discharge status are reviewed and documented at each WRPC. **Findings:** This monitor reviewed eight charts (AMA, APT, CM, DWN, EA, JMI, MAO and RR). Seven of the WRPs in the charts (AMA, APT, CM, EA, JMI, MAO and RR) contained documentation that discharge criteria and discharge status were reviewed at the WRPC; there was no documentation in the remaining chart (DWN). **Recommendation 4, August 2007:** Ensure that the discharge criteria and discharge status are reviewed with the individual at each WRPC. **Findings:** This monitor reviewed nine charts (AFC, DP, DTP, JJ, KS, MP, PC, SL and THE). One of the WPRs in the charts (SL) contained documentation that the discharge criteria/barriers and the individual's understanding of these were discussed with the individual. The remaining nine (AFC, DP, DTP, JJ, KS, MP, PC and THE) did not. **Recommendation 5, August 2007:** Develop a tool to monitor these requirements. **Findings:** MSH is using the DMH WRP Discharge Planning and Community Integration Audit Form to monitor these requirements. **Compliance:** Partial.

<table>
<tr>
<td></td>
<td></td>
<td>Current recommendations:
1. Ensure that discharge setting and relevant skills for that setting are developed at the first seven-day WRP.
2. Ensure appropriate linkage between each discharge criteria, focus of hospitalization and relevant PSR Mall groups or individual therapy (as needed) to achieve that discharge criteria.
3. Ensure that the discharge criteria and discharge status are reviewed and documented at each WRPC.
4. Ensure that the discharge criteria and discharge status are reviewed with the individual at each WRPC.</td>
</tr>
<tr>
<td>E.1.a</td>
<td>those factors that likely would foster successful discharge, including the individual's strengths, preferences, and personal life goals;</td>
<td>Current findings on previous recommendations:

Recommendation 1, August 2007:
Ensure that the individual's strengths and preferences are utilized to achieve discharge goals. These should be linked to the interventions that impact the individual's discharge criteria.

Findings:
MSH used item #1 (Those factors that likely would foster successful discharge, including the individual's strengths, preferences, and personal life goals) from the MSH WRP Discharge Planning and Community Integration Form to address this recommendation, reporting 33% compliance. The table below with its monitoring indicator showing the number of WRPs due each month (N), the number of WRPs audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.
<table>
<tr><td></td><td>Nov</td><td>Dec</td><td>Jan</td><td>Mean</td></tr>
<tr><td>N</td><td>672</td><td>667</td><td>678</td><td></td></tr>
<tr><td>n</td><td>16</td><td>44</td><td>53</td><td></td></tr>
<tr><td>%S</td><td>3</td><td>7</td><td>8</td><td></td></tr>
</table>
</td>
</tr>
</table>

%C #1	25	32	42	33	

This monitor reviewed eight charts (CO, CW, EA, JMI, MAO, MTS, RMP and RR). Two of the WRPs in the charts (CO and RMP) utilized the individual's strengths and preferences in the service of achievement of the individual's discharge goals and were linked to the interventions impacting the individual's discharge criteria. The remaining six (CW, EA, JMI, MAO, MTS and RR) did not have identified strengths in all the interventions related to the individual's discharge.

Recommendation 2, August 2007:
The individual's life goals should be linked to one or more foci of hospitalization, with associated objectives and interventions.

Findings:
This monitor reviewed seven charts (CO, CW, DTP, MP, RMT, SL and TS). Three of the WRPs in the charts linked the individual's life goals to one or more foci of hospitalization with associated objectives and interventions and the remaining four did not.

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 recommendation:** **Recommendation, August 2007:** 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:** MSH used item #2 (*The individual's level of psychosocial functioning*) from the MSH WRP Discharge Planning and Community Integration Form to address this recommendation, reporting 66% compliance. The table below with its monitoring indicator showing the number of WRPs due for each month (N), the number of WRPs audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data. This monitor reviewed 18 charts (AFC, BL, CW, DP, DTP, ES, EZ, JJ, JL, KS, MAO, MP, MTS, PC, SB, SL, TB and THE). Nine of the WRPs in the charts (BL, CW, ES, JL, MAO, MP, SL, TB and THE) described the individual's functional status adequately in the individual's Present Status section. The other nine (AFC, DP, DTP, EZ, JJ, KS, MTS, PC and SB) did not adequately describe the individual's functional status. **Compliance:** Partial.

	Nov	Dec	Jan	Mean
N	672	667	678	
n	16	44	53	
%S	3	7	8	
%C #2	60	59	78	66

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

Recommendation 1, August 2007:
Ensure that discharge barriers, especially difficulties in previously unsuccessful placements, are discussed with the individual at scheduled WRPCs.

Findings:
MSH used items #3 and 3a from the MSH WRP Discharge Planning and Community Integration Form to address this recommendation, reporting 29% and 55% compliance respectively. The table below with its monitoring indicators showing the number of WRPs due each month (N), the number of WRPs audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

#3: Any barriers preventing the individual from transitioning to a more integrated environment, especially difficulties raised in previously unsuccessful placements.

#3a: The individual's barriers to discharge, including difficulties encountered in previous placements are mentioned in the Present Status Section of the WRP.

<table>
<tr><td></td><td>Nov</td><td>Dec</td><td>Jan</td><td>Mean</td></tr>
<tr><td>N</td><td>672</td><td>667</td><td>678</td><td></td></tr>
<tr><td>n</td><td>16</td><td>44</td><td>53</td><td></td></tr>
<tr><td>%S</td><td>3</td><td>7</td><td>8</td><td></td></tr>
<tr><td>%C #3</td><td>40</td><td>23</td><td>23</td><td>29</td></tr>
</table></td></tr>
</table>

%C #3a	67	54	44	55	

This monitor reviewed 18 charts (AFC, CO, DP, EZ, FG, JF, JL, JRB, KS, MAO, MP, RH, RN, SD, SL, TB, THE and YFH). Three of the WRPs in the charts (JF, SL and YFH) contained documentation that discharge barriers were discussed with the individual. The remaining 15 (AFC, CO, DP, EZ, FG, JL, JRB, KS, MAO, MP, RH, RN, SD, TB and THE) did not contain such documentation.

Recommendation 2, August 2007:
Include all skills training and supports in the WRP so that the individual can overcome the stated barriers.

Findings:
This monitor reviewed eight charts (FG, JF, JRB, KH, RH, RN, SD and YFH). One of the WRPs in the charts (KH) included skills and supports needed for the individual to overcome the barriers and the remaining seven (FG, JF, JRB, RH, RN, SD and YFH) did not.

Recommendation 3, August 2007:
Report to the WRPT, on a monthly basis, the individual's progress in overcoming the barriers to discharge.

Findings:
This monitor reviewed six charts (CO, JRB, KH, RH, RM and YFH). One of the WRPs in the charts (KH) documented the individual's progress in overcoming the barriers to discharge. The remaining five (CO, JRB, RH, RM and YFH) did not.

Compliance:
Partial.

<table>
<tr><td></td><td></td><td>Current recommendations:
1. Ensure that discharge barriers, especially difficulties in previously unsuccessful placements, are discussed with the individual at scheduled WRPCs.
2. Include all skills training and supports in the WRP so that the individual can overcome the stated barriers.
3. Report to the WRPT, on a monthly basis, the individual's progress in overcoming the barriers to discharge.</td></tr>
<tr><td>E.1.d</td><td>the skills and supports necessary to live in the setting in which the individual will be placed.</td><td>Current findings on previous recommendations:

Recommendation 1, August 2007:
Assess skills and supports deficits the individual may have for the intended placement.

Findings:
MSH used item #4 (The skills and supports necessary to live in the setting in which the individual will be placed) from the MSH WRP Discharge Planning and Community Integration Form to address this recommendation, reporting 30% compliance. The table below with its monitoring indicator showing the number of WRPs due each month (N), the number of WRPs audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

<table>
<tr><td></td><td>Nov</td><td>Dec</td><td>Jan</td><td>Mean</td></tr>
<tr><td>N</td><td>672</td><td>667</td><td>678</td><td></td></tr>
<tr><td>n</td><td>16</td><td>44</td><td>53</td><td></td></tr>
<tr><td>%S</td><td>3</td><td>7</td><td>8</td><td></td></tr>
<tr><td>%C #4</td><td>33</td><td>23</td><td>34</td><td>30</td></tr>
</table>

This monitor reviewed nine charts (CO, FG, JRB, KH, MCL, RH, RN, SD and YFH). Two of the WRPs in the charts (KH and YFH) identified the skills and supports needed by the individual in the intended placement.</td></tr>
</table>

		The remaining seven (CO, FG, JRB, MCL, RH, RN, and SD) did not. This monitor's review of Social Work progress notes (for example, CAO and LLD) found that the notes contained information on the individual's needs, strengths, and challenges related to discharge matters that are rarely incorporated into the individual's Present Status section of the WRP. **Recommendations 2 and 3, August 2007:** • Assess the skills and supports that will be needed by the individual for a successful transition to the identified setting. • Include these skills and supports in the individual's WRP at the next scheduled conference. **Findings:** This monitor reviewed nine charts (CO, FG, JRB, KH, MCL, RH, RN, SD and YFH). Three of the WRPs in the charts (KH, MCL and YFH) had defined the skills and supports the individual needs for a successful transition to the next setting. The remaining six (CO, FG, JRB, RH, RN and SD) did not. **Compliance:** Partial. **Current recommendations**: 1. Assess skills and supports deficits the individual may have for the intended placement. 2. Assess the skills and supports that will be needed by the individual for a successful transition to the identified setting. 3. Include these skills and supports in the individual's WRP at the next scheduled conference.

E.2	Each State hospital shall ensure that, beginning at the time of admission and continuously throughout the individual's stay, the individual is an active participant in the discharge planning process, to the fullest extent possible, given the individual's level of functioning and legal status.	**Current findings on previous recommendations:** **Recommendation 1, August 2007:** Ensure that the individual is an active participant in the discharge planning process. **Findings:** MSH used item #12 (*Each State hospital shall ensure that, beginning at the time of admission and continuously throughout the individual's stay, the individual is an active participant in the discharge planning process, to the fullest extent possible, given the individual's level of functioning and legal status*) from the MSH WRP Observation Monitoring Form to address this recommendation, reporting 58% compliance. The table below with its monitoring indicator showing the number of WRPs due each month (N), the number of WRPs audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

	Aug	Sep	Oct	Nov	Dec	Jan	Mean
N	674	666	659	672	667	678	
n	95	100	77	108	91	106	
%S	14	15	12	16	14	16	
%C #12	76	56	58	56	51	53	58

This monitor reviewed eight charts (BT, CO, DTS, MCL, PJL, RAL, RB and SL). Three of the WRPs in the charts (MCL, RAL and SL) contained documentation that the individual was a participant in the discharge planning process. The remaining five (BT, CO, DTS, PJL and RB) did not.

Recommendation 2, August 2007:
Develop individualized and measurable discharge criteria.

		Findings: This monitor reviewed ten charts (AFC, CO, DTS, KH, KS, MCL, OS, PC, RB and YFH). One of the WRPs in the charts (KH) had developed individualized and measurable discharge criteria. In the remaining nine (AFC, CO, DTS, KS, MCL, OS, PC, RB and YFH), one or more of the discharge criteria were not written in a measurable/observable manner. For example, two of AFC's discharge criteria were written as, "She will develop an understanding of her mental illness and symptoms," and "She will be free from physical assault for a significant amount of time." For RB, the word "minimal" was used in more than one discharge criteria; and for OS one of the discharge criteria read, "Auditory hallucinations must not interfere with his ADLs." **Recommendation 3, August 2007:** Prioritize objectives and interventions related to the discharge processes. **Findings:** This monitor reviewed eight charts (ALC, CO, DTS, JL, MCL, OS, RAL and RB). Three of the WRPs in the charts (MCL, RAL and RB) had developed foci, objectives, and interventions addressing the individual's discharge criteria. The remaining five (ALC, CO, DTS, JL and OS) did not. **Compliance:** Partial. **Current recommendations**: 1. Ensure that the individual is an active participant in the discharge planning process. 2. Develop individualized and measurable discharge criteria. 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:	**Current findings on previous recommendation:** **Recommendation, August 2007:** Follow the established DMH WRP process for discharge planning to ensure that each individual has a professionally developed discharge plan that is integrated within the individual's WRP. **Findings:** A summary analysis of the findings in the "Discharge Planning and Community Integration" section shows that except for SL's WRP, most of the other WRPs reviewed in this section do not have a well-developed discharge plan integrated into the individual's WRP. MSH has set up systems and structures (tools, training, mentors, review process) that when fully implemented, and when individuals responsible for their areas are held accountable, will produce well-integrated WRPs that fully follow the DMH WRP process for discharge planning. **Compliance:** Partial. **Current recommendations**: Follow the established DMH WRP process for discharge planning to ensure that each individual has a professionally developed discharge plan that is integrated within the individual's WRP.
E.3.a	measurable interventions regarding these discharge considerations;	**Current findings on previous recommendation:** **Recommendation, August 2007:** Write all interventions, including those dealing with discharge criteria, in behavioral and measurable terms.

<table>
<tr>
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Findings:
MSH used item #6 (Measurable interventions regarding these discharge considerations) from the MSH WRP Discharge Planning and Community Integration Form to address this recommendation, reporting 37% compliance. The table below with its monitoring indicator showing the number of WRPs due each month (N), the number of WRPs audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.
<table>
<tr><td></td><td>Nov</td><td>Dec</td><td>Jan</td><td>Mean</td></tr>
<tr><td>N</td><td>672</td><td>667</td><td>678</td><td></td></tr>
<tr><td>n</td><td>16</td><td>44</td><td>53</td><td></td></tr>
<tr><td>%S</td><td>3</td><td>7</td><td>8</td><td></td></tr>
<tr><td>%C #6</td><td>33</td><td>32</td><td>46</td><td>37</td></tr>
</table>
This monitor reviewed 13 charts (AFC, BT, CO, DTS, JL, KS, MC, PC, PJL, RAL, RB, SB and THE). Six of the WRPs in the charts (BT, DTS, JL, MC, RB and THE) included observable/measurable objectives, and the remaining eight (AFC, CO, KS, PC, PJL, RAL and SB) did not.

Compliance:
Partial.

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

Recommendations 1-3, August 2007:
• Ensure that for each intervention in the Mall or for individual therapy, the name of the staff member responsible is noted.
• Confirm that the staff to be listed in the WRP is actually involved
</td>
</tr>
</table>

in facilitating the activity, group, or intervention.

- Ensure that there is a system for identifying when a staff member is no longer responsible for the individual's assigned group and that the WRPT is alerted.

Findings:
MSH used item #7 (*The staff responsible for implementing the interventions*) from the MSH WRP Discharge Planning and Community Integration Form to address this recommendation, reporting 59% compliance. The table below with its monitoring indicator showing the number of WRPs due each month (N), the number of WRPs audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

	Nov	Dec	Jan	Mean
N	672	667	678	
n	16	44	53	
%S	3	7	8	
%C #7	85	38	53	59

This monitor reviewed six charts (ALC, JL, LB, OBJ, OS and RF). Two of the WRPs in the charts (LB and OBJ) identified the staff member(s) responsible for implementing the interventions, and the remaining four (ALC, JL, OS and RF) contained one or more interventions that did not identify the staff member(s) responsible for implementing the interventions.

This monitor's documentation review (WRPs and Mall schedule) and observation of Mall groups found that the staff member(s) listed in the WRP and Mall schedule were providing the groups (Mock Trial, two different Community Integration groups, and Mindfulness). In one of the Community Integration groups the staff member listed was absent and the group was managed by substitute staff.

		MSH does not have a proper system of review/feedback to the WRPTs when a Mall group staff member is no longer responsible for the group. **Compliance:** Partial. **Current recommendations**: 1. Ensure that for each intervention in the Mall or for individual therapy, the name of the staff member responsible is noted. 2. Confirm that the staff to be listed in the WRP is actually involved in facilitating the activity, group, or intervention. 3. Ensure that there is a system for identifying when a staff member is no longer responsible for the individual's assigned group and that the WRPT is alerted.
E.3.c	The time frames for completion of the interventions.	**Current findings on previous recommendation:** **Recommendation, August 2007:** For each intervention in the Mall or for individual therapy, clearly state the time frame for the next scheduled review. This review should be the same as the individual's scheduled WRPC. **Findings:** MSH used item #8 (*The time frames for completion of interventions*) from the MSH WRP Discharge Planning and Community Integration Form to address this recommendation, reporting 56% compliance. The table below with its monitoring indicator showing the number of WRPs due each month (N), the number of WRPs audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

<table>
<tr>
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<td>
<table>
<tr><td></td><td>Nov</td><td>Dec</td><td>Jan</td><td>Mean</td></tr>
<tr><td>N</td><td>672</td><td>667</td><td>678</td><td></td></tr>
<tr><td>n</td><td>16</td><td>44</td><td>53</td><td></td></tr>
<tr><td>%S</td><td>3</td><td>7</td><td>8</td><td></td></tr>
<tr><td>%C #8</td><td>73</td><td>50</td><td>46</td><td>56</td></tr>
</table>

This monitor reviewed nine charts (ABJ, AFC, DTP, JJ, MP, PC, SB, SL and THE). Three of the WRPs in the charts (AFC, PC and SB) identified the time frames for the next scheduled review for all active objectives and interventions, and the remaining six (ABJ, DTP, JJ, MP, SL and THE) did not. For example, MP's WRPC was on 3/16/2008, and one of the interventions had a review date of 2/13/2008).

Compliance:
Partial.

Current recommendations:
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
</td>
</tr>
<tr>
<td>E.4</td>
<td>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:</td>
<td>**Compliance:**
Partial.</td>
</tr>
<tr>
<td>E.4.a</td>
<td>individuals who have met discharge criteria are discharged expeditiously, subject to the availability of suitable placements; and</td>
<td>**Current findings on previous recommendations:**

Recommendation 1, August 2007:
Reduce the overall number of individuals still hospitalized after referral for discharge has been made.</td>
</tr>
</table>

		Findings: This monitor's documentation review and interview of the Chief of Social Work found that as of March 14, 2008, MSH cared for 25 individuals who had been referred for discharge but were still in the hospital. Some of these individuals have been waiting to be discharged since January 2006 (JL). Eighteen of the individuals are from Los Angeles County, and the remaining from other counties. Eleven of them are persons in the CONREP program who were originally committed under PC 1026 or 2972. **Recommendation 2, August 2007:** Identify and resolve system factors that act as barriers to timely discharge. **Findings:** This monitor's interview of the Chief of Social Work found that the system factors faced by MSH regarding timely discharge of individuals referred for discharge continue to be external system factors including CONREP, courts, and conservators. The Social Work Department is working closely with CONREP to improve the situation. According to the Chief of Social Work, the reduction of case managers from three last year to 1.5 this year has not helped the situation. **Recommendation 3, August 2007:** Develop and implement a tracking and monitoring system for obtaining data on all individuals delayed from their discharge. **Findings:** This monitor's interview of the Chief of Social Work found that MSH has established a number of steps to improve the tracking and monitoring of individuals delayed in their discharge, including the creation of a court report writing team to ensure timely reports to the courts, tracking monthly updates of the individuals originally committed

<table>
<tr><td></td><td></td><td>under PC 1026 or 2972s with CONREP referrals, and monthly updates of the Los Angeles County placements. MSH also has set up monthly meeting with Orange County representatives. In addition, Social Work staff is to have monthly phone contacts with representatives from other counties.

Current recommendations:
Reduce the overall number of individuals still hospitalized after referral for discharge has been made.</td></tr>
<tr><td>E.4.b</td><td>Individuals receive adequate assistance in transitioning to the new setting.</td><td>Current findings on previous recommendations:

Recommendation, August 2007:
Ensure and document that individuals receive adequate assistance when they transition to the new setting.

Findings:
MSH used item #10 (Individuals receive adequate assistance in transitioning to the new setting) from the MSH WRP Discharge Planning and Community Integration Form to address this recommendation, reporting 59% compliance. The table below with its monitoring indicator showing the number of WRPs due each month (N), the number of WRPs audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

<table>
<tr><td></td><td>Nov</td><td>Dec</td><td>Jan</td><td>Mean</td></tr>
<tr><td>N</td><td>672</td><td>667</td><td>678</td><td></td></tr>
<tr><td>n</td><td>16</td><td>44</td><td>53</td><td></td></tr>
<tr><td>%S</td><td>3</td><td>7</td><td>8</td><td></td></tr>
<tr><td>%C #10</td><td>60</td><td>54</td><td>64</td><td>59</td></tr>
</table>

This monitor's findings from review of documentation and interview of the Chief of Social Work are in agreement with the facility's data. The</td></tr>
</table>

		Chief of Social Work reported that the information often found in Social Work monthly progress notes is seldom integrated into the individuals' WRPs (for example, AH, KG, KN and MF). It is difficult to provide transitional support when the skills and supports needed by the individuals are not identified (for example, JRB, RH and RN). The Social Work Chief noted that Social Work monthly notes document such needs but do not get integrated in the individuals' WRP. There are many Mall groups (for example, WRAP groups and Discharge Planning and Community Integration groups) that provide opportunities for identifying such needs and preparing the individual for transitional supports; these opportunities should be capitalized upon and integrated into the individual's WRP. **Current recommendations**: Ensure and document that individuals receive adequate assistance when they transition to the new setting.
E.5	For all children and adolescents it serves, each State hospital shall:	**Compliance:** Full.
E.5.a	develop and implement policies and protocols that identify individuals with lengths of stay exceeding six months; and	**Current findings on previous recommendation:** **Recommendation, August 2007:** Continue current practice. **Findings:** MSH cares for one adolescent and she is soon to be transferred to another facility.
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	**Current findings on previous recommendation:** **Recommendation, August 2007:** Continue current practice.

	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.	**Findings:** MSH cares for one adolescent and she is soon to be transferred to another facility.

F. Specific Therapeutic and Rehabilitation Services	
	Summary of Progress: **Psychiatric Services** 1. MSH has initiated individualized medication guidelines regarding the use of lithium, carbamazepine, venlafaxine, buproprion and mirtazapine. 2. MSH has reduced the use of regular benzodiazepine treatment for individuals with substance use disorders and/or cognitive impairments. 3. MSH has reduced the use of anticholinergic treatment for elderly individuals and for individuals with cognitive disorders. 4. MSH has improved reporting, tracking and analysis of Adverse Drug Reactions (ADRs). 5. MSH has improved reporting and tracking of medication variances. **Psychological Services** 1. MSH is implementing a System-Wide PBS Plan. 2. MSH has initiated the monthly "Specialty Services Meeting" to address complex cases in an interdisciplinary manner. 3. MSH has piloted a Mall Program addressing all aspects of the program with specific ideas/plans to improve the quality of Mall services. 4. MSH's BY CHOICE program has improved its services through better training, enhanced its incentive stores, prepared fliers/handouts in multiple languages, and prepared health-related videos. 5. MSH's PBS services have improved. PBS teams now routinely conduct structural/functional assessments when developing PBS plans, integrate other therapeutic modalities into their plans, conduct fidelity checks, and train staff responsible for implementing the plans.

	Nursing Services 1. Nursing has revised a number of its policies and procedures in alignment with the EP and Wellness and Recovery. 2. Nursing has implemented inter-rater reliability testing for most of its monitoring tools. 3. All the required competency-based training has been integrated into the new employee orientation as well as into the mandatory annual training. **Rehabilitation Therapy Services** 1. Lesson Plans for PSR Mall groups facilitated by Rehabilitation Therapists continue to be developed and appear to be in line with state-wide format. 2. Progress notes for PSR Mall groups run by Rehabilitation Therapists have been initiated, though they are not consistently completed according to EP and state requirements. 3. Rehabilitation Therapy process, procedure and audit tool for WRP role have been implemented. **Nutrition Services** 1. The Mealtime Tray Accuracy audit has been implemented and outcomes for compliance with in vivo provision of prescribed diets are in substantial compliance. 2. PSR Mall groups facilitated by Clinical Dietitians have been implemented. **Pharmacy Services** 1. The Pharmacy Department has received the necessary IT support/resources to accomplish EP-related objectives. 2. The main factor underpinning Pharmacy staff shortages has been rectified.

	General Medical Services 1. MSH has revised its medical policies and procedures and adequately addressed the deficiencies in these procedures that were outlined by this monitor in previous reports. 2. The DMH has standardized the monitoring tools that address EP requirements in this section, except for the tools regarding the initial medical admission assessment and the medical emergency response system. **Infection Control** 1. The Infection Control Department has begun to integrate its compliance data into the Infection Control Committee Meetings, the Medical Executive Committee Meetings and the Interdepartmental Performance Improvement Committee Meetings. 2. Since the implementation of the statewide Infection Control monitoring tools at MSH, the department has consistently audited samples sizes of 20% and greater. 3. The department has developed policy drafts addressing Hepatitis C in response to issues identified from the department's compliance data. **Dental Services** 1. The statewide Dental Monitoring tool has been approved and will be implemented to generate data for the next review period. 2. The Dental Department has clarified requirements for documentation that facilitates interpretation of the dental treatment and treatment plan. 3. The data provided by the Dental Department for this review is in alignment with current practice.

1. Psychiatric Services		
		Methodology: Interviewed: 1. Michael Barsom, MD, Medical Director 2. Nady Hanna, MD, Medical Staff President 3. Bala Gulasekaram, MD, Chief of Psychiatry 4. Christopher Heh, MD Reviewed: 1. The charts of the following 49 individuals: ABW, AJG, AM, BJL, BRS, CR, CRC, DE, DEL, DG, DT, EW, EWVC, FDA, FL, GWB, HC, JC, JEF, JGH, JJB, JL, JLM, JM, JS, JV, LW, MJ, MJR, MMK, MML, MTR, NB, NB, NV, OS, PDF, PW, RAL, RMT, RRF, SMN, SNM, SS, SW, TM, TP, VAB and WH 2. MSH individualized medication guidelines regarding the use of lithium, carbamazepine, venlafaxine, buproprion and mirtazapine 3. Current DMH Psychotropic Medication Policies and Guidelines 4. MSH Staff Psychiatrist Manual 5. DMH Admission Psychiatric Assessment Auditing Form 6. DMH Admission Psychiatric Assessment Auditing Form Instructions 7. MSH Admission Psychiatric Assessment Auditing summary data (August 2007 to January 2008) 8. DMH Integrated Assessment: Psychiatry Section Auditing Form 9. DMH Integrated Assessment: Psychiatry Section Auditing Form Instructions 10. MSH Integrated Assessment: Psychiatry Section Auditing summary data (August 2007 to January 2008) 11. DMH Monthly Psychiatric Progress Notes Auditing Form 12. DMH Monthly Psychiatric Progress Notes Auditing Form Instructions 13. MSH Monthly Psychiatric Progress Notes summary data (August 2007 to January 2008)

		14. MSH Psychiatric PRN Stat Medications Monitoring Form 15. MSH Nursing PRN Medications Monitoring Form 16. MSH Nursing Stat Medications Monitoring Form 17. MSH PRN Stat monitoring summary data (August 2007 to January 2008) 18. MSH Benzodiazepine Monitoring summary data (November 2007 to January 2008) 19. MSH Anticholinergics Monitoring summary data (September, October and December 2007 and January 2008) 20. MSH Polypharmacy Monitoring summary data October and November 2007 and January 2008) 21. MSH summary monitoring data regarding use of new generation antipsychotic medications 22. DMH Tardive Dyskinesia (TD) Monitoring Form 23. DMH TD Monitoring Form Instructions 24. MSH TD Monitoring summary data (August 2007 to January 2008) 25. MSH data regarding Adverse Drug Reactions (ADRs) and medication variances from September 2007 to January 2008 26. Last ten completed ADR reporting forms 27. Last ten completed medication variance reporting forms 28. Intensive case analyses (#2) for ADRs during this review period 29. Format of Intensive Case Analysis regarding medication variances 30. MSH instructions to staff regarding reporting of medication variance 31. Meeting minutes of the Pharmacy and Therapeutics (P&T) Committee (August 2007 to December 2007) 32. MSH data regarding continuing education status of psychiatry staff
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,	**Current findings on previous recommendations:** **Recommendation 1, August 2007:** Implement individualized medication guidelines that include specific

	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:	information regarding indications, contraindications, clinical and laboratory monitoring and adverse effects for all psychotropic and anticonvulsant medications in the formulary. The guidelines must be derived from current literature, relevant clinical experience and current generally accepted professional practice guidelines. **Findings:** California DMH Psychotropic Medication Policies and Guidelines have been implemented statewide. Since the initial version of the guidelines was issued (March 2007), a statewide committee has implemented updates of these guidelines. The most recent version (June 2007) included the following updates: 1. Laboratory monitoring requirements regarding the use of clozapine, olanzapine, risperidone, ziprasidone and divalproex; 2. Clinical monitoring requirements regarding the use of lamotrigine; 3. Precautions/contraindications regarding the use of olanzapine and divalproex; and 4. Therapeutic Review Committee oversight regarding upper dose limits for combinations of oral and depot formulations of the same medications. DMH also developed DUE monitoring instruments that are aligned with the DMH individualized medication guidelines. Since the last review, MSH has developed and implemented guidelines for the mood stabilizers lithium and carbamazepine and the antidepressants venlafaxine, buproprion and mirtazapine. These guidelines were not included in the DMH Psychotropic Policies and Guidelines. **Recommendation 2, August 2007:** Same as in D.1.c, D.1.d, D.1.e and F.1.g.

		Findings: Same as in D.1.c, D.1.d, D.1.e and F.1.g. **Recommendation 3, August 2007:** Continue to monitor this requirement. **Findings:** MSH used the DMH Admission Psychiatric Assessment, Integrated Assessment (Psychiatry) and Monthly Physician Progress Note (PPN) Audit Forms to assess compliance with this requirement (August 2007 to January 2008). The average sample sizes were 90%, 75% and 14% respectively. The compliance rates are presented for each sub-cell below. The monitoring indicators are listed if they represented subcomponents of the corresponding requirement. The facility has reportedly instructed the senior psychiatrists to focus on mentoring staff psychiatrists to improve performance on all items that demonstrate low compliance ratings. **Other findings:** The use of the DMH standardized tools has improved data gathering, presentation and alignment with each requirement in this cell. **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. 2. Monitor these requirements using standardized indicators across state facilities. 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		
1.	*Regular psychotropic medications with rationale (in the plan of care)*	61%
2.	*PRN and/or Stat medication as applicable, with specific behavioral indications (in the plan of care)*	No data yet
3.	*Special precautions to address risk factors, as indicated (in the plan of care)*	92%

The facility's data analysis showed a trend of significant improvement in items 1 and 3 above during this reporting period.

Integrated Assessment (Psychiatry)		
1.	*Diagnostic formulation*	67%
2.	*Current target symptoms*	33%

The facility has instructed the senior psychiatrists to focus on mentoring staff psychiatrists to improve compliance.

Monthly PPN		
1.	*Identified target symptoms are documented.*	86%
2.	*The risks, benefits, and rationale for the current psychopharmacology plan including anticholinergics, benzodiazepines, and polypharmacy are documented.*	69%
3	*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.*	76%

<table>
<tr><td></td><td></td><td>The facility's data analysis showed significant improvement in these items in December 2007.</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>1.</td><td>Current psychotropic medication dosage/laboratory monitoring/diagnostic testing and consultation protocols are followed as indicated (as per DMH Psychotropic guidelines).</td><td>76%</td></tr>
</table>
</td></tr>
<tr><td>F.1.a.iii</td><td>tailored to each individual's symptoms;</td><td>
<table>
<tr><td colspan="3">Admission Psychiatric Assessment</td></tr>
<tr><td>1.</td><td>Regular psychotropic medications with rationale (in the plan of care)</td><td>61%</td></tr>
<tr><td>3.</td><td>Special precautions to address risk factors, as indicated (in the plan of care)</td><td>92%</td></tr>
</table>
Integrated Assessment (Psychiatry) and Monthly PPN: 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>1.</td><td>Identified target symptoms are documented.</td><td>86%</td></tr>
<tr><td>2.</td><td>Participation in treatment is documented.</td><td>86%</td></tr>
<tr><td>3.</td><td>Progress towards objective in the Wellness and Recovery Plan</td><td>76%</td></tr>
</table>
The facility's data analysis showed significant improvement in these items in December 2007.
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<table>
<tr><td>F.1.a.v</td><td>monitored appropriately for side effects;</td><td>
<table>
<tr><td colspan="3">Monthly PPN</td></tr>
<tr><td>1.</td><td>Monitoring of side effects</td><td>78%</td></tr>
<tr><td>2.</td><td>AIMS is completed.</td><td>68%</td></tr>
</table>
See comments in D.1.f.v.
</td></tr>
<tr><td>F.1.a.vi</td><td>modified based on clinical rationales;</td><td>
<table>
<tr><td colspan="3">Monthly PPN</td></tr>
<tr><td>1.</td><td>The risks, benefits, and rationale for the current psychopharmacology plan including anticholinergics, benzodiazepines, and polypharmacy are documented.</td><td>69%</td></tr>
<tr><td>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>76%</td></tr>
</table>
The facility's data analysis showed significant improvement in these items in December 2007.
</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>1.</td><td>Participation in treatment is documented.</td><td>86%</td></tr>
<tr><td>2.</td><td>Monitoring of side effects, including sedation.</td><td>78%</td></tr>
<tr><td>3.</td><td>AIMS is completed</td><td>68%</td></tr>
</table>
The facility's data analysis showed significant improvement in these items in December 2007.
</td></tr>
<tr><td>F.1.a.viii</td><td>Properly documented.</td><td>As requested by this monitor, the facility provided the following data regarding the weighted means for all items above. The information is relevant to this requirement.</td></tr>
</table>

<table>
<tr><td></td><td></td><td>
<table>
<tr><td>Admission Psychiatric Assessment</td><td>86%</td></tr>
<tr><td>Integrated Assessment (Psychiatry)</td><td>68%</td></tr>
<tr><td>Monthly PPN</td><td>76%</td></tr>
</table>

The facility's data analysis showed a trend of significant improvement in the above weighted items during this reporting period</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:

Recommendations 1 and 2, August 2007:
• Consolidate the monitoring instruments regarding PRN and Stat medications, and report data that address EP requirements regarding each of the following:
▪ Psychiatric documentation of PRN medication use.
▪ Psychiatric documentation Stat medications.
▪ Nursing documentation of PRN medication use.
▪ Nursing documentation of Stat medication use.
• Continue to monitor the use of PRN and Stat medications based on at least a 20% sample.

Findings:
Using a variety of MSH instruments, the facility has consolidated the data presentation regarding nursing and psychiatric documentation of PRN medications use. The monitoring indicators regarding psychiatric documentation have yet to include requirements for psychiatrist's review of PRN medications and for adjustment of regular treatment based on this review, as indicated. The following is an outline of the monitoring tools and corresponding average sample sizes:
<table>
<tr><td>Monitoring tool</td><td>Average %S</td></tr>
<tr><td>Psychiatric PRN Medications Monitoring Form</td><td>30</td></tr>
<tr><td>Psychiatric Stat Medications Monitoring Form</td><td>14</td></tr>
</table>
</td></tr>
</table>

Nursing PRN Medications Monitoring Form	31
Nursing Stat Medications Monitoring Form	27

The following table summarizes the monitoring indicators and corresponding mean compliance rates (additional data relevant to psychiatric documentation were presented in D.1.f.vi) :

1.	*Psychotropic PRN medications are prescribed for specified and individualized behaviors.*	47%
2.	*A psychiatrist conducts a face-to-face assessment of the individual within 24 hours of the administration of a Stat/emergency psychotropic medication; and the assessment addresses reason for Stat administration, individual's response, and as appropriate, adjustment of current treatment and/or diagnosis.*	52%
3.	*Nursing staff document the circumstances requiring PRN medication*	86%
4.	*Does documentation include interventions that were attempted prior to the administration of PRN medication?*	69%
5.	*Nursing staff assess the individual within one hour of the administration of the psychiatric PRN medication.*	77%
6.	*Nursing staff document the individual's response to PRN medication.*	67%
7.	*Nursing staff document the circumstances requiring Stat medication*	88%
8.	*Does documentation include interventions that were attempted prior to the administration of Stat medication?*	71%
9.	*Nursing staff assess the individual within one hour of the administration of the psychiatric Stat medication.*	81%
10.	*Nursing staff document the individual's response to Stat medication.*	76%

		MSH has identified a trend of improvement in the documentation of the reasoning for the use of psychotropic PRNs. This improvement was attributed to the limitation on continuous PRN orders for psychotropics to 14 days. The facility also identified a pattern of low compliance with the requirement that a face-to-face assessment was conducted after a Stat medication was administered. Many of these administrations are reportedly ordered by the on-call physicians. The facility has reportedly addressed this issue with the physicians who provide on=call coverage. **Recommendation 3, August 2007:** Provide ongoing feedback and mentoring by senior psychiatrists to ensure correction of the deficiencies noted by this monitor. **Findings:** As mentioned earlier, the facility currently has an adequate structure for oversight by the senior psychiatrists. The system includes adequate mechanisms for feedback to practitioners and review with facility leadership. **Other findings:** See D.1.f for this monitor's review of the appropriateness of PRN/Stat medication use. These reviews and other chart reviews by this monitor found that MSH has yet to make significant progress in correcting the deficiencies outlined in this and previous reports regarding the use of PRN and Stat medications. **Compliance:** Partial.

		Current recommendations: 1. Standardize the monitoring tools regarding PRN and Stat medications for use across state facilities. 2. Monitor this requirement based on at least a 20% sample. 3. Provide data analysis that evaluates low compliance and delineates relative improvement (during the reporting period and compared to the previous period). 4. Utilize current oversight system to improve compliance.
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:** **Recommendation 1, August 2007:** Continue to monitor the use of benzodiazepines, anticholinergics and polypharmacy, based on DMH medication guidelines and ensure at least a 20 % sample of the target population. **Findings:** MSH participated in a statewide forum in which the following tools were finalized: 1. DMH Benzodiazepine Audit Form; 2. DMH Benzodiazepine Audit Form Instructions; 3. DMH Anticholinergics Audit Form; 4. DMH Anticholinergics Audit Form Instructions; 5. DMH Polypharmacy Audit Form; and 6. DMH Polypharmacy Audit Form Instructions. The above tools have indicators and operational instructions that are appropriate for use across facilities. MSH used the DMH Benzodiazepine (November 2007 to January 2008), Anticholinergics (September, October and December 2007 and January 2008) and Polypharmacy (October and November 2007 and

January 2008) Audit Forms to assess compliance. The use of the standardized tools has resulted in a decrease in compliance ratings for some items, which was attributed to more stringent monitoring. The facility has instructed its senior psychiatrists to provide mentoring to improve overall compliance.

The following is a summary outline of the monitoring indicators and corresponding mean compliance rates:

Benzodiazepines (average %S=24):

1.	*Indication for regular use of benzodiazepine clearly documented in PPN*	60%
2.	*Routine benzodiazepine use for more than two months clearly documents in PPN risks of:*	
2.a	*Sedation*	42%
2.b	*Drug dependence*	37%
2.c	*Cognitive decline*	35%
2.d	*Gait unsteadiness/falls (for individuals > 60 y/o or are predisposed to falls)*	25%
2.e	*Respiratory depression (for those with underlying respiratory problems, e.g., COPD).*	13%
2.f	*Toxicity if used in individuals with liver impairment (if using long acting agents).*	0%
3.	*TRC consult approval obtained for use >two months (If yes, date of consult)*	17%
4.	*Benzodiazepine use for individuals with alcohol/drug use problems justified in PPN*	28%
5.	*Benzodiazepine use for individuals with cognitive disorders justified in PPN*	27%
6.	*Treatment modified in an appropriate and timely manner to ensure proper indications and minimize risk*	47%

Anticholinergics (%S=27):

1.	*Documentation in the Physician's Progress Note (PPN) justifies regular use of anticholinergic*	30%
2.	*Anticholinergic use in individuals (over 60) and/or individuals with cognitive disorders includes documentation that addresses the risk of:*	
2.a	*Cognitive impairment*	43%
2.b	*Sedation (if using antihistaminic, e.g., diphenhydramine*	0%
2.c	*Gait unsteadiness/falls (for individuals > 60 on antihistamine, e.g., diphenhydramine)*	0%
2.d	*Blurred vision, constipation, urinary retention*	27
2.e	*Worsening narrow angle glaucoma if present*	NA
3.	*Anticholinergic use for more than two months includes documentation that address the risk of*	
3.a	*Cognitive impairment*	15%
3.b	*Sedation (if using antihistaminic, e.g., diphenhydramine*	21%
3.c	*Gait unsteadiness/falls (for individuals > 60 on antihistamine, e.g., diphenhydramine)*	5%
3.d	*Blurred vision, constipation, urinary retention*	15%
3.e	*Worsening narrow angle glaucoma if present*	NA
3.f	*Substance abuse (esp trihexyphenidyl)*	9%
3.g	*Worsening TD if present*	27%
4.	*TRC consult approval obtained for use > two months (if yes, date of consult)*	10%
5.	*Treatment modified in an appropriate and timely manner to ensure proper indications and minimize risk*	32%

Polypharmacy (%S=19):

1.	*Target symptoms were clearly identified*	65%
2.	*Documentation in physician progress notes (PPN) justified the need for interclass polypharmacy*	39%
3.	*Documentation in PPN justifies the need for intraclass polypharmacy*	37%
4.	*Documentation in the PPN elucidates the risks of polypharmacy*	25%
5.	*Polypharmacy use modified in a timely manner to ensure proper indications and minimize risks*	36%
6.	*A TRC consult obtained in polypharmacy if use exceeded 60 days.*	20%
7.	*Target symptoms were clearly identified*	65%

Recommendation 2, August 2007:
Provide ongoing feedback and mentoring by senior psychiatrists to improve compliance.

Findings:
Same as Findings for Recommendation 3 in F.1.b.

Recommendation 3, August 2007:
Identify patterns and trends regarding high-risk medication uses and implement corrective and educational actions.

Findings:
Same as Findings for Recommendation 1.

Other findings:
Chart reviews by this monitor revealed that, in general, the facility has reduced the use of regular benzodiazepine treatment for individuals

with substance use disorders and/or cognitive impairments and the use of anticholinergic treatment for elderly individuals and for individuals with cognitive disorders. However, some individuals are still receiving long-term regular treatment with benzodiazepines (lorazepam and/or clonazepam) and/or anticholinergic medications (benztropine and/or diphenhydramine) without documented justification. The following table outlines examples of this practice in the presence of diagnoses that increase the risks of treatment for the individuals. The diagnoses are listed only if they signify conditions that increase the risk of continued use.

Initials	Medication(s)	Diagnosis
ABW	Benztropine (discontinued in February 2008)	Cognitive Disorder, NOS
AJG	Clonazepam	Polysubstance Dependence
BJL	Benztropine	
BRS	Lorazepam	Polysubstance Dependence
CR	Lorazepam	Alcohol Dependence, Cannabis Dependence and Amphetamine Dependence.
DE	Clonazepam	Alcohol Abuse and cannabis Abuse
HC	Benztropine, and diphenhydramine (discontinued in February 2008)	Borderline Intellectual Functioning
JC	Lorazepam	Polysubstance Dependence
JJB	Lorazepam	Polysubstance Dependence
JM	Clonazepam	Mild Mental Retardation
JV	Clonazepam and (lorazepam PRN)	Cocaine Abuse and Cannabis Abuse
LW	Lorazepam	Borderline Intellectual Functioning

MJ	Lorazepam	Borderline Intellectual Functioning (discontinued in March 2008)
MJR	Lorazepam	Polysubstance Dependence
MML	Benztropine	
NB	Diphenhydramine	Tardive Dyskinesia
NV	Lorazepam	Cocaine Abuse
PW	Clonazepam	Borderline Intellectual Functioning
SMN	Benztropine	Mild Mental Retardation
TM	Benztropine	
VAB	Benztropine and diphenhydramine	

In addition, this monitor reviewed the charts of nine individuals who have received various forms of polypharmacy. The review found some improvement in the documentation of the risks of each medication. However, there continues to be general evidence of inadequate documentation of the rationale for polypharmacy, of associated risks including drug-drug interactions and/or of attempts to simplify/optimize the regimen. The following are examples:

Individual	Medications	Diagnosis
CR	Lorazepam, olanzapine, quetiapine, haloperidol, lithium and benztropine	Schizoaffective Disorder, Bipolar Type, Alcohol Dependence, Cannabis Dependence, Amphetamine Dependence
DT	Clonazepam, buproprion, buspirone, risperidone, quetiapine and ziprasidone.	Schizophrenia, Paranoid Type, Continuous and Polysubstance Dependence

		FDA	Clozapine, quetiapine, lorazepam, lamotrigine, paroxetine and divalproex	Schizophrenia, Paranoid Type
		JM	Clozapine, olanzapine, oxcarbazepine and clonazepam	Schizoaffective Disorder, Bipolar Type, Borderline Personality Disorder and Seizure Disorder
		MMK	Chlorpromazine, buproprion, diphenhydramine and divalproex	Schizoaffective Disorder, Depressive Type and Polysubstance Dependence
		RAL	Clozapine, lorazepam, aripiprazole, venlafaxine and lithium	Schizoaffective Disorder, Depressive Type
		SNM	Clonazepam, clozapine, loxapine, citalopram and trazodone	Schizoaffective Disorder, Bipolar Type and Polysubstance Dependence
		SW	Clonazepam, gabapentin, olanzapine, risperidone, risperidone consta, oxcarbazepine and topiramate	Bipolar Disorder, Severe, with Psychotic Features, Post-Traumatic Stress Disorder, Attention Deficit Disorder, Hyperactivity Type, Borderline Personality Disorder and Seizure Disorder
		WH	Clonazepam, loxapine, quetiapine, haloperidol decanoate, benztropine, and diphenhydramine,	Schizophrenia, Paranoid Type

		Compliance: Partial. **Current recommendations**: 1. Continue to monitor this requirement using the DMH instruments. 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. Utilize current oversight system to improve compliance.
F.1.d	Each State hospital shall ensure the monitoring of the metabolic and endocrine risks associated with the use of new generation antipsychotic medications.	**Current findings on previous recommendations:** **Recommendation 1, August 2007:** Same as in F.1.a and F.1.g. **Findings:** Same as in F.1.a and F.1.g. **Recommendation 2, August 2007:** Continue to monitor this requirement using at least a 20% sample. **Findings:** MSH used its current monitoring tool to assess its compliance with this requirement. Monitoring of the new generation antipsychotic medications was done on a rotating basis. The facility reviewed the use of aripiprazole (September 2007), clozapine (August and December 2007), olanzapine (October 2007), quetiapine (September and October 2007), risperidone (November 2007) and ziprasidone (August and October 2007 and January 2008). The facility presented data for each specific medication and for all medications. The following table is a summary outline of the monitoring indicators and corresponding mean compliance rate for all new generation antipsychotic medications:

		1.	*Family/personal risk factors addressed in PPN (if medication started within last 90 days)*	18%
		2.	*Justification for use documented in PPN for individuals with diagnosis of (for olanzapine, risperidone, quetiapine)*	
		2.a	*Dyslipidemia*	33%
		2.b	*Diabetes*	41%
		2.c	*Obesity*	40%
		3	*Justification for use documented in PPN for individuals on risperidone with hyperprolactinemia*	13%
		4.	*Appropriate monitoring for postural hypotension for individual >60y/o with BP<90/60 on quetiapine*	NA
		5.	*ECG within previous 12 months*	44%
		6.	*Appropriate baseline and regular monitoring of:*	
		6.a	*Body Mass Index*	86%
		6.b	*Waist Circumference*	69%
		6.c	*Fasting Blood Sugar (FBS) monthly (if started olanzapine or clozapine w/in last 6 months)*	30%
		6.d	*FBS quarterly (including olanzapine and clozapine after first 6 months)*	91%
		6.e	*Triglycerides*	81%
		6.f	*Cholesterol*	82%
		6.g	*HgbA1C if FBS high*	86%
		6.h	*Prolactin level*	30%
		6.i	*Breast exam*	91%
		6.j	*AIMS exam*	81%
		7.	*Serum amylase/lipase (if on clozapine, olanzapine, risperidone)*	26%
		8.	*PPN documentation of potential and actual risk for each medication used*	43%
		9.	*Treatment modified in an appropriate and timely manner to address identified risks*	55%

The facility has instructed its senior psychiatrists to ensure improved practice regarding all items with low compliance.

Other findings:
This monitor reviewed the charts of 12 individuals who are receiving new generation antipsychotic agents and are 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
CRC	Quetiapine	Hyperlipidemia
DG	Olanzapine	Diabetes Mellitus (with renal complications).
EWVC	Risperidone	Diabetes Mellitus
FL	Clozapine	Hyperlipidemia
GWB	Risperidone	Diabetes Mellitus
JEF	Risperidone	Obesity and Hyperprolactinemia (undocumented)
JL	Risperidone	Diabetes Mellitus
JLM	Olanzapine	Diabetes Mellitus
JS	Clozapine	Hyperlipidemia
RMT	Olanzapine	Diabetes Mellitus
RRF	Risperidone and quetiapine	Hyperlipidemia
SS	Risperidone and quetiapine	Hyperprolactinemia (undocumented)

This review found that in general, the facility provides adequate laboratory monitoring of the metabolic indicators, blood counts and vital signs in individuals at risk. However, deficiencies still exist that must be corrected in order to achieve substantial compliance. The

		following is an outline of these deficiencies: 1. There was no documentation of any psychiatric reassessment since December 2007 in an individual who is diagnosed with diabetes mellitus, is receiving treatment with a high-risk antipsychotic medication (olanzapine) and has had recent significant change in laboratory findings related to risks of treatment (JLM). 2. There was no documentation of any psychiatric monthly reassessments since at least October 2007 of an individual diagnosed with diabetes mellitus who continues to receive treatment with risperidone, a high-risk antipsychotic medication (JL). 3. The WRP did not document obesity as a diagnosis or include focus, objectives or interventions to address this problem in an individual who is diagnosed with diabetes mellitus, has a BMI >38 and is receiving risperidone, a high-risk antipsychotic medication (GWB). 4. The most current WRP did not document a diagnosis or include focus, objectives or interventions to address the development of hyperlipidemia in an individual who is diagnosed with diabetes mellitus (with renal failure) and receives olanzapine, a high risk antipsychotic medication (DG). 5. The frequency of required laboratory monitoring (lipid profile) in an individual (FL) who is diagnosed with hyperlipidemia and is taking clozapine, a high-risk antipsychotic agent, was inadequate. 6. The WRPs did not document objectives and/or interventions to address the repeated refusals of blood work by an individual who is diagnosed with hyperlipidemia and is taking quetiapine (CRC) and another individual diagnosed with diabetes mellitus and receiving risperidone (GWB). 7. The psychiatric reassessments did not document a trend of weight gain in an individual receiving combination treatment of risperidone and quetiapine and diagnosed with hyperlipidemia (RRF). 8. The psychiatric progress notes did not document an adequate

		assessment of the risks and benefits of continued treatment with olanzapine for an individual who suffers from hyperlipidemia and is diagnosed with diabetes mellitus with renal failure (DG). 9. The psychiatric progress notes did not adequately address the risks and benefits of continued treatment with risperidone for an individual who is diagnosed with diabetes mellitus and has had significant elevations of the level of HgA1C (EWVC). 10. The psychiatric progress notes did not document a recent finding of significant elevation of prolactin level in a female individual who is receiving treatment with risperidone and suffering from obesity (JEF). The risk/benefit assessment does not address this finding. 11. The psychiatric progress notes documented theoretical side effects of risperidone that the individual does not appear to suffer from, but did not address a significant side effect (hyperprolactinemia) despite recent evidence of its presence (SS). **Compliance:** Partial. **Current recommendations**: 1. Standardize the monitoring tool regarding the use of new generation antipsychotic medications. 2. Ensure that the monitoring indicator regarding serum amylase/lipase also includes quetiapine. 3. Continue to monitor this requirement based on at least a 20% sample and provide data both for all medications (aggregate) and for each specific medication. 4. Provide data analysis that evaluates low compliance and delineates relative improvement (during the reporting period and compared to the last period).
F.1.e	Each State hospital shall ensure regular monitoring, using a validated rating instrument	**Current findings on previous recommendations:**

	(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.	**Recommendation 1, August 2007:** Implement revised protocol for the diagnosis and management of TD, including follow-up at the TD clinic. **Findings:** MSH has implemented this recommendation. The Staff Psychiatrist Manual has been updated to include this protocol. **Recommendation 2, August 2007:** Standardize the TD monitoring form for use across state facilities. **Findings:** The DMH has standardized the monitoring tool for statewide use. **Recommendation 3, August 2007:** Provide feedback and mentoring by senior psychiatrists to correct the deficiencies outlined above. **Findings:** The facility currently has an adequate structure for oversight by the senior psychiatrists. **Recommendation 4, August 2007:** Monitor this requirement based on a 100% sample. **Findings:** MSH used the DMH Tardive Dyskinesia (TD) Monitoring From to assess compliance (August 2007 to January 2008). The facility reviewed a 100% sample (N=6) of individuals currently identified to have a diagnosis of TD. The following is a summary outline of the monitoring indicators and mean corresponding compliance rates:

1.	*Do monthly progress notes or PPNs for past three months regarding prescribed antipsychotic medications discuss documented benefits?*	44%
2.	*Do monthly progress notes or PPNs for past three months regarding prescribed antipsychotic medications discuss the tolerability of the medications?*	44%
3.	*If a conventional antipsychotic is used, is there evidence in PPN or monthly progress note of justification of using the older generation medication?*	N/A
4.	*Was an AIMS exam done on admission?*	100%
5.	*Was an annual AIMS exam done at time of last annual physical exam?*	100%
6.	*If this patient has TD, was a new AIMS exam done every three months?*	13%
7.	*If this individual has a history of TD, was an AIMS done every three months?*	100%
8.	*Do monthly progress notes for past 3 months indicate that antipsychotic treatment has been modified for individuals with TD, a history of TD, or a positive AIMS test to reduce risk?*	50%
9.	*Was a diagnosis of TD listed on Axis I and/or Axis III?*	22%
10.	*Was TD included as a Focus in Domain #6 of the WRP?*	22%
11.	*Were objectives and interventions developed?*	11%
12.	*Was a neurology consult completed?*	63%
13.	*Was a TRC Consult completed every six months? (If applicable)?*	86%
14.	*Was the individual referred to TD Clinic?*	N/A

		MSH's report did not provide information regarding corrective actions to improve compliance. **Other findings:** This monitor reviewed the charts of all individuals who were identified on the facility's current database as having TD. The database identified eight individuals (AM, DEL, EW, JGH, JLM, OS, SS, and TP). This review indicated that the facility has made some progress as follows: 1. Admission AIMS tests were completed in all the cases reviewed that were admitted after 2003. 2. Quarterly AIMS were completed in some cases (DEL and OS). 3. The WRPs included tardive dyskinesia as a focus with corresponding objectives and interventions in most cases (AM, EW JGH, JLM, OS and SS). 4. Some of the individuals' objectives were appropriately based on learning outcomes (AM and JLM). 5. The charts document attempts to use safer antipsychotic medication alternatives in most individuals (AM, EW, JLM, OS, SS and TP). 6. The WRP of an individual includes a plan of neurological assessment to address the undetermined etiology of the abnormal movement disorder (OS). The monitor's review also found the following deficiencies: 1. The WRP did not include a diagnosis of TD or corresponding focus, objectives or interventions (DEL and TP). 2. The WRP identified TD as a diagnosis but did not include corresponding focus, objectives or interventions (SS). 3. The WRP includes an intervention of quarterly monitoring using AIMS forms, but this monitoring is being completed on an annual

		basis (AM). 4. The WRP includes unattainable objectives for individuals suffering from TD (JGH, JLM and OS). 5. AIMS test was not conducted on a quarterly basis as required for most of the individuals reviewed (AM, EW JGH, JLM, SS and TP). 6. There is evidence of long-term treatment with an anticholinergic treatment without monitoring or documentation of the risks (OS). In addition, this monitor found examples of individuals who were not identified on the facility's TD database but received a diagnosis of TD that was documented in the WRPs and the psychiatric progress notes (e.g. NB and PDF). **Compliance:** Partial. **Current recommendations**: 1. Continue to monitor this requirement based on a 100%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).
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, August 2007:** Implement revised ADR data collection tool, policy and procedure and written instructions to staff. **Findings:** MSH has implemented this recommendation. The new data collection tool was introduced on September 15, 2007.

Recommendations 2 and 3, August 2007:

- Increase reporting of ADRs.
- Implement plan to improve current tracking log and data analysis systems to provide an adequate basis for identification of patterns and trends of ADRs.

Findings:
MSH has implemented these recommendations. During this review period, the facility reported 56 reactions compared to only three during the previous period. The facility aggregated data related to ADRs during this reporting period. The following table is a summary outline:

	Sep*	Oct	Nov	Dec	Jan
Total ADRs	1	17	15	13	10
Outcome:					
Mild		3	1	1	2
Moderate		7	1	1	3
Severe		0	1	0	0
Causality:					
Doubtful		4	0	0	0
Possible		5	0	2	2
Probable		0	1	0	3
Definite		0	1	0	0

Recommendation 4, August 2007:
Develop and implement an intensive case analysis (ICA) procedure based on established severity/outcome thresholds. The analysis must include proper discussion of history/circumstances, preventability, contributing factors and recommendations.

Findings:
MSH has implemented this recommendation. During this review period,

		the facility completed two ICAs: one for an ADR of Neuroleptic Malignant Syndrome and the other for an ADR of orthostatic hypotension. Review of the two analyses found they met generally accepted standards and that appropriate recommendations were made based on these analyses. **Compliance:** Partial. **Current recommendations**: 1. Continue efforts to increase reporting of ADRs. 2. Present data regarding ADRs including total number during the reporting period compared with the number during the last period, probability and severity classification of ADRs and any ICAs done.
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, August 2007:** Revise current DUE policy and procedure to ensure systematic review of all medications, with priority given to high-risk, high-volume uses. **Findings:** MSH has implemented this recommendation. **Recommendation 2, August 2007:** 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. **Findings:** MSH has yet to implement this recommendation.

		Recommendation 3, August 2007: Ensure that the individualized medication guidelines are continually updated to reflect current literature, relevant clinical experience and current professional practice guidelines. **Findings:** Same as Findings for Recommendation 1 in F.1.a. **Compliance:** Partial. **Current recommendations**: Conduct DUEs that include review of use, analysis of trends/patterns, conclusions regarding findings and recommendations for corrective actions/education activities based on the review.
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:** **Recommendations 1 and 2, August 2007:** • Implement the revised MVR form and written instructions to staff and develop a policy/procedure to codify this system. • Develop and implement tracking log and data analysis systems. **Findings:** MSH has implemented these recommendations. **Recommendation 3, August 2007:** Provide educational programs to address trends in the occurrence of MVRs. **Findings:** MSH has yet to implement this recommendation or identify trends in the occurrence of variances. The facility aggregated its data during

this reporting period. The following table is a summary outline:

	Sept*	Oct	Nov	Dec	Jan
Total Variances	17	92	86	89	114
# Potential	3	15	17	44	29
# Actual	10	61	27	24	45
# Prescribing	2	36	14	9	16
# Transcribing	3	11	4	8	13
# Order/Procure	0	1	1	0	1
# Dispensing	0	0	6	33	23
# Administration	3	20	17	7	13
# Drug Security	0	1	0	0	0
# Document	5	7	2	11	8
Outcome A	2	5	15	35	19
Outcome B	1	15	1	10	28
Outcome C	8	56	27	22	26
Outcome D	2	0	1	1	1
Outcome E	0	0	0	0	0
Outcome F	0	0	0	0	0
Outcome G	0	0	0	0	0
Outcome H	0	0	0	0	0
Outcome I	0	0	0	0	0

The above data show that no individual has suffered a serious outcome as a result of medication variance(s) during this review period. The data also show that, in general, the number of potential variances has increased while the number of actual variances has decreased. This appears to indicate the effectiveness of the new system.

Recommendation 4, August 2007:
Develop and implement an intensive case analysis procedure based on established severity/outcome thresholds. The analysis must include

		proper discussion of history/circumstances, preventability, contributing factors and recommendations. **Findings:** MSH has developed an adequate format for completing intensive case analysis of medication variances. The format includes a review of clinical outcome, contributing factors, preventability, process deficiencies, system response details and recommendations for corrective actions to prevent recurrence. The facility has yet to implement this procedure. As shown above, none of the variances reported during this review period met the severity threshold for an intensive case analysis. **Compliance:** Partial. **Current recommendations**: 1. Continue efforts to report medication variances. 2. Present data regarding actual and potential variances during the reporting period compared with the last period, classification of categories of variance, outcome of variances and any intensive case analysis done.
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, August 2007:** Same as in F.1.a through F.1.h. **Findings:** Same as in F.1.a through F.1.h. **Recommendation 2, August 2007:** Improve IT resources to the pharmacy to facilitate the development of

		databases regarding medication use. **Findings:** Same as in F.6. **Other findings:** MSH has begun to review the Physician Quality Profiles that include data relevant to this requirement. The Medical Director and senior psychiatrists reportedly have conducted 32 reviews between September and December 2007, including meetings with the psychiatrists to discuss findings and expectations. The facility has yet to provide information regarding trends/patterns based on integration of the data specified in this requirement and of corrective actions/education activities to address these trends/patterns, as needed. **Compliance:** Partial. **Current recommendations**: Continue to utilize the current mechanism of Physician Quality Profile, including data relevant to this requirement, and identify trends and patterns, with corrective actions/educational activities as needed.
F.1.j	Each State hospital shall ensure feedback to the practitioner and educational/corrective actions in response to identified trends consistent with generally accepted professional standards of care.	**Current findings on previous recommendation:** **Recommendation, August 2007:** Same as above. **Findings:** Same as above.

		Compliance: Partial. **Current recommendations**: Same as above.
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, August 2007:** Same as above. **Findings:** Same as above. **Compliance:** Partial. **Current recommendations**: Same as above.
F.1.l	Each State hospital shall ensure that all physicians and clinicians are verifiably competent, consistent with generally accepted professional standards of care, in appropriate medication management, interdisciplinary team functioning, and the integration of behavioral and pharmacological treatments.	**Current findings on previous recommendation:** **Recommendation, August 2007:** Same as in D.1.b, D.1.c, D.1.f.viii and F.1.a through F.1.h. **Findings:** Same as in D.1.b, D.1.c, D.1.f.viii and F.1.a through F.1.h. **Compliance:** Partial. **Current recommendations**: Same as in D.1.b, D.1.c, D.1.f.viii and F.1.a through F.1.h.

F.1.m	Each State hospital shall review and ensure the appropriateness and safety of the medication treatment, consistent with generally accepted professional standards of care, for:	**Compliance:** Partial.
F.1.m.i	all individuals prescribed continuous anticholinergic treatment for more than two months;	**Current findings on previous recommendations:** **Recommendation 1, August 2007:** Same as in F.1.c. **Findings:** Same as in F.1.c. **Recommendation 2, August 2007:** Ensure that this practice is triggered for review by the facility's psychopharmacology consultant, with corrective follow-up actions by the Psychiatry Department. **Findings:** MSH's report did not address this recommendation. **Current recommendations**: 1. Same as in F.1.c. 2. Ensure that this practice is triggered for review by the facility's psychopharmacology consultant, with corrective follow-up actions by the Psychiatry Department.
F.1.m.ii	all elderly individuals and individuals with cognitive disorders who are prescribed continuous anticholinergic treatment regardless of duration of treatment;	**Current findings on previous recommendation:** **Recommendation, August 2007:** Same as above.

		Findings: Same as above. **Current recommendations**: Same as above.
F.1.m.iii	all individuals prescribed benzodiazepines as a scheduled modality for more than two months;	**Current findings on previous recommendation:** **Recommendation, August 2007:** Same as above. **Findings:** Same as above. **Current recommendations**: Same as above.
F.1.m.iv	all individuals prescribed benzodiazepines with diagnoses of substance abuse or cognitive impairments, regardless of duration of treatment; and	**Current findings on previous recommendation:** **Recommendation, August 2007:** Same as above. **Findings:** Same as above. **Current recommendations**: Same as above.
F.1.m.v	all individuals with a diagnosis or evidencing symptoms of tardive dyskinesia.	**Current findings on previous recommendation:** **Recommendation, August 2007:** Same as F.1.e.

		Findings: Same as F.1.e. **Current recommendations**: Same as F.1.e.
F.1.m.vi	all individuals diagnosed with dyslipidemia, and/or obesity, and/or diabetes mellitus who are prescribed new generation antipsychotic medications	**Current findings on previous recommendation:** **Recommendation, August 2007:** Same as in F.1.d. and F.1.g. **Findings:** Same as in F.1.d. and F.1.g. **Current recommendations**: Same as in F.1.d. and F.1.g.
F.1.n	Each State hospital shall ensure that the medication management of individuals with substance abuse disorders is provided consistent with generally accepted professional standards of care.	**Current findings on previous recommendation:** **Recommendation, August 2007:** Same as in C.2.o, F.1.c and F.1.m.iii. **Findings:** Same as in C.2.o, F.1.c and F.1.m.iii. **Compliance:** Partial. **Current recommendations**: Same as in C.2.o, F.1.c and F.1.m.iii.
F.1.o	Metropolitan State Hospital shall provide a minimum of 16 hours per year of instruction,	**Current findings on previous recommendation:**

	through conferences, seminars, lectures and /or videotapes concerning psychopharmacology. Such instruction may be provided either onsite or through attendance at conferences elsewhere.	**Recommendation, August 2007:** Ensure full and consistent compliance with this requirement. **Findings:** MSH has yet to implement this recommendation. The facility's data indicated that 45 out of 51 psychiatrists (%C=88) have met this requirement during this review period. **Compliance:** Partial. **Current recommendations**: Ensure full and consistent compliance with this requirement.

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. Three individuals: PZ, RK and SM 2. Ana Peeks, PsyD, Psychologist (A) 3. Ashvind Singh, PhD, Psychologist 4. Edwin Poon, PhD, Senior Psychologist 5. Gretchen Hunt, BY CHOICE Coordinator 6. John Pyle, PTA 7. Karen Chong, Program Director 8. Ken Layman, Treatment Enhancement Coordinator 9. Kirk Hartley, PhD, Senior Psychologist 10. Mary Lou Xxx, Assistant Chief, Central Program Services 11. Richard Hartley, PhD, Psychologist, PBS team leader, Coordinator Specialty Services 12. Sean Johnson, Assistant BY CHOICE Coordinator 13. Stacy Weeks, PsyD, Psychologist 14. Steve Yang, PsyD, Psychologist 15. Swati Roy, PhD, Chief of Psychology <u>Reviewed</u>: 1. Charts of the following 34 individuals: AF, AFC, BW, CM, CO, DA, DG, DP, DTP, DY, JG, JJ, JS, KR, KS, LB, MC, MCL, ML, MP, NR, PC, PJL, PW, PZ, RH, RM, SB, SL, THE, TJE, TM, TP and TS 2. Behavior Consultation Committee-Attendance Roster 3. Behavior Guidelines (BW, DA, JS, RH and TM) 4. BY CHOICE Individual Satisfaction Survey 5. BY CHOICE Satisfaction Survey 6. BY CHOICE Training Log (August 2007 – January 2008) 7. DMH Psychology Services Monitoring Form 8. Enrichment Activity Summary

		9. Fidelity Check Data (DG, MC, ML, and JG) 10. Individual enrichment activity participation hours list 11. Individual Mall hours summary 12. List of individuals receiving DCAT services 13. List of individuals that need neuropsychological services 14. Medication Consultation Progress Notes. (DYM, KR, MC, ML and TP) 15. MSH Neuropsychology Service Referral Tracking Database 16. PBS Plans (DY, MC, ML, PW and TP) 17. Positive Behavior Support Instructions for PBS team (August 2007) 18. Positive Behavior Support: Instructions for Positive Behavior Support Team Members 19. Program III Spring 2008 PSR Alignment Plan 20. Psychology Specialist Service Committee Meeting Notes 21. Staff Certification Logs (DG, JG, MC and ML) 22. System-Wide PBS Model Plan 23. Weekly Group Activity Schedule <u>Observed</u>: 1. WRPC for DAMB, Unit 405, Program V 2. WRPC for JF, Unit 401,Program III 3. WRPC for JP, Unit 407, Program III 4. PSR Mall Service: Motivational Room, Program V 5. PSR Mall Service: Mindfulness, Program II 6. PSR Mall Service: Community Integration, Program III 7. PSR Mall Service: Mock Trial, Program III
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	**Current findings on previous recommendations:** **Recommendation 1, August 2007:** Ensure that all PBS psychologists use the PBS model as currently identified in the literature.

	competence, consistent with generally accepted professional standards of care, in the following areas:	**Findings:** This monitor's interview of the Chief of Psychology, Swati Roy, PhD, and the Senior Psychologists (Edwin Poon, PhD, Kirk Hartley, PhD and Ana Peeks, PsyD) indicated that the PBS teams lack psychologists. Currently, Kirk Hartley is acting as the PBS team leader, providing support to the PBS team members. This monitor's documentation review (PBS plans, Structural and Functional Assessments), and interviews of the Chief of Psychology and the PBS team leader found that PBS teams received training from the CRIPA consultant, Nirbhay Singh, as well as their DMH consultant Angela Adkins. The PBS teams are applying the current model of PBS services. Furthermore, MSH is implementing the System-Wide PBS Plan developed by the CRIPA consultant. **Recommendation 2, August 2007:** Provide Positive Behavior Supports training to all PBS team members. Specifically, train these members on the reliable use of evidence-based tools. Recruit data analysts for all PBS teams. **Findings:** MSH continues to provide PBS training to PBS team members. Nirbhay Singh, the Chief CRIPA Consultant, conducted training on October 19, 2007. This monitor's review of documentation found that MSH utilizes evidence-based tools. According to the Chief of Psychology, the PBS team leader, Kirk Hartley, was providing weekly supervision to all PBS team members. **Recommendation 3, August 2007:** Recruit Data Analysts for all PBS teams. **Findings:** This monitor's interview of the PBS team leader indicated that MSH

		now has a Data Analyst to support its PBS teams. The Data Analyst was hired on February 1, 2008. **Compliance:** Substantial. **Current recommendations**: Continue current practice.
F.2.a.i	the development and use of positive behavior support plans, including methods of monitoring program interventions and the effectiveness of the interventions, providing staff training regarding program implementation, and, as appropriate, revising or terminating the program; and	**Current findings on previous recommendations:** **Recommendation 1, August 2007:** Continue current practices of training of PBS staff members. **Findings:** See Findings for Recommendation 2 in F.2.a. **Recommendation 2, August 2007:** Conduct treatment implementation fidelity checks regularly. **Findings:** This monitor's review of PBS plans and fidelity check data (DY, MC, ML, PW and TP) found that PBS teams conduct fidelity checks on all PBS plans. According to the PBS team leader, low fidelity is addressed through additional training using Performance Improvement measures. **Recommendation 3, August 2007:** Ensure that all PBS team leaders receive training in the development of structural assessment, functional assessment and functional analysis, and the development and implementation of PBS plans. **Findings:** This monitor's interview the Chief of Psychology found that currently

		PBS teams do not have team leaders. Kirk Hartley, PhD, Senior Psychologist is acting as PBS team leader and assisting PBS team members with PBS services. Dr. Hartley is trained in the development of structural assessments, functional assessments and functional analysis, and in the development and implementation of PBS plans. MSH is actively recruiting to fill the PBS team leader positions. **Recommendation 4, August 2007:** Ensure that all RNs, PTs and data analysts on the PBS teams receive guidelines for using evidence-based tools for referrals, training on evidence-based tools for data collection and that a team leader performs reliability checks in this area. **Findings:** Information from the Chief of Psychology and the Acting PBS team leader, and review of documentation (training records) found that PBS team members receive regular training and weekly supervision on the use of evidence-based tools (for example, QABF, Maladaptive Behavior Record, Functional Assessment Inventory, and Strength Based Conversation). **Compliance:** Partial. **Current recommendations**: 1. Continue with training of PBS team members in structural and functional assessments, utilization of evidence-based tools and development and implementation of PBS plans. 2. Conduct treatment implementation fidelity checks regularly in all settings where the PBS plans are implemented.

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, August 2007:** Continue with competency-based training of all staff in correctly implementing the BY CHOICE program. **Findings:** This monitor's documentation review (training log) and interview of the BY CHOICE coordinator, Gretchen Hunt, found that competency-based training of staff in correctly implementing the BY CHOICE program is ongoing. The BY CHOICE coordinator regularly meets with the unit staff to give feedback on implementing the BY CHOICE program. The BY CHOICE coordinator and her staff have developed and implemented the Group Monitoring Tool and the BY CHOICE Point Card Audit Tool. The BY CHOICE coordinator continues to meet with individuals to review the BY CHOICE program. The BY CHOICE coordinator and her staff also have prepared videos on dietary-health choice matters to educate individuals, and produced information cards/fliers on the BY CHOICE program in Spanish, Vietnamese, Korean, and Chinese. New staff is trained once a month during New Employee orientation. Further training is conducted during the Hospital Annual Update training period. **Recommendation 2, August 2007:** Implement the program as per the manual. **Findings:** This monitor's documentation review (BY CHOICE manual), tour of the facility, and interview of individuals found that the BY CHOICE program is being implemented system-wide. MSH has seven incentive stores, and one of the recent stores is modeled after a cafeteria. This monitor's visit to the incentive store found that the store was equipped with game equipment, exercise equipment and books.

Recommendation 3, August 2007:
Continue to train WRPTs and individuals on the individuals' final choices in allocating points per cycle, ranging from 0 to 100 per cycle.

Findings:
This monitor's documentation review (BY CHOICE training log) and interview of the BY CHOICE coordinator found that WRPT members and individuals receive training on BY CHOICE point allocation procedures and the individual's right to point allocation with support and guidance from the WRPT. However, point allocation with individuals during WRPCs is not always thorough and documentation is poor.

Recommendation 4, August 2007:
Report BY CHOICE point allocation statement in the Present Status section of the individual's case formulation and update at every scheduled WRPC.

Findings:
MSH used item #16 (*The BY CHOICE point allocation is updated monthly in the individual's Wellness and Recovery Plan*) from the Psychology Services Monitoring Form to address this recommendation, reporting 29% compliance. The table below with its morning indicator showing the number of WRPCs each month (N), the number of WPRCs audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

	Aug	Sep	Oct	Nov	Dec	Jan	Mean
N	662	656	649	643	641	678	
n	112	143	114	129	133	134	
%S	17	22	18	20	21	20	
%C #16	31	26	29	26	38	34	29

		This monitor reviewed 12 charts (AFC, CO, DY, JJ, LB, MC, MCL, PJL, PW, PZ, THE and TP). All 12 charts had some mention of the individual's BY CHOICE point participation. Six of the WRPs in the charts (AFC, DY, MC, PJL, PW and TP) contained acceptable documentation; the remaining six (CO, JJ, LB, MCL, PZ and THE) did not. None of the WRP's documentation noted that the individual was the one who allocated the BY CHOICE points with assistance from the WRPT. In the case of PZ, documentation under the BY CHOICE section stated, "See symptoms." The "symptoms" under the Present Status section had BY CHOICE documentation from 5/2/2007, whereas the WRP was dated 2/15/2008. **Compliance:** Partial. **Current recommendations**: 1. Continue with competency-based training of all staff in correctly implementing the BY CHOICE program. 2. Continue to train WRPTs and individuals on the individuals' final choices in allocating points per cycle, ranging from 0 to 100 per cycle. 3. Report BY CHOICE point allocation statement in the Present Status section of the individual's case formulation 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 Team and the By CHOICE incentive program.	**Current findings on previous recommendation:** **Recommendation, August 2007:** Continue current practice. **Findings:** The Chief of Psychology continues to have the responsibility for the clinical and administrative responsibility for the Positive Behavior

		Support teams and the BY CHOICE incentive program. **Compliance:** Full. **Current recommendations**: 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, August 2007:** 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 log, PBS plans and graphical data presentation) and interview of the Chief of Psychology and the PBS team leader found that PBS team members receive weekly supervision and training. In addition, the teams have been receiving training from the CRIPA consultant. **Recommendation 2, August 2007:** Ensure that senior Psychologists monitor the appropriateness of Behavior Guidelines, Crisis Intervention Plans and the need for a referral to PBS teams. **Findings:** This monitor's interview of the Chief of Psychology and the PBS team leader indicated that all Behavior Guidelines and Crisis Intervention Plans are sent to the Senior Supervising Psychologist and PBS team

		leader, Kirk Hartley, PhD, for review and feedback. This monitor was alerted to a Behavior Guideline that was written and implemented without being sent for review by the PBS team leader. This was a very poorly written Behavior Guideline that when brought to the attention of the PBS team leader was revised to appropriately address the target behaviors. This monitor's review of Behavior Guidelines (BW, DA, JS, RH and TM) found that a number of the Behavior Guidelines were of poor quality. For example, the addressograph on many of them was different from the name listed in the plan. The information in the "Tracking the Target Behavior" section is absent or incomplete. Treatment/ intervention steps are imbedded in the prevention section (for example, BW). Conceptualization of interventions is weak. For example, one of the recommendations for BW read, "Staff response should be minimized as not to reinforce the behavior . . . but should be told that her behavior was not appropriate." Except for JS, the guidelines did not identify "trigger" behaviors that will help staff to intervene before the target behavior is exhibited. Staff training is not always conducted before the plan is implemented (for example, the plan for RH stated that "staff will be educated to praise R"). **Current recommendations**: 1. Train PBS team members in functional assessment, data collection, data analysis, graphing, plan implementation and data interpretation. 2. Ensure that Senior Psychologists monitor the appropriateness of Behavior Guidelines, Crisis Intervention Plans and the need for a referral to PBS teams.
F.2.c.ii	hypotheses of the maladaptive behavior are based on structural and functional assessments;	**Current findings on previous recommendation:**

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Recommendation, August 2007:
Ensure that hypotheses of the maladaptive behaviors are based on structural and functional assessments and clearly stated in the PBS documentation.

Findings:
MSH used item #6 (*The hypotheses of the maladaptive behavior are based on structural and functional assessments*) from the Psychology Services Monitoring Form to address this recommendation, reporting 89% compliance. The table below with this monitoring indicator showing the number of PBS plans in effect each month (N), the number of PBS plans audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

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<tr><td></td><td>Aug</td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Mean</td></tr>
<tr><td>N</td><td>13</td><td>11</td><td>11</td><td>11</td><td>12</td><td>16</td><td></td></tr>
<tr><td>n</td><td>13</td><td>11</td><td>11</td><td>11</td><td>12</td><td>16</td><td></td></tr>
<tr><td>%S</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td></td></tr>
<tr><td>%C #6</td><td>77</td><td>82</td><td>82</td><td>91</td><td>92</td><td>100</td><td>89</td></tr>
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This monitor reviewed five PBS Plans (DY, MC, ML, PW and TP). All five PBS plans had been developed from hypotheses derived from data analyzed through structural and functional assessments.

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

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<td>F.2.c.iii</td>
<td>There is documentation of previous behavioral interventions and their effects;</td>
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Current findings on previous recommendation:

Recommendation, August 2007:
Ensure that previous interventions and their effectiveness are

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<td>documented in the behavioral assessments.

Findings:
MSH used item #7 (There is documentation of previous behavioral interventions and their effects) from the Psychology Services Monitoring Form to address this recommendation, reporting 100% compliance. The table below with this monitoring indicator showing the number of PBS plans in effect each month (N), the number of PBS plans audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

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<tr><td>n</td><td>13</td><td>11</td><td>11</td><td>11</td><td>12</td><td>16</td><td></td></tr>
<tr><td>%S</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td></td></tr>
<tr><td>%C #7</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td></tr>
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This monitor reviewed five structural/functional assessments (KR, NR, RM, TP and TS). All five of them had documentation of previous behavioral interventions and their effects.

Current recommendations:
Continue current practice.</td>
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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>
<td>Current findings on previous recommendation:

Recommendation, August 2007:
Continue current practice.

Findings:
MSH used item #8 (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</td>
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contingencies) from the Psychology Services Monitoring Form to address this recommendation, reporting 100% compliance. The table below with this monitoring indicator showing the number of PBS plans in effect each month (N), the number of PBS plans audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

	Aug	Sep	Oct	Nov	Dec	Jan	Mean
N	13	11	11	11	12	16	
n	13	11	11	11	12	16	
%S	100	100	100	100	100	100	
%C #8	100	100	100	100	100	100	100

This monitor's review of five PBS plans (DY, MC, ML, PW and TP) and five Behavioral Guidelines (BW, DA, JS, RH and TM) found that all of them were based on a Positive Behavior Support model.

Current recommendations:
Continue current practice.

F.2.c.v

behavioral interventions are consistently implemented across all settings, including school settings;

Current findings on previous recommendations:

Recommendations 1 and 2, August 2007:

- Ensure that staff across settings is aware of individual's behavioral plan, and that they receive written plans and training.
- Ensure that all behavioral interventions are consistently implemented across all settings, including mall, vocational and education settings.

Findings:
This monitor's documentation review (fidelity check logs, and staff certification) found that staff in the settings in which the PBS plans were to be implemented were aware of the individual's behavioral plan,

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<td>especially the staff who were trained in the plans.

MSH used item #9 (Behavioral interventions are consistently implemented across all settings, including school settings) from the Psychology Services Monitoring Form to address this recommendation, reporting 69% compliance. The table below with this monitoring indicator showing the number of PBS plans in effect each month (N), the number of PBS plans audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

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<tr><td>n</td><td>13</td><td>11</td><td>11</td><td>11</td><td>12</td><td>16</td><td></td></tr>
<tr><td>%S</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td></td></tr>
<tr><td>%C #9</td><td>54</td><td>55</td><td>73</td><td>82</td><td>70</td><td>73</td><td>69</td></tr>
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This monitor's findings based upon documentation review of fidelity check data and staff certification data are aligned with the facility's data.

Current recommendations:
1. Ensure that staff across settings is aware of the individual's behavioral plan and that staff receive written plans and training.
2. Ensure that all behavioral interventions are consistently implemented across all settings, including mall, vocational and education settings.</td>
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<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 recommendation:

Recommendation, August 2007:
Continue current practice.</td>
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		Findings: MSH has established the trigger criteria. The Chief of Psychology and the Senior Psychologists reported that they attend the weekly trigger meetings to examine the data. Individuals who meet trigger thresholds are discussed with the PBS teams. The PBS teams then collaborate with the WRPTs and determine the appropriate behavioral interventions for the individuals presenting problems. This monitor's documentation review found that MSH's list of individuals needing PBS plans included 66 names. According to the Chief of Psychology and the Senior Psychologists, MSH in place has 40 Behavior Guidelines, and 16 active PBS plans. On the other hand, MSH's trigger list included names of 144 individuals who have triggered higher than threshold levels. There appears to be a significant discrepancy between the number of individuals with high triggers and the numbers of behavior guidelines and PBS plans. At the very least, all of these individuals should have a Behavior Guideline if they did not have one before. Those who had a Behavior Guideline but did not show improvement should be referred to the PBS team via the PBS-BCC checklist, and those not making timely progress on the PBS plans should be referred to the BCC. The PBS teams should be more active in addressing this discrepancy. MSH also has put into motion the System-Wide Positive Behavior Support program. As part of this program, a Psychology Specialist Services Committee has been established and weekly case management meetings are held to discuss individuals with learned maladaptive behaviors. A number of cases under seclusion, restraint, and PRN and Stat meds were brought to this monitor's attention (for example, WH) by the court monitoring team. Review of the cases with the PBS team leader indicated that either the cases did not meet trigger thresholds or a

		behavioral intervention was underway. MSH should review the trigger threshold so that severe/serious cases, especially those exhibiting dangerousness to self and/or others, get prompt attention for behavioral interventions. PBS teams should make a determination to transfer cases under Behavior Guidelines to PBS plans much sooner, if appreciable improvement does not occur within a month (or sooner depending upon the severity/ intensity of the behavior). In addition, certain high-risk cases may have to be referred directly to the PBS team and not wait for the Behavior Guideline to be tried first. **Current recommendations**: 1. Resolve the discrepancy between the number of individuals with high triggers and the number of individuals with Behavior Guidelines/PSB plans by evaluating and implementing appropriate behavioral interventions. 2. Evaluate trigger thresholds and amend as necessary so that serious/severe behavior management issues are appropriately elevated for behavioral interventions.
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 recommendation:** **Recommendation, August 2007:** Integrate all behavioral interventions with other treatment modalities, including drug therapy. **Findings:** MSH used item #11 (*Positive behavior support teams and team psychologists integrate their therapies with other treatment modalities, including drug therapy*) from the Psychology Services Monitoring Form to address this recommendation, reporting 60% compliance. The table below with this monitoring indicator showing the number of PBS plans in effect each month (N), the number of PBS plans audited (n), and the percentage of compliance obtained (%C) is a

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<td>summary of the facility's data.

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<tr><td>n</td><td>13</td><td>11</td><td>11</td><td>11</td><td>12</td><td>16</td><td></td></tr>
<tr><td>%S</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td></td></tr>
<tr><td>%C #11</td><td>15</td><td>18</td><td>45</td><td>82</td><td>82</td><td>100</td><td>60</td></tr>
</table>

This monitor's findings from documentation review (progress notes, WRP documentation and graphing data) are in agreement with the facility's data. A multidisciplinary approach should be considered for all cases, and justification offered where it is felt the approach is not needed.

Current recommendations:
Integrate all behavioral interventions with other treatment modalities, including drug therapy.</td>
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<tr>
<td>F.2.c.viii</td>
<td>all positive behavior support plans are specified in the objectives and interventions sections of the individual's Wellness and Recovery Plan;</td>
<td>**Current findings on previous recommendation:**

Recommendation, August 2007:
Specify PBS plans in the objectives and interventions sections of the individual's WRP as outlined in the DMH WRP Manual.

Findings:
MSH used item #12 (*All positive behavior support plans are specified in the objectives and interventions sections of the individual's Wellness and Recovery Plan*) from the Psychology Services Monitoring Form to address this recommendation, reporting 99% compliance. The table below with this monitoring indicator showing the number of PBS plans in effect each month (N), the number of PBS plans audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.</td>
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<tr><td></td><td>Aug</td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Mean</td></tr>
<tr><td>N</td><td>13</td><td>11</td><td>11</td><td>11</td><td>12</td><td>16</td><td></td></tr>
<tr><td>n</td><td>13</td><td>11</td><td>11</td><td>11</td><td>12</td><td>16</td><td></td></tr>
<tr><td>%S</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td></td></tr>
<tr><td>%C #12</td><td>92</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>99</td></tr>
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This monitor reviewed five charts (DY, MC, ML, PW and TP) of individuals with PBS plans. All five plans were specified in the interventions sections of the individuals' WRP.

Current recommendations:
Specify PBS plans in the objectives and interventions sections of the individual's WRP as outlined in the DMH WRP Manual.
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<tr>
<td>F.2.c.ix</td>
<td>all positive behavior support plans are updated as indicated by outcome data and reported at least quarterly in the Present Status section of the case formulation in the individual's Wellness and Recovery Plan</td>
<td>
Current findings on previous recommendation:

Recommendation, August 2007:
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.

Findings:
This monitor reviewed five charts (DY, MC, ML, PW and TP) of individuals with PBS plans. All five plans were documented in the Present Status section of the individuals' WRP. Documentation of PBS plans in the individual's Present Status section of the WRP has improved with PBS team members participating in WRPCs. For example, in the case of ML, integrity check data and implementation across settings was documented; in the case of DY, involvement of other treatment modalities with the PBS team was stated.
</td>
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		Current recommendations: 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, August 2007:** Provide competency-based training to appropriate staff on implementing specific behavioral interventions for which they are responsible, and have performance improvement measures in place for monitoring the implementation of such interventions. **Findings:** MSH used 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 Psychology Services Monitoring Form to address this recommendation, reporting 91% compliance. The table below with this monitoring indicator showing the number of PBS plans in effect each month (N), the number of PBS plans audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data. This monitor's documentation review of WRPs (KR) and fidelity check data on four individuals (DG, JG, MC and ML) found that PBS team members were conducting fidelity checks. According to the PBS team

	Aug	Sep	Oct	Nov	Dec	Jan	Mean
N	13	11	11	11	12	16	
n	13	11	11	11	12	16	
%S	100	100	100	100	100	100	
%C #14	77	82	91	100	100	100	91

		leader, performance improvement is tracked through the fidelity check score and staff is trained to competency when performance is low. **Current recommendations**: Provide competency-based training to appropriate staff on 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, August 2007:** Ensure that all PBS team members provide PBS services fulltime until the needs of all individuals requiring behavioral interventions is met. **Findings:** This monitor's interview of the Chief of Psychology and the PBS team leader indicated that PBS team members provide fulltime services without any other tasks interfering with their role as PBS team members. **Current recommendations**: Continue current practice.
F.2.c.xii	the By CHOICE point allocation is updated monthly in the individual's Wellness and Recovery Plan.	**Current findings on previous recommendations:** **Recommendation 1, August 2007:** Ensure that BY CHOICE point allocation is updated monthly in the individual's WRP. **Findings:** MSH used item #16 (*The BY CHOICE point allocation is updated monthly in the individual's Wellness and Recovery Plan*) from the

Psychology Services Monitoring Form to address this recommendation, reporting 29% compliance. The table below with this monitoring indicator showing the census for each month (N), the number of WRPs audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

	Aug	Sep	Oct	Nov	Dec	Jan	Mean
N	662	656	649	643	641	678	
n	112	143	114	129	133	134	
%S	17	22	18	20	21	20	
%C #16	31	26	29	26	38	34	29

This monitor reviewed 12 charts (AF, AFC, CM, DP, DTP, DY, JJ, KS, MP, SB, SL and TP). Five of the WRPs in them (AFC, DY, JJ, MP and SL) had documentation on BY CHOICE points, and indications that the individual was involved in the point allocation, and the remaining seven (AF, CM, DP, DTP, KS, SB and TP) did not.

Recommendation 2, August 2007:
Ensure that individuals who are bed-bound and individuals whose primary language is not English are fully included in the plan.

Findings:
MSH was not caring for any bed-bound individuals during this monitor's visit. This monitor toured the units (418, 419, and 420) where medically involved and bed-bound individuals are served. There was no individual in bed during this monitor's visit to the units. The non-ambulatory individuals were wheeled out for services. This monitor's interview with unit staff and the BY CHOICE coordinator found that all individuals, including both bed-bound and non-English-speaking, are included in the BY CHOICE program. MSH has prepared BY CHOICE cards in English, Korean, Chinese, Vietnamese, and Spanish, and BY

		CHOICE fliers in English and Spanish. **Current recommendations**: Ensure that individuals who are bed-bound and individuals whose primary language is not English are fully included in the 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 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.	**Current findings on previous recommendations:** **Recommendation 1, August 2007:** Hire all members of the DCAT. **Findings:** MSH does not have a full DCAT. The team is short a Psychologist and a Social Worker. MSH recently has hired a psychologist who is expected join the DCAT soon. MSH is actively recruiting for a Social Worker to join the DCAT. **Recommendation 2, August 2007:** Ensure that all DCAT team members receive appropriate training. **Findings:** The DCAT members attend the same training as the PBS teams. DCAT members also receive weekly supervision and teaching/training from the Chief of Psychology and the PBS team leader. **Compliance:** Partial. **Current recommendations**: 1. Hire all members of the DCAT. 2. Ensure that all DCAT team members receive appropriate training.

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, August 2007:** Use the PBS-BCC checklist to define the sequence of steps for referrals to the BCC. **Findings:** This monitor's documentation review (completed PBS-BCC checklists) found that MSH continues to use the PBS-BCC checklist as a pathway for referrals to the BCC. This monitor's review of Seclusion and Restraint data and reports from the Court Monitor's team suggests that in severe cases in which improvement is not forthcoming within two to three weeks of full PBS plan implementation, the BCC should be brought into play sooner to address the individual's behaviors, especially dangerousness to self/others. Individuals under behavioral interventions who continue to trigger present a special set of problems. These individuals who trigger often lose the opportunity to earn reinforcers as designed in the intervention plans, and make it difficult for staff to implement the behavioral plans on the days the individuals trigger. **Recommendation 2, August 2007:** Ensure that all standing members of the BCC attend every meeting. **Findings:** This monitor's documentation review (BCC attendance summary) found that attendance at BCC meetings has improved. Most meetings are attended by the core Committee members, and according to the Chief of Psychology, the required quorum was present at every meeting in the last six months. A review of the BCC's meeting minutes found that the Committee consulted with 10 candidates in the last six months.

		Recommendation 3, August 2007: Set up a system of accountability to ensure that BCC plans are properly implemented when indicated. **Findings:** This monitor's interview of the Chief of Psychology and the PBS team leader indicated that MSH has decided to have PBS team members track and monitor the implementation of BCC plans. This monitor is in agreement with this process since it is essentially the PBS plan with modifications from the BCC. Furthermore, the PBS teams have the knowledge and skill to evaluate plan implementation, as well as the relationships with unit staff that place them in a unique position to take on the task of tracking and monitoring the BCC plans. **Compliance:** Substantial. **Current recommendations**: Ensure that all standing members of the BCC attend every meeting.
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 recommendation:** **Recommendation, August 2007:** Increase the number of neuropsychologists to meet the anticipated demand for neuropsychological services and to fully participate in EP requirements. **Findings:** This monitor's documentation reviews (MSH's Psychology Department Staffing List) and interview of the Chief of Psychology found that MSH now has four neuropsychologists. Two were hired recently (October 2007, and January 2008). One of the two newly hired

		psychologists speaks both English and Spanish, and is evaluating individuals whose primary/preferred language is Spanish. This monitor reviewed MSH's Neuropsychology referral database. Twelve referrals closed in the last six months were indexed as "N/A" under their referral date section. This makes it impossible to determine the time taken by the Neuropsychology staff to complete evaluations. Ten referrals received prior to September 2007 were closed/completed only in the last six months; for example, the referral for FL was received on March 18, 2004 and was completed on January 29, 2008. Referrals received since October 2007 had a faster turnaround (in most cases within 60 days). Four of the referrals in the database were considered to be inappropriate referrals (CS, JU, OS and SE). MSH should continue to educate WRPTs on making appropriate referrals. A number of referrals were indexed as "Referral cancelled by WRPT." It will be helpful to identify the reasons for such cancellations (for example, individual discharged from the facility, individual transferred to another unit, team was tired of waiting for results, inappropriate referral, etc.). **Compliance:** Substantial. **Current recommendations**: Ensure that Neuropsychology referrals are addressed in a timely manner.
F.2.g	All clinical psychologists with privileges at any State Hospital shall have the authority to write orders for the implementation of positive behavior support plans, consultation for educational or other testing, and positive behavior support plan updates.	**Current findings on previous recommendation:** **Recommendation, August 2007:** Continue current practice.

		Findings: This monitor's documentation review (AD#0151 and PBS Manual) and interview of the Chief of Psychology found that clinical psychologists with privileges at MSH have the authority to write orders for the implementation of Positive Behavior Support plans, consultation for educational or other testing, and Positive Behavior Support plan updates. **Compliance:** Full. **Current recommendations**: 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. Joellyn Arce, Nursing Coordinator 2. Carmen Fayloga, RN, Health Service Specialist 3. Aurora Hendricks, Nurse Administrator 4. Aubri Griffis, Unit Supervisor, Admissions Unit 5. Linda Scott, Program Assistant, Program I 6. Rebecca Schneider, RN, Assistant Coordinator of Nursing Services Reviewed: 1. MSH's progress report and data 2. Nursing Policy/Procedure 528, PRN Orders (revised November 2007); 530, Stat Orders (revised March 2008); 546, Medication Variance Report (revised February 2008); 518, Adverse Drug Reaction (revised February 2008); 710, Change of Shift Report (revised March 2008) 3. DMH Nursing Services PRN/Stat Medications Monitoring Form 4. DMH Nursing Services PRN/Stat Medications Monitoring Form instructions 5. Medication Variance Reporting and Monitoring Form (revised February 2008) 6. Nursing Medication Treatment Record (MTR) Monitoring Form 7. MSH Nursing Services: Nursing Staff Knowledge of Goals, Objectives, and Interventions Monitoring Form 8. MSH Nursing Services: Nursing Staff Knowledge of Goals, Objectives, and Interventions Monitoring Form instructions 9. DMH Nursing Services: Shift Change Monitoring Form 10. MH Nursing Services: Shift Change Monitoring Form instructions 11. Change in Status Monitoring Form 12. Change in Status Monitoring Form instructions 13. Medication Observation Tracking data

		14. Therapeutic Milieu Observations Monitoring tool 15. Therapeutic Milieu Observations Monitoring tool instructions 16. PBS training rosters for 2004-2008 17. New Employee Orientation training rosters 18. Nursing Annual Update training rosters 19. Nursing Orientation Tracking records 20. Medical records for the following 65 individuals: AFA, AMA, BDR, BE, BF, BG, BM, BMY, CAC, CAZ, CG, CGU, CJ, CKW, CR, DAC, DC, DG, DLT, DM, DR, DT, EWK, FMC, GF, GRS, IRG, JAS, JC, JCS, JF, JLS, JP, KMA, KR, LB, MG, ML, MRW, MSP, MT, NA, PAA, PDF, PV, RBG, REG, RNM, RR, SB, SD, SF, SMM, SMV, SR, SW, TAN, TC, TP, TW, VMD, WH, WJH, WJM and WKB <u>Observed</u>: 1. Medication administration pass on the admissions unit 2. WRPC (Program III, unit 407) for review of JM 3. Shift change report on unit 412
F.3.a	Each State hospital shall develop and implement policies and protocols regarding the administration of medication, including pro re nata ("PRN") and "Stat" medication (i.e., emergency use of psychoactive medication), consistent with generally accepted professional standards of care, to ensure:	**Compliance:** Partial.
F.3.a.i	safe administration of PRN medications and Stat medications;	**Current findings on previous recommendations:** **Recommendation 1, August 2007:** Report data by item to ensure accurate interpretation. **Findings:** MSH's data has been separated and reported by item, addressing this

		recommendation. **Recommendation 2, August 2007:** Continue to monitor this requirement. **Findings:** MSH's data from the Medication Administration Competency Validation Monitoring Form audit, based on a 17% mean sample of number of nursing staff observed during medication administration (n) from August 2007 to January 2008, indicated 100% compliance with the standard that nursing administers the correct medication in the correct dose to the correct individual by the correct route, and 99% compliance with the standard that the medication is given at the correct time/date. **Current recommendations**: Continue to monitor this requirement.
F.3.a.ii	documentation of the circumstances requiring PRN and Stat administration of medications;	**Current findings on previous recommendation:** **Recommendation, August 2007:** Continue to monitor this requirement. **Findings:** MSH's data from the PRN Medications Monitoring Form audit, based on a 30% mean sample of PRN audits (n) from August 2007 to January 2008, indicated 86% compliance with the requirement that nursing staff documents the circumstances requiring PRN medication. MSH's data from the Stat Medications Monitoring Form audit, based on a 27% mean sample of Stat audits (n) from August 2007 to January 2008, indicated 88% compliance with the requirement that nursing staff documents the circumstances requiring Stat medication.

		However, the overall mean inter-rater agreement for the PRN/Stat tool was reported at 76%. This monitor's review of charts of 10 individuals with a collective total of 50 incidents of PRN medications (BMY, CG, CKW, DG, DLT, KR, ML, SW, TP and WH) found that circumstances necessitating the PRN medication were adequately documented in 39 instances. This monitor's review of charts of 11 individuals with a collective total of 50 incidents of Stat medications (AFA, BM, BMY, CG, DM, DT, KR, ML, SW, TC and WH) found that circumstances necessitating the Stat medication were adequately documented in 43 instances. **Other findings:** In several of the Inter-Disciplinary Notes (IDNs), the dose, route, and/or site, if given intramuscularly, of the PRN or Stat medications were not consistently documented. **Current recommendations**: 1. Increase inter-rater reliability to an acceptable level (85% or above). 2. Continue to monitor this requirement.
F.3.a.iii	documentation of the individual's response to PRN and Stat medication.	**Current findings on previous recommendations:** **Recommendation, August 2007:** Continue to monitor this requirement. **Findings:** MSH's data from the PRN Medications Monitoring Form audit, based on a 30% mean sample of PRN audits (n) from August 2007 to January 2008, indicated 67% compliance with the requirement that nursing staff documents the individual's response to the PRN medication.

		MSH's data from the Stat Medications Monitoring Form audit, based on a 27% mean sample of Stat audits (n) from August 2007 to January 2008, indicated 76% compliance with the requirement that nursing staff documents the individual's response to the Stat medication. This monitor's review of charts of 10 individuals with a collective total of 50 incidents of PRN medications (BMY, CG, CKW, DG, DLT, KR, ML, SW, TP and WH) found that the individual's response to the PRN medication was adequately documented in 24 instances. This monitor's review of charts of 11 individuals with a collective total of 50 incidents of Stat medications (AFA, BM, BMY, CG, DM, DT, KR, ML, SW, TC and WH) found that the individual's response to the Stat medication was adequately documented in 42 instances. MSH uses a medication nurse to administer all medications during the shift, including PRNs and Stats. However, the unit nursing staff usually determine when an individual warrants a PRN and/or Stat medication, not the medication nurse. Consequently, much of the documentation regarding PRN and Stat medications is done by the medication nurse, not the nurse who assessed the individual. This system appears to contribute to the inadequate documentation found in the progress notes regarding PRN and Stat medications. **Current recommendations**: 1. Evaluate current medication administration system. 2. Continue to monitor this requirement.
F.3.b	Each State hospital shall ensure that all failures to properly sign the Medication Treatment Record (MTR) or the controlled medication log are treated as medication variances, and that appropriate	**Current findings on previous recommendation:** **Recommendation, August 2007:** Continue to monitor this requirement.

	follow-up occurs to prevent recurrence of such variances.	**Findings:** MSH's data indicated that 139 signatures, titles and/or initials were missing from the MTRs from August 2007 to January 2008, but only 62 Medication Variance Reports (MVRs) completed. For the same time period, 13 signatures were noted to be missing from the Controlled Medication Log, but and only six Medication Variance Reports were completed. MSH had recently revised the MVR form to include the elements of this requirement. In addition, the NOC shift HSSs are reviewing the Controlled Medication Log and including any variances found in their daily report, which is reviewed daily by the Executive Advisory Committee Risk Management. This monitor's review of the MTRs and the Controlled Medication log on the admission's unit found no MTR blanks or missing signatures. **Compliance:** Partial. **Current recommendations**: Continue to monitor this requirement.
F.3.c	Each State hospital shall ensure that all nursing interventions are fully integrated into the therapeutic and rehabilitation service plan and that nursing interventions are written in a manner aligned with the rest of the interventions in the therapeutic and rehabilitation service plan, in particular, in observable, behavioral, and/or measurable terms. No nursing care plans other than the nursing interventions integrated in the	**Current findings on previous recommendations:** **Recommendation 1, August 2007:** Continue testing for reliability until an acceptable percentage of agreement (85% or higher) is achieved. **Findings:** MSH indicated that the new statewide Nursing Interventions Audit was currently being completed and inter-rater reliability testing will be

	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.	established when it is completed. **Recommendation 2, August 2007:** Provide retraining regarding WRP interventions. **Findings:** MSH's data indicated that 97% of RNs and 95% of PTs scored 95% or above on the WRP knowledge assessment test. In addition, eight-hour training was provided to new Consistent and Enduring Team members and staff who had not attended the full WRP training in addition to two-hour update training for WRPT members. Also, since the last review, MSH has implemented a senior clinical mentoring process from different disciplines that were trained and assigned to mentor all WRPTs. **Recommendation 3, August 2007:** Continue to monitor this requirement. **Findings:** MSH's data from the Nursing Interventions Monitoring Form audit, based on a 20% mean sample of WRP nursing interventions audits (August 2007 to January 2008), indicated the following mean compliance score for each listed item: 1. *All Nursing Interventions are fully integrated into the WRP.* 88% 2. *Nursing Interventions are written in a manner aligned with the rest of the interventions in the WRP.* 92% 6. *Nursing Interventions include proactive interventions related to the individual's needs.* 77% 7. *There are no separate nursing care plans other than the interventions integrated in the WRP.* 91%

8.	*There are no nursing diagnoses other than as specified in the WRP in terms of the current DSM criteria.*	92%

MSH indicated that overall mean inter-rater agreement was 73%

This monitor's review of 39 individuals' WRPs (AFA, AMA, BE, BF, BG, BM, CAC, CAZ, CJ, DAC, EWK, FMC, GRS, IRG, JAS, JCS, JF, JLS, KMA, MG, MRW, MSP, MT, PAA, PDF, PV, RBG, REG, RR, SB, SD, SF, SMM, SMV, SR, TW, VMD, WJM and WKB) found that there had been basically no improvement in this area since the last review. Many of the nursing interventions were inadequate or inappropriate. This monitor again noted several interventions stating "give medications as ordered." In many cases, information contained in the nursing assessments regarding an individual's coping strategies or stress relievers was not included in the individual's WRP. If education was provided as stated in the WRP, there was no documentation assessing the individual's response. Contrary to MSH's data, this monitor found little to no documentation of proactive nursing interventions in the WRPs. Additionally, this monitor's review found no separate nursing care plans or nursing diagnoses. However, MSH indicated that some nursing diagnoses were still being used on the Skilled Nursing Units and that this would be resolved by the next review.

As mentioned in the previous report, this area needs significant improvement. The additional Wellness and Recovery training, psychiatric nursing training, and the addition of the statewide Nursing Admission and Integrated Assessments have not yet had an impact on the development of meaningful WRP interventions.

Other findings:
MSH provided data regarding nursing interventions. However, it was agreed that the nursing objectives, rather than interventions, should

		be monitored regarding observable, behavioral, and/or measurable terms. **Compliance:** Partial. **Current recommendations**: 1. Increase inter-rater reliability to an acceptable level (85% or above). 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, August 2007:** Continue to evaluate staffing patterns to promote continuity of care. **Findings:** No data was provided addressing this recommendation. **Recommendation 2, August 2007:** Continue to monitor this requirement. **Findings:** MSH implemented the new statewide Nursing Staff Familiarity Monitoring tool in February 2008 and data from this tool will be presented at the next review. The data provided by MSH for this review was generated from the facility's Nursing Staff Knowledge of Goals, Objectives, and Interventions Monitoring tool. MSH's data from the audit conducted with this tool, based on a 19% mean sample of nursing staff audited (August 2007 to January 2008), indicated 71% mean compliance with the standard that nursing staff working with the individual is able to verbalize the individual's life goals; 89% mean compliance with the standard that nursing staff is able to state one

		objective for a selected focus; 88% mean compliance with the standard that nursing staff is able to state Mall services and/or interventions for this objective; and 80% mean compliance with the standard that nursing staff is able to state therapeutic milieu interventions for this objective. **Compliance:** Partial. **Current recommendations**: 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:** **Recommendation 1, August 2007:** Revise current monitoring instruments as discussed during review. **Findings:** MSH implemented a "Change in Status" audit to review individuals who were identified by trigger data as having a change in status. However, a new statewide tool, "Nursing Triggers and Shift Change," was developed and implemented in February 2008 and includes both change of shift report and the change of status. This tool will be used to generate the data for the next review. **Recommendation 2, August 2007:** Develop and implement a standardized format for shift change report in alignment with the EP. **Findings:** MSH's progress report indicated that the Statewide Nursing Administrators group is currently working on a standardized format for Change of Shift Report that will be aligned with the Enhancement Plan.

		As of yet it has not been developed and implemented. **Recommendation 3, August 2007:** Continue to monitor this requirement. **Findings:** <u>Shift Report</u> MSH's data from the Shift Change Monitoring Form audit (August 2007 to January 2008), based on a 15% mean sample of shift changes observed indicated 96% compliance with the requirement that individuals' response to active treatment was addressed; 92% with the requirement that when new clinical data was presented, staff discussed the information/change for baseline data; and 86% compliance with the requirement that if any individual was scheduled for diagnostic procedure/consultation, the consent, preparation, transportation and escort was addressed. MSH indicated that the overall mean inter-rater agreement was 80%; In observing shift change report on unit 412, this monitor noted that the Axis I diagnoses were reported for each individual and attendance at groups was addressed. In addition, other pertinent information was provided by staff members to assist the oncoming shift with individuals' care. However, the shift report was in excess of 45 minutes and when staff was asked about the lengthy report, they candidly stated that more information was provided because the monitor observing. Although the information that was provided during this shift report was significant, there needs to be a standard template developed for use on all units. <u>Change in Status</u> MSH's data from the Change in Status Monitoring Form audit, based on a 23% mean sample of individuals identified to have changes in

		psychiatric and/or medical status (N) (August 2007 to January 2008), indicated 92% mean compliance with the requirement that changes in individual's health or mental health status are documented in a timely manner; 93% mean compliance with the requirement that changes in status are documented in a way that enables the interdisciplinary team to assess each individual's status and response to interventions and to modify plan of care as appropriate; and 90% mean compliance with the requirement that the documentation reflects referral to the appropriate clinician and/or team member for intervention and follow-up. **Other findings:** This monitor reviewed the charts of 12 individuals (BDR, CG, CG-2, CGU, DC, DR, GF, JC, NA, RNM, TAN and WJH) who required emergency medical care. Below is a summary of findings: 1) BDR was admitted to the community hospital on 1/21/08 for evaluation. Issues included: a) No nursing assessment was documented prior to BDR being sent to hospital. b) No summary of hospital findings was documented upon return. c) Lung sounds were not assessed for symptoms of congested cough and elevated temperature. 2) CG was admitted to the community hospital on 8/4/07 for decreased platelets. Issues included that No nursing assessment was documented prior to CG being sent to hospital. 3) CG-2 was admitted to the community hospital for right lower lobe pneumonia on 8/6/07. Issues included: a) Elevated temperature since 8/3/07; individual complained of coughing and was incontinent. No assessment of lung sounds found in the ID documentation.

		b) No nursing assessment was documented prior to CG-2 being sent to hospital for pneumonia. c) No documentation of status updates while hospitalized from 8/8/07-8/13/07. d) No summary of hospitalization and treatment provided documented upon return to MSH. e) No lung sounds assessed upon return from hospital for pneumonia. 4) DC was admitted to the community hospital on 11/20/07 for abdominal distention. Issues included that no vital signs were obtained upon return to MSH. 5) DR was admitted to the community hospital for anemia and to rule out a gastrointestinal bleed on 8/8/07. Issues included: a) No nursing assessment documented prior to leaving MSH for the emergency room (ER). b) No vital signs documented prior to transfer to the ER c) No documentation of status updates while hospitalized from 8/8/07-8/16/07. d) No summary of hospitalization and treatment provided documented upon return to MSH. e) No indication if new treatments/medications were started as a result of the hospitalization. f) No mention of hospitalization in weekly progress note. 6) GF was admitted to the community hospital on 12/21/07 for status epilepticus. Issues included: a) No documentation of status updates while hospitalized from 12/21/07-12/29/07. b) No summary of hospitalization and treatment provided documented upon her return to MSH.

		7) JC was admitted to the community hospital on 10/9/07 for Dysphagia and rule out Aspiration Pneumonia. Issues included: a) No assessment, vital signs, lung sounds or oxygen saturations documented prior to transfer to hospital. b) No lung sounds assessed upon return from hospital. 8) NA was admitted to the community hospital on 12/19/07 for seizure activity. Issues included that some ID notes were difficult to read. 9) RNM was admitted to the community hospital on 9/8/07 for ingestion of a foreign body. Issues included no documentation of status updates while RNM was hospitalized from 9/8/07-9/14/07. 10) TAN was admitted to the community hospital on 8/23/07 for hyponatremia. Issues included no documentation of status updates while TAN was hospitalized from 8/23/07-9/3/07. 11) WJH was admitted to the community hospital on 1/12/08 for respiratory arrest post choking. Issues included no ID note or nursing assessment upon WJH's return from hospital. **Compliance:** Partial. **Current recommendations**: 1. Increase inter-rater reliability to an acceptable level (85% or above) for the Change of Shift monitoring tool. 2. Ensure that nursing staff are documenting adequate assessments of individuals prior to and upon return from ER visits or hospitalizations. 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:** Substantial.
F.3.f.i	nursing staff are knowledgeable regarding each individual's prescribed medications;	**Current findings on previous recommendations:** **Recommendation, August 2007:** Continue to monitor this requirement. **Findings:** MSH has developed a tracking form indicating on a five-month cycle when each nurse is due for Medication Administration Competency Validation. MSH's data from the Medication Administration Competency Validation Monitoring Form audit, based on a 17% mean sample of observed medication administration (August 2007 to January 2008), indicated the following mean compliance score for each listed item: 1. *Verbalizes generic and trade names of medications administered.* 93% 2. *Describes therapeutic effects, usual doses, and routes of medications administered.* 99% 3. *Differentiates expected side effects from adverse reactions.* 98% 4. *Explains "sliding scale" for regular insulin.* 99% 5. *Verbalizes symptoms and appropriate interventions of hypo/hyperglycemia.* 99% **Current recommendations**: 1. Continue to monitor this requirement. 2. Increase audited sample size for this tool to 20%.

F.3.f.ii	education is provided to individuals during medication administration;	**Current findings on previous recommendation:** **Recommendation, August 2007:** Continue to monitor this requirement. **Findings:** MSH's data from the Medication Administration Competency Validation Monitoring Form audit, based on a 17% mean sample of observed medication administration (August 2007 to January 2008), indicated 91% mean compliance with the requirement that the education is provided to individuals during medication administration. In observations of medication administration on the admissions unit, this monitor noted that the nurse used the appropriate medication administration protocol and did provide very basic education regarding the medications individuals were given. However, there were a number of other educational issues that were not addressed such as the meaning of blood sugars obtained, comparing them to earlier values, things that affect blood sugars, and allowing individuals to obtain and track their own blood sugar readings with supervision. **Current recommendations**: See F3.f.i.
F.3.f.iii	nursing staff are following the appropriate medication administration protocol; and	**Current findings on previous recommendation:** **Recommendation, August 2007:** Continue to monitor this requirement. **Findings:** MSH's data from the Medication Administration Competency Validation Monitoring Form audit, based on a 17% mean sample of observed medication administration (August 2007 to January 2008), indicated

the following mean compliance score for each listed item:

6.	*Assesses individual before administering PRN or Stat medication*	98%
7.	*Administers correct medication*	100%
	in correct dose,	100%
	to correct individual,	100%
	by correct route,	100%
	at correct time/date.	99%
8.	*Educates the individual regarding medications.*	91%
9.	*Applies principles of asepsis to medication administration.*	94%
10.	*Prepares/organizes medications no more than one hour before administration.*	99%
11.	*Identifies individual by name and photograph to ensure correct identification.*	100%
12.	*Checks for allergies.*	98%
13.	*Measures, interprets, and records BP and pulse before administering cardiac and anti-hypertensive medication. Withholds medication as indicated.*	98%
14.	*Opens/pours medication in front of individual.*	98%
15.	*Correctly administers crushed and liquid medications.*	98%
16.	*Checks medication with MTR three times.*	95%
17.	*Ensures that the individual swallowed all medications.*	98%
18.	*Applies proper technique with use of safety syringes.*	99%
19.	*Ensures individual's privacy and confidentiality.*	96%
20.	*Properly administers eye/ear drops, inhalers/spray.*	97%

Current recommendations:
See F3.f.i.

<table>
<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, August 2007:
Continue to monitor this requirement.

Findings:
MSH's data from the Medication Administration Competency Validation Monitoring Form audit, based on a 17% mean sample of observed medication administration and completion of the MTR (August 2007 to January 2008), indicated the following mean compliance score for each listed item:

<table>
<tr><td>21.</td><td>Documents reasons for administering PRN or Stat medications.</td><td>97%</td></tr>
<tr><td>22.</td><td>Documents involuntary and/or emergency medication administration for PRN or Stat.</td><td>97%</td></tr>
<tr><td>23.</td><td>Documents effects of PRN or Stat medication within one hour.</td><td>96%</td></tr>
<tr><td>24.</td><td>Documents and signs out controlled medication log correctly</td><td>96%</td></tr>
<tr><td>25.</td><td>Documents medication that is given on MTR immediately after administering.</td><td>98%</td></tr>
<tr><td>26.</td><td>Documents on MTR when medication is not taken and notifies physician.</td><td>99%</td></tr>
<tr><td>27.</td><td>Documents telephone order, read back, noting, and transcribing orders.</td><td>99%</td></tr>
</table>

In observations of medication administration documentation on the admissions unit, this monitor noted that the nurse giving the medication appropriate documented on the MTR and counted and signed the Controlled Medication log.

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</table>

		Current recommendations: See F.3.f.i.
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 recommendations:** **Recommendation 1, August 2007:** Ensure required documentation for bed-bound individuals is contained in the medical records. **Findings:** The new statewide Bed-Bound Audit that MSH implemented in February 2008 adequately addresses the required documentation for this requirement. The data provided by MSH during this review was generated by the facility's Bed-Bound Individuals Monitoring tool. Data generated from the new tool will be presented at the next review. **Recommendation 2, August 2007:** Continue to monitor this requirement. **Findings:** MSH's data from the Bed-bound Individuals Monitoring Form, based on a 100% sample (N=3) of bed-bound individuals (August 2007 to January 2008), indicated the following compliance score for each listed item: 1. *The Physician's Order identified the clinical reason for the bed-bound status.* 100% 2. *The WRP includes active interventions to integrate the Individual into milieu activities both in and out of room.* 100% 3. *The Physician's Progress Notes reflect clinical justification, period of commitment, and on-going progress.* 100%

		This monitor's review of three individuals who had been bed-bound during this review period (CR, JP and LB) found that the appropriate documentation was contained in the physician's orders, the WRP, and the physician's progress notes. For each of these individuals, the bed-bound status was noted to be temporary, usually due to a hospitalization or illness. From all their efforts, MSH has virtually eliminated total bed-bound status. **Compliance:** Substantial. **Current recommendations**: Maintain current practice.
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 recommendation:** **Recommendation, August 2007:** Continue to monitor this requirement. **Findings:** Since the last review, MSH has integrated 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 into the competency-based curriculum for Nursing Orientation for newly hired nursing staff. MSH's data indicated that all 12 nursing staff hired since August 2007 have passed the competency-based training addressing this

<table>
<tr><td></td><td></td><td>requirement, supported by training rosters and test scores.

Current recommendations:
Continue to monitor this requirement.</td></tr>
<tr><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 recommendations:

Recommendations 1 and 2, August 2007:
• Develop and implement strategies and interventions to assist the nursing staff in developing therapeutic relationships with the individuals in order to effectively execute Wellness and Recovery Plans.
• Continue to monitor this requirement.

Findings:
MSH's data from the Therapeutic Milieu Observation Monitoring Form audit, based on a 12% mean sample of units observed (August 2007 to January 2008), indicated the following mean compliance scores for each listed item:

<table>
<tr><td>1.</td><td>More staff are in the Milieu than in the nursing station.</td><td>77%</td></tr>
<tr><td>2.</td><td>Staff in the Milieu are interacting with individuals, not simply observing them.</td><td>88%</td></tr>
<tr><td>3.</td><td>There are unit recognition programs.</td><td>65%</td></tr>
<tr><td>4.</td><td>Positive affirmations about recovery and hope are posted throughout the unit.</td><td>79%</td></tr>
<tr><td>5.</td><td>Unit rules are posted and reflect recovery language and principles.</td><td>83%</td></tr>
<tr><td>6.</td><td>Unit bulletin boards are posted with religious/cultural activities.</td><td>59%</td></tr>
<tr><td>7.</td><td>Staff respect confidentiality.</td><td>94%</td></tr>
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</table>

8.	*Staff are observed offering praise or positive feedback to individuals.*	77%
9.	*Staff are heard acknowledging individuals' strengths and abilities.*	61%
10.	*Staff are observed responding appropriately to individuals' requests for assistance.*	94%
11.	*Staff are observed offering choices to individuals.*	71%
12.	*Staff are observed discussing mall activities with individuals.*	39%
13.	*Staff use label-free language.*	85%
14.	*Staff makes use of language and terms used in Recovery Training.*	74%
15.	*Staff are actively engaged in listening.*	96%
16.	*Staff interact with individuals in a respectful and courteous manner.*	96%
17.	*Staff encourages individuals to help each other*	55%
18.	*Staff encourages individuals to interact with each other.*	38%
19.	*Staff react calmly in escalating situations.*	91%
20.	*Staff are observed using "Conflict Resolution" principles and techniques.*	88%
21.	*Staff respect privacy.*	91%
23.	*Staff know individuals' Wellness and Recovery Plans*	76%

MSH's progress report indicated that the low compliance with Item 6 low was discussed with the Rehab Coordinator to improve compliance in this area and the low compliance for Item 12 was due to the auditor only observing in the nurse's station and dayroom, not at the Mall. MSH indicated that the auditors have now been instructed to conduct all Therapeutic Milieu Audits throughout the entire unit, which may increase compliance scores.

		Current recommendations: Continue to monitor this requirement.
F.3.h.iii	positive behavior support principles.	**Current findings on previous recommendation:** **Recommendation, August 2007:** Continue to monitor this requirement. **Findings:** MSH's progress report indicated that of 662 total nursing staff, 632 staff has been trained on the eight-hour PBS. In addition, from 528 staff who attended the one-hour PBS class that has been integrated in the Hospital Annual Update, 251 passed the annual update. Other variables that affect this issue include staff on disability leave, vacation and sick leave who have not completed the update. **Current recommendations**: Continue to monitor this requirement.
F.3.i	Each State hospital shall ensure that, prior to assuming their duties and on a regular basis thereafter, all staff responsible for the administration of medication has successfully completed competency-based training on the completion of the MTR and the controlled medication log.	**Current findings on previous recommendation:** **Recommendation, August 2007:** Continue to monitor this requirement. **Findings:** Since the last review, MSH has required the Nursing Annual Update class, which includes competency-based curriculum on medication administration, as an annual mandatory class for all nursing staff. In addition, the competency-based curriculum for administration of medication is a mandatory class for all newly hired nursing staff. MSH's data indicated that all 12 of the nurses hired between August

		2007 and January 2008 completed the competency-based training during Nursing Orientation, addressing this requirement. In addition, of 321 existing staff who were required to take the Nursing Annual Update class from August 2007 to January 2008, 240 (75%) completed the class. **Compliance:** Partial. **Current recommendations**: Continue to monitor this requirement.

4. Rehabilitation Therapy Services		
	Each State hospital shall provide adequate, appropriate, and timely rehabilitation therapy services to each individual in need of such services, consistent with generally accepted professional standards of care.	**Methodology:** <u>Interviewed</u>: 1. Rebecca McClary, Program Assistant 2. Mari Cobb, Chief of Rehabilitation Therapy Services 3. Jack McClary, Supervisor of Vocational Services 4. Julia Hastings, Physical Therapist 5. Andrea Cirota, Rehabilitation Therapy Supervisor 6. Asha Vij, Occupational Therapist 7. Marion Paclibar, Physical Therapist 8. Barbara Rodriguez, RNA (Restorative Nursing Assistant) 9. Dawn Lyons, Dance Movement Therapist 10. Jamie Critie, Mall Coordinator Program 6 11. Emily Dukesherer, Recreation Therapist 12. Marsha Jordan-Woods, Recreation Therapist 13. The following six individuals in direct treatment, PSR Mall groups, and with adaptive equipment: JD, JM, MG, MM, RA and SL <u>Reviewed</u>: 1. DMH Rehabilitation Therapy Service Manual 2. MSH Mall Course Schedule for week of review 3. Occupational, Speech, and Physical Therapy direct treatment schedule for week of review 4. MSH Rehabilitation Therapy Audit (WRPC) 5. MSH Rehabilitation Therapy Audit (Progress Notes) 6. Mall Facilitator Monitoring Form 7. Writing Recovery Based Lesson Plan training materials 8. Rehabilitation Service Mentoring Acknowledgement Form 9. Mentoring Call Log 10. Role of the Rehabilitation Therapist in the WRP training roster and training checklist

		11. Direct Care Staff training rosters for training given by POST team members 12. Rehabilitation Therapy New Employee training records 13. New Employee Orientation Checklist 14. Duty Statement for RT POST Supervisor 15. WRP Observation Monitoring data for RT attendance from August 2007- January 2008 16. MSH Rehabilitation Therapy Wellness and Recovery Planning Audit data for August 2007- January 2008 17. WRP Mall Facilitator Audit Form for Rehabilitation Therapist led groups from August 2007- January 2008 18. Rehabilitation Therapy Mall Facilitator Monthly Progress Notes audit data for August 2007- January 2008 19. Adaptive Equipment Tracking Log 20. Records for the following six individuals with adaptive equipment: HC, JM, LB, LP, MG and RM 21. Records for the following 19 individuals participating in observed Mall groups: AJH, BRB, BU, EB, GB, GCA, GCR, GR, HAS, JAM, JD, JG, JHT, JSA, NEJ, RK, SE, SO and TB 22. Lesson plans and rosters for the following RT led Mall groups: Coping Skills Through Art Therapy, Culture and the Arts, Welcome to Reality, Music and Movement, Leisure Skills, and Fitness Fun 23. 12 Week Lesson Plan for Introduction to Vocational Services 24. Review of WRPC documents corresponding to the sample of RIAT Pilot assessments and Integrated Assessments-Rehabilitation Therapy Section completed for the following individuals: 25. List of individuals with Dining Plans developed or revised from August 2007-January 2008 26. Records of the following six individuals who had a Dining Plan developed or revised from August 2007-January 2008: AM, DG, HC, JS, KH and MG 27. List of individuals who had Occupational Therapy direct treatment from August 2007- January 2008

		28. Records of the following individuals who had Occupational Therapy assessment/consultation during the August 2007- January 2008 review period: 29. Records for the following nine individuals receiving OT direct treatment from August 2007- January 2008: CP, CW, DLG, JG, JM, LP, MM, RW and SL 30. List of individuals who received direct Physical Therapy services from August 2007- January 2008 31. Records for the following individuals who received Physical Therapy assessment/consultation during the August 2007- January 2008 review period to compare assessments and corresponding WRPs: 32. Records for the following 10 individuals who received direct Physical Therapy services between August 2007- January 2008: BM, EL, ELN, GP, KR, MEB, MG, RA, SJ and TP 33. List of individuals who received direct Speech Therapy services from August 2007- January 2008 34. Records for the following three individuals who received direct Speech Therapy services from August 2007- January 2008: DT, KWM and MG 35. Program 6 database with list of individuals receiving RNA 36. Records for the following five individuals receiving RNA Services (indirect Physical Therapy Services implemented by Nursing): DCE, JP, MD, MG and RF <u>Observed</u>: 1. Coping Skills Through Art Therapy PSR Mall group 2. Culture and the Arts PSR Mall group 3. Welcome to Reality PSR Mall group 4. Music and Movement PSR Mall group 5. Leisure Skills PSR Mall group 6. Fitness Fun PSR Mall group 7. WRPC for RAM on Program 3, Unit 407 8. WRPC for CL on Program 2, Unit 412

		9. The following three individuals during Occupational Therapy direct treatment: CW, MM and SL 10. The following two individuals during Physical Therapy direct treatment: GP and RA 11. The following three individuals with Dining Plans during mealtime: AM, DG and MG 12. The following six individuals with adaptive equipment: HC, JM, LB, LP, MG and RM 13. The following individual receiving RNA services for Physical Therapy program: DCE
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 recommendation:** **Recommendation 1, August 2007:** Develop and implement a procedure to specify WRPC attendance requirements per discipline, according to individualized needs (e.g., receiving direct treatment). **Findings:** Upon review of the DMH Rehabilitation Therapy Services manual and facility report, psychosocial Rehabilitation Therapists are to attend all WRPCs, and will act as a liaison for the other Rehabilitation Therapy disciplines (Vocational Rehabilitation, Occupational, Physical, and Speech Therapists). **Recommendation 2, August 2007:** Develop and implement a procedure that specifies criteria for the need

		for and implementation of a 24-hour support plan related to physical and/or nutritional support. **Findings:** This recommendation has not been addressed. **Recommendation 3, August 2007:** Revise and implement current Dining Plan (focused on dysphagia management) so that it is able to address any nutritional, physical, and/or communication support needs, with focus on support and function in addition to management of risk and implement 24-hour Physical/Nutritional Support Plan. **Findings:** This recommendation has not been addressed. An integrated individualized plan to provide 24-hour indirect physical and/or nutritional rehabilitation support to minimize risk and maximize independence in all functional domains has not yet been developed. **Recommendation 4, August 2007:** Revise and implement the Physical, Occupational, and Speech Therapy procedure (AD 1052) to encompass all direct 1:1 Rehabilitation Therapy Services, and include descriptions of format and means by which to report findings to the WRPT for all Rehabilitation Therapy documentation of progress regarding direct treatment in Vocational Rehabilitation, Physical Therapy, Speech Therapy, Occupational Therapy and Psychosocial Rehabilitation Therapy. **Findings:** AD 1052 was revised, approved and implemented in November 2007 to include instructions for the RT to report findings regarding monthly progress toward direct Occupational, Physical, and/or Speech therapy treatment objectives to the WRP team. However, a format for

		progress note documentation by OT, PT, SLP that is consistent among the state hospitals and that meets practice act requirements has not yet been developed. **Recommendation 5, August 2007:** Provide competency-based training to Rehabilitation Therapy staff regarding Recommendation #4. **Findings:** This recommendation has not been addressed; currently competency-based training for Rehabilitation Therapy staff (Rehabilitation Therapists, Vocational Rehabilitation staff, and POST team members) regarding the role of the RT as WRP liaison is pending. **Recommendation 6, August 2007:** Ensure that all Rehabilitation Therapy staff is provided competency-based training on documentation of progress towards individual objectives using the Mall Facilitator Monthly Progress note. **Findings:** According to facility report, all existing Rehabilitation Therapists have received training on documentation of progress towards individual objectives using the Mall Facilitator Monthly Progress note in 2005, and training continues currently via monthly mentoring. New employees receive training regarding the Mall Facilitator Monthly Progress note during New Employee Orientation, yet according to facility report, no new RT employees have been hired during this review period. **Recommendation 7, August 2007:** Develop and implement an audit tool to ensure the adequate and timely provision and implementation of Rehabilitation Services, including direct treatment and indirect supports (e.g., Dining Plan, adaptive equipment), corresponding documentation of supports and progress, and

		incorporation of objectives and recommendations into the WRP. **Findings:** This recommendation has not been addressed. An F.4 monitoring tool is pending development. However, an audit tool has been developed and implemented to audit the role of the Rehabilitation Therapist in the WRPC. **Recommendation 8, August 2007:** Establish inter-rater reliability among staff performing audit prior to implementation of this audit tool. **Findings:** This recommendation has not yet been met, as the audit tool has not been developed. **Current recommendations**: 1. Develop and implement a procedure that specifies criteria for the need and implementation (including training and monitoring) of a 24-hour support plan related to physical and nutritional rehabilitation supports that is consistent between the state hospitals. 2. 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. 3. Provide training to all Rehabilitation Therapy staff (Rehabilitation Therapists, Vocational Rehabilitation staff, and POST team members) regarding the role of the RT as WRP liaison. 4. 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 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. 5. Establish inter-rater agreement among staff performing audit prior to implementation.
F.4.a.ii	the oversight by rehabilitation therapists of individualized physical therapy programs implemented by nursing staff.	**Current findings on previous recommendations:** **Recommendation, August 2007:** Develop and implement a plan to ensure in vivo monitoring of Physical Therapy programs occurs as needed. **Findings:** Indirect Physical and Occupational Therapy programs are currently implemented by the RNA on the SNF unit. There is an informal process in place, but no procedure is written regarding this process. In addition, the RNA program is only conducted on the SNF unit at this time. Currently there is no database to track individuals who require Indirect Physical or Occupational therapy programs , track when staff has received competency-based training/return demonstration, and track how often the individual should be re-assessed by the Physical or Occupational Therapist to determine the continued appropriateness of the program. There is not currently a system in place to provide oversight to program implementation. **Current recommendations**: 1. Develop and implement a procedure for RNA provision of indirect Physical and Occupational Therapy programs. 2. Develop and implement a database to track individuals receiving RNA services, as well as when staff has received competency-based training/return demonstration, and how often the individual should

		be re-assessed by the Physical or Occupational Therapist to determine the continued appropriateness of the program. 3. 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/re-assessment findings, timeliness of re-assessment, and whether program is modified as needed.
F.4.b	Each State hospital shall provide competency-based training to nursing staff, as appropriate, on the use and care of adaptive equipment, transferring, and positioning, as well as the need to promote individuals' independence.	**Current findings on previous recommendations:** **Recommendation 1, August 2007:** Continue to provide competency-based training for individualized Physical/Nutritional support plans that require return demonstration or test as needed to determine competence. **Findings:** According to facility report and review of training rosters/competency check-offs, training to relevant staff has been provided by POST team members in the following areas: Dining Plan, mobility devices, adaptive equipment, dysphagia, fluid consistency/thickening, positioning and transfers, self-feeding techniques, and falls prevention. However, there is no system in place to track whether an individual or the staff serving the individual requires competency-based training, as well as when training was provided, with competency scores/return demonstration ability listed. **Recommendation 2, August 2007:** Develop and implement a plan to ensure that in vivo monitoring of supports occurs as needed on an individualized basis as determined by specified criteria to ensure compliance with implementation and continued appropriateness of supports.

		Findings: This recommendation has not been addressed. Additional findings regarding this recommendation will be addressed in F.4.c. **Compliance:** Partial. **Current recommendations**: 1. Develop and implement a plan to ensure that competency-based training on the use and care of adaptive equipment, transferring, and positioning, as well as the need to promote individuals' independence occurs as needed. 2. Ensure that databases for Physical and Occupational Therapy programs implemented by nursing staff, adaptive equipment, 24-hour plans, track the need and provision of competence based training for individuals and/or staff.
F.4.c	Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.	**Current findings on previous recommendation:** **Recommendation 1, August 2007:** Develop and implement a plan to track Rehabilitation Therapy staff attendance at WRP meetings as indicated per revised procedure. **Findings:** According to facility report, in addition to facility WRP attendance data, the Supervising Rehab Therapists also collect data to address the oversight of the rehab therapy attendance at the WRPCs through the MSH Rehabilitation Therapy WRP Monitoring form. Review of audit data from the RT WRP Monitoring form for August 2007-January 2008 revealed 79% WRPC attendance for Rehabilitation Therapists. Record review of RIAT Pilot assessments from October 2007-

		December 2007 or IA-RTS assessments in January 2008 showed that RT attendance was noted at 56% of WRPCs as evidenced by attendance rosters reviewed. Upon in-vivo observation of two WRPC meetings, it was noted that Rehabilitation Therapists were present at both meetings. **Recommendation 2, August 2007:** Ensure that audit tool recommended in F.4.a.i monitors for WRP inclusion of recommendations/objectives made by Rehabilitation Therapy as well as progress towards objectives. **Findings:** According to facility audit data from the RT WRP Monitoring form for August 2007-January 2008, the Rehabilitation Therapist reported assessment findings to the team to be included in present status in 46% of WRPCs, reported progress from POST disciplines in 43% of WRPCs, and provided Focus 10 objectives in observable, measurable, and behavioral format for 34% of WRPCs. Upon in-vivo observation of two WRPCs, it was noted in both meetings the Rehabilitation Therapists presented assessment findings to the team to be included in present status, and provided Focus 10 objectives in observable, measurable, and behavioral format. **Recommendation 3, August 2007:** Ensure that all Rehabilitation Therapists have received competency-based training on Psychosocial Mall Manual contents regarding the development of curricula, lesson plans, and course outlines, as well as WRP process and Enhancement Plan requirements. **Findings:** According to facility report, all existing Rehabilitation Therapists have

		received training on development of curricula, lesson plans, and course outlines, as well as WRP process and Enhancement Plan requirements in 2005, and training continues currently via monthly mentoring. New employees receive training regarding development of curricula, lesson plans, and course outlines, as well as WRP process and Enhancement Plan requirements during New Employee Orientation, yet according to facility report, no new RT employees have been hired during this review period. However, no data was provided as to whether POST team members and Vocational Rehabilitation staff have received training related to development of curricula, lesson plans, and course outlines, as well as WRP process and Enhancement Plan requirements. **Other findings:** During observation of six PSR Mall groups led by Rehabilitation Therapists, it was noted that five out of six had lesson plans and the facilitators were following lesson plans; two out of six had 12-week lesson plans. Upon review of a sample of Integrated Assessments- Rehabilitation Therapy Section, it was noted that 88% of assessments included WRP recommendation for focus, 81% included objectives, and 75% included interventions. Review of corresponding WRP documents indicated 55% inclusion of foci, 50% inclusion of objectives, and 60% inclusion of recommendations. Upon review of a sample of Physical Therapy assessments, it was noted that none of the assessments included WRP recommendation for focus, 86% included objectives, and 100% included interventions. Review of corresponding WRP documents indicated 40% inclusion of foci, 0% inclusion of objectives, and 40% inclusion of recommendations.

		Upon review of a sample of Occupational Therapy assessments, it was noted that none of the assessments included WRP recommendation for focus, 100% included objectives and interventions. Review of corresponding WRP documents found that none included foci, objectives or recommendations. Upon review of a sample of Speech Therapy assessments, it was noted that none of the assessments included WRP recommendation for focus, 60% included objectives, and 40% included interventions. Review of corresponding WRP documents indicated 25% inclusion of foci, 25% inclusion of objectives, and 50% inclusion of recommendations. Upon review of a sample of Vocational Rehabilitation assessments, it was noted that none of the assessments included WRP recommendation for focus, objectives or interventions. Review of corresponding WRP documents indicated 0% inclusion of foci, objectives or recommendations. Record review of individuals receiving direct Physical Therapy treatment revealed that 100% of records contained IDN documentation of progress, and 33% contained documentation of progress in the WRP. Of the two individuals observed in direct Physical Therapy treatment, both individuals were engaged in activities that aligned with assessment findings and objectives. Upon interview with one of these individuals (RA), it was noted that the individual was aware of his objectives and reported progress and benefits of Physical Therapy direct treatment. Record review of individuals receiving direct Speech Therapy treatment revealed that 100% of records contained IDN documentation of progress, and 50% contained documentation of progress in the WRP.

		Record review of individuals receiving direct Occupational Therapy treatment revealed that 100% of records contained IDN documentation of progress, and none contained documentation of progress in the WRP. Of the three individuals observed in direct Occupational Therapy treatment, all three individuals were engaged in activities that aligned with assessment findings and objectives. Upon interview with two of these individuals (SL, MM), it was noted that the individuals were aware of her/his objectives and reported progress and benefits of Physical Therapy direct treatment. There is no system in place to determine when and how often an individual with a 24-hour plan requires re-assessment of in vivo supports. Re-assessment of the 24-hour plans should be done on an individualized basis as determined by procedures, and this should be monitored as part of the F.4 monitoring tool. There is not currently a database in place to track how often the individual should be re-assessed by the Physical, Occupational, or Speech Therapist to determine the continued appropriateness of the 24-hour plan. There is not currently a system in place to provide oversight to 24-hour plan implementation. Record review of individuals with Dining Plans (24-hour plans) revealed that 50% of plans were aligned with assessment findings, and 60% of WRP documents showed inclusion of 24-hour plan. Three individuals with Dining Plans developed were observed during mealtime. None of the three individuals had Dining Plans that were fully implemented, and two out of three appeared to be appropriate to meet individual's needs in regards to function and safety.

		Record review of individuals with Physical or Occupational Therapy programs implemented by nursing staff revealed that 40% were aligned with assessment findings, 0% were re-assessed to determine continued appropriateness (though facility reports that this occurs informally), and 100% of WRP documents showed inclusion of programs. **Compliance:** Partial. **Current recommendations**: 1. 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. 2. 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 re-assessed by the POST team member(s) to determine the continued appropriateness of the plan. 3. Develop and implement an audit tool to provide oversight to individuals with 24-hour plans to assess for appropriateness of program, alignment with assessment/re-assessment findings, timeliness of re-assessment, and whether plan was modified as needed.
F.4.d	Each State hospital, consistent with generally accepted professional standards of care, shall ensure that each individual who requires adaptive equipment is provided with equipment that meets his/her assessed needs and promotes his/her independence, and shall provide individuals with training and support to use such equipment.	**Current findings on previous recommendation:** **Recommendation 1, August 2007:** Develop and implement a plan to ensure that in vivo monitoring of adaptive equipment occurs as needed on an individualized basis by a professional with clinical expertise to determine compliance with both implementation and continued appropriateness of supports.

		Findings: This recommendation has not been addressed. Upon in vivo observation of individuals with adaptive equipment, it was noted that 100% of individuals observed had equipment in use/in good repair; the equipment appeared appropriate for individuals' needs, and was aligned with assessment findings. **Recommendation 2, August 2007:** Revise and implement current adaptive equipment log to track when a piece of equipment is ordered, as well as the date of training/implementation of the equipment. **Findings:** This recommendation has not been addressed. This current list of individuals with adaptive equipment reports that 36 individuals require the use of adaptive equipment. However, this does not align with the numbers noted during in vivo observation. **Compliance:** Partial. **Current recommendations**: 1. 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 re-assessed by the POST team member(s) to determine the continued appropriateness of the equipment. 2. 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/re-assessment findings, timeliness of re-assessment, and whether equipment was modified as needed.

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. Chris Marshall, Director of Dietetics 2. David Daniels, Registered Dietitian 3. Portia Salvacion, Assistant Director of Dietetics Reviewed: 1. Meal monitoring data for August 2007-January 2008 (weighted mean) 2. Nutrition Care Monitoring Tool audit data from August 2007-January 2008 3. Records for the following five individuals receiving type a. assessments from August 2007-January 2008: APT, CW, DEL, JS and TS 4. Record for the following four individuals receiving type c. assessments from August 2007-January 2008: BJ, LB, NA and RB 5. Records for the following four individuals receiving type d. assessments from August 2007-January 2008: CM, MAO, PB and RMT 6. Records for the following five individuals receiving type e. assessments from August 2007-January 2008: ARF, BEA, PD, SB and WJM 7. Records for the following seven individuals receiving type f. assessments from August 2007-January 2008: AE, BF, CA, EWK, FM, REG and RJD 8. Records for the following seven individuals receiving type g. assessments from August 2007-January 2008: CJ, JAN, JCT, JDS, JM, LI and RV 9. Records for the following nine individuals receiving type i. assessments from August 2007-January 2008: CEM, DPM, FMK, JR, LEW, RD, RLS, SS and VMR

		10. Records for the following four individuals receiving type j.i assessments (random sample across subtypes) from August 2007-January 2008: CR, GS, MOS and SMA, 11. Records for the following three individuals receiving type j.ii assessments from August 2007-January 2008: HL, JM and TAN 12. Audit data for August-December 2007 regarding WRP integration of Nutrition Services recommendations 13. Nutrition PSR Mall group and training roster 14. Records for the following individuals from observed Nutrition PSR Mall group: 15. Cooking/Multicultural Cooking Class Lesson Plan 16. Weight Management Phase 1 Lesson Plan 17. Weight Management Phase 2 Lesson Plan 18. SNF/Food Guide Lesson Plan 19. SNF/Nutrition and Disease Management Lesson Plan 20. Nutrition Education Lesson Plan 21. Facilitator hour summary for Dietitians for August 2007-January 2008 22. Audit data for August-December 2007 regarding WRP integration of Nutrition Services recommendations <u>Observed</u>: Nutrition 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,	**Current findings on previous recommendations:** **Recommendation 1, August 2007:** Implement Meal Accuracy Report procedure to monitor for implementation of in vivo nutritional supports/recommendations. **Findings:** The Meal Accuracy Report was implemented in August 2007 to monitor in vivo mealtime tray accuracy. According to facility report, trays

	consistent with generally accepted professional standards of care.	(regular and modified diets) audited from August 2007- January 2008 (total of 779) were 100% accurate. **Recommendation 2, August 2007:** Continue current practice. **Findings:** Lesson Plans written by Nutrition Services appear to meet requirements of the PSR Mall/EP in regards to content (set up in 12 weekly sessions), but do not appear to be consistent with statewide PSR mall 12-week lesson plans. Upon observation of Nutrition PSR Mall group, it was noted that a lesson plan had been written, but was not being followed. Nutrition Education/Training is a direct service provided by Dietitians to individuals and is based on objective assessment findings. According to record review of a sample of Nutrition assessments across assessment sub-types, (weighted mean of) 93% of Nutrition Care Assessments had evidence of Nutrition Training/Education, and 97% of Nutrition Care Assessments had evidence of individual response to MNT (Medical Nutrition Training). Facility database for all assessment types per month for August 2007-January 2008 was reviewed, and weighted mean revealed that 100% of assessments audited from August 2007-January 2008 had evidence of Nutrition Education/Training and of individual response to NMT. **Compliance:** Partial.

		Current recommendations: 1. Ensure that PSR Mall 12-week lesson plans are in state approved format, and are followed by Nutrition group facilitators. 2. Continue current practice.
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, August 2007:** Continue current practice. **Findings:** The current process by which the Nurse reports findings regarding Nutrition Services recommendations to the WRPT continues; however, the process does not appear to be optimal, as the data for WRP integration reveals less than substantial compliance. Currently, when Nutrition groups or other interventions are recommended, they are not written in the WRP format required (focus, objective, intervention). The implementation of this process may improve WRP integration and alignment for Nutrition Services recommendations. Upon record review of a sample of Nutrition Care assessments completed across assessment sub-types, it was noted that 87% of corresponding WRP documents contained Nutrition Care foci and 72% contained WRP inclusion of objectives and interventions. According to facility report of audit data (n of 266) for August 2007-January 2008, 85% of corresponding WRP documents contained Nutrition Care foci and 68% contained WRP inclusion of objectives and interventions. **Compliance:** Partial.

		Current recommendations: 1. Continue current practice. 2. Provide and implement training to Dietitians to write Nutrition recommendations in WRP format (focus, objective, and intervention) for report by nurse to the WRPT.
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, August 2007:** Continue current practice. **Findings:** The DMH Statewide Dietetics Department Policy: Dysphagia and Aspiration Management was revised and implemented in October 2007. This procedure 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 recommendations:** **Recommendation 1, August 2007:** Discontinue tracking of dysphagia training by Director of Dietetics for all MSH staff, and focus on tracking whether dysphagia-related competency-based training for Dietitians has occurred. **Findings:** This recommendation has been met. Currently, the Director of

		Dietetics tracks whether dysphagia-related competency-based training for all Clinical Dietitians and Dietetic Technicians has occurred for existing and new employees. **Recommendation 2, August 2007:** Continue current practice. **Findings:** According to facility report, at the time of the last review, 78% of dietitians had received Dysphagia Training. No data was provided this review to demonstrate that all Clinical Dietitians and Dietetic Technicians have received competency-based Dysphagia training. **Compliance:** Partial. **Current recommendation**: Ensure that all existing and new Clinical Dietitian and Dietetic Technician staff has received competency-based training in regards to the Dietitian's role in dysphagia management.
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 recommendations:** **Recommendation, August 2007:** Collaborate with relevant disciplines (e.g., OT, PT, SLP, Nurses, Physicians) to develop and implement a plan/procedure to ensure ongoing assessment of the individuals receiving enteral nutrition, to determine the feasibility of returning them to oral intake status or justification of continued NPO status. **Findings:** MSH Dietitians have collaborated as part of the Nutrition Task Force to develop the DMH Statewide Dietetics Department Policy for Tube

		Feeding (final draft 8/3/07) to determine the role the Dietitian in regards to enteral nutrition. Current procedure was reviewed and 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:** <u>Interviewed</u>: 1. Glen Itow, PharmD, Director, Pharmacy Department 2. Harold Plon, PharmD, Assistant Director, Pharmacy Department <u>Reviewed</u>: 1. MSH monitoring data regarding recommendations made by the pharmacists and physicians' responses to these recommendations. 2. Memorandum from the Medical Director to the Medical Staff (August 24, 2007) regarding follow-up on pharmacists' recommendations.
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:** **Recommendation 1, August 2007:** Continue to provide the needed IT support in collaboration with the pharmacy department and provide a specific outline of the implementation. **Findings:** The Pharmacy Director stated that the service currently has the IT support that is needed to ensure implementation of this requirement of the EP. Since October 2007, the facility has been able to count the number of new orders, including changes in the existing orders and has used this system to monitor this requirement. **Recommendation 1 August 2007:** Continue to monitor this requirement. **Findings:** MSH has reviewed new medication orders, including changes in existing

orders, and assessed compliance with this requirement (August 2007 to January 2008). The following is a summary outline of the mean number of recommendations made by the Pharmacy Department and their types:

1.	Drug-drug interactions	3.8
2.	Side effects	0.5
3.	Need for laboratory testing	47.0
4.	Contraindications	0
5.	Drug allergy	0.5
6.	Dose adjustment	5.2
7.	Indications	2.5
8.	Polypharmacy	0.8
9.	Food-drug interactions	0.3
Total number of recommendations		60.5

MSH did not offer an explanation regarding the fact that the majority of these recommendations focused on the need for laboratory testing.

Recommendation 2, August 2007:
Address and correct factors related to shortages of pharmacy staff.

Findings:
MSH's report indicated that the main factor related to shortages of pharmacy staff has been resolved through recent salary adjustments.

Compliance:
Partial.

Current recommendations:
1. Continue to monitor this requirement.
2. Provide data analysis to explain why the pharmacists were concerned about the need for further laboratory testing for new

		orders. 3. Ensure that current vacancies in pharmacy staff are filled.
F.6.b	Physicians to consider pharmacists' recommendations, and for any recommendations not followed, document in the individual's medical record an adequate clinical justification.	**Current findings on previous recommendations:** **Recommendation 1, August 2007:** Develop a medical staff procedure addressing physicians' responsibilities and actions regarding pharmacists' recommendations. **Findings:** On August 24, 2007, a memo was sent from the Medical Director to the medical staff requiring the staff to review all recommendations and to respond to these recommendations. **Recommendation 2, August 2007:** Continue to monitor this requirement. **Findings:** MSH monitored this requirement (August 2007 to January 2008). The data indicate that on average for each month during this review period, 22 recommendations were followed, 1.3 recommendations were not followed but adequate clinical justification was documented and 37.3 recommendations were not followed without documented justification. The facility acknowledged that the lack of documented justification is due to inadequate communications between the Pharmacy Department and the Medical Staff. **Compliance:** Partial. **Current recommendations**: 1. Continue to monitor this requirement. 2. Implement corrective actions to improve compliance.

7. General Medical Services		
		Methodology: Interviewed: 1. Michael Barsom, MD, Medical Director 2. Niza Uy-Uyan, MD, Acting Program Director of Medical Services 3. Dung Nguyen, MD, Physician and Surgeon 4. Leonard Liu, MD, Physician and Surgeon 5. Tuyen Le, MD, Physician and Surgeon 6. Thai Vu, MD, Physician and Surgeon 7. Chi Vu, MD, Physician and Surgeon 8. Nae Kim, MD, Physician and Surgeon 9. Adella Davis-Sterling, RN, Supervising RN of Medical Service Reviewed: 1. The charts of the following nine individuals who were transferred to an outside medical facility during this reporting period: BR, CG, CG-2, DB, DC, GF, NA, RM and WH 2. MSH Medical Care Policy and Procedure (revised) 3. MSH Medical Emergencies Policy and Procedure (revised) 4. MSH Laboratory Testing Policy and Procedure (revised) 5. Nursing Policy #402 6. Nursing Policy #600 7. DMH Medical Surgical Progress Notes Audit Form 8. DMH Medical Surgical Progress Notes Audit Form Instructions 9. DMH Integration of Medical Conditions into the WRP Audit Form 10. DMH Integration of Medical Conditions into the WRP Audit Form Instructions 11. DMH Medical Transfer Audit Form 12. DMH Medical Transfer Audit Form Instructions 13. DMH Diabetes Mellitus Audit Form 14. DMH Diabetes Mellitus Audit Form Instructions 15. DMH Hypertension Audit Form

		16. DMH Hypertension Audit Form Instructions 17. DMH Dyslipidemia Audit Form 18. DMH Dyslipidemia Audit Form Instructions 19. DMH Asthma/COPD Audit Form 20. DMH Asthma/COPD Audit Form Instructions 21. MSH Admission Assessment Monitoring summary data (August 2007 to January 2008) 22. MSH Ongoing Medical Care Monitoring summary data (August 2007 to January 2008) 23. MSH Non-Emergent Medical Care Monitoring summary data (August 2007 to January 2008) 24. MSH Medical Emergency Response Monitoring summary data (August 2007 to January 2008) 25. MSH Medical Emergency Drill summary data (August 2007 to January 2008) 26. MSH Outside Appointments and Hospitalizations Monitoring summary data (August 2007 to January 2008) 27. MSH X-ray, EKG and Critical Laboratory Testing Monitoring summary data (August 2007 to January 2008) 28. MSH Medical Conditions Focus 6 Monitoring summary data (August 2007 to January 2008) 29. MSH Metabolic Disease Monitoring summary data (August 2007 to January 2008) 30. MSH Asthma/COPD Monitoring summary data (August 2007 to January 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,	**Current findings on previous recommendations:** **Recommendation 1, August 2007:** Revise the Medical Policies and Procedures to address and correct deficiencies outlined under Recommendation 1 above. The facility needs to organize the required information within three main documents. The following is a suggested outline of the scope of each

	assessed, diagnosed, treated, monitored and, as monitoring indicates is necessary, reassessed, diagnosed, and treated, consistent with generally accepted professional standards of care.	document: a. Medical Attention to Individuals Policy and Procedure: This document should provide requirements for: 1) initial medical assessment of individuals upon admission and for regular reassessments during the hospital stay; 2) assessing changes in the physical status by nursing and medical staff, including physician-nurse communications; 3) transfer and return transfer of individuals for/from care at a general medical facility; 4) integration of medical and mental health care; and 5) monitoring the timeliness and quality of these services. b. Medical Emergency Response Policy and Procedure: This document should provide requirements regarding: 1) the organization, training, equipment and operations of a medical emergency response system for the immediate assessment and initial care of individuals pending transfer to a general medical facility; 2) medical emergency drills procedure, including frequency of drills, composition of the teams, adequate scenarios of simulated emergencies, drill evaluation sheets and a performance improvement system; and 3) monitoring the timeliness and quality of these services. c. Medical Diagnostic Testing and Consultations: This document should provide requirements for 1) obtaining medical diagnostic testing and consultation services; 2) providing appropriate follow-up regarding these services; and 3) monitoring the timeliness and quality of these services. **Findings:** MSH has implemented this recommendation. The facility participated in a statewide meeting of the Medical Services Chiefs (November 2007) to address this recommendation. Subsequent to this meeting, the facility revised its existing ADs/policies/procedures. The revisions adequately address the deficiencies cited by this monitor as follows:

		1. Timeliness and documentation requirements of initial assessments: The MSH Medical Care Policy and Procedure (pages 2-4 and attachment #1) indicates 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 which 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 WRP. 2. Timeliness and documentation requirements regarding medical attention to changes in the status of individuals: The MSH Medical Care Policy/Procedure (pages 4-9) indicates the following: a) The PMC will collect information on all significant active clinical issues from nursing staff and the on-call physician; b) Nursing staff is required to notify PMC/MOD of any change as it occurs and relay information during inter-shift report to incoming nursing staff for continuity of care; c) Physicians are required to evaluate all conditions with a face-to-face evaluation; d) PMCs are required to make daily rounds, read the daily Health Service Specialist (HSS) report, and treat and document in the PPN; e) Reassessments are required at least quarterly; f) All active medical conditions are addressed in Focus 6

		of the WRP. 3. Requirements for the preventive health screening of individuals: The MSH Medical Care Policy/Procedure (pages 2-5) sets standards for the initial and annual health screening to be done by the PMC, including vaccinations, sexually transmitted disease (STD) workup, PAP smear, rectal exam, mammogram, PSA, thyroid, baseline EKG, stool for occult blood, and routine labs. 4. Proper physician-nurse communications and physician response with timeframes that reflect the urgency of the condition: MSH Medical Care Policy/Procedure (pages 6-7) outlines the minimum standards for communication and documentation of evaluation, documentation and follow-up of urgent and emergent medical conditions for nurses, PMCs, and MOD/POD. The RN is required to make the initial assessment and determine the level of urgency and communicate to the PMC. All PMCs are required to carry a pager when on duty. The policy outlines the timeframes for notification and response according to the level of urgency. 5. Emergency medical response system, including drill practice: MSH Medical Emergencies Policy and Procedure (pages 1-5) outlines the requirements for response to medical emergencies, including the responsibilities of the qualified medical emergency leader and ancillary staff. 6. Communication of needed data to consultants: MSH Medical Care Policy/Procedure (page 7 section F and pages 8-9, section H) and Laboratory Testing Policy/Procedure (page 1) outline the requirements for physicians to document any changes in the individual's medical/health status, critical labs/testing and consultation reports within specified timeframes. Laboratory is required to report to the unit any critical lab values within one hour and Nursing Policy #402 requires notification to the physician within 30 minutes.

		7. Timely review and filing of consultations and laboratory reports: MSH Medical Care Policy/Procedure (page 7, section F) outlines the requirements for review of consultation reports within two days and documentation by initials and date that reports have been reviewed. Reports are filed by NOC shift staff (Nursing Policy #600) in the ancillary reports section of the chart. 8. Follow-up on consultant's recommendations: MSH Medical Care Policy/Procedure outlines the requirement that the recommendations of consults 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: MSH Medical Care Policy/Procedure requires the PMC to update the Medical Conditions Form (Focus 6) to ensure that diagnosis and active medical conditions are always current. The WARMSS allows the PMC to update the WRP at any time for significant medical conditions or changes in health status requiring immediate intervention. **Recommendation 2, August 2007:** Implement the revised policies and procedures. **Findings:** The revised policies and procedures have been implemented. **Recommendations 3 and 4, August 2007:** • Monitor this requirement based on at least a 20% sample. • Address and correct deficiencies outlined by this monitor under Other Findings in the same cell of the previous report.

		Findings: At the request of this monitor, the DMH recently standardized monitoring instruments, indicators and operational instructions for this section of the EP. The following is an outline of these instruments: 1. DMH Medical Surgical Progress Notes Audit Form 2. DMH Integration of Medical Conditions into the WRP Audit Form 3. DMH Medical Transfer Audit Form 4. DMH Diabetes Mellitus Audit Form 5. DMH Hypertension Audit Form 6. DMH Dyslipidemia Audit Form 7. DMH Asthma/COPD Audit Form The implementation of these tools should facilitate more meaningful, streamlined and standardized data. The DMH has yet to standardize the monitoring forms regarding the initial admission medical assessment and the emergency medical response system. This monitor has asked the facilities to report internal monitoring data under sections F.7.b.i (initial admission assessment and medical surgical progress notes), F.7.b.ii (medical emergency response, medical transfers and integration of medical conditions into the WRPs) and F.7.c (specific medical conditions: diabetes mellitus, hypertension, dyslipidemia and asthma/COPD) as appropriate to the requirements in these sections. **Other findings:** This monitor reviewed the charts of nine individuals who were transferred to an outside medical facility during this review period. The following table outlines the individuals' initials, date/time of physician evaluation at the time of transfer from MSH and the reason for the transfer:

Individual	Date/time of physician evaluation	Reason of transfer
BR	O1/20/08 20:45	Syncopy and Fever
CG	08/03/07 15:16	Severe Thrombocytopenia
CG-2	08/06/07 09:40	Pneumonia, Recurrent
DB	08/07/07 09:45	R/O Gastrointestinal Bleed
DC	11/20/07 10:10	Colonic Ileus
GF	12/21/07 13:10	New Onset seizure Disorder
NA	12/19/07 11:00	Grand Mal Seizure
RNM	09/08/07 11:15	Abdominal Pain S/P Foreign Body Ingestion
WH	01/11/08 (time NA)	Respiratory Failure

The review found that in general, the facility provided adequate and timely care. However, there continues to be a pattern of significant deficiencies that must be corrected in order to achieve substantial compliance with this requirement. The following are examples:

1. The regular Physician and Surgeon could not identify any risk factors or need for medication adjustments in the care of an individual who recently suffered Colonic Ileus and continues to receive unnecessary long-term treatment with an anticholinergic drug (DC).
2. The physician's documentation of an assessment of the status of an

		individual who had suffered cluster seizures was inadequate (GF). 3. The physician was unable to adequately state the type of metabolic workup needed to assess an individual who had a new onset seizure (GF). 4. There is evidence of inadequate nursing assessments and documentation of these assessments and delayed physician notification by the nursing staff regarding a significant change in the status of an individual (BR). 5. The physician evaluation of an individual who had suffered syncopy did not include assessment of blood pressure to determine if postural hypotension was a factor (BR). 6. There is evidence of inappropriate increase in the dose of clozapine for an elderly individual with history of a seizure disorder and documented vascular dementia. This appeared to have resulted in recurrent grand mal seizure activity (NA). This individual did not receive neurological assessment during her stay at the facility prior to the event. 7. There is no documentation of the duration of seizure activity or response to emergency administration of medications in an individual who appeared to have suffered continuous seizure for at least five minutes (NA). 8. The nurse's documentation of a significant change in the status of an individual (abdominal pain) did not include the correct timeframes of the change (RM). 9. Upon the return of an individual from outside hospitalization (S/P "Severe Thrombocytopenia"), the physician's evaluation did not include a review of possible contributing factors or any special precautions regarding the future care of this individual (CG). 10. There is no documentation of WRP interventions to address repeated refusal of blood work by an individual receiving divalproex (CG). 11. There is no documentation of WRP interventions to address repeated refusals of blood work, laboratory testing and physical

		examinations by an individual who has history of chronic significant anemia (DB). 12. The WRP does not include a focus, objective or interventions to address the behavior of snatching and rapidly swallowing food by an individual who suffered respiratory failure as a result of choking (WH). **Compliance:** Partial. **Current recommendations**: 1. Ensure proper oversight of medical services to correct this monitor's findings of clinical deficiencies (listed in other findings above). 2. Continue implementation of the revised medical policies and procedures.
F.7.b	Each State hospital shall develop and implement protocols and procedures, consistent with generally accepted professional standards of care, that:	Please see sub-cells for compliance findings.
F.7.b.i	require the timely provision of initial and ongoing assessments relating to medical care, including but not limited to, vision care, dental care, and laboratory and consultation services;	**Current findings on previous recommendation:** **Recommendation, August 2007:** Same as above. **Findings:** MSH used the current Initial Admission Assessment Monitoring Form to assess compliance (August 2007 to January 2008). The facility reviewed a sample of 100% of new admissions. The data are the same as in D.1.c.i. The mean compliance rate was 99%. MSH has yet to utilize the DMH Surgical Medical Progress Notes Audit

Form. However, the facility reported data regarding ongoing medical care using its current tool (August 2007 to January 2008). The average sample size was 66% of individuals who were diagnosed with chronic diseases (e.g. diabetes mellitus, asthma, hypertension or other medical problems) and were seen at the clinic. The data showed compliance rates in excess of 90% for all the indicators, except for the following:

1.	*Rectal examination (completed)*	89%
2.	*Rectal examination reoffered if refused*	53%
3.	*Pap smears (completed)*	67%
4.	*The chronic medical conditions have been addressed and integrated into the WRP?*	77%

Overall, the data showed improving trend regarding completion of the rectal examinations and pap smears. The facility's data analysis also showed that 98% of acute and chronic medical problems had been addressed, treated and documented appropriately and that 100% of medical ancillary reports (x-ray, EKG, blood tests and consultations) had been initialed and reviewed by PMC as per policy.

The facility also reported data derived from the Non-Emergent Medical Care Monitoring Form (August 2007 to January 2008). The average sample size was 38% of individuals who had significant medical problems (e.g. fever and cough to R/O pneumonia, fall with ankle injury to R/O bone fracture, head trauma, seizure, self-inflicted laceration, pica behavior, critical lab value, etc.) that were reported daily by HSS. These data showed more than 90% compliance with all applicable indicators.

Other findings:
Same as in D.1.c.i. In addition, this monitor's findings of deficiencies in F.7.a conflicts with the facility's data regarding documentation of

		management of acute and chronic medical problems. **Compliance:** Partial. **Current recommendations**: 1. Standardize the monitoring tool regarding the initial admission assessments for use across facilities. 2. Monitor this requirement based on a 100% sample using the DMH Initial Medical Assessment Audit Form (when completed) and the DMH Surgical Medical Progress Notes Audit Form. 3. Provide data analysis that evaluates low compliance and delineates relative improvement (during the reporting period and compared to the last period). 4. Implement corrective actions to address the lack of documentation of follow-up when individuals refuse the examination or parts of the examination.
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 recommendation:** **Recommendation, August 2007:** Same as above. **Findings:** As mentioned earlier, the DMH has yet to develop a standardized tool to address the Medical Emergency Response System. The facility presented its data regarding this system based on the current MSH Medical Emergency Response and MSH Medical Emergency Response Drill Monitoring Forms (August 2007 to January 2008). The average sample size was 100% of actual emergencies and of drills. The data showed almost 100% compliance with all indicators, except for the following (regarding actual emergencies):

1.	*Physician arrived within 15 minutes*	86%
2.	*HSS arrived within 15 minutes*	86%

MSH did not address corrective actions regarding the above data.

MSH has yet to utilize the DMH standardized tool regarding Medical Transfers. Instead, the facility presented data using the current MSH Outside Appointments and Hospitalizations Monitoring Form (August 2007 to January 2008). The average sample was 100% of the total number of off-site clinic visits and hospitalizations. These data showed mean compliance rates of 90% or more with the indicators regarding the individual's return from the hospital with records, including recommendations for follow up and discharge summaries. Following the tour, the state clarified that of all individuals who required medical transfer or outside clinic visits, 52% required (and received) subsequent follow-up.

MSH has yet to utilize the DMH standardized tool regarding the integration of medical conditions into the WRP. However, the facility presented data based on its current Medical Conditions Focus 6 Monitoring Form (August 2007 to January 2008). The average sample size was 20% of the monthly census. The following is a summary outline of the indicators and corresponding mean compliance rates:

1.	*Each of the open medical conditions listed on the Medical Conditions List are identified in the WRP under Focus #6..*	39%
2.	*Does the WRP identify the general medical diagnosis?*	92%
3.	*Does the WRP identify the treatment to be employed for this condition?*	71%
4.	*Does the WRP identify the related symptoms to be monitored by nursing staff?*	43%

5.	*Does the WRP identify by what means staff will monitor these symptoms?*	59%
6.	*Does the WRP identify by what frequency staff will monitor these symptoms?*	29%
7	*Staff to perform these interventions is identified by title.*	14%
8.	*Each medical condition listed in Axis III is identified in the Medical Conditions lists and in the WRP under Focus #6.*	61%
9.	*All changes in medical status of the individual are incorporated in the WRP.*	67%
10.	*Each Focus #6 has a corresponding objective and active and/or therapeutic milieu intervention.*	55%

To address low compliance ratings, MSH indicated that the Nursing Department has increased the frequency of meetings with Unit Supervisors/Nursing Coordinators group to twice a month to discuss data results of the Medical Integration of Medical Conditions into the WRP and documentation requirements.

MSH also presented monitoring data that assess systems for the reporting of x-ray, EKG and Stat/critical laboratory results. The data were based on a review of a 100% sample and showed 100% compliance with all indicators.

Other Findings;
Refer to this monitor's reviews in F.7.a.

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 standardized tools: Medical Emergency Response System (when completed), Medical Transfers and Integration of Medical Conditions into the WRP Audit Forms.
F.7.b.iii	define the duties and responsibilities of primary care (non-psychiatric) physicians;	**Current findings on previous recommendation:** **Recommendation, August 2007:** Same as above. **Findings:** Same as Findings for Recommendation 1 in F.7.a. **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 recommendations:** **Recommendations 1 and 2, August 2007:** • Continue current practice. • DMH should ensure that individuals residing in all facilities receive the same level of psychiatric back-up support after hours. **Findings:** MSH has maintained after-hours coverage by a Medical Officer of the Day (MOD) and a Psychiatric Officer of the Day (POD) for all individuals in the facility. The revised Medical Care Policy and

		Procedure (pages 12-13) codifies this practice. Review of the facility's MOD/POD schedule indicates that the facility has maintained this practice. **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 recommendation:** **Recommendation, August 2007:** Same as in F.7.a. **Findings:** The facility presented data based on the current Outside Appointments and Hospitalizations Monitoring Form (see F.7.b.ii). As mentioned earlier, the facility has yet to utilize the DMH standardized tool regarding Medical Transfers. **Compliance:** Partial. **Current recommendations**: Same as in F.7.b.ii.
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	**Current findings on previous recommendations:** **Recommendation 1, August 2007:** Continue to monitor this requirement and simplify current monitoring tool.

status indicators.

Findings:
The DMH is in the process of standardizing the monitoring tools regarding specific medical conditions, including diabetes mellitus, dyslipidemia, hypertension and asthma/COPD.

Recommendation 2, August 2007:
Address and correct factors related to low compliance.

Findings:
MSH used the current Quality of Care: Metabolic Disease monitoring form to assess compliance (August 2007 to January 2008). The average sample size was 70% of the individuals who were diagnosed with diabetes mellitus, hypertension, dyslipidemia and/or obesity and were seen at the clinic. The following is a summary outline of the relevant indicators and corresponding man compliance rates:

1.	*If diabetes present, has HgbA1C quarterly ordered?*	98%
2.	*If HgbA1C ordered, has HgbA1c < or = to 7%?*	83%
3.	*Is blood sugar (FBS, glucoscan) currently monitored?*	100%
4.	*If hypertension present, is blood pressure < than or = to 130/80?*	98%
5.	*If dyslipidemia present, has it been treated?*	98%
6.	*Is HDL level M > 45, F > 55?*	25%
7.	*LDL level ≤ 100?*	74%
8.	*Triglyceride ≤150*	55%
9.	*Does the individual have a BMI > than or = to 27 or waist circumference M > 40 or F > 35? (circle one) – For Plato, add to comments.*	62%
10.	*Has a special diet been ordered?*	100%
11.	*Has a weight control program been initiated?*	100%
12.	*Unless contraindicated, (and if the individual is age 40 or older) has aspirin been ordered for the Diabetes/Hypertension individual?*	72%

13.	*Has ophthalmologist/optometrist completed an eye exam at least annually for the individual with a history of Diabetes/Hypertension?*	100%
14.	*Has foot care been given for the diabetes individual at least annually by podiatrist?*	100%
15.	*Are diabetes, hypertension, or dyslipidemia included on Focus 6?*	75%
16.	*Does the WaRMSS reflect objectives and interventions for diabetes, Hypertension, or dyslipidemia?*	76%

The facility's data analysis reiterated the findings, but did not include an evaluation of low compliance or corrective actions to improve compliance. In this monitoring, MSH included an indicator regarding the use of new generation antipsychotic medications, but did not specify what compliance meant.

MSH also used the current Asthma/COPD Monitoring Form to assess compliance (August 2007 to January 2008). The average sample size was 32% of individuals diagnosed with asthma/COPD and seen at the clinic. The data showed compliance rates of 90% or more for all indicators except for the indicator that requires the inclusion of asthma/COPD in Focus 6 of the WRP (86%). This issue was addressed in F.7.b.ii.

Compliance:
Partial.

Current recommendations:
1. Standardize monitoring instruments regarding the management of specific medical conditions including diabetes mellitus, dyslipidemia, hypertension and asthma/COPD.
2. Ensure that the monitoring instruments regarding diabetes mellitus

		and dyslipidemia address the use of new generation antipsychotic medications. This indicator should require documentation of justification of treatment, risks and benefits for the individuals and attempts to use safer alternatives, as clinically indicated. 3. Monitor this requirement using the standardized instruments.
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, August 2007:** Same as in F.7.a. **Findings:** Same as in F.7.a. **Recommendation 2, August 2007:** Continue to provide data on the medical triggers identified in the Key Indicators. The facility may establish additional indicators of outcomes to the individuals and the medical systems of care. **Findings:** The facility has continued to provide this data. **Recommendations 3 and 4, August 2007:** • Continue to identify trends and patterns based on clinical and process outcomes. • Provide corrective actions to address problematic trends and patterns. **Findings:** MSH did not provide information regarding trends/patterns of practice at the medical service relevant to requirements of the EP. However, the facility provided further data regarding the trends/patterns of MRSA skin infections (2004 to 2007) to assess antibiotic susceptibility

		testing. The facility's report included appropriate recommendations for performance improvement. **Recommendation 5, August 2007:** Expedite efforts to automate data systems to facilitate data collection and analysis. **Findings:** The facility reported that efforts are underway for an automated laboratory system (LIS). **Compliance:** Partial. **Current recommendations**: 1. Continue to identify trends and patterns based on clinical and process outcomes. 2. Provide corrective actions to address problematic trends and patterns. 3. Expedite efforts to automate data systems to facilitate data collection and analysis and provide information on current status regarding these efforts.

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. Charlene Hooper, PHN 2. Loraine Clinton, PHN 3. Niza Uy-Uyan, MD, Acting Chief of Medical Services Reviewed: 1. MSH's progress report and data 2. Infection Control's automated database 3. Infection Control Meeting Minutes dated 9/26/07, 10/24/07, 11/28/07, 12/26/07 and 1/23/08 4. Nursing Policy/Procedure draft for Immunization; 1728.1, Hepatitis C Virus (HCV) draft 5. Memo (no date) regarding Immunizations 6. Clinic Appointment log data 7. MSH Interdepartmental Performance Improvement Committee minutes dated 11/27/07, 12/18/07, and 1/22/08 8. Medical Executive Committee Meeting minutes dated 10/15/07 9. Medical records for the following 39 individuals: AFA, AJG, ATC, BH, CJL, DG, DGI, DT, ES, GB, GJZ, GLJ, HHL, IG, JLG, JM, JP, JS, JSA, JSL, KDR, LCT, LT, MCF, MD, MSP, MTS, NA, NLM, PAA, REG, RLH, SE, SSG, TP, VM, WKB, WL and YFH
F.8.a	Each State hospital shall establish an effective infection control program that:	**Compliance:** Partial.
F.8.a.i	actively collects data regarding infections and communicable diseases;	**Current findings on previous recommendation:** **Recommendation 1, August 2007:** Continue to implement monitoring instruments in alignment with the EP.

		Findings: MSH's progress report indicated that Infection Control Monitoring tools were revised in alignment with the EP and implemented in September 2007. There are some inconsistencies between the tools and MSH's policies and procedures that resulted in low compliance rates in some areas that have been identified in the appropriate cell. **Recommendation 2, August 2007:** Continue to monitor this requirement. **Findings:** <u>PPDs</u> MSH's data from the Admission PPD Monitoring Form audit (August 2007 to January 2008), based on a 47% mean sample of PPDs due each month (N), indicated 100% compliance with the requirement that there was notification by the unit via a PPD form sent to the Infection Control Department for all PPD readings. MSH's data from the Annual PPD Monitoring Form audit (August 2007 to January 2008), based on a 68% mean sample of annual PPDs due each month (N), indicated 90% compliance with the requirement that there was notification by the unit via a PPD form sent to the Infection Control Department for all PPD readings. MSH's data from the Positive PPD Monitoring Form audit (August 2007 to January 2008), based on a 67% mean sample of positive tuberculosis skin tests using PPD (TSTs) each month (N), indicated 92% compliance with the requirement that there was notification by the unit via a PPD form sent to the Infection Control Department for all PPD readings. <u>Refusals</u> MSH's data from the Refusal Admission/Annual Lab Work or Admission

		Annual PPD Auditing Form (August 2007 to January 2008), based on a 100% sample of refused admission/annual lab work or PPD each month (N), indicated 50% compliance with the requirement that the unit notified the Infection Control Department that the individual refused his/her admission or annual lab work or PPD. The Infection Control staff indicated that Public Health is consistently notified of TST refusals since the department has a TST Screening Nurse who enters the data into the database. However, the department indicated that there was no notification by the units that labs were refused. This data was identified during the audit and accounts for the low compliance rate. MSH's data from the Immunization Refusals Monitoring Form audit (August 2007 to January 2008), based on a 100% sample of refusals identified/called to public health each month (N=3), indicated 0% compliance with the requirement that the unit notified the Infection Control Department of the individual's refusal of the immunization(s). <u>Immunizations</u> MSH's data from the Immunization Monitoring Form audit (August 2007 to January 2008), based on a 53% mean sample of immunizations done each month (N), indicated 89% mean compliance with the requirement that the lab notified the Infection Control Department of an individual's immunity status and 90% mean compliance with the requirement that the lab notified the unit housing the individual regarding their immunity status. <u>Sexually Transmitted Disease</u> The presentation of MSH's data from the Sexually Transmitted Disease Auditing Form was ambiguous and no explanation was provided to clarify the data. Subsequent to the tour, the State clarified the data indicating that in January, 2008, one individual tested positive for an STD and there was compliance with the requirement to notify the

		Infection Control Department and the unit. <u>Hepatitis C</u> MSH's data from the Hepatitis C Monitoring Form audit (September-December 2007 and January 2008), based on a 100% sample of individuals Hepatitis C + each month (N), indicated 96% mean compliance with the requirement that the lab notified the Infection Control Department identifying the individual with a positive Hepatitis C Antibody and 86% mean compliance with the requirement that the lab notified the unit housing the individual that he/she had a positive Hepatitis C Antibody test. <u>MRSA</u> MSH's data from the MRSA Auditing Form audit (August 2007 to January 2008), based on a 100% sample of individuals with MRSA each month (N), indicated 100% compliance with the requirement that the lab notifies the Infection Control Department when an individual has a positive culture for MRSA and 60% mean compliance with the requirement that the lab notifies the unit housing the individual that a positive culture for MRSA was obtained. <u>HIV</u> MSH's data from the HIV Positive Monitoring Form audit (August 2007 to January 2008), based on a 100% sample of individuals HIV+ each month (N= 3), indicated 33% mean compliance with the requirement that the lab notifies the Infection Control Department identifying the individual with a positive HIV Antibody and 33% mean compliance with the requirement that the lab notifies the unit housing the individual that he/she has a positive HIV Antibody test. No explanation was provided regarding these low compliance rates. **Current recommendations**: 1. Reconcile inconsistencies between current Infection Control

		policies/procedures and indicators for monitoring. 2. Continue to monitor this requirement.
F.8.a.ii	assesses these data for trends;	**Current findings on previous recommendation:** **Recommendation, August 2007:** Provide data for this requirement in narrative form demonstrating assessment of trends by the Infection Control Department. **Findings:** The table data provided by MSH regarding this requirement could not be interpreted. It was discussed during the review that either narrative data discussing data trends and/or graphs and meeting minutes identifying data trends would provide more meaningful information and would demonstrate compliance with the EP. This monitor's review of the Infection Control Committee minutes for 9/26/07, 10/24/07, 1128/07, 12/26/07, and 1/23/08 found little to no discussion of facility trends for TB, Hepatitis A and B, Hepatitis C, HIV, sexually transmitted diseases (STDs) or MRSA. The minutes indicated that there had been eight new cases of MRSA cutaneous infections with transmission identified for Unit 418. It was noted that observations of nursing staff indicated that standard precautions were not being followed. However, there was no corrective action plan addressing this finding found in the minutes. I did find mention of observations of individuals regarding the use of Alcohol Gel. Although this process was discontinued due to the lack of Infection Control staff, there were no results reported from the observations conducted or discussion of delegating the survey to other disciplines. Overall, the minutes contained little information addressing the activities of the department and clinical trends and outcomes for the individuals. Problematic issues and data related to Tuberculosis (TB) and

		vaccination screening for non employees were addressed in a number of the minutes that generated the development of a Public Health protocol. The facility's current Flu Plan was also addressed, but there was no analysis of past years' interventions related to facility outcomes. In addition, audit results were addressed in the minutes with associated action steps identified. However, there was no mention of outcomes for these action steps addressed in subsequent minutes reviewed. Also, problematic issues regarding reporting employee illnesses including Gastroenteritis, MRSA, and respiratory illness was mentioned noting less than 50% compliance with reporting. However, there was no indication of an analysis identifying unit trends or corrective action plan addressing this issue. Review of MSH's Infection Control Committee minutes indicated that the department is integrating its audit findings into their minutes but there was a lack of clinical review of outcomes regarding these problematic issues. This process needs to continue and become more detailed in the department's analysis and clinical outcomes of these trends. Overall, the minutes from the Infection Control Committee did not adequately validate that MSH assesses its data for trends. If the department has additional reports addressing and analyzing the facility's Infection Control data trends, this need to be included in the progress report's supporting documentation to verify compliance with this requirement. If this documentation does not currently exist, the department needs to develop a system to identify, analyze, develop corrective plans of action, monitor, and document clinical outcomes. **Current recommendations**: 1. Provide data in a format that demonstrates compliance with this requirement. 2. Continue to monitor this requirement.

F.8.a.iii	initiates inquiries regarding problematic trends;	**Current findings on previous recommendation:** **Recommendation, August 2007:** Same as F.8.a.i. **Findings:** The table data provided by MSH regarding this requirement could not be interpreted. As previously noted, either narrative data discussing data trends and/or graphs, reports and meeting minutes identifying problematic data trends would provide more meaningful information and would demonstrate compliance with the EP. The minutes from the Infection Control meetings indicated problematic issues regarding submission of Infection Control policies by departments; immunizations not being ordered within five days of notification; deficits in documentation of the immunization records; objectives and interventions not being written in WRPs for Hepatitis C; lack of documentation regarding the need for Hepatitis A and B vaccines; no documentation of refusals for STD testing, and; no documentation of offering HIV antibiotic testing. For these issues, there were inquires noted as well as action steps listed. Also, as noted in cell F.8.a.ii, there was evidence that problematic trends were identified regarding employee's health issues. **Current recommendations**: See F.8.a.ii
F.8.a.iv	identifies necessary corrective action;	**Current findings on previous recommendation:** **Recommendation, August 2007:** Continue to monitor this requirement.

		Findings: See F.8.a.ii and F.8.a iii. <u>PPD</u> MSH's data from the Admission PPD Monitoring Form audit (August 2007 to January 2008), based on a 47% mean sample of PPDs due each month (N), indicated 100% compliance with the requirement that PPDs were ordered by the physician during the admission procedure and 88% compliance with the requirement that a chest x-ray was ordered by the physician if indicated. MSH reported that the compliance rate for chest x-rays included those ordered for other than TST-positive individuals such as individuals with a history of asthma, diabetes or other chronic illness. In discussion with the Infection Control staff, it was agreed that only chest x-rays for positive TSTs will be included in these data MSH's data from the Annual PPD Monitoring Form audit (August 2007 to January 2008), based on a 68% mean sample of annual physical examination due with PPD by month (N), indicated 93% mean compliance with the requirement that PPDs were ordered by the physician during the annual review procedure. MSH's data from the Positive PPD Monitoring Form audit (August 2007 to January 2008), based on a 67% mean sample of individuals PPD+ each month (N), indicated 92% mean compliance with the requirement that all positive PPDs received PA and lateral chest x-rays and 85% mean compliance with the requirement that that all positive PPDs received an evaluation by the Med-Surg Physician. The facility reported there were no individuals with active disease identified during this review period. MSH indicated that individuals who refused x-rays and/or clinic appointments accounted for lower-than-expected compliance rates. Currently, after three consecutive refusals, a referral is sent to the WRPT. However, the WRPTs have not been addressing refusals

		thus far. <u>Immunizations</u> MSH's data from the Immunization Monitoring Form audit (August 2007 to January 2008), based on a 53% mean sample of immunizations each month (N), indicated 14% mean compliance with the requirement that immunizations were ordered by the physician within five days of receiving notification by the lab. MSH's current process for immunizations includes notification to the medical consultant of the individual's housing unit of a non-immune status. A second notification is sent if orders for vaccines have not been written. MSH indicated that the physicians were informed of the results of this audit and the names of noncompliant physicians will be forwarded to the Infection Control Committee and the Medical Director. <u>STDs</u> MSH's data from the Sexually Transmitted Disease Auditing Form Immunization Monitoring Form audit (August 2007 to January 2008), based on a 41% mean sample of STDs each month (N), indicated 98% mean compliance with the requirement that an RPR is ordered during the admission process for each individual; 33% mean compliance with the requirement that an HIV antibody test is offered to every individual upon admission; and 39% mean compliance with the requirement that Chlamydia and Gonorrhea test are ordered during the admission procedure for all female individuals. In response to the lack of documentation regarding HIV antibody tests offered during the admission process, training was provided in January 2008 to physicians in the admission suite and nursing to include documentation of HIV testing in the physician and IDN progress notes. Addressing the lack of testing for Chlamydia and Gonorrhea for female individuals, clinic schedules and results of lab work are now being forwarded to public health to ensure appropriate testing. Refusals

		(three consecutive) are being referred to WRPTs. <u>Hepatitis C</u> MSH's data from the Hepatitis C Monitoring Form audit (August 2007 to January 2008), based on a 100% sample of individuals Hepatitis C+ each month (N= 29), indicated 0% compliance with the requirement that the Hepatitis C Tracking sheet is initiated for each individual testing positive for Hepatitis C Antibody and 52% mean compliance with the requirement that the individual's Medication Plan is evaluated and immunizations for Hepatitis A and B are considered. At the time of this review, MSH's procedures did not include the use of a tracking sheet for positive Hepatitis C Antibody, which accounts for the 0% compliance. The discrepancies between the facility's procedure and the audit criteria will need to be reconciled. <u>MRSA</u> MSH's data from the MRSA Auditing form (August 2007 to January 2008), based on a 100% sample of individuals with MRSA each month (N=5), indicated 67% mean compliance with the requirement that the individual is placed on contact precaution per MRSA policy; 100% compliance with the requirement that the appropriate antibiotic is ordered for treatment of the infection(s); and 100% compliance with the requirement that the public health office contacts the unit RN and provides MRSA protocol and guidance for the care of the individual. MSH indicated that discrepancies between its use of Standard Precautions and colonization and the audit requiring contact precautions/isolation accounts for the low compliance rate. This issue will also need to be reconciled. <u>HIV</u> MSH's data from the HIV Positive Monitoring Form audit (August 2007

		to January 2008), based on a 100% sample of HIV positive individuals each month (N=3), indicated 67% mean compliance with the requirement that if the individual is admitted with a diagnosis of HIV positive, a referral is made to the appropriate clinic during the admission and 100% compliance with the requirement that the individual is seen by the appropriate clinic every three months for ongoing care and treatment, unless another timeframe is ordered by the physician. **Current recommendations**: See F.a.i.
F.8.a.v	monitors to ensure that appropriate remedies are achieved; and	**Current findings on previous recommendation:** **Recommendation, August 2007:** Continue to monitor this requirement. **Findings:** <u>PPDs</u> MSH's data from the Admission PPD Monitoring Form audit (August 2007 to January 2008), based on a 47% mean sample of PPDs due each month (N), indicated 85% mean compliance with the requirement that PPDs are administered by the nurse within 24 hours of the physician's order; 95% mean compliance with the requirement that first-step PPDs are read by the nurse within seven days of administration; and 72% mean compliance with the requirement that second-step PPDs are read by the nurse within 48-72 hours of administration. MSH indicated that discrepancies between audit time frames and facility procedures account for low compliance rates. MSH's data from the Annual PPD Monitoring Form audit (August 2007 to January 2008), based on a 68% mean sample of annual physical

		examination due with PPD each month (N), indicated 72% mean compliance with the requirement that PPDs were administered by the nurse within 24 hours of the order and 89% mean compliance with the requirement that PPDs were read by the nurse between 48-72 hours after administration. Again, MSH indicated that discrepancies between audit requirements and facility procedures account for low compliance rates. <u>Refusals</u> MSH's data from the Refusal Admission/Annual Lab Work or Admission Annual PPD Auditing Form (August 2007 to January 2008), based on a 100% sample of individuals who refused admission/annually lab work or PPD each month (N), indicated 0% compliance with the requirement that there are appropriate objectives and interventions written for the lab work or PPD refusal. The department has identified problematic issues with the units reporting refusals for immunizations. The available data provided by MSH regarding these refusals indicated 0% compliance with the requirements that a Focus is opened for the refusal of the immunization(s); that appropriate objective(s) are developed for the refusal of immunization(s); and that appropriate interventions are written for the objective(s) developed for the refusal of immunization(s). MSH has not yet implemented a system to ensure that refusals are addressed by the WRPTs and included in the WRPs. <u>Immunizations</u> MSH's data from the Immunization Monitoring Form audit (August 2007 to January 2008), based on a 53% mean sample of immunizations each month (N), indicated 92% mean compliance with the requirement

		that immunizations are administered by the nurse within 24 hours of the physician order and completed within specified timeframes. <u>STDs</u> MSH's data from the Sexually Transmitted Disease Auditing Form (August 2007 to January 2008), based on a 43% mean sample of STDs each month (N), indicated 33% mean compliance with the requirement that if the individual is involved in a sexual incident, he/she is offered appropriate STD testing; 20% mean compliance with the requirement that a Focus 6 is opened for an individual testing positive for an STD; and 0% compliance with the requirement that appropriate objective(s) are written. To ensure accurate data, the Infection Control Department has asked Standards Compliance to send its report regarding sexual activity between individuals for inclusion in this audit. <u>MRSA</u> MSH's data from the MRSA Auditing Form (August 2007 to January 2008), based on a 100% sample of individuals with MRSA each month (N=5), indicated 40% mean compliance with the requirement that a Focus 6 is opened for MRSA; 0% that appropriate objectives are written to include prevention of spread of infection; and 20% compliance with the requirement that appropriate interventions are written to include contact precautions. <u>Hepatitis C</u> MSH's data from the Hepatitis C Monitoring Form audit (August 2007 to January 2008), based on a 100% sample of individuals Hepatitis C+ each month (N), indicated 72% mean compliance with the requirement that a Focus 6 is opened for Hepatitis C; 14% mean compliance with the requirement that appropriate objective(s) are written to include treatment as required by the Hepatitis C Tracking Sheet; and 10%

		mean compliance with the requirement that appropriate interventions are written to include treatment as required by the Hepatitis C Tracking Sheet. This monitor's review of MSH's progress report, the Infection Control Committee meeting minutes and WRPs found a significant problem regarding staffs' knowledge of Hepatitis C. The Infection Control Committee has recently approved Nursing Procedure 1728.1 Hepatitis C Virus (HCV). Training regarding this policy will be scheduled for all nursing staff. <u>HIV</u> MSH's data from the HIV Positive Monitoring Form audit (August 2007 to January 2008), based on a 100% sample HIV-positive individuals (N=3), indicated 100% compliance with the requirement that a Focus 6 is opened for HIV (unspecified viral illness) if the individual is admitted with a diagnosis of HIV-positive; 50% compliance with the requirement that appropriate objective(s) are written to address the progression of the disease; and 100% compliance with the requirement that appropriate interventions are written. **Other findings:** This monitor reviewed the charts of six individuals with a positive PPD (GLJ, IG, NA, REG, VM and WL) and could not find the x-ray in the chart for one individual (IG). In addition, there was no documentation of the x-ray noted on the Immunization Records for all six individuals reviewed. There was no indication that a positive TST was included in the Axis III diagnoses for five individuals (GLJ, IG, NA, VM and WL). Although the WRPs for five individuals addressed the positive TST status, the quality of the objectives and interventions were poor in four of the five. This monitor reviewed the charts of seven individuals who refused

		their PPDs (AJG, CJL, ES, GJZ, HHL, JSL and MCF) and found no opened problem on the WRP for any of the individuals addressing refusals. This monitor reviewed the charts of six individuals with MRSA/ORSA (DT, JLG, JP, JS, SE and TP) and found that four individuals did not have an open Focus 6 addressing MRSA/ORSA (DT, TP, JP, and JS). Although two individuals had an open Focus 6, the interventions and objectives were not adequate. In the case of JP, there was no indication from the WRP, progress notes or Axis III diagnoses that his urine sample was positive for MRSA. This monitor reviewed the charts of 15 individuals with Hepatitis C (DG, DGI, GB, JM, JSA, KDR, LCT, LT, MD, MSP, MTS, PAA, REG, WKB and YFH) and found that seven did not have an open Focus 6 addressing Hepatitis C (DG, DGI, GB, LCT, LT, REG and YFH). For the eight individuals whose WRPs did address Hepatitis C, overall the objectives and interventions were significantly inadequate. In addition, when the lab work indicated that immunization for Hepatitis A and B should be considered, this monitor found no documentation that this occurred. This monitor reviewed the charts of six individuals with HIV (AFA, ATC, BH, NLM, RLH and SSG) found that all had an open Focus 6 addressing unspecified viral illness. However, most of the objectives and interventions were generic. Clinic notes indicated that the individuals were appropriately seen and followed and all had Unspecified Viral Illness listed in the Axis III diagnoses. In general, this monitor's findings are aligned with the data provided by MSH. Processes that are dependent on the unit staff have accounted for a majority of the low compliance rates and are barriers to the department achieving substantial compliance in many areas.

		Current recommendations: See F.a.i.
F.8.a.vi	integrates this information into each State hospital's quality assurance review.	**Current findings on previous recommendation:** **Recommendation, August 2007:** Provide data to demonstrate compliance with this requirement. **Findings:** This monitor's review of MSH Interdepartmental Performance Improvement Committee minutes dated 11/27/07, 12/18/07 and 1/22/08 found a number of Infection Control issues discussed during these meetings with associated actions to be taken. Although the actions addressed issues such as restructuring housekeeping to ensure a clean environment, documenting immunizations, and developing a protocol for Hepatitis C to assist staff in writing appropriate objectives and interventions, the review did not find any clinical discussion of how these identified problems were affecting the care of the individuals on the units. In addition, from review of the Medical Executive Committee Meeting minutes dated 10/15/07 found a brief mention of Infection Control regarding the need to report on issues related to infections and how they relate to the medical staff. This monitor was only provided minutes for only one meeting, so did not find an indication that issues related to immunizations and Axis III diagnoses were adequately addressed. This monitor's review of the provided documentation found that overall, there is a lack of integration of Infection Control throughout the facility including risk management or quality assurance/improvement reviews. **Current recommendations**: Provide data/reports/minutes addressing this requirement.

9. Dental Services		
	Each State hospital shall provide individuals with adequate, appropriate and timely routine and emergency dental care and treatment, consistent with generally accepted professional standards of care.	**Methodology:** Interviewed: 1. Toni Nguyen, DDS 2. Rung Tan, DDS 3. Adella Davis-Sterling, Supervising RN, Medical Services 4. Kenneth Best, Program Assistant, Program VI Reviewed: 1. MSH Organization Chart including Chief Dentist position 2. DMH Dental Services Audit Form and instructions 3. MSH's progress report and data 4. Preventative/Restorative monitoring tool 5. Dental stamps for documentation 6. Refusal Issues form 7. Medical/Dental records for the following 42 individuals: ADH, AH, BM, BW, BY, CL, CM, DG, DKS, DL, DM, DT, EE, FG, GOR, HC, HH, JA, JAB, JAM, JB, JD, JL, JPP, KR, MC, MW, NM, PD, PL, RD, RH, RL, RM, RO, SB, SD, SG, SP, TAN, TC and WW
F.9.a	Each State hospital shall retain or contract with an adequate number of qualified dentists to provide timely and appropriate dental care and treatment to all individuals it serves;	**Current findings on previous recommendations:** **Recommendation 1, August 2007:** Evaluate the need for a Chief Dentist position. **Findings:** Dr. Nguyen and the Executive Director reported that MSH has submitted the appropriate paperwork requesting the addition of a Chief Dentist position to the Dental Department. MSH submitted an organization chart demonstrating where the Chief Dentist position would be placed.

		Recommendation 2, August 2007: Continue to monitor this requirement. **Findings:** At the time of this review, MSH currently has two full-time dentists, two full time dental assistants, a retired annuitant dentist and dental assistant. MSH's progress report indicated that due to the return of the annuitant dentist and dental assistant, compliance rates for delivering dental care in a timely manner has increased. **Compliance:** Partial. **Current recommendations**: Continue to monitor this requirement.
F.9.b	Each State hospital shall develop and implement policies and procedures that require:	**Compliance:** Partial.
F.9.b.i	comprehensive and timely provision of dental services;	**Current findings on previous recommendations:** **Recommendation 1, August 2007:** Continue to revise the Dental Clinic Policy and Procedures Manual to include the documentation requirements for dental services regarding comprehensive exams and extractions and Wellness and Recovery language. **Findings:** MSH's progress report indicated that there have been no revisions to the Dental Clinic Policy and Procedure Manual since the last review. **Recommendation 2, August 2007:** Ensure dentists clearly document their dental treatment plans.

		Findings: MSH has purchased and initiated the use of custom stamps to facilitate the documentation of dental treatment plans, adequately addressing this recommendation. **Recommendation 3, August 2007:** Continue to monitor this requirement. **Findings:** At the time of this review, the Dental Department has been using its own monitoring tools. However, statewide monitoring tools have been developed and will be implemented for data collection after this review. MSH data from the Timely Response to Dental Referrals Monitoring audit for September, November, and December 2007, based on a 100% sample of dental referrals (including Stat and emergency within 24 hours and routine within two weeks), indicated 97% compliance for timeliness. No data was submitted for August and October 2007 and January 2008. MSH's data for timeliness of admission and annual dental exams (August 2007 to January 2008), based on a 100% sample, indicated 89% and 92% compliance respectively. This monitor's review of 18 individuals' admission dental exams (ADH, AH, BM, CL, CM, DG, DL, DM, FG, HC, JA, JAB, JB, KR, PD, RD, RH and RL) found that all but one (JA) were seen within 90 days of admission. This monitor's review of five individuals' annual dental exams (HH, JPP, NM, SD and WW) found that one was not timely seen (JPP).

		Other findings: This monitor's review of the dental clinic records and the dental records contained in the medical record for 18 individuals (ADH, AH, BM, CL, CM, DG, DL, DM, FG, HC, JA, JAB, JB, KR, PD, RD, RH and RL) found that only one individual's dental records from both the Dental Clinic and the medical record had identical documentation (RH). There were discrepancies in the notes in the other 17 records reviewed. A system should be implemented to ensure that the medical record contains the same dental progress notes as the Dental Clinic record. **Current recommendations**: 1. Develop and implement a system to ensure that the medical record contains the same dental progress notes as the Dental Clinic record 2. Implement statewide dental monitoring tools. 3. Continue to monitor this requirement.
F.9.b.ii	documentation of dental services, including but not limited to, findings, descriptions of any treatment provided, and the plans of care:	**Current findings on previous recommendation:** **Recommendation 1, August 2007:** Report data for each element of this requirement separately. **Findings:** Data provided by MSH regarding this requirement was not reported separately and thus could not be accurately interpreted. However, MSH has implemented a stamp to facilitate the documentation of this requirement. **Recommendation 2, August 2007:** Continue to monitor this requirement. **Findings:** See above.

		Current recommendations: 1. Report data for each element of this requirement separately. 2. Continue to monitor this requirement.
F.9.b.iii	use of preventive and restorative care whenever possible; and	**Current findings on previous recommendations:** **Recommendation 1, August 2007:** Develop and implement a system to identify and track individuals who are not getting their dental needs met. **Findings:** Dr. Nguyen has developed a form to track the preventative and restorative needs and treatments provided to individuals as identified during the dental exam. **Recommendation 2, August 2007:** Continue to monitor this requirement. **Findings:** MSH data for August-October 2007 regarding preventative and restorative dental care delivered, based on a 100% sample of dental exams done monthly, indicated 68% and 48% mean compliance respectively. This monitor's review of 11 individuals' dental treatments (BW, DKS, DM, DT, JAM, JD, PL, RM, SG, TAN and TC) found that five did not receive preventative treatment and five did not receive restorative treatment (four refused and one not seen). **Current recommendations**: Continue to monitor this requirement.

F.9.b.iv	tooth extractions be used as a treatment of last resort, which, when performed, shall be justified in a manner subject to clinical review.	**Current findings on previous recommendation:** **Recommendation 1, August 2007:** Develop and implement a monitoring instrument addressing specific clinical criteria justifying tooth extractions. **Findings:** MSH has developed specific clinical criteria justifying tooth extractions and has implemented a stamp to facilitate documentation of these criteria. The statewide Dental Monitoring tool will be implemented and data generated from this tool will be presented at the next review. **Recommendation 2, August 2007:** Ensure MSH dentists are retrained to include the clinical criteria for extractions in their progress notes. **Findings:** No data was provided addressing this recommendation. **Recommendation 3, August 2007:** Continue to monitor this requirement. **Findings:** MSH's data for August 2007-January 2008, based on a 100% sample of extractions done each month, indicated 100% compliance with the requirement that these extractions were clinically justified. This monitor's review of the charts of 14 individuals who had a tooth extraction (BY, DG, DM, EE, FG, GOR, JD, JL, MC, MW, RO, SB, SP and TC) found that all contained documented clinical justifications for the extraction.

		Current recommendations: Continue to monitor this requirement.
F.9.c	Each State hospital shall ensure that dentists demonstrate, in a documented fashion, an accurate understanding of individuals' physical health, medications, allergies, and current dental status and complaints.	**Current findings on previous recommendation:** **Recommendation 1, August 2007:** Ensure that each element of this requirement is addressed in the monitoring instrument. **Findings:** The statewide Dental Monitoring tool adequately addresses this recommendation. However, the tool used by MSH to generate data for this review did not address each element of this requirement. **Recommendation 2, August 2007:** Report compliance data for each element of this requirement separately. **Findings:** Data provided by MSH could not be accurately interpreted. Elements of this requirement were not reported separately as recommended. **Recommendation 3, August 2007:** Monitor compliance with this requirement. **Findings:** Same as above. **Compliance:** Noncompliance. **Current recommendations**: 1. Implement use of the statewide Dental monitoring tools.

		2. Monitor this requirement.
F.9.d	Each State hospital shall ensure that transportation and staffing issues do not preclude individuals from attending dental appointments, and individuals' refusals are addressed to facilitate compliance.	**Current findings on previous recommendations:** **Recommendation 1, August 2007:** Implement a system to monitor and track reasons for dental refusals and unavailability for dental appointments. **Findings:** MSH has implemented an adequate system addressing this recommendation. **Recommendation 2, August 2007:** Continue to monitor this requirement. **Findings:** The data from the Reasons for Incomplete Scheduled Dental Appointments (August 2007 to January 2008), based on a 100% sample of incomplete dental appointments each month (N), indicated that refusals accounted for 78% of incomplete appointments and staffing issues accounted for 1%. Transportation issues were not the reason for any incomplete appointments. **Compliance:** Partial. **Current recommendations**: 1. See F.9.e. 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	**Current findings on previous recommendations:**

	participate in dental appointments.	**Recommendation 1, August 2007:** Expand and implement the policy regarding dental refusals. **Findings:** The Executive Director reported that a universal policy regarding all refusals is being developed. **Recommendation 2, August 2007:** Monitor the elements of this requirement. **Findings:** No data was provided addressing this requirement. **Other findings:** Discussions with several disciplines at MSH revealed that unit staff has not yet been trained regarding procedures for refusals or addressing refusals in the individuals' WRPs. This issue needs to be addressed within the next six months. **Compliance:** Noncompliance. **Current recommendations**: 1. Provide training to unit staff regarding procedures for refusals that includes addressing this issue in the WRPs. 2. Develop and implement policy/procedure regarding refusals. 3. Monitor this requirement.

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. MSH has significantly decreased its use of seclusion and restraint in moving toward the Wellness and Recovery philosophy. 2. The facility no longer uses side rails as a form of restraint on the Skilled Nursing Facility and has recently implemented a number of systems addressing risk for falls. 3. MSH has integrated competency-based training regarding restraints, seclusion, and PRN and Stat Medications into its new employee orientation and mandatory annual training.
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. Cynthia Lusch, Clinical Administrator 2. Renee Kelly, Program Director, Program VI 3. Karen Chong, Program Director, Program II 4. Aurora Hendrick, Nurse Administrator 5. Michael Nunley, RN, Standards Compliance Director 6. Carmen Fayloga, RN, HSS Standards Compliance 7. Ezzat Gettas, RN, HSS, CNS <u>Reviewed</u>: 1. AD 3306. Behavioral Seclusion or Restraint 2. MSH's progress report and data 3. PMAB training rosters 4. Nursing Annual Update attendance records 5. MSH's Falls Committee Charter description 6. AD 3138, Falls Prevention/Management Program (August 29, 2007) 7. Nursing Policy/Procedure 303, Safety Side Rails; 8. Nursing Policy/Procedure 528, PRN Orders 9. Falls Risk Assessment Lesson Plan

		10. MSH Falls Prevention pamphlet 11. RN Assessment note form 12. Use of Side Rails and Other Device/Equipment Monitoring Form 13. Use of Side Rails and Other Device/Equipment Monitoring Form instructions 14. In-Service Update on Seclusion or Restraint agenda and attendance records 15. Dialectical Behavior Therapy Training rosters 16. MSH Seclusion and Restraint Review tool 17. MSH Seclusion and Restraint Review tool instructions 18. Inter-rater reliability data 19. AD 3133.1, Trigger Response 20. Trigger Response WRP Conference Tracking Form 21. Medical records for the following 32individuals: ARF, BMY, CB, CG, CKW, CR, DG, DLH, DLT, DM, DY, FEA, FR, HO, IER, JG, JLB, JM, JP, KR, LB, MC, MC, ML, NR, PW, RH, RL, RM, SW, TP, TS and WH
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, August 2007:** Continue to monitor this requirement. **Findings:** MSH's progress report indicated that there was no use of prone restraints, prone containment, or prone transportation during the review period. This monitor's review of medical charts, Behavior Guidelines and PBS plans found no indication of the use of prone restraints, containment, or transportation. AD 3306, Behavioral Seclusion or Restraint prohibits the use of these procedures. **Compliance:** Substantial.

		Current recommendations: Continue current practice.
H.2	Each State hospital shall ensure that restraints and seclusion:	**Compliance:** Partial.
H.2.a	are used in a documented manner and only when individuals pose an imminent danger to self or others and after a hierarchy of less restrictive measures has been considered in a clinically justifiable manner or exhausted;	**Current findings on previous recommendations:** **Recommendation 1, August 2007:** Retrain auditors regarding appropriate documentation criteria for restraints and seclusion. **Findings:** Training rosters for Seclusion or Restraint indicated that MSH provided re-training focused on appropriate documentation to 100% of Health Services Specialists (auditors). In addition, Seclusion or Restraint Review inter-rater agreement testing among five pairs of auditors was completed, resulting in an overall mean inter-rater agreement of 84%. **Recommendation 2, August 2007:** Continue to monitor this requirement. **Findings:** MSH's data from the Restraint Review Monitoring Form audit (August 2007 to January 2008), based on a 91% mean sample of restraint events each month (N), indicated 99% mean compliance with the requirement that the physician's orders include the specific behavior justifying the use of restraints; 99% mean compliance with the requirement that the documentation describes cause/reason necessitating restraints; and, 93% mean compliance with the requirement that least restrictive alternatives were documented.

		MSH's data from the Seclusion Review Monitoring Form audit (September-December 2007 and January 2008), based on a 100% sample of seclusion events each month (N), indicated 86% mean compliance with the requirement that the physician's orders include the specific behavior justifying the use of seclusion; 100% compliance with the requirement that the documentation describes cause/reason necessitating seclusion; and, 86% mean compliance with the requirement that least restrictive alternatives were documented. This monitor's review of 34 episodes of restraints for 11 individuals (ARF, BMY, CKW, DLH, DLT, DM, FEA, IER, KR, SW and WH) found that the documentation for eight episodes did not support the decision to place the individual in restraints. There was improvement in the documentation of least restrictive alternatives tried in 23 episodes reviewed. However there were significant inconsistencies in documentation regarding the time an individual was placed in restraints and if restraints or seclusion was implemented. Many of the orders and observation forms were not adequately completed. It was difficult at times to determine from the IDN notes when the individual was actually released from restraints. In addition, most of the documentation contained on the Post-Incident Debriefing section was meaningless. This monitor's review of three episodes of seclusion for three individuals (DLH, DLT and JLB) found that the documentation indicated the specific reason for the placement and that alternative measures were documented in two of the episodes. **Other findings:** Discussion with an HSS auditor revealed that there are discrepancies in the auditing process. The auditor reported that after he reads the record regarding the incident, he also interviews the staff and the individual to ascertain if restraint or seclusion was warranted.

		However, the instructions for the Seclusion or Restraint Review tool do not include interviews, only documentation review. Inconsistent auditing methods jeopardize the reliability of the data. **Current recommendations**: 1. Ensure that seclusion and restraints forms are accurate and complete. 2. Ensure that all auditors are consistently following the monitoring tool instructions. 3. 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 recommendations:** **Recommendations 1 and 2, August 2007:** • Provide staff training regarding Axis II diagnoses. • Develop and implement strategies and interventions to therapeutically address behaviors and ensure that they are included in the WRPs **Findings:** Training roster and course outlines indicated that MSH provides ongoing training on Psychiatric Nursing and Dialectical Behavior Therapy (DBT), adequately addressing this recommendation, **Recommendation 3, August 2007:** Continue to monitor this requirement. **Findings:** MSH's data from the Restraint Review Monitoring Form audit (August 2007 to January 2008), based on a 91% mean sample of restraint events each month (N), indicated 95% mean compliance with the requirement that restraints were not used in the absence of or as an alternative to active treatment; 96% mean compliance with the

		requirement that restraints were not used as punishment; and, 94% mean compliance with the requirement that restraints were not used for the convenience of staff. MSH's data from the Seclusion Review Monitoring Form audit (September-December 2007 and January 2008), based on a 100% sample of seclusion events each month (N), indicated 86% mean compliance with the requirement that seclusion was not used in the absence of or as an alternative to active treatment; 86% mean compliance with the requirement that seclusion was not used as punishment; and, 86% mean compliance with the requirement that seclusion was not used for the convenience of staff. This monitor's review of the charts of 11 individuals (ARF, BMY, CKW, DLH, DLT, DM, FEA, IER, KR, SW and WH) found that restraints were used in the absence of or as an alternative to active treatment since there were little to no documentation addressing the individuals' participation in Mall groups. **Current recommendations**: See H.2.a.
H.2.c	are not used as part of a behavioral intervention; and	**Current findings on previous recommendations:** **Recommendation, August 2007:** Continue to monitor this requirement. **Findings:** MSH's data from the DMH Psychology Services Monitoring Form audit (August 2007 to January 2008), based on a 100% sample of Positive Behavior Support (PBS) plans (N), indicated 100% compliance with the requirement that behavioral interventions, which include PBS plans, are based on a positive behavior support model, and do not include the use

		of aversive or punishment contingencies. This monitor's review of PBS plans for 15 individuals (AF, CB, DY, FR, JB, JG, KR, MC, ML, NR, PW, RL, RM, TP and TS) found that none contained the use of restraint or seclusion as part of a behavioral intervention. **Other findings:** This monitor's review of the WRP for WH found that the use of restraints was documented as part of his plan and that the restraints could be discontinued slowly, maintaining a minimum of two restraints to opposite limbs. This type of "fading" procedure is inappropriate. In addition, there appeared to be only Behavior Guidelines and not a PBS Plan as mentioned in the current WRP. **Current recommendations**: 1. Ensure that the practice of fading restraints is prohibited. 2. Continue to monitor this requirement.
H.2.d	are terminated as soon as the individual is no longer an imminent danger to self or others.	**Current findings on previous recommendations:** **Recommendation 1, August 2007:** See H.2.a, Recommendation 1. **Findings:** See H.2.a. **Recommendation 2, August 2007:** Identify and document specific exit criteria for seclusion and restraints. **Findings:** MSH has revised the forms for physician orders for behavioral

		seclusion and restraint to include specific behaviors for exit criteria, and revised the Observation Record for Behavioral Seclusion and Restraint to include documentation of specific behaviors every 15 minutes and release after 15 minutes of calmness. Implementation of these forms will be in early March 2008. **Recommendation 3, August 2007:** Implement guidelines using 15-minute timeframes of demonstrated release criteria to guide staff's decisions regarding releasing individuals from seclusion and restraints. **Findings:** See above. **Recommendation 4, August 2007:** Continue to monitor this requirement. **Findings:** MSH's data from the Restraint Review Monitoring Form audit (August 2007 to January 2008), based on a 91% mean sample of restraint events each month (N), indicated 96% mean compliance with the requirement that the individual was released when criteria met. MSH's data from the Seclusion Review Monitoring Form audit (September-December 2007 and January 2008), based on a 100% sample of seclusion events each month (N), indicated 86% mean compliance with the requirement that the individual was released when criteria met. See also H.6.a. **Other findings:** This monitor found no specific release exit criteria for restraint or

		seclusion other than when no longer a danger to others/danger to self (DTO/DTS). **Current recommendations**: 1. Identify and document specific exit criteria for seclusion and restraints. 2. Continue to monitor this requirement.
H.3	Each State hospital shall comply with 42 C.F.R. § 483.360(f), requiring assessments by a physician or licensed clinical professional of any individual placed in seclusion or restraints within one hour. Each State hospital shall also ensure that any individual placed in seclusion or restraints is continuously monitored by a staff person who has successfully completed competency-based training on the administration of seclusion and restraints.	**Current findings on previous recommendation:** **Recommendation 1, August 2007:** Continue PMAB training to ensure all direct care nursing staff are competency-based trained on restraints and seclusion. **Findings:** Training information provided by MSH indicated that Preventive Management of Assaultive Behavior (PMAB) is a mandatory competency-based class provided to all newly hired nursing staff and to all nursing staff annually. Currently, the Statewide PMAB Manual is being revised, integrating Wellness and Recovery principles and EP requirements. MSH's progress report indicated that all staff (n=253) who attended the PMAB training for this review period passed the competency test. **Recommendation 2, August 2007:** Continue to monitor this requirement. **Findings:** MSH's data from the Restraint Review Monitoring Form audit (August 2007 to January 2008), based on a 91% mean sample of restraint events each month (N), indicated 95% mean compliance with the requirement that the Physician/Licensed Independent Practitioner

		conducted a face-to-face evaluation within one hour; 95% mean compliance with the requirement that the results of Physician/Licensed Independent Practitioner's face-to-face evaluation are documented in the Physician Progress Notes; and, 96% mean compliance with the requirement that the order was signed within one hour. MSH's data from the Seclusion Review Monitoring Form audit (September-December 2007 and January 2008), based on a 100% sample of seclusion events each month (N), indicated 86% mean compliance with the requirement that the Physician/Licensed Independent Practitioner conducted a face-to-face evaluation within one hour; 86% mean compliance with the requirement that the results of Physician/Licensed Independent Practitioner's face-to-face evaluation are documented in the Physician Progress Notes; and, 86% mean compliance with the requirement that the order was signed within one hour. This monitor's review of the charts of six individuals (CG, HO, JLB, JM, MC and RH) who were placed in seclusion or restraints found that all were seen by a RN within one hour and the documentation was found in the ID notes. In addition, all physicians' orders for seclusion or restraints were signed within one hour. **Compliance:** Substantial. **Current recommendations**: Continue current practice.
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 recommendations:** **Recommendation, August 2007:** Continue to monitor this requirement.

		Findings: Although the facility has provided re-training to the HSS auditors, concerns remain regarding auditing methods and interpretation of the documentation (see H.2.a). Seclusion or Restraint Review overall inter-rater agreement testing was reported as 84% and PRN/Stat Medications Monitoring Form overall inter-rater agreement was 76%. Inter-rater agreement testing needs to continue until an acceptable level (85% or above) is achieved. The use of the Plato Data Analyzer for data entry and reporting has assisted in ensuring data accuracy. **Compliance:** Partial. **Current recommendations**: 1. Continue inter-rater agreement testing until an acceptable level (85% or above) is achieved. 2. Continue to monitor this requirement.
H.5	Each State hospital shall revise, as appropriate, and implement policies and procedures to require the review within three business days of individuals' therapeutic and rehabilitation service plans for any individuals placed in seclusion or restraints more than three times in any four-week period, and modification of therapeutic and rehabilitation service plans, as appropriate.	**Current findings on previous recommendation:** **Recommendation 1, August 2007:** Develop and implement a system to ensure compliance with this requirement. **Findings:** Discussions with the Standards Compliance Director indicated that the facility's trigger for restraint/seclusion is not in alignment with the requirement of the EP. This issue needs to be addressed promptly. **Recommendation 2, August 2007:** Continue to monitor this requirement.

		Findings: MSH's data from the Restraint and Seclusion Review Monitoring Form audit (August 2007 to January 2008), based on a 100% sample of events that triggered review of the individual's WRP (N), indicated 17% (restraint) and 40% (seclusion) mean compliance with the requirement that if an individual had been placed in restraint or seclusion more than three times in a four-week period, the WRP is reviewed within three business days and revised as appropriate. **Compliance:** Partial. **Current recommendations**: 1. Reconcile trigger indicators in alignment with the EP for this requirement. 2. 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 recommendation:** **Recommendation 1, August 2007:** Implement the PRN and Stat Trigger System. **Findings:** MSH has implemented the PRN and Stat Trigger System. **Recommendation 2, August 2007:** Provide trigger data by month.

		Findings: MSH's trigger data regarding PRNs and Stats was provided by month. **Recommendation 3, August 2007:** Continue to monitor this requirement. **Findings:** MSH's data from the PRN Medication Triggers audit (August 2007 to January 2008) indicated that a total of 193 PRN Medication Triggers were sent to the WRPTs and 69 PRN Medication Trigger Responses were received back from the WRPTs. In the case of Stat triggers, a total of 91 Stat Medication Triggers were sent to the WRPTs during the same review period and 42 Medication Trigger Responses were received from the WRPTs. **Other findings:** This monitor reviewed the charts of six individuals (CG, HO, JLB, JM, MC and RH) regarding PRN/Stat medications in relation to the individuals' incidents of seclusion/restraints. The review focused on the nurses' clinical decisions regarding PRN/Stat medication use and the resulting impact on the seclusion/restraint event. In the case of JM, the ID notes indicated that he was agitated and threatening to kill a peer at 0645. The notes indicated that he received a PRN of chlorpromazine 100mg intramuscularly (IM) at that time and that he continued to escalate, breaking the peer's radio and threatening to kill his peer. He was placed in five-point restraints at 0700. The notes indicated that he received another PRN of diphenhydramine, lorazepam, and haloperidol IM while in restraints. The documentation indicated that staff had tried to calm JM by giving him a PRN when he was getting agitated and upset. However, there was

		no documentation indicating that attempts to separate him and the peer were made at the time he received the PRN, which may have facilitated the effects of the medication and possibly averted the use of restraints. Additional issues for JM included: 1. No site documented for PRN IMs. 2. No specific exit criteria other than no longer danger to other/danger to self (DTO/DTS). 3. Was cooperative with arm out of restraint to eat breakfast, but was placed back in five-point restraints for another hour. 4. The Behavioral Seclusion and Restraint Documentation form indicated that alternative/less restrictive interventions attempted included decrease stimulation and verbal de-escalation. However, neither of these interventions was documented in the ID notes. In the case of MC, the ID notes indicated that she started yelling and screaming after she asked for extra food while at dinner and was told by staff that she could not have any. The notes indicated that she was brought back to the unit and given a PRN of olanzapine 10mg. She continued to yell and throw chairs. The notes indicated that the focus of her anger was directed to the staff member who made her angry. The staff even wrote in the ID notes that he stayed in the nurses' station to try to de-escalate since he was the focus of MC's anger. However, she became aggressive when he came out of the nurses' station and was placed in five-point restraints. While in restraints, she received a Stat dose of olanzapine 10mg and lorazepam 2mg IM. Although MC was given a PRN when she became upset and angry, had the staff member responded to her request differently, she may not have needed the PRN, the Stat medication or the restraints.

		Additional issues for MC included: 1. MC's WRP indicated that she is obese and has a BMI of 42.5. The staff could have used her request as an opportunity to assist her in making a healthy choice as to what extra food would be best for her rather than flatly denying her request. Unfortunately, the olanzapine she received as a PRN and Stat can increase appetite. 2. From review of this episode, the documentation indicated that it was staff-provoked. 3. The documentation indicated that MC was not de-escalating while the staff member stayed in the nurses' station. It may have been more therapeutic for the staff to apologize to MC for upsetting her. 4. No route documented in the ID notes for the PRN of olanzapine and no site documented for the Stat IM. 5. No specific release criteria were documented other than no longer DTO/DTS. 6. The documentation by the RN while MC was in restraints was excellent regarding specific interventions provided, MC's response, and specific behaviors demonstrated by MC. In the case of JLB, the ID notes indicted that he became upset during his WRPC and started to throw chairs. However, there was no documentation indicating what had upset him during the meeting. The notes indicated that he was first placed in the reflection room, but continued to escalate and kick the door. He was placed in locked seclusion and given a PRN of lorazepam 2 mg IM and olanzapine 10mg IM. The ID notes did not clearly indicate the time he went to the reflection room and the time he was placed in locked seclusion. Consequently, it is difficult to determine if JLB could have benefited from a receiving a PRN earlier than he did. The notes indicated that he was released from locked seclusion as soon as he was calm.

		Additional issues for JLB included: 1. The ID notes stated that the lorazepam 2 mg IM was given "site 2" and olanzapine 10 mg IM was given "site 1." This is not standard nursing documentation for administration of IMs. 2. No specific release criteria were documented other than no longer DTO/DTS noted. 3. The Behavioral Seclusion and Restraint Documentation form indicated that alternative/less restrictive interventions attempted included one-to-one session. However, no indication of this was found in the documentation. In the case of HO, the ID notes indicated that there were no behavioral warning signs prior to HO pushing the office door open and striking out at staff. The notes indicated that he received a PRN of haloperidol 5 mg IM, lorazepam 2 mg IM, and diphenhydramine 50 mg IM while in restraints and was released when he was calm. Additional issues for HO: 1. Only temperature was documented on Observation Record. 2. Both seclusion and restraint were checked on Observation Record. 3. Both seclusion and restraint were checked on the Physician Order for Behavioral Seclusion and Restraint form. 4. No specific release criteria were documented other than no longer DTO/DTS noted. 5. The sites for the IMs were documented as "to both sides of gluteal muscles;" this is not standard nursing documentation for injection sites. In the case of RH, the ID notes indicated that she was getting upset and yelling and got into an altercation with a peer. The notes indicated that a PRN was offered to her after the fight, but she refused it. The

		notes indicated that about thirty minutes later, she attacked a peer and then started to strike out at staff. She was placed in five-point restraints and remained in them from 2030 to 0015. The notes during this time indicated that she was unable to calm down and had stated "I cannot help myself." There was no indication that she was offered a PRN or assessed for a Stat medication while in restraints. Additional issues for RH: 1. There is no documentation on the Behavioral Seclusion and Restraint Documentation form indicating if RH is in seclusion or restraint. 2. Both seclusion and restraint were checked on the Physician Order for Behavioral Seclusion and Restraint form. 3. No vital signs were documented except for respirations while RH was in restraints. There is no indication of further attempts to obtain vital signs after 2300. 4. No specific release criteria were documented other than no longer DTO/DTS noted. In the case of CG, the ID notes indicated that she was severely agitated the night prior to her restraint episode and had received olanzapine 10 mg IM. The notes indicated that she was demonstrating similar behaviors the next morning and received another PRN of olanzapine 10 mg IM. She continued to escalate and threatened staff with a mop. She was place in five-point restraints and released after 45 minutes as soon as she was calm. The documentation indicated that staff appropriately provided PRN medication to CG. Additional issues for CG: 1. There is no documentation on the Behavioral Seclusion and Restraint Documentation form indicating if RH is in seclusion or

		restraint. 2. Both seclusion and restraint were checked on the Physician Order for Behavioral Seclusion and Restraint form. 3. No specific release criteria were documented other than no longer DTO/DTS noted. 4. Follow-up documentation for PRN was noted as "partially effective" rather than describing specific behaviors. 5. No site was documented for either PRNs of olanzapine IMs. **Current recommendations**: 1. Ensure that documentation for PRN and Stat medication in the ID notes is in alignment with generally accepted standards of nursing practice. 2. 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, August 2007:** Continue to monitor this requirement. **Findings:** MSH's data from the PRN Medication Audit (August 2007 to January 2008), based on a 7% mean sample of PRN medications administered each month (N), indicated 47% mean compliance with the requirement that psychotropic PRN medications are prescribed for specified and individualized behaviors. This monitor's review of psychotropic PRN orders for 11 individuals (ARF, BMY, CKW, DLH, DLT, DM, FEA, IER, KR, SW and WH) found that only two had orders for specific and individualized behaviors. **Current recommendations**: Continue to monitor this requirement.

H.6.c	PRN medications are appropriately time limited.	**Current findings on previous recommendation:** **Recommendation, August 2007:** Continue to monitor this requirement. **Findings:** The facility has implemented a practice of limiting all orders for Psychotropic PRN Medications to 14 days. The Nursing Policy & Procedure 528, PRN Orders was revised in November 2007 to reflect this change. This monitor's review of 11 individuals' medical records who were administered PRNs (BMY, CG, CKW, DG, DLH, DLT, KR, ML, SW, TP and WH) found that all PRN orders were limited to 14 days. **Current recommendations**: 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, August 2007:** Continue to monitor this requirement. **Findings:** MSH's data from the PRN Monitoring Form audit (August 2007 to January 2008), based on a 30% mean sample of PRN medications administered each month (N), indicated 77% mean compliance with the requirement that the nursing staff assessed the individual within one hour of the administration of the psychiatric PRN medication and 67% mean compliance with the requirement that the nursing staff documented the individual's response to PRN medication.

		MSH's data from the Stat Monitoring Form audit (August 2007 to January 2008), based on a 27% mean sample of Stat medications administered each month (N), indicated 81% mean compliance with the requirement that the nursing staff assessed the individual within one hour of the administration of the psychiatric Stat medication and 76% mean compliance with the requirement that the nursing staff documented the individual's response to the Stat medication. **Other findings:** See F.3.a.iii. **Current recommendations**: 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, August 2007:** 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. **Compliance:** Partial. **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	**Current findings on previous recommendations:** **Recommendation, August 2007:** Continue to monitor this requirement.

	less restrictive interventions.	**Findings:** See H.3, F.3.i, and F.3.h.i. **Compliance:** Partial. Current **recommendations:** Continue to monitor this requirement.
H.8	Each State hospital shall:	**Compliance:** Partial.
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 recommendations:** **Recommendation 1, August 2007:** Continue to implement the system to monitor this requirement. **Findings:** Since the last review, the facility has obtained low beds for seven individuals on Unit 418 and 14 individuals on Unit 419, replacing the need for full side rails. In addition, the Falls Prevention/Management Committee at the facility reviews individuals based on Fall Triggers, referrals, and Falls data to assist teams in implementing interventions. Also, AD 138, Falls Prevention/Management Program was approved for implementation. The Fall Risk Assessment and Prevention was integrated in the Nursing Orientation Curriculum and Nursing Annual Update. The Physical Therapist also provided training regarding Wheelchair Transfer and Safety. The facility has developed an educational pamphlet, Falls Prevention Education for Individuals and Families, which is given to each individual on admission and has been distributed to all the units. The facility has put a great deal of effort into addressing this recommendation.

		Recommendation 2, August 2007: Ensure adequate assessments are completed to justify decisions regarding side rail use. **Findings:** The Standards Compliance Director indicated in discussion that audit results (see H.8.b) were shared with the Skilled Nursing Facility (SNF) Nursing Coordinator and Unit Supervisors to focus on problematic areas, including completing and documenting RN assessments addressing the use of side rails and other devices. **Recommendation 3, August 2007:** Continue to monitor this requirement. **Findings:** See H.8.b. **Other findings:** Discussions with nursing indicated that the use of full side rails as a restraint no longer exists at MSH. Any side rails that are currently being used are the half side rails. **Current recommendations:** 1. Continue implementation of this system. 2. 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	**Current findings on previous recommendations:** **Recommendation 1, August 2007:** Continue to monitor this requirement. **Findings:** MSH's data from the Use of Side Rails and Other Device/Equipment

	appropriate.	Monitoring Form audit, based on a 36% mean sample of individuals using side rails (N) (August 2007 to January 2008), indicated the following mean compliance scores for each listed item:

There is a physician's order for the use of side rail and/or other device/equipment.	100%
The physician's order includes clinical justification and duration of use.	100%
There is an RN Assessment in the IDN addressing the use of side rail and/or other device/equipment with every physician's initial or renewal order.	24%
There is documentation in the Daily Care Flow Sheet (MSH 1152) for use of side rail and chair that prevents rising.	93%
There is documentation in the Physical Restraint Observation Sheet (MSH/SNF 1201b) for use of trunk restraint, limb restraint, and mittens.	85%
There is documentation in the Nursing Weekly Summary and Nursing Monthly Summary.	44%
The WRP expressly addresses the use of side rails and/or other device/equipment:	73%
including identification of the medical symptoms that warrant the use of side rails and/or other device/equipment;	100%
methods to address the underlying causes of such medical symptoms; and	100%
strategies to reduce the use of side rails and/or other device/equipment, if appropriate.	93%

This monitor's review of the charts of three individuals (CR, JP and LB) who use side rails found physicians' orders that included justification for the use of side rails for all three individuals. The Daily Flow Sheet was utilized for documentation of side rails and the medical symptoms/condition was included in the WRP. However, there was no

		RN assessment addressing the use of side rails for any of the three individuals. **Recommendation 2, August 2007:** Separate other restraint devices in the data. **Findings:** MSH's data clearly addresses this recommendation. **Current recommendations:** 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. MSH has developed procedures for the review of Special Incident Reports (SIR) that has increased accuracy and that identifies common errors in completing the SIRS, so that targeted training can be provided. 2. The SIR form has been revised and now guides the staff member completing it through a series of questions that will result in more thoughtful Level I and Level II reviews. 3. The Headquarters Reportable Brief form has been shortened and it was agreed that the draft of SO 227.08 would be revised to extend the time to complete the brief from 30 to 60 days. 4. Investigations and the investigation reports have continued to improve. There is evidence that investigators are making an effort to find additional witnesses, seeking the consult of clinicians when necessary and more commonly and critically reviewing relevant documentation. 5. The vast majority of Hospital Police officers have been trained using the Incident Management curriculum. 6. MSH is alerting WRPTs when an individual reaches a trigger and is tracking the WRPT's response. Although the response rate is low, the facility has a plan to increase the visibility of this problem and improve the number of responses. The facility is also auditing a sample of the responses to ensure implementation. 7. Standards Compliance has completed outstanding studies on falls and aggression and is undertaking a study of individuals who swallow foreign objects. The findings, along with other incident data reports, for example those on multiple victims and aggressions, incident location and time of day, are presented to the Performance Improvement Committee. 8. The Human Resources (HR) Department continues to collect, implement and track the counseling and training recommendations

		related to incidents. The HR Director will begin meeting monthly with the Program Directors and Discipline Chiefs to ensure that no recommendations are missed.

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. C. Lusch, Clinical Administrator 2. G. Hahn, Hospital Administrator 3. D. Bates, Human Resource Director 4. H. Mears, Chief of Hospital Police 5. M. Nunley, Standards Compliance Director 6. L. Dieckmann, Standards Compliance Lead Psychologist 7. C. Rivera, Standards Compliance 8. M. McNeil, Standards Compliance 9. S. Gutierrez, Standards Compliance 10. K. Kolasinski, RN, Central Nursing Services Reviewed: 1. Mortality Review Committee minutes for September 2007—January 2008. 2. 15 investigations completed by the Office of Special Investigator or Hospital Police 3. Five death investigations 4. 15 Special Incident Reports 5. 10 Headquarters Reportable Briefs 6. Investigation Compliance Monitoring Data 7. Investigation Recommendation Follow-up Monitoring Data 8. Personnel records for 12 staff 9. Aggregate incident and investigation data 10. Incident pattern and trend reports 11. Records of 16 individuals (for rights acknowledgement forms) 12. Draft of Special Order 227.08: Special Incident Reports 13. Incident Review Committee (IRC) minutes 14. Performance Improvement Committee Minutes

I.1.a	Each State hospital shall review, revise, as appropriate, and implement incident management policies, procedures and practices that are consistent with generally accepted professional standards of care. Such policies, procedures and practices shall require:	**Compliance:** Partial.
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, August 2007:** Look for evidence of under-reporting. **Findings:** In three of the investigations reviewed, it was determined that a staff member had not reported the incident in a timely manner (by the end of the shift, per facility policy). (The incidents cited occurred on 6/24, 8/23 and 11/2/07.) In two of these instances, the staff person was counseled or counseling was in process. In the third, HR did not catch this recommendation and therefore no action was taken. These findings indicate that the facility is recognizing and addressing the staff's obligation to report incidents in the manner consistent with facility policy. The incidents cited occurred on 6/24, 8/23 and 11/2/07. These findings are consistent with the facility's finding that over the period August 2007-- January 2008, reporting was in compliance with policy in 81% of the cases. The facility further reports that beginning in February 2008, the HR Director will meet monthly with the Program Directors/Discipline Chiefs to "review and monitor compliance with recommendations for programmatic actions resulting from investigations."

		Recommendation 2, August 2007: Review training materials and ensure that neglect, as it would likely occur in the hospital setting (as contrasted with familial neglect), is adequately covered, along with the responsibility to report. **Findings:** These areas are covered in the training materials. **Current recommendations**: Proceed with plans for the HR Director, Program Directors and Discipline Chiefs to meet to ensure that all programmatic recommendations are implemented in a timely fashion.
I.1.a.ii	identification of the categories and definitions of incidents to be reported, and investigated; immediate reporting by staff to supervisory personnel and each State hospital's executive director (or that official's designee) of serious incidents, including but not limited to, death, abuse, neglect, and serious injury, using standardized reporting across all settings, including school settings;	**Current findings on previous recommendations:** **Recommendation, August 2007:** Initiate close review of SIRs on the unit level and continue the review as SIRs are processed and information entered into databases. **Findings:** All SIRs are reviewed at the program level and by a staff member in Standards Compliance. When Standards Compliance finds an error, the staff member who completed the form initially is contacted and the necessary change is discussed and made. Standards Compliance is keeping a record of the types of errors and the staff members responsible so that training can be provided if a pattern is detected. This data indicates that the most common errors were made in coding the type, type of involvement of the staff member or individual, and severity of injury. **Other findings:** The revised SIR definitions were referenced in the summary section of the investigation reports reviewed.

		Current recommendations: Continue current practice.
I.1.a.iii	mechanisms to ensure that, when serious incidents such as allegations of abuse, neglect, and/or serious injury occur, staff take immediate and appropriate action to protect the individuals involved, including removing alleged perpetrators from direct contact with the involved individuals pending the outcome of the facility's investigation;	**Current findings on previous recommendations:** **Recommendation, August 2007:** Provide the necessary clinical interventions in the WRP to those individuals identified as having a history of making false allegations and monitor the effectiveness of treatment. **Findings:** Facility data indicates that this problem was not the subject of a focus in the WRPs of any of the 25 individuals who were determined to have a history of making false allegations. It was rather often identified in the WRP but incorporated into a focus that addressed other behavioral issues. **Other findings:** In the investigations reviewed, the named staff person was initially removed from the unit until further investigation/review was completed. **Current recommendations**: Whenever an investigation report states that an individual has a history of making false allegations, cite the source of this assertion and include information as to whether this issue is a focus in the WRP.
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, August 2007:** Standardize the instruction for classifications of staff members, both in what is offered and how it is recorded on the training records.

Findings:
Some training records indicate the annual training on Individuals' Rights is one hour long; other records document the training as 30 minutes.

Other findings:
Review of the training records for 12 staff members revealed that 83% had had annual Rights Training within the last year.

Staff member's last initial*	Annual Rights Training update	Child Abuse Mandatory Reporting form	Dependent Adult Abuse Mandatory Reporting form	Background clearance
__R	6/13/07	9/29/00	Not signed	9/26/00
__B	12/12/07	2/4/00	2/4/00	1/5/00
__L	7/19/07	9/17/90	12/3/91	from ASH
__H	7/16/07	8/29/88	8/29/88	Too early for documentation
__F	10/17/07	9/10/04	9/10/04	7/23/04
__N	1/19/07	12/2/05	12/2/05	11/7/06
__B	4/10/07	Not in record	3/3/06	1/4/06
__S	6/16/07	10/29/99	10/29/99	9/9/99
__R	1/25/08	6/20/97	6/20/97	No date—just "Yes"
__V	1/24/08	6/9/97	12/5/94	Not reviewed
__T	9/20/07	Not reviewed	Not reviewed	Not reviewed
__R	7/17/06	Not reviewed	Not reviewed	Not reviewed

* First initial not provided for confidentiality reasons.

Current recommendations:
1. Ensure that all staff completes required competency-based annual training.

		2. Standardize the documentation of the length of the Individuals' Rights annual training.
I.1.a.v	notification of all staff when commencing employment and adequate training thereafter of their obligation to report abuse or neglect to each State hospital and State officials. All staff persons who are mandatory reporters of abuse or neglect shall sign a statement that shall be kept with their personnel records evidencing their recognition of their reporting obligations. Each State hospital shall not tolerate any mandatory reporter's failure to report abuse or neglect;	**Current findings on previous recommendations:** **Recommendation, August 2007:** Identify a system that will ensure that an SOC 341 is completed when there is an abuse allegation. Perhaps CNS could remind the caller of the need to complete this form when the caller is requesting an SIR number for an abuse allegation. **Findings:** This recommendation has been implemented with the result that an SOC 341 was completed for all dependent adult abuse SIRs reviewed. **Other findings:** See above for dates on which selected staff members signed child abuse and dependent adult abuse mandatory reporting forms. The personnel records of eight of the 10 staff members contained both signed mandatory reporting forms. The facility reported that all 83 employees newly hired during the report period signed the mandatory reporting forms. In the investigation report of the verbal abuse allegation made on 6/24/07, a staff member was found to not have reported an incident in a timely manner and was to be counseled for the omission. The counseling was not done. **Current recommendations**: Same as in I.1.a.i.
I.1.a.vi	mechanisms to inform individuals and their conservators how to identify and report	**Current findings on previous recommendation:**

suspected abuse or neglect;

Recommendation, August 2007:
Ensure that AD 3350.1 entitled Notification of Patients' Rights has been published/disseminated and spot-check compliance.

Findings:
AD 3350.1 was published and disseminated and in August 2007, the Clinical Director distributed a memo restating that annual signing of the Notification of Rights by individuals should be included in the monitoring WRPs.

Other findings:
Review of the most recent signing of the Notification of Patients' Rights for 16 individuals found that 63 percent of the individuals sampled had signed the Notification within the last year.

Individual's initials	Date signed
ML	10/8/07
GA	Refused to sign on 10/8/07
KZ	8/30/07
JA	8/7/07
CR	12/4/07
EV	3/22/07
RS	6/12/03
JA	10/25/07
TN	2/21/07
DC	Not in record
WW	9/15/06
SG	Not in record
RC	1/4/08
BW	1/25/06
WB	1/22/08

		MW | 2/5/08 **Current recommendations**: Continue to ensure that signing the Rights Notification is part of the annual Wellness and Recovery planning process and whenever there is a change in legal status.
I.1.a.vii	posting in each living unit and day program site a brief and easily understood statement of individuals' rights, including information about how to pursue such rights and how to report violations of such rights;	**Current findings on previous recommendation:** **Recommendation 1, August 2007:** Include the name of the PRA on the posters when one is hired. **Findings:** The name of the PRA had been added to each of the posters in the units toured. **Recommendation 2, August 2007:** Question individuals (perhaps at the Individuals' Council or Senate) to ensure that they are receiving a response to their complaints from the PRA office and program leaders during this interim period when there is no PRA. **Findings:** The facility now has a Patients Rights Advocate. In the investigations reviewed in which the individual initially contacted the Advocate, the investigation file contained a copy of a letter to the individual acknowledging receipt of the complaint and advising the individual that the complaint was being forwarded to the facility for investigation. **Other findings:** See the results of a survey of individuals reported in Section J of this report that suggests individuals are not advised of the outcomes of their grievances.

		Current recommendations: Continue current practice of notifying individuals that their complaints have been received and forwarded. Ensure the individual learns the disposition of the complaint/grievance.
I.1.a.viii	procedures for referring, as appropriate, allegations of abuse or neglect to law enforcement; and	**Current findings on previous recommendation:** **Recommendation, August 2007:** Identify and correct the problem that is causing delays in incidents reaching the attention of Hospital Police for several weeks or more in some cases. **Findings:** Problems remain in this area. In some instances, the problem resulted from the Incident Review Committee undertaking a review before forwarding the incident to the hospital police. The 7/17/07 incident involving SW was not assigned until 9/6/07. The IRC reviewed the incident on 8/22/07 before sending it on to the hospital police, thus delaying the investigation. Similarly, the 8/23/07 allegation by JC of physical and psychological abuse was reviewed by the IRC on 9/5/07 and then forwarded to the Hospital Police for investigation. In other incidents, the reason for the delay in assigning the case for investigation is not clear. The verbal abuse allegation made by BT on 6/6/07 was not assigned until 8/7/07. The psychological abuse allegation made by GC in July 2007 was not assigned for investigation until December 2007. Shorter delays also occurred. The 1/3/08 allegation by AB of verbal abuse was received on that same day but not assigned until 1/30/08.

		Other findings: With full staffing in the Office of the Special Investigator expected shortly, including the hiring of a Supervising Special Investigator, incident investigations should be assigned as soon as they are received. **Current recommendations**: 1. Discontinue the practice of IRC reviewing an allegation before handing it off to the Hospital Police. 2. Develop procedures whereby relevant incidents are immediately reported to the Office of the Special Investigator and are assigned for investigation promptly.
I.1.a.ix	mechanisms to ensure that any staff person, individual, family member or visitor who in good faith reports an allegation of abuse or neglect is not subject to retaliatory action, including but not limited to reprimands, discipline, harassment, threats or censure, except for appropriate counseling, reprimands or discipline because of an employee's failure to report an incident in an appropriate or timely manner.	**Current findings on previous recommendation:** **Recommendation, August 2007:** Continue current practice of opening an investigation when there is an allegation of retaliation or threat of retaliation. **Findings:** No allegations of retaliation or threat of retaliation for reporting an incident were reported during the last six months. **Current recommendations**: 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,	**Current findings on previous recommendations:**

	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;	**Recommendation 1, August 2007:** Identify a procedure whereby serious injuries are investigated by trained staff members who have no reporting obligations to the program or elements of the facility associated with the allegation. **Findings:** All investigations reviewed were conducted by Hospital Police (including Special Investigators) except one (allegation of sexual abuse made by SW on 7/17/07), which was conducted by a Program Director who does not supervise the program where the incident occurred. **Other findings:** It has been agreed that all injuries of unknown origin that require medical treatment will require a Headquarters Reportable Brief and will require investigation by a personnel trained in incident investigation who are not associated with the individual. Review of the Mortality Review Committee minutes reveals that all cases opened since September 2007 have either been held open pending autopsy results or closed with the provision that they will be reopened pending the autopsy results. Several issues remain unresolved: • The September 4 minutes noted that concerns were raised regarding the delay in receiving autopsies and recommended that Standards Compliance compile a list of outstanding autopsies and that a meeting be held with the Medical Director. No further mention is made of this recommendation in the subsequent minutes. • The reviews of the deaths of two individuals (DR and DH) imply concern over the lack of action by WRPTs when individuals refuse medical evaluation and treatment. • Medical records for JC from Norwalk Community Hospital were

		requested in the October 30, 2007 minutes for review in response to concerns about the care the individual received there. There is no documentation in the succeeding minutes that these records were received and reviewed. The case was closed during the November 20 meeting at which time the autopsy results had been received. • The failure of the physician to document his interventions in response to CG's increasing symptoms remains unaddressed, with no action taken to ensure that other individuals treated by this physician are not at risk. **Current recommendations**: 1. Complete Headquarters Reportable Briefs on all injuries of unknown origin that require medical treatment and ensure their investigation by trained personnel not associated by the individual. 2. Ensure that "old business" is carried forward in the Mortality Review Committee minutes so that issues are not forgotten and dropped. 3. Implement to the degree possible the procedures for the review of deaths described in SO 205.04: Mortality Review.
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 recommendations:** **Recommendation 1, August 2007:** Clarify the correct coding for an individual who has completed or attempted suicide. **Findings:** This coding confusion is no longer a problem. **Recommendation 2, August 2007:** Require programs to review SIRs for completeness and accuracy and communicate promptly with units about deficient SIRs to ensure their

		correction. **Findings:** This recommendation has been successfully implemented. See I.1.a.ii. **Other findings:** Review of the Incident Management Training list for Hospital Police indicates that 52 (84%) have been trained and 11 (17%) remain to be trained. Several officers have not been trained because they are on or have just returned from medical or military leave. In summary, since Hospital Police conduct all the investigations with rare exceptions and since nearly all of the officers have been trained on investigation procedures for the facility in addition to their police officer training, the facility has ensured that trained staff members are completing investigations of abuse allegations, deaths, and other matters that may constitute a crime or violation of facility policy. **Current recommendations**: Train the remaining officers as they become available and any other staff who may be called upon to conduct incident investigations.
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, August 2007:** Continue current practice. **Findings:** This monitor found no evidence in the investigations reviewed that physical evidence was not safeguarded in accordance with standard practice. In those instances where photos were taken, the number and location of the photos were documented.

		Current recommendations: 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 recommendations:** **Recommendation 1, August 2007:** The Chief of Police will review the monitoring form with the Special Investigators and officers completing investigations, so that they will understand the criteria used to evaluate their work. **Findings:** In September 2007, the Chief of Police met for several hours with the officers completing special investigations, reviewing the portions of the Enhancement Plan that address their work and the investigation monitoring forms. **Recommendation 2, August 2007:** The Chief of Police will complete the monitoring form at the close of each investigation as he reviews it for completeness and accuracy. This is not to impinge on the work of Standards Compliance in this area. **Findings:** This recommendation has been implemented. When the Supervising Special Investigator is hired, he will complete the monitoring forms. **Current recommendations**: Provide feedback and guidance to officers completing investigations, using the monitoring form as a tool when an investigation fails to meet monitoring standards.
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, August 2007: Revise supervision of the Special Investigators so that investigators meet with supervisors to review progress on cases at least bi-weekly. Provide mentoring and assistance as necessary. Use the Investigation Compliance Monitoring form as a training and supervision tool. **Findings:** The facility reports that the Special Investigators meet with the Chief of Police and the Hospital Administrator weekly. **Other findings:** As reported in I.1.a.viii, a problem remains in opening an investigation in a timely manner in some instances. Facility data indicates that approximately one-half of the investigations were opened within 24 hours during the period August 2007—January 2008. **Current recommendations**: Develop procedures whereby the Hospital Police are immediately advised of an incident that requires their investigation.
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 recommendations:** **Recommendation, August 2007:** Change the procedures for assigning and supervising investigations in order to identify the source of the tardiness problems and take corrective actions. **Findings:** The intervention of the IRC is responsible for the delay in opening some investigations as discussed in I.1.a.viii. The source of other delays is not clear.

		Other findings: Review of the Hospital Police Investigation log for the period July 2007 through early January 2008 indicates that nine investigations (death investigations were not counted, as waiting for autopsy results often delays closing) were not closed within 30 business days. The IRC (see below) closed a total of 16 cases. This influenced this finding, as all IRC closings were within the 30 business day time limit, although not all of the investigations had been completed when they were closed by the IRC. **Current recommendations**: 1. Revise procedures so that incidents are reported to the Hospital Police quickly and are assigned for investigation in a timely manner. 2. Discontinue the practice of the IRC reviewing incidents before they are handed over to the hospital police, thus delaying the start of an investigation.
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 its conclusion. The report shall set forth explicitly and separately:	**Current findings on previous recommendation:** **Recommendation 1, August 2007:** Continue the use of the face sheet to provide critical information up front. **Findings:** The use of the face sheet has continued and provides critical information in an easy-to-use format. **Recommendation 2, August 2007:** Discourage the practice of completing the summary section of the investigation by cutting and pasting large sections of interviews. The summary should include only the salient points that must be considered in making a determination.

Findings:
The practice has been discontinued as recommended. None of the investigation reports reviewed contained cut-and-paste sections of interviews in the summary sections.

Recommendation 3, August 2007:
Place all findings that support a determination in the body of the report. This is not to suggest that conflicting evidence should not also be presented.

Findings:
In the review of incidents, this monitor found no instances in which determinations were made based on facts that were not presented in the body of the investigation report.

Other findings:
In the investigations reviewed, recommendations were made for training and/or counseling for 12 staff members. There was evidence that these measures were completed or in process as follows:

Incident date	Counseling completed as recommended	Training completed as recommended
9/7/07	Yes	Yes
6/24/07	No	
8/27/07		Yes
12/23/07	In process	In process
12/22/07		In process
12/17/07		Yes
12/17/07		In process
11/2/07		Yes
11/2/07		Yes
5/07	Yes	Yes
8/23/07	In process	

		8/23/07 | In process | In a substantiated case of verbal abuse that occurred on 7/16/07, no action was taken against the employee. These findings are not inconsistent with the facility's self-assessment that 80% of the programmatic recommendations made during the period August 2007--January 2008 were implemented. See also I.1.a.i. The IRC closed investigations before the investigations were complete. Determinations should be made by the investigator only after all investigative efforts have been completed. A review of the Hospital Police investigation log indicates that in the period July—December 2007, the IRC closed six cases involving allegations of physical abuse, six involving allegations of verbal abuse and four other incidents. These 16 incidents constituted one-third of the 47 investigations (death investigations were not counted) reported on the log during the July—December time period. **Current recommendations**: 1. Discontinue the practice of the IRC closing investigations. 2. See also the recommendation in I.1.c.
I.1.b.iv. 3(i)	each allegation of wrongdoing investigated;	**Current findings on previous recommendations:** **Recommendation, August 2007:** Continue current practice. **Findings:** The mother of an individual made an allegation that she was verbally abused by a Hospital Police officer and that her son was physically abused by a Hospital Police officer during a visit on 8/22/07. The verbal abuse allegation was investigated and determined by the IRC to

		be unsubstantiated. There was no investigation of the allegation that her son was pushed against the wall other than to assert that he was properly searched. **Current recommendations**: Investigate all aspects of a compound allegation. Complete two SIRs when the victims are different people.
I.1.b.iv. 3(ii)	the name(s) of all witnesses;	**Current findings on previous recommendations:** **Recommendation 1, August 2007:** Train Hospital Police officers to gather information on witnesses (including individuals as well as staff) when they are called to the scene of an incident. **Findings:** Some investigations reviewed evidenced specific efforts to find witnesses. For example, in the investigation of the allegation by AB of verbal abuse, nine staff members were interviewed to ensure that all staff witnesses were identified. Similarly, in the investigation of the physical abuse allegation by RH on 12/23/07, the investigator interviewed multiple staff in an attempt to find a witness to the event. In the investigation of the allegation of physical abuse by TC on 11/1/07, the investigator conducted a second interview of a staff member who other staff said was present during the incident, but who could not remember being present. **Recommendation 2, August 2007:** Start Special Investigations in a timely manner. **Findings:** Delays in receiving incidents and in assigning them for investigation continue to delay the start of investigations as described in I.1.a.viii.

		Current recommendations: 1. See the recommendation in I.1.b.iv.2. 2. Look for additional witnesses among individuals as well as staff during investigations.
I.1.b.iv. 3(iii)	the name(s) of all alleged victims and perpetrators;	**Current findings on previous recommendation:** **Recommendation, August 2007:** Continue current practice. **Findings:** In all investigations reviewed, the names of the alleged victims and perpetrators were clearly identified on the face sheet. **Current recommendations**: Continue current practice.
I.1.b.iv. 3(iv)	the names of all persons interviewed during the investigation;	**Current findings on previous recommendation:** **Recommendation, August 2007:** Continue current practice. **Findings:** Each of the investigations reviewed contained the names of all persons interviewed. **Current recommendations**: Continue current practice.
I.1.b.iv. 3(v)	a summary of each interview;	**Current findings on previous recommendation:**

		Recommendation, August 2007: Move beyond a free narrative of events and ask pointed questions that will help to highlight conflicting evidence and explain the disparities. **Findings:** The interviews in the investigations reviewed did not ask questions that required a response beyond a narrative describing the person's account of what had occurred. The question sometimes asked that queried why one person would make a statement about another ("Why would person X say that about you?") was the exception. **Other findings:** Several investigations reviewed were closed before interviews were completed: • In the investigation of the allegation by HN of physical abuse on 8/14/07, the investigation report states that HN and the nurse to whom he reported the allegation were interviewed, but no summary of these interviews was provided. • In the investigation of the allegation by JS of psychological abuse by JS on 1/11/08, there was no documentation of an interview of the named staff person. • The named staff person was also not interviewed in the investigation of the allegation made by MC on 12/18/07 that she did not feel safe because of the actions of the named staff person. • In the investigation of the allegation by TR of verbal abuse on 12/22/07, the named staff member was not interviewed. In the investigation of the 12/17/07 allegation of verbal abuse, a summary of interviews was presented, but the interviews did not address the verbal abuse allegation.

		Current recommendations: 1. Interview all relevant parties and provide a summary of each interview that addresses the issue under investigation. 2. Discontinue the practice of closing incident review prior to the completion of the investigation. 3. Encourage investigators to ask direct questions (in second interviews if necessary) to solicit information that will help reconcile conflicting information.
I.1.b.iv. 3(vi)	a list of all documents reviewed during the investigation;	**Current findings on previous recommendation:** **Recommendation, August 2007:** Continue current practice. **Findings:** The investigations reviewed clearly identified the documents reviewed by the investigator. In many instances, copies of the documents were included in the investigation file. For example, in the 7/26/07 allegation of psychological abuse, GC alleged the staff member threatened, "I'll fix you" and then wrote a note in his treatment record. The investigator included a copy of the note as part of the investigation. Similarly, in the investigation of the allegation by RH of physical abuse (12/23/07), the investigator included a copy of the medication administration record in question Copies of the training records of named staff members were included in several of the investigations reviewed. See below. **Current recommendations**: Continue current practice of including copies or excerpts of relevant documents in the investigation reports as well as a listing of documents on the face sheet.

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, August 2007:** Review investigations during supervision to ensure that both sources of information (incident history and discipline history) are reviewed and documented. **Findings:** Several investigations reviewed included documentation that the investigator had reviewed the personnel file and/or the training record of the named staff member and the incident history of the individual. These investigations include those for the following allegations: • Psychological abuse, made by JS on 1/11/08; • Verbal abuse, made by AB on 1/30/08; • Verbal abuse, made by RD on 8/22/07; • Sexual abuse, made by SW on 7/17/07; • Physical abuse, made by RH, on 12/23/0; • Psychological abuse, made by RM on 12/18/07. **Current recommendations**: Continue current practice of documenting the results of the review of staff members' personnel and training records and individuals' incident histories as appropriate.
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 1, August 2007:** Continue the current practice of painstakingly reviewing the investigation reports, identifying needed corrective measures and deficiencies in the investigation process.

		Findings: The facility has continued the careful review of investigations from the unit level through the Clinical Administrator, Medical Director and the Executive Director. These reviews primarily identified disciplinary and training recommendations for the staff members involved. Recommendations for training entire units or shifts were made occasionally. In some instances, however, this review has been bypassed. The IRC closed some of the investigations reviewed and found them unsubstantiated before the investigation was completed. Examples include the investigations of the allegation of psychological abuse of MC (12/18/07), the verbal abuse allegation of TR (12/22/07), and the allegation of physical abuse of HN (8/14/07). See also I.1.b.iv.3. **Recommendation 2, August 2007:** Revise summary statements to support the determinations made, citing specific information and addressing conflicting information. **Findings:** Summary statements do not cite supporting findings and acknowledge conflicting information. Rather, they assert the evidence (without citing specifics) does not meet the definition of the incident type in question. **Current recommendations**: Write a short paragraph at the close of each investigation stating critical points that support the determination, acknowledging conflicting testimony and citing the relevant portion of the revised incident definition.
I.1.b.iv. 3(ix)	the investigator's reasons for his/her conclusions, including a summary indicating	**Current findings on previous recommendation:**

	how potentially conflicting evidence was reconciled; and	**Recommendation 1, August 2007:** Revise summary statements to support the determinations made, citing specific information and addressing conflicting information. **Findings:** See above. **Recommendation 2, August 2007:** Identify relevant conflicting evidence and document clearly attempts to reconcile conflicting evidence. **Findings:** While there is some evidence that investigators are aware of the need to make efforts to reconcile conflicting evidence (see I.1.b.iv.3(ii)), investigations would be improved by clearly identifying the conflicting evidence and asking pointed questions to address the discrepancies. **Other findings:** One investigation reviewed did not provide an adequate rationale for the determination. On 12/23/07, RH alleged she was physically and verbally abused when a staff member called her a foul name and deliberately shut the medication room door on her arm. RH's arm was injured. No one witnessed the incident. One staff member described the named staff member as "aggressive toward staff and individuals." The investigation was determined unsubstantiated because the named staff member denied the allegation and because there were no witnesses. At a minimum, this allegation required further investigation. The denial and lack of witnesses are not a sufficient foundation for determining these allegations to be unsubstantiated.

		Current recommendations: 1. Ensure that investigations fairly weigh the evidence to determine preponderance in making determinations. 2. See also recommendation in I.1.b.iv.3(viii).
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 recommendations:** **Recommendation, August 2007:** Evaluate the effectiveness of the new review form once in use to ensure it is meeting its objectives. **Findings:** The form is meeting the objective of focusing attention on critical issues such as timeliness, application of the revised definitions, assistance/consultation with medical personnel when indicated and review of incident histories of individuals and personnel files of staff members. **Other findings:** See the findings in I.1.b.ii that report on the training of officers using the Incident Management curriculum. In the investigation of the allegation of physical abuse made by RH on 12/23/07, the investigator interviewed the pharmacist and the Chief of Nursing Education about the proper timing of the administration of a medication. This type of outreach is prompted by the review form and is to be commended. **Current recommendations**: Continue current practice.
I.1.c	Each State Hospital shall ensure that whenever disciplinary or programmatic action is necessary to	**Current findings on previous recommendations:**

	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.	**Recommendation 1, August 2007:** Take measures to ensure that units respond to the memos from HR regarding disciplinary and programmatic corrective actions in a timely manner. **Findings:** In all but two investigations reviewed where disciplinary or training was recommended, HR was tracking the implementation of the recommendation. The exceptions were the substantiated case of verbal abuse that occurred on 7/16/07 in which no action was taken against the employee and the 6/24/07 allegation of abuse in which the staff member was not counseled for failure to report. See I.1.b.iv.3 for additional information. **Recommendation 2, August 2007:** Continue current practice of HR providing the units with complete information about which actions need to be taken and requesting evidence of completion. **Findings:** See above. **Compliance:** Partial. **Current recommendations**: Continue current practice of HR identifying and tracking the completion of recommendations from incident review and meeting with Program Directors and Discipline Chiefs to ensure the implementation of recommendations.
I.1.d	Each State hospital shall have a system to allow the tracking and trending of investigation results.	**Compliance:** Partial.

	Trends shall be tracked by at least the following categories:	
I.1.d.i	type of incident;	**Current findings on previous recommendations:** **Recommendation, August 2007:** Write Performance Improvement Committee minutes to reflect discussion of the reports and actions recommended. **Findings:** The facility reported that it will be able to generate and then review the types of tracking reports required by the Enhancement Plan when the Record Management System (RMS) is operational. The RMS is scheduled to be installed in mid-April. **Other findings:** The facility has produced trend data by incident type for the periods March—August 2007 and September 2007—February 2008 that indicates that the number of incidents in the latter period is smaller for accidental injuries, peer-to-peer aggression, aggression toward staff and self-harm. The facility also produced a facility-wide report on incidents of self-harm. This self-harm data indicates that 143 individuals committed acts of self-harm between September 2006 and November 2007. Fourteen individuals committed 20 or more acts of self-harm in the review period. Unit 412 had the highest number of self-harm acts, 46% higher than the next highest unit. **Current recommendations**: Expand the production, analysis and review of reports using incident data as the technology becomes available.

I.1.d.ii	staff involved and staff present;	**Current findings on previous recommendation:** **Recommendation, August 2007:** Continue to review the incident and disciplinary history of staff and the incident history of individuals during investigations and document the results of this review in the investigation report. **Findings:** The facility has continued to implement this recommendation. See I.1.b.iv.3(vii). **Current recommendations**: Continue to document the incident history of individuals and the discipline/counseling/training history of named staff members.
I.1.d.iii	individuals directly and indirectly involved;	**Current findings on previous recommendations:** **Recommendation 1, August 2007:** Document the analysis of the reports produced and the actions taken in response. **Findings:** The self-harm study identified the 14 individuals with the highest number of aggressive acts to self during the 9/06—11/07-report period. The number of these incidents for the 14 individuals ranged from 23 to 66, according to facility data. The study managers selected the two individuals who had the highest number of these incidents and developed a fishbone diagram identifying factors in six domains that may be impacting the actions of these individuals. The domains are assessment, PBS planning, medication, communication, treatment planning and therapeutic milieu.

		Recommendation 2, August 2007: Standardize the correct coding for individuals who attempt suicide. **Findings:** This has been done. **Current recommendations**: 1. Document the actions agreed upon in response to these reports in the minutes of the Performance Improvement Committee and track implementation. 2. Introduce the fishbone analysis to teams serving individuals with very high needs that place them and/or others in danger.
I.1.d.iv	location of incident;	**Current findings on previous recommendation:** **Recommendation, August 2007:** Document the analysis of these reports and the recommendations that result from the Performance Improvement Committee's discussion of these reports. **Findings:** For the period September 2007--February 2008, the facility produced a report that matched types of incidents with the location in which they occurred. It was surprising to find that 21% of incidents of self-harm occurred in the hallway. The hallway and dayroom were the sites of 58% of the incidents of peer-to-peer aggression. The analysis of acts of self-harm revealed that Unit 412 in Program II was the site of most of these acts. Six of the 14 individuals with the highest number of these incidents reside on Unit 412. On that unit, bedrooms and hallways were the site of approximately 45% of these acts. The study provided the location of these acts for each of the units in which they were reported.

		A trend report on the total number of incidents of aggression to self reported during the period January 2006—December 2007 in Program II indicated that the number of these incidents was higher in the first seven months of 2007 than in the same period in 2006. The number was lower in 2007 for four of the remaining five months. The average number of incidents per month was 23.5 in 2006 and 31.3 in 2007. The facility has also produced a trend report on the total number of incidents of aggression toward a peer reported during the period January 2006—December 2007 in Program II. The number of these incidents was higher in the first ten months of 2007 than in the same period in 2006. The numbers were equal in November and showed a sharp decline in December 2007 to less than half the incidents of December 2006. The average number per month was 20.4 in 2006 and 29.6 in 2007. The trend report for aggression to staff for the same period in Program II indicates that in the first seven months of 2007, the number exceeded the same period during 2006 and then ran below 2006 from August through December. The average number of incidents per month was 21.6 in 2006 and 27.3 in 2007. A trend analysis was also done on these types of aggression for three units in Program II—Units 412, 414 and 416. Caution should be exercised in interpreting these data, as changes in reporting requirements occurred in mid-2006, resulting in increased reporting. **Current recommendations**: Continue the production of incident trend reports and the conduct of focused studies. Ensure that the minutes of the Performance

		Improvement Committee reflect discussion of these findings and the identification of action steps.
I.1.d.v	date and time of incident;	**Current findings on previous recommendation:** **Recommendation, August 2007:** Document the discussion of this and like reports and any recommendations identified during the review by the Performance Improvement Committee. **Findings:** The data described below in Other Findings is presented to and reviewed by the Performance Improvement Committee. The recommended action was to promulgate the findings. **Other findings:** Incidents have been tracked by type and day of the week for the period September 2007—February 2008. No incidents occurred on the weekends for 40 of the 53 separate types of incidents. Most incidents occurred mid-week, Tuesday, Wednesday and Thursday. The time of incidents has been tracked for the period September 2007—February 2008. This data indicates that 31% of the incidents reported occurred within the four-hour period from 3:00 to 7:00PM. **Current recommendations**: Continue the current practice of tracking the time of occurrence of incidents and determine what, if any, measures are required to address the findings in the Performance Improvement Committee or other appropriate forum. Document the discussion and the action steps.
I.1.d.vi	cause(s) of incident; and	**Current findings on previous recommendation:**

		Recommendation, August 2007: Review the Headquarters Reportable Briefing forms to ensure that they reflect thoughtful consideration of the contributing factors. **Findings:** Review of ten Headquarters Reportable Briefing forms for incidents occurring in December 2007 and January 2008 revealed that the Analysis section was not completed on eight of the briefs and the Corrective Actions section was not completed on seven. On two briefs, one or more contributing factors were identified; these were the briefs for the 1/29/08 incident involving RZ and the 1/27/08 incident involving GL. Contributing factors were not identified on the remaining eight briefs. Corrective actions were identified in three briefs: verbal abuse allegation incident involving KR on 12/17/07, the peer-to-peer aggression incident involving BS on 11/16/07 and the walk-away incident involving KR. **Other findings:** The draft of Special Order 227.08 required the completion of the Headquarters Reportable Brief within 30 days. It was agreed that this left insufficient time for the completion of the investigation and review of the incident. It was further agreed that the draft would be revised to allow 60 days for the completion of the briefs in the hope that this would result in a thoughtful review and analysis of incidents. It was also agreed that injuries of unknown origin that required medical attention would require a Headquarters Reportable Brief. **Current recommendations**: 1. Finalize Special Order 227.08. 2. Review Headquarters Reportable briefs for completeness and

		thoroughness under the broader timeframes.
I.1.d.vii	outcome of investigation.	**Current findings on previous recommendation:** **Recommendation, August 2007:** Revise summary statements to support the determinations made, citing specific information and addressing conflicting information. **Findings:** See I.1.b.iv.3(viii). **Other findings:** The facility has not produced a report on the outcome/determination of investigations. Review of the Hospital Police investigation log for the period July 2007—January 2008 indicates that three cases were substantiated and 19 were not. **Current recommendations**: Produce and review a report on incident type and outcome.
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 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	**Current findings on previous recommendation:** **Recommendation, August 2007:** Continue current practices related to the removal of staff members when credible allegations of abuse, neglect and exploitation are made. **Findings:** The facility continues to remove staff members when there is an allegation of abuse. **Other findings:** In the investigations reviewed, the named staff person was initially removed from the unit until further investigation/review was

	where the investigation indicates that the staff person or volunteer may pose a risk of harm to such individuals.	completed. Removal was specifically documented in the SIR and/or the investigation report. The facility reported that in the period August 2007--January 2008, eight applicants for employment, one contractor and one volunteer applicant did not receive fingerprint clearance and were not engaged by the facility. See also I.1.a.iv for background clearance information on nine staff members that indicates the date of clearance was available for six of the individuals and clearance was referenced without a specific date for two others. The third individual was hired 20 years ago and documentation of the background check is not available. **Compliance:** Partial. While there is evidence that named staff members are removed from the units when there is a credible allegation of abuse, neglect or exploitation, since investigations have been closed and staff members returned to their previous positions before investigations were complete, the facility cannot be determined to be in substantial compliance. **Current recommendations**: Discontinue the practice of closing cases before the investigation is complete.

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. M. Nunley, Standards Compliance Director 2. M. McNeil, Standards Compliance 3. C. Lusch, Clinical Administrator 4. L. Dieckmann, Standards Compliance Lead Psychologist 5. S. Gutierrez, Standards Compliance Reviewed: 1. Aggregate key indicator data 2. Multiple aggressor and multiple victim reports 3. Weekly trigger meeting minutes 4. AD 3133.1 Trigger Response 5. Report of WRT Responses to Activated Triggers 6. Data regarding WRTs' responses to triggers 7. Performance Improvement Committee minutes 8. Standards Compliance studies and trend reports
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 recommendations:** **Recommendation, August 2007:** Revisit and clarify the business rules for counting key indicators so that consistent information is collected across all facilities. **Findings:** DMH Headquarters is ensuring that the business rules for key indicators are consistent across the facilities.

		Other Findings: See I.1.d.i and I.1.d.iv for discussion of trend and pattern reports on incidents and Standards Compliance studies on self-harm and aggression. **Current recommendations**: Increase the number and kind of reports that shed light on high-risk situations and individuals. Document the discussion of these report and the action steps identified.
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 recommendation:** **Recommendation, August 2007:** Same as Recommendation in I.2.a.i. **Findings:** See above. **Other findings:** The data for individuals who have been the victim of two or more physically aggressive acts for the period August 2007—February 2008 indicates that nine individuals appear in total and two individuals, JV and AF, appear for two consecutive months. Further review reveals that several of these individuals were victimized by the same peer multiple times. For example, in December 2007, CO was the victim of aggression by JR three times in a seven-day period. Medical treatment was necessary in one incident. Overall, no treatment was necessary in 27 incidents, first aid was provided in five incidents and medical treatment in one. Data for individuals engaging in two or more physically aggressive acts

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<td>during the same time period indicates that one individual (ML) appears on the list in each of five months and another individual (WH) appears in each of four months.

Further analysis finds that 27 individuals hurt 123 individuals in 90 incidents during the seven-month time period.

<table>
<tr><th>Month</th><th>Number of incidents</th><th>Number of aggressors</th><th>Number of victims</th></tr>
<tr><td>August 2007</td><td>18</td><td>5</td><td>22</td></tr>
<tr><td>September 2007</td><td>11</td><td>3</td><td>10</td></tr>
<tr><td>October 2007</td><td>14</td><td>3</td><td>10</td></tr>
<tr><td>November 2007</td><td>22</td><td>4</td><td>26</td></tr>
<tr><td>December 2007</td><td>18</td><td>5</td><td>22</td></tr>
<tr><td>January 2008</td><td>18</td><td>4</td><td>22</td></tr>
<tr><td>February 2008</td><td>11</td><td>3</td><td>11</td></tr>
<tr><td>Total</td><td>90</td><td>27</td><td>123</td></tr>
</table>

Current recommendations:
1. Review the data and target the WRPT responses for individuals who are most frequently victimized and those who are the most frequent aggressors as a starting point to ensure an appropriate clinical response has been implemented.
2. Track individuals who are aggressors and victims multiple times to determine if interventions are effective.</td>
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<td>I.2.a.iii</td>
<td>identification of systemic trends and patterns of high risk situations.</td>
<td>Current findings on previous recommendation:

Recommendation August 2007:
Expand the type of reports produced and document the facility's discussion of the reports and any measures recommended in response.</td>
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		Findings: See I.1.d.i and I.1.d.iv for other reports that have been completed by Standards Compliance. This department has also completed a study on falls that began 18 months ago. It identified Unit 412 as the having the highest number of falls. The individuals with the most falls are referred to the Falls Committee, composed of clinicians in the physical therapies, physician, nurse, psychologist and a pharmacist who make recommendations to the WRTs. **Current recommendations**: Continue the work being done by Standards Compliance in studying high-risk situations and individuals who constitute a high risk to themselves and others.
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 1, August 2007:** Discuss this report in the appropriate forum to determine if the results are as expected. **Findings:** The reports on the response of WRPTs and the implementation of these interventions have been shared in the Performance Improvement Committee. **Recommendation 2, August 2007:** Take appropriate measures to get responses back from WRPTs to ensure attention is being paid to these high-risk individuals.

		Findings: See I.2.b.ii. **Current recommendations**: See I.2.b.ii.
I.2.b.ii	timely corrective actions by teams and/or disciplines to address systemic trends and patterns;	**Current findings on previous recommendation:** **Recommendation August 2007:** Take appropriate measures to get responses back from WRPTs to ensure attention is being paid to these high-risk individuals. **Findings:** The facility has not been successful in getting responses back from WRPTs when an individual has reached a trigger. This is reportedly due in part to misunderstandings, e.g., the team believes it had to respond only to new triggers that an individual had not reached before. **Other findings:** The facility data shows a 20% response rate to triggers from WRPTs in January 2008. The monthly average response rate for the period August—December 2007 was 16%. This is consistent with this monitor's findings from the review of triggers for the one-week period January 21-25, 2008, which revealed a 75% no-response rate (no response was received for 40 of the 53 triggers). In an effort to raise the visibility of the poor response rate, the facility will begin producing a monthly report that identifies the type and number of triggers by unit and the number of responses received. This report will be distributed to the Program Directors and the Performance Improvement Committee.

		Current recommendations: Implement the plan to produce and distribute a monthly report on triggers by unit with the expectation that this will increase the number of responses.
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, August 2007:** Track the discussion of individuals in the weekly trigger meeting and ensure that all discussions come to closure in a timely manner. **Findings:** As reported, the facility has only a 20% response rate from WRPTs. This is not due to a failure to notify the teams in a timely fashion. **Current recommendations**: Same as in I.2.b.ii above.
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, August 2007:** Improve the response from units back to the Standards Compliance and to the weekly trigger meeting. **Findings:** See findings in I.2.b.ii. **Other findings:** The problem does not lie in the notification process, but rather in the lack of response back to Standards Compliance from the WRPTs. **Current recommendations**: Same as in I.2.b.ii.

I.2.b.v	monitoring and oversight systems to support timely implementation of interventions and corrective actions and appropriate follow up.	**Current findings on previous recommendations:** **Recommendation 1, August 2007:** Select a sample of the responses from WRPTs and ensure that the actions described have been implemented by the date indicated. **Findings:** The facility has implemented this recommendation. Standards Compliance selects a sample of 20% of the responses received each month and monitors for implementation. The facility data for September 2007—January 2008 shows implementation rates ranging from 67% to 90%. The January 2008 rate was 83%. This monitor's limited review of implementation is consistent with these findings. Review of the implementation of five responses received for triggers identified during the week of January 21-25, 2008 found that four had been implemented (medication changes) and one had not (consultation ordered). **Recommendation 2, August 2007:** Produce a report of these findings and share it with the Performance Improvement Committee and the sampled units. **Findings:** The information described above was shared with the Performance Improvement Committee. **Current recommendations**: Same as in I.2.b.ii.
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 recommendation:** **Recommendation, August 2007:** See recommendations throughout this report that address the

		facility's self-assessment process. **Findings:** Overall, the data presented through the self-assessment process has improved. **Other findings:** The November 27, 2007 minutes of the Performance Improvement Committee describe the four priorities of the MSH 2007-2008 Performance Improvement Plan: staff development, employee satisfaction, focus on aggressive acts to others and aggressive acts to self. The facility either has completed or is in the process of planning work on these priorities. **Compliance:** Partial. **Current recommendations**: Continue implementation of plans to address the facility's priorities.

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. H. Mears, Chief of Police 2. D. Hill, Health and Safety 3. M. Marshall, Chief of Plant Operations 4. G. Hahn, Hospital Administrator Reviewed: 1. AD 3412: Sexuality and Safety of Individuals 2. Nursing Policy 321: Bowel and Bladder Incontinence Management 3. Suicide/Safety Priority Grids 4. WRPs of 15 individuals 5. Nursing training records 6. Facility audits of WRPs for individuals with incontinence and audits of the response to individuals involved in sexual contact incidents Toured: 1. Unit 405 2. Unit 409 3. Unit 411 4. Unit 412 5. Unit 414
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, August 2007:** Take appropriate action when a unit does not respond to an inspection report to ensure that issues have been addressed. **Findings:** The facility reports that due to changes in procedure, with non-

		responders being reported to the Clinical Administrator, the response rate has risen from 66% in July 2007 to 100% in January 2008. **Recommendation 2, August 2007:** Review environmental conditions more critically during daily and end-of shift inspections. **Findings:** Review of the end-of-shift monitoring reports on several units indicated that environmental rounds were conducted. The units were clean at the time this monitor toured them. One individual stated at the Council Senate meeting that the facility is cleaner now than in the past and two unit staff members made the same comment during the tour. **Recommendation 3, August 2007:** Direct attention in the WRP to the needs of individuals who compromise their own and the health of others by unsanitary bathroom habits. **Findings:** The facility is compiling a list of individuals who have hygiene and grooming addressed in their WRP. Work still needs to be done on behalf of those individuals who have need for hygiene and grooming interventions but whose WRPs do not address this. **Other findings:** The facility reports that it has taken several measures directly related to environmental safety: all spring mattresses have been replaced by pan beds, shower grab bars and shower heads have been modified or replaced so that they no longer support a ligature and glass windows have been replaced with plexiglass. A budget proposal has been submitted for changing the bathroom partitions. The push device for turning on the

		shower will be shortened again to ensure it will not hold a ligature. MSH is using a Suicide/Safety Priority Grid for identifying repairs needed to conditions that present a suicide/safety risk. A suicide hazard was identified in several areas during this monitor's tour of the units: the ventilation screens have holes large enough to string a ligature through. This was pointed out to and discussed with the accompanying staff. This is particularly dangerous where these screens are directly above toilets or where furniture can be moved to directly below them. While it is being determined how these screens can be replaced--smaller mesh screens would compromise ventilation--the accompanying staff were asked to make all unit staff aware of this hazard. *The Suicide/Safety Grid completed on 8/29/07 for Room 221 on Unit 415 states, "Air vent with metal grid had strip of sheet hanging. Possible to hold body weight?" This should have alerted the facility to the danger these screens might represent.* Four women in one bedroom on Unit 412 were not allowed to use sheets or pillowcases because these presented a danger that the women might hurt themselves. Review of the WRPs of three of the four women revealed no order for Observational Status for any of the women; the WRP for one woman specifically stated that she did not engage in self-harming behavior; the WRP for a second woman discussed self-harming behavior but nothing that would require the removal of sheets and pillowcases; and the third woman was determined to be at low risk for "danger to self." These restrictions were not approved by the Executive Director. Individuals from the forensic compound are handcuffed and shackled when transported to the Rehabilitation Building. Once inside, only one pair of limbs is released. These restraints discourage participation in

		therapy, as individuals refuse rather than be restrained in this manner. It further compromises some therapies and the safety of the individuals, e.g. balance exercises with hands cuffed limits the protection from falls. The facility hopes to get modular buildings and outfit them for therapies within the compound. **Compliance:** Partial. **Current recommendations**: 1. Alert unit staff to the suicide hazard created by the ventilation screens, particularly those directly above toilets and in other private areas where furniture could be moved to access them. 2. Continue efforts to keep the environment clean. 3. Investigate the bedroom on Unit 412 discussed above and take measures to restore full bedding to the individuals. Ensure that there are no other units in the facility with restrictions that have not been approved by the Executive Director. 4. Clarify procedures for getting approval for additional restrictions on individuals, so that there is documentation that approval had been received from the proper authority. 5. Secure the Rehabilitation building and allow individuals to fully participate in therapies until a permanent solution is provided.
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 recommendations:** **Recommendation, August 2007:** Continue current practice. **Findings:** The facility reports that in the period August 2007—January 2008, Plant Operations responded to 94 calls and corrected all of the problems cited. More calls were received during the warmer weather.

		Other findings: The units visited were comfortable. **Compliance:** Substantial, based on a limited sample of units. **Current recommendations**: 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 recommendations:** **Recommendation 1, August 2007:** Implement the Nursing Policy as revised in June 2007 and continue to monitor for compliance. **Findings:** Training on Nursing Policy 321: Bowel and Bladder Incontinence Management began in July and continued until nearly 1000 staff members were trained (per training records supplied). **Recommendation 2, August 2007:** Expand the monitoring form to move it beyond a paper review to include an observation of the individual and interview when possible to determine if individual is clean, dry and odor-free and whether he/she is cooperating in addressing the incontinence problem. **Findings:** This recommendation has been implemented at MSH and the other facilities. The statewide monitoring tool was revised and was implemented at MSH on February 1, 2008.

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Other findings:
Review of the WRPs of 10 individuals identified as having a problem of incontinence revealed that there was no current recognition of the problem in the WRP for three of the ten, as indicated below:

<table>
<tr><th>Individual's initials</th><th>Listed as problem</th><th>Identified in focus 6</th><th>Objective and interventions</th></tr>
<tr><td>KG</td><td>Yes</td><td>Yes</td><td>Yes</td></tr>
<tr><td>RF</td><td>Yes</td><td>Yes</td><td>Yes</td></tr>
<tr><td>MA</td><td>No</td><td>No</td><td>No</td></tr>
<tr><td>HC</td><td>No</td><td>Yes</td><td>Yes</td></tr>
<tr><td>TC</td><td>No</td><td>Yes-inactive</td><td>Yes</td></tr>
<tr><td>DL</td><td>Yes</td><td>Yes</td><td>Yes</td></tr>
<tr><td>JL</td><td>Yes</td><td>Yes</td><td>Yes</td></tr>
<tr><td>MD</td><td>Yes</td><td>Yes</td><td>Yes</td></tr>
<tr><td>MC</td><td>Yes</td><td>No</td><td>No</td></tr>
<tr><td>SH</td><td>No</td><td>No</td><td>No</td></tr>
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The facility data for August 2007—January 2008 indicates 50% of the individuals sampled had incontinence listed as a problem and incontinence was identified in Focus #6 in 59% of the individuals. The facility also produces this data broken down by unit.

Compliance:
Partial.

Current recommendations:
Continue to monitor the support provided to individuals with incontinence and share this information with the programs so that they can take action to ensure adequate care and support.

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<tr>
<td>I.3.d</td>
<td>Each State hospital thoroughly reviews and revises, as appropriate, its policy and practice regarding</td>
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Current findings on previous recommendations:

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	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	**Recommendation, August 2007:** Review AD 3412 and clearly identify those portions that apply only to adults. **Findings:** This clarification has been made in the policy. **Other findings:** The facility audited 22 sexual incidents in the period August 2007—January 2008. Items with 100% compliance included: • In all instances between September 2007 and January 2008, a physician and program management were notified; • A psychiatrist was notified in all cases; • Chart documentation was adequate; • The individual was advised why an intervention was necessary. Review of two of the five incidents in January 2008 revealed no documentation that a physician was notified in one of the incidents. Contrary to the facility's findings that all five individuals were provided psychological care and sexual education, this monitor did not find documentation of these services for one individual (JG, 1/15/08). The January facility audit indicated that a dependent adult abuse recording form (SOC 341) was required in all five instances, but was completed in only three. It may be that the form was not necessary, as the abuse was not allegedly perpetrated by a caregiver. **Compliance:** Partial. **Current recommendations:** 1. Ensure that auditors are aware of the circumstances that require a

		SOC 341. 2. Conduct a look-behind audit of a sample of cases to test the reliability of the data. Identify problems, if any, and provide the necessary training to correct the problems.
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, August 2007:** Identify all Mall providers and check that list against the required course attendance sheets to ensure that all have completed the required courses. **Findings:** The facility has implemented this recommendation with the result that it found that 53% of its 58 non-clinical Mall providers have completed Group Leadership training and 27 staff still require training. Training is available quarterly during the Mall break. **Compliance:** Partial. **Current recommendations**: Identify a method whereby the remaining staff can be trained expeditiously.

J. First Amendment and Due Process		
J		**Summary of Progress:** 1. Administrators, including the Executive Director, continue to attend Council and Senate meetings, answer questions as candidly as they can and respond to the concerns expressed by the individuals. 2. The Individuals' Council is active in providing perspective to facility leadership on issues that directly affect the quality of life of individuals. 3. The conduct of meetings and the minutes reflect a coherent and fair venue for raising and seeking resolutions to issues. 4. The Council conducted a Safety and the Environment survey.
J	Each State hospital unconditionally permits individuals to exercise their constitutional rights of free speech, including the right to petition the government for redress of grievances without State monitoring, and provides them due process.	**Methodology:** <u>Interviewed</u>: Several individuals during unit tours <u>Reviewed</u>: 1. Individuals' Council meeting minutes for August, September, November and December 2007 2. Individuals' Council's survey results—January 2008 <u>Observed</u>: Meeting of the Council Senate
J		**Current findings on previous recommendation:** **Recommendation 1, August 2007:** Continue current practice of soliciting input from the Individual Council on substantive matters.

		Findings: Council minutes indicate that individuals have been involved in surveys, an art contest to promote wellness and recovery, and had input into the "allowables" list. The Individuals' Council November minutes document an explanation of the LPS (Lanterman-Pertis-Short) status by the Chief of Social Work provided at the request of the Council. **Recommendation 2, August 2007:** Continue the work of the Safety Team. **Findings:** The Team has worked on the Sexuality and Safety of Individuals policy. **Recommendation 3, August 2007:** Clarify whether there is a problem with individuals being denied copies of their WRPs and take appropriate action. **Findings:** MSH has trained the WRPTs on the requirement to give individuals a copy of their WRP. Approximately 100 individuals were sampled each month between August 2007 and January 2008, with the finding that 81% of those sampled had received a copy of their WRP. **Recommendation 4, August 2007:** DMH should exercise any influence it has in increasing the capacity of CONREP. **Findings:** Training for clinicians and managers on CONREP requirements in order to improve the discharge process and process changes made by the Forensics Services Director requiring psychiatrists to call CONREP regarding future recommendations are two of the efforts cited as measures taken by the facility to improve the likelihood of successful

discharges.

Other findings:
The main topic of the Senate meeting was inadequate housing resources within CONREP. Individuals spoke about the frustration of having achieved their discharge criteria and yet not being able to move to a less restrictive environment because of the lack of placements, particularly in certain counties.

The Individuals' Council meeting minutes for August 2007 raise problems about the new "allowables" list. The issue is raised repeatedly in the following months, and as of the December minutes, all of the issues had not yet been resolved.

Selected questions from the January 2008 Safety and the Environment survey completed by 124 individuals yielded the following results.

Question	% Yes
Feel safe	77
Environment clean and safe	78
Access to personal hygiene supplies	91
Treated with respect	87
Substantive input into therapeutic & rehab services	80
Family, advocates & attorneys encouraged to participate	70
Grievance process works	73
Know how grievance was resolved	66
If you see abuse/neglect, can you report it	86

Compliance:
Partial.

		Current recommendations: 1. DMH should continue to exercise any influence it has in increasing the capacity of CONREP. 2. Hold a Council meeting for the express purpose of discussing the "allowables" list. Advertise the purpose of the meeting in advance and ensure the presence of administrators, the Chief of Police, and anyone else needed to answer questions. 3. Ensure that procedures are in place and are working effectively to advise individuals of the results/outcome of their grievances.