

REPORT 1
NAPA BASELINE EVALUATION

July 24-28, 2006

THE HUMAN POTENTIAL CONSULTING GROUP
ALEXANDRIA, VIRGINIA

Introduction

A. Background Information

The evaluation team, consisting of court monitor (Mohamed El-Sabaawi, M.D.) and three expert consultants (Vicki Lund, Ph.D., M.S.N, A.R.N.P.; Ramasamy Manikam, Ph.D.; and Elizabeth Chura, M.S.R.N.) visited Napa State Hospital (NSH) from July 24 to 28, 2006 to evaluate the facility's compliance with the Enhancement Plan (EP). The evaluators' objective was to develop a detailed baseline assessment of the status of compliance with all action steps of the EP.

The baseline 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.

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.

B. Methodology

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

C. Findings

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

1. Key Indicator Data

The key indicator data are graphed and presented in the appendix. At this stage, the following observations are made:

- a) The key indicator data provide a global assessment of the clinical and process outcomes at the facility and should not be seen as just another requirement of the EP.
- b) At present, the key indicators lack completeness, consistency and reliability. As a result, the data cannot provide the basis for an accurate global assessment. Consequently, it cannot be used to improve the functional status of the individuals and/or drive changes in processes at the system level. Specific deficiencies include:
 - i. The data are not provided on all required areas. Missing data include the fields of homicidal threats or ideation, one-to-one observations for behavioral/psychiatric reasons, medication variances, non-adherence to Wellness and Recovery Plans, neurological and medical conditions (seizure disorders, diabetes mellitus, aspiration pneumonia, skin integrity, polydipsia and bowel obstruction) and stat medications.
 - ii. The available data are incomplete. Examples include the fields of body weight and suicidal threats or ideation.
 - iii. The data are not collected and presented in a timely manner. There is a need to accelerate efforts to automate data collection systems.
 - iv. The data collection systems and the definition of many key indicators appear to vary from facility to facility. These must be uniform statewide.
 - v. The reliability of the data is an issue that must be addressed by the facility.

2. Monitoring

The facility has developed a large number of monitoring tools to assess its compliance with the EP. The following observations are relevant to this effort.

- a) Many of the facility's tools are well aligned with the requirements of the EP. Examples include the tools related to case formulation, inter-unit transfers, high risk medication uses (e.g. PRN medications, benzodiazepines, anticholinergics and polypharmacy), court assessments and psychological assessments.
- b) A variety of the tools do not address the key requirements of the EP (e.g. most WRP processes and general medical services).

- c) Some tools are redundant, repetitive and contain more than one function in the same item. This lends itself to misinterpretation by the raters and contributes to lack of reliability. All tools need to be consolidated and clearly aligned with the key requirements in the EP.
- d) Not all the tools are accompanied by instructions and operational definitions that can standardize the use within and across the facilities.
- e) Monitoring tools are not used accurately. For example, raters are often very generous in their ratings, invalidating the facility's self-assessment of progress in the implementation of the EP.
- f) There is no reliability data on internal monitoring. Approximately 20% of the data collected should be assessed for reliability.
- g) Most often the sample size is too small and the method of selection is unstated. The sample size must be representative of the total population or subpopulations that are being assessed.
- h) Monitoring is not undertaken by staff that is knowledgeable and dedicated specifically to monitoring. This is a system deficit that is evident in many disciplines. New positions are needed in each discipline to undertake this function. For example, monitoring in psychiatry may be best performed by a senior or lead psychiatrist within a new oversight model that provides dedicated positions for chief of service and a lead for each program.
- i) All monitoring tools must be standardized for use statewide.
- j) Given the amount of monitoring that is required, the tools and data collection must be automated.

3. Self-Evaluation

Using the above mentioned monitoring system, the facility has conducted a self-evaluation of its processes and status of compliance relevant to the EP. This process is an essential tool to ensure proper attention by facility staff and leadership to the expectations of the EP as well preparing the facilities for eventual self-monitoring independent of external oversight. The following observations are important at this stage:

- a) The above mentioned monitoring deficiencies must be corrected to ensure that that the process is meaningful and has integrity.
- b) In the process of verifying the validity and reliability of the data, the court monitor and expert consultants require that the facilities readily demonstrate methods of data collection, where the data is documented and information about timeliness, completeness and quality of the documentation.
- c) To ensure the proper utilization of the current monitoring tools in the process of self-evaluation, the tools must address quality of services and not be limited to timeliness and presence or absence of various components. It is expected that quality indicators change slowly overtime, but the process must be oriented to these indicators from the beginning.

4. Implementation of the EP

a) Structure of current and planned implementation:

- i. The state and its consultants have instituted a person-centered wellness and recovery oriented model of service delivery. This model embodies all the key requirements of the EP. It provides the basis for services that can meet the full needs of individuals, including not only reduction of symptoms of the illness but also provision of skills and supports to assist individuals in overcoming the impairments that accompany the illness and interventions to improve the quality of life of the individuals.
- ii. The Wellness and Recovery Planning (WRP) model is a state-of-the-art system that utilizes the potential of the recovery model for all individuals served in the state inpatient system, including all individuals with forensic issues.
- iii. The Positive Behavior Support (PBS) and By CHOICE programs are by design state-of-the-art.
- iv. The Psychosocial Rehabilitation Mall (PSR) mall is state-of-the-art in terms of its potential for delivering recovery-focused services.

b) Function of current and planned implementation:

- i. Although there is an excellent manual of WRP, the implementation of the principles and practice requirements outlined in this manual is, in general, inadequate.
- ii. Many staff members are not familiar with the actual requirements of the EP and therefore have little knowledge of the key changes that they need to make.
- iii. Although many professional and direct care professionals have embraced the new model, some key disciplines have not yet learned the model or accepted its potential to achieve the desired outcomes.
- iv. Staff is not fully conversant with the recovery model, concepts of psychiatric rehabilitation, and the PBS and By CHOICE systems.
- v. Functional outcomes of the current structural changes are yet to be developed and implemented to guide further implementation.
- vi. In general, staff appears to utilize the format of the new system as a vehicle to provide the same content of the old system.

D. Monitor's Evaluation of Compliance

The status of compliance is assessed considering the following factors:

1. An objective review of 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 is inconsistent with these patterns and trends.
6. When no instance of a specific requirement was found in the baseline assessment, the compliance was rated as Not Applicable for This Evaluation.

E. Next Steps

1. The following is the schedule of the baseline assessments of facilities through the end of this calendar year.

	Sep	Oct	Nov	Dec
MSH	18-22			
ASH			13-17	
PSH				4-8

2. All compliance reports should be reviewed and utilized, as applicable, by all facilities to guide implementation efforts regardless of the schedule of facility-specific assessments.

Section	Enhancement Tasks	Monitoring Instruments Source Documents	What the Court Monitor will be looking for
A	Definitions		
1	Effective Date		
	The Effective Date will be considered the first day of the month following the date of execution of the agreement by all parties. Unless otherwise specified, implementation of each provision of this Plan shall begin no later than 12 months after the Effective Date.		
2	Consistent with Generally Accepted Professional Standards of Care		
	A decision by a qualified professional that is substantially aligned with contemporary, accepted professional judgment, practice, or standards as to demonstrate that the person responsible based the decision on such accepted professional judgment.		
B	Introduction		
	Each State hospital shall use a Recovery philosophy of care and a Psychiatric Rehabilitation model of service delivery. Therapeutic and rehabilitative services provided by each State hospital shall be based on evidence-based practices and practice-based evidence, shall be age-appropriate, and shall be designed to: strengthen and support individuals' recovery, rehabilitation, and habilitation; enable individuals to grow and develop in ways benefiting their mental health, health and well being; and ensure individuals' reasonable safety, security, and freedom from undue bodily restraint. Relationships between each State hospital staff and the individuals whom they serve shall be positive, therapeutic and respectful.		
	Each individual served by each State hospital shall be encouraged to participate in identifying his or her needs and goals, and in selecting appropriate treatment options. Therapeutic and rehabilitation services shall be designed to		

	<p>address each individual's needs and to assist individuals in meeting their specific recovery and wellness goals, consistent with generally accepted professional standards of care. Each State hospital shall ensure clinical and administrative oversight, education, and support of its staff in planning and providing care and treatment consistent with these standards.</p>	
C	Integrated Therapeutic and Rehabilitation Services Planning	
	<p>Each State hospital shall provide coordinated, comprehensive, individualized protections, services, supports, and treatments (collectively "therapeutic and rehabilitation services") for the individuals it serves, consistent with generally accepted professional standards of care. In addition to implementing the therapeutic and rehabilitation planning provisions set forth below, each State hospital shall establish and implement standards, policies, and practices to ensure that therapeutic and rehabilitation service determinations are consistently made by an interdisciplinary team through integrated therapeutic and rehabilitation service planning and embodied in a single, integrated therapeutic and rehabilitation service plan.</p>	<p>Summary of Progress:</p> <ol style="list-style-type: none"> 1. NSH is transitioning from a traditional medical psychiatric and forensic model of care to a person-centered Wellness and Recovery system. 2. NSH has a Wellness and Recovery Plan (WRP) manual that codifies state-of-the-art elements in recovery-oriented services for individuals with serious mental illnesses. 3. NSH provides services within an interdisciplinary team model. 4. NSH has initiated improvements in its substance abuse programs guided by the adoption of a manual that contains current generally accepted professional standards of care. The facility developed a training curriculum for its staff that is aligned with the stages of change model. 5. Many of the interdisciplinary providers at NSH are dedicated and caring professionals who are making a sincere effort to provide services within the new wellness and recovery system. 6. NSH has implemented the new template for the Wellness Recovery Plan (WRP). 7. NSH has implemented a new model of providing services to individuals through the psychosocial rehabilitation mall. This model represents current professionally accepted standards in psychosocial rehabilitation of individuals with serious mental illnesses in hospital settings.

		<p>8. NSH has developed and implemented a variety of monitoring instruments, including both process observations and chart audits, to assess its compliance with the enhancement plan.</p> <p>9. NSH has completed a thorough self-assessment process based on current monitoring instruments. The process has heightened staff awareness of the EP and its expectations.</p>
1	Interdisciplinary Teams	
	<p>The interdisciplinary team's membership shall be dictated by the particular needs and strengths of the individual in the team's care. At a minimum, each State Hospital shall ensure that the team shall:</p>	<p>Methodology: Attended WRP team meetings for quarterly reviews of individuals RJ (July 26, 2006) and KB, DW, and SH (July 27, 2006). Reviewed DMH Wellness Recovery Plan (WRP) Manual (Draft July 2006). Reviewed all WRP Conference Report Attendance Sheets for programs II (February and March 2006), and V (March and April 2006). Reviewed WRP Conference Monthly Program Report. Interviewed Carmen Caruso, the Treatment Enhancement Coordinator. Reviewed NSH Administrative Directive (AD) #785 regarding Wellness and Recovery Plan (WRP). Reviewed WRP Process Observation Forms. Reviewed Process Observation Summary Data of Quarterly and Annual WRP meetings (January 4, 2006 to May 23, 2006). Reviewed Chart Audit Forms. Reviewed Chart Audit Summary Data (February 22, 2006 to May 23, 2006). Reviewed the Psychiatric Physician's Manual. Reviewed training database of members listed in the WRP team membership chart. Reviewed WRP training post-test.</p>
a	<p>Have as its primary objective the provision of individualized, integrated therapeutic and rehabilitation services that</p>	<p>Findings: NSH has developed a draft DMH WRP manual. The manual (section 3.</p>

	<p>optimize the individual's recovery and ability to sustain himself/herself in the most integrated, appropriate setting based on the individual's strengths and functional and legal status and support the individual's ability to exercise his/her liberty interests, including the interests of self determination and independence.</p>	<p>Assessments, 3.2 Integrated Assessments, 3.4 Strengths, 3.5 stages and Readiness of Change) contains state-of-the-art principles and practice requirements in recovery-oriented services that meet the key elements in this section.</p> <p>NSH has developed a draft AD regarding the new WRP model, which is derived from the DMH WRP manual.</p> <p>NSH has instituted a training program of its WRP members on the principles and practice of WRP consistent with the elements outlined in this cell. The State consultant has initiated and currently supervises this program. The Treatment Enhancement Coordinator is the master trainer for the facility and there is a designated trainer for each program. NSH has developed a post-training test to assess competency of trainees. However, at present, there is no record of training to competency of either the program trainers or the WRP team members.</p> <p>Chart reviews (please see Section C.2 below) indicate that, in general, the process and content of Wellness Recovery Planning at NSH are deficient and that the principles and practice elements outlined in the DMH WRP manual are yet to be properly implemented.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Finalize, approve and implement the DMH WRP manual. 2. Provide documentation that WRP trainers and WRP team members have been trained to competency. 3. Continue and strengthen current training program. In particular, the facility needs to make further efforts to build the competency of program trainers and to increase
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		<p>training sessions for all members of the WRP teams.</p> <ol style="list-style-type: none"> 4. Streamline and refine current WRP monitoring instruments to reflect the specific recommendations in sections b through g below. 5. Ensure that the AD regarding WRP is aligned with the DMH WRP Manual.
b	<p>Be led by a clinical professional who is involved in the care of the individual.</p>	<p>Findings:</p> <p>At NSH, the psychiatrists are designated as the team leaders and coverage is provided by Psychologists during the absence of the designated leaders. The facility has developed and implemented a monitoring system to assess participation by "either Psychiatry or Psychology" in the team meetings. The system consists of a review of 10% sample of all programs and data indicate 100% compliance. The data does not identify the number of times when the designated leader was absent.</p> <p>The team meetings that this reviewer attended included participation by psychiatrists as team leaders in all cases. In reviewing the attendance sheets of programs II and V, there are only rare examples of non-attendance by psychiatry. However, the team meetings demonstrate that, with possibly one exception, the team leaders do not perform their primary function of ensuring a structure that allows members to: a) provide, combine and coordinate their efforts; b) address all relevant planning issues during the meeting time and c) obtain meaningful input from the individuals.</p> <p>The sequence of tasks identified in the DMH WRP manual regarding the team member responsibilities do not include the responsibility of the leader to ensure that members: a) communicate results of the assessments prior to the planning process and b) update the present status section of the case formulation.</p>

		<p>The DMH WRP manual includes team responsibilities at 7-day, 14-day, monthly, quarterly and annual reviews. The responsibilities at the 14-day and monthly reviews do not include discussion of PBS data, MOSES data and the individual's medical condition,</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Present data regarding presence of team leaders in terms of designated leader and coverage when the designated leader was not present. 2. Monitor both presence and proper participation by the team leaders. 3. Develop and implement a peer mentoring system to ensure competency in team leadership skills. 4. The Psychiatric Physician Manual should include specific requirements regarding WRP leadership. The requirements must be aligned with the WRP team responsibilities that are outlined in the DMH WRP manual. 5. The DMH WRP manual should include information regarding the leader's responsibility to ensure appropriate parameters for participation by the individual in the team meeting. 6. The DMH WRP manual should address the leader's responsibility to ensure that members provide concise presentation of the results of their assessments prior to the discussion of objectives and interventions. 7. The DMH WRP manual should address the leader's responsibility to ensure that the present status section of the case formulation is updated during the WRP team meetings and that other sections in the formulation are consequently updated as clinically indicated.
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		<p>8. The DMH WRP manual should combine tables 5.1 and 5.2 regarding team responsibilities during WRP reviews to include the same expectations regarding discussion of PBS data, MOSES data and the individual's current medical condition.</p>
c	Function in an interdisciplinary fashion.	<p>Findings: The DMH WRP manual (section 5.2, WRP Team Responsibilities at 7-day, quarterly and annual reviews) outlines the responsibilities of each team member. This outline contains the key requirements that enable an effective interdisciplinary process.</p> <p>NSH has instituted and implemented a monitoring tool- "Wellness and Recovery Plan (WRP) Process Observation Form." This tool assesses quarterly and annual meetings regarding compliance with this section. The observations are conducted by eight auditors from the Department of Standards Compliance. In performing this function, the auditors are trained to competency by the State consultant. The facility has data based on a review of an approximately 10% sample of WRP meetings (110 individuals). The data shows the following deficiencies that are relevant to the process of interdisciplinary functioning of the team, and the compliance rate is included for each category:</p> <ol style="list-style-type: none"> 1. "Each team member giving a summary report of the individual's progress on each team objective and progress in meeting discharge criteria (4% compliance)"; 2. "Interdisciplinary review with the individual regarding cultural preferences and concerns that may impact treatment (11% compliance)"; 3. "Interdisciplinary review of individuals following reports of suicidal threats or behavior (17% compliance)"; 4. "Interdisciplinary review of current risk factors e.g.

		<p>suicidal thoughts and/or behavior, AWOL (31% compliance)"; and</p> <p>5. "Identification of key questions or items to address with the individual (35% compliance)".</p> <p>Other data presented by NSH do not address the process of interdisciplinary functioning but, rather, the content of planning.</p> <p>Observations of the team meetings attended by this monitor confirm the low compliance rates of the key interdisciplinary functions that are identified in the facility's monitoring data. In addition, WRP team meetings reveal a pattern of deficiencies in the key processes that facilitate proper sequencing of tasks for team members and that ensure appropriate parameters for participation by the individuals in the team meetings. These deficiencies have resulted in team meetings that consist mostly of a series of disciplinary monologue assessments of the individuals at the expense of an interdisciplinary process that facilitates planning of services.</p> <p>Chart reviews (as per Section C.2) also demonstrate deficiencies in the content of planning (e.g. proper development and revision of case formulations, foci of hospitalization and interventions) that are, at least partly, a derivative of ineffective interdisciplinary functions.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Same as in C.1.a and b. 2. Ensure that WRP Process Observation Form is also used to assess team functions at the 7-day and 14-day conferences. 3. Ensure that monitoring items are aligned with the key requirements of each action step of the EP.
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d	<p>Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary, and appropriate psychiatric and medical care.</p>	<p>Findings: The Psychiatric Physician's Manual outlines two main duties of the psychiatrists--patient care and staff leadership. The duties encompass the responsibilities for therapeutic (psychiatric and medical) as well as rehabilitation services.</p> <p>NSH has conducted a survey to assess the views of WRP team members (four members in each of the five programs) regarding: a) adequate performance by the team leaders of the responsibilities identified in this section; and b) whether team leaders assumed these responsibilities. The results were affirmative in 47% (a) and 63% (b) of responders.</p> <p>The team meetings attended by this monitor indicate a pattern of deficiency in the first element in this item. Findings regarding the performance of team leaders in the provision of competent psychiatric and medical care are detailed in Sections D and F below.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Same as in C.1.a, b and c. 2. NSH should continue current practice of surveying the views of team members regarding the functions of their designated leaders.
e	<p>Ensure that each member of the team participates appropriately in competently and knowledgeably assessing the individual on an ongoing basis and in developing, monitoring, and, as necessary, revising the therapeutic and</p>	<p>Findings: Based on the WRP process observation data (10% sample), NSH has identified a variety of deficiency patterns. The following is a summary of the deficiencies that are relevant to this step, with the compliance</p>

	<p>rehabilitation services.</p>	<p>rates identified:</p> <ol style="list-style-type: none"> 1. "Assessments were presented by each discipline and are brief and non-redundant." (42%) 2. "WRP team revised or added new treatment objectives and/or interventions as appropriate." (45%) 3. "WRP team evaluated the need for additional assessments and when an assessment was indicated, a team member took the responsibility for scheduling and coordination of the assessment by the next WRP review." (42%) 4. "WRP team discussed with the individual his/her cultural preferences and concerns that may impact treatment." (11%) 5. "WRP team asked the individual for input in the evaluation of progress in meeting each treatment objective. Each objective was reviewed with the individual in light of target dates, data from interventions or need for new interventions." (28%) <p>In addition, auditors from the Department of Standards Compliance conducted chart audits of an approximately 20% sample. The audit is focused on the timeliness and quality of different components of the WRP. NSH has data that demonstrate the following deficiencies that are relevant to this section, and the compliance rates are included:</p> <ol style="list-style-type: none"> 1. "If the WRP includes a rule out or deferred diagnosis on Axis I or Axis II, it is not present for longer than 60 days from the day it was noted." (7%) 2. "When the individual has not met the objective at the target date, either the objective or the intervention is changed or a justification for continuing without change is included in the WRP." (30%) <p>The audit data do not include other important information to assess</p>
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		<p>this step.</p> <p>The team meetings attended by this monitor reveal a general pattern of deficiencies in the implementation of all the key process elements in this section. In addition, this monitor found deficiencies in the implementation of all the key content elements of the WRP system as outlined in section C (case formulation, foci of hospitalization, objectives and interventions) and section D (psychiatric assessments and reassessments) are such that the content of WRP is overall inadequate. The deficiencies in both process and content render the current implementation of the WRP system ineffective in meeting the treatment, rehabilitation and enrichment needs of the individuals. As mentioned earlier, the DMH WRP manual contains almost all required elements.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Same as in C.1.a through C.1.d. 2. Same as in D.1.a through D.1.e. 3. Improve clinical oversight to ensure competency in the processes of assessments, reassessments, interdisciplinary team functions and proper development and timely and proper updates of case formulations, foci of hospitalization, objectives and interventions. 4. Ensure that the monitoring tools adequately address the quality of assessments.
f	<p>Ensure that assessment results and, as clinically relevant, consultation results, are communicated to the team members, along with the implications of those results for diagnosis, therapy and rehabilitation by no later than the</p>	<p>Findings: NSH has monitoring data based on the use of the "WRP Process Observation Form" that reveal a number of deficiencies. The process involved a review of a 10% sample of WRP meetings. The following is an</p>

	<p>next review.</p>	<p>outline of the patterns of deficiency that are relevant to the key elements in this step, with the compliance rates indicated:</p> <ol style="list-style-type: none"> 1. "The assessments were presented by each discipline and are brief and non-redundant." (42%) 2. "The team reviewed current risk factors e.g. suicide, AWOL, etc." (31%) 3. "If there has been a suicide threat, behavior or report by others since last WRP, then the findings of the completed suicide assessment and treatment implications were discussed." (17%) 4. "WRP updated and continued to develop the case formulation." (44%) 5. "WRP team updated present status of the case formulation and diagnosis based on current assessments, progress reviews and the individual's thoughts and concerns about treatment." (59%) <p>In addition, chart audits of a 20% sample reveal 31% compliance with the requirement that the present status of the case formulation include assessments, results and implications for treatment.</p> <p>Observations of the team meetings attended by this monitor indicate general deficiency in the key requirements of presenting results of the assessments and analyzing those results to assess implications for diagnosis, treatment and/or rehabilitation of individuals.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Same as in C.1.a through C.1.e. 2. Ensure that monitoring items are not redundant and/or
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		overinclusive.
g	Be responsible for the scheduling and coordination of assessments and team meetings, the drafting of integrated treatment plans, and the scheduling and coordination of necessary progress reviews.	<p>Findings: The DMH WRP manual (3. Assessment, 3.1 Admission Assessment, 3.2 Integrated Assessment, 3.3 Clinically Indicated Assessment, 3.6 Assessment Schedule, 4. WRP Schedule and 4.3 WRP Conferences) includes practice requirements regarding the key elements in this step.</p> <p>NSH monitors the responsibility for drafting of WRPs and for review and revision of the plans as per schedule. Data based on the WRP process observation method (10% sample) show 88% compliance with the requirement that the team to identify a treatment team recorder who is responsible for drafting the document. The chart audit system demonstrates 54% compliance with the requirement to review and revise the WRP according to the established schedule.</p> <p>Review of charts by this monitor (see section D) indicates that the admission and integrated assessments are not being completed consistently on admission and long-term teams. Only three teams facility-wide have implemented the review of the WRPs according to the established schedule. Most teams review the plans only quarterly. The teams on the skilled nursing unit are yet to implement the admission and integrated assessments as well as WRP system.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that all assessments are completed on all units as per the schedule established in the DMH WRP manual. 2. Ensure that WRPs are completed and reviewed as per the schedule established in the DMH WRP manual. 3. Evaluate the current method for assigning responsibilities

		<p>for coordination and completion of assessments and WRPs and ensure compliance.</p> <p>4. Revise current monitoring instruments to address above recommendations.</p>
h	<p>Consist of a stable core of members, including at least the individual served; the treating psychiatrist, treating psychologist, treating rehabilitation therapist, the treating social worker; registered nurse and psychiatric technician who know the individual best; and one of the individual's teachers (for school-age individuals), and, as appropriate, the individual's family, guardian, advocates, attorneys, and the pharmacist and other staff.</p>	<p>Findings:</p> <p>The DMH WRP manual (2. Brief Definitions, 2.3 The WRP Team, 5. WRP Team Member Responsibilities) addresses the key requirement in this subsection.</p> <p>NSH monitors the attendance by core members in its WRP team conferences. The facility has data showing that some teams do not have the full complement of core members (e.g. T7B) and that, in some units (e.g. Q3/4), two teams assume the responsibility for the case load of three teams.</p> <p>The program monthly report indicates numerous vacancies in all disciplines in all programs.</p> <p>NSH has developed a monitoring tool to monitor whether WRP conferences are held as scheduled and attended by core members. The data are incomplete.</p> <p>This monitor's review of WRP Conference Report Attendance Sheets for programs II (February and March 2006), and V (March and April 2006) confirms the deficiencies identified in the facility's monitoring data.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <p>1. Recruit clinical staff and fill vacancies ASAP to ensure</p>

		<p>compliance with this requirement.</p> <p>2. Complete the process of monitoring of the attendance by core team membership.</p>
i	<p>Not include any core treatment team members with a case load exceeding 1:15 in admission teams (new admissions of 90 days or less) and, on average, 1:25 in all other teams at any point in time.</p>	<p>Findings: NSH has data that demonstrate that the majority of admission WRP teams exceed the ratio of 1:15 and that the majority of long-term teams exceed 1:25.</p> <p>Compliance: Partial.</p> <p>Recommendation: Same as in C.1.h #1.</p>
j	<p>Not include staff that is not verifiably competent in the development and implementation of interdisciplinary wellness and recovery plans.</p>	<p>Findings: The training database of members listed in the WRP team membership chart verifies that the majority of WRP team members have received WRP training provided by the State consultant and the master trainer. The facility has no documentation, at this time, that members were trained to competency.</p> <p>DMH has developed a WRP post-test that is yet to be implemented. The instrument is sufficient to ensure competency.</p> <p>This monitor's observations of team meetings reveals that most team leaders and members are not yet fully trained to meet the expectations in this step.</p> <p>Compliance: Partial.</p>

		<p>Recommendations:</p> <ol style="list-style-type: none"> 1. Same as in C. 1.a through C.1.f. 2. Implement the WRP training post-test to ensure competency of staff. 3. Include WRP training in new employee orientation and in the proctoring and mentoring of new employees during their first year of employment.
2	<p>Integrated Therapeutic and Rehabilitation Service Planning (WRP)</p> <p>Each State hospital shall develop and implement policies and protocols regarding the development of therapeutic and rehabilitation service plans, referred to as "Wellness and Recovery Plans" [WRP]) consistent with generally accepted professional standards of care, to ensure that:</p>	<p>Methodology:</p> <p>Attended WRP team meetings for quarterly reviews of individuals RJ (July 26, 2006) and KB, DW, and SH (July 27, 2006). Observed mall activities, both at the "virtual mall" and at group activities on the units.</p> <p>Reviewed charts of 49 individuals (RT, DS, DA, BJ, BAJ, MAP, MWP, VCB, VDB, DB, CR, TG, NJ, AA, KP, ST, GF, NA, RH, JS, EL, WJ, TNG, KZ, DF, JP, MA, TM, RP, MC, KP, RI, JL, BH, AG, JB, AG, DS, KP, CWP, NM, RL, ES, SD, RB, JR, SW, RS and PR). Reviewed DMH WRP Manual (Draft July 2006). Interviewed Scott Sutherland, D.O., Chief of Medical Staff. Interviewed Regina Ott, M.S. Program Director, Central Program Services. Interviewed Charles Oncea, Mall Program Director. Interviewed Kathy Michaels, Resource Coordinator, Central Program Services. Reviewed NSH AD # 785 regarding the Wellness Recovery Plan (WRP). Reviewed WRP Process Observation Forms. Reviewed Process Observations Data Summary (January - June 2006). Reviewed Chart Audit Forms. Reviewed WRP Chart Audit Data Summary (January - June 2006). Reviewed "My Activity and Participation Plan (MAPP)" database regarding hours of active treatment scheduled and attended. Reviewed PSR Mall Schedule.</p>

		<p>Reviewed PSR Mall curricula and manuals. Reviewed Mall Alignment Protocol. Reviewed list of all individuals by program x unit x scheduled hours of mall groups or individual therapy x actual hours attended. Reviewed list of all individuals by program x unit x actual hours of attendance during enrichment activities (outside of mall hours). Reviewed database of therapists verifying competency training and certification in substance abuse counseling. Reviewed list of all individuals by program x unit x scheduled medication education group (if needed) x actual attendance. Reviewed Medication Education group curriculum. Reviewed WRP Case Formulation Monitoring Form. Reviewed Substance Abuse Screening Policy. Reviewed Substance Abuse Check List and Data. Reviewed Mall Facilitator Monitoring Form. Reviewed NSH Key Indicator (trigger) Data for April through June 2006.</p>
a	<p>Individuals have substantive input into the therapeutic and rehabilitation service planning process, including but not limited to input as to mall groups and therapies appropriate to their WRP.</p>	<p>Findings: NSH has process observation (10% sample) monitoring data. The following is an outline of relevant patterns of deficiency and the compliance rates:</p> <ol style="list-style-type: none"> 1. "WRP team discussed with the individual changes in case formulation and diagnosis." (42%) 2. "WRP team discussed with the individual his/her satisfaction with treatment and services." (42%) 3. "WRP team reviewed with the individual By CHOICE points, preferences and allocations." (40%) 4. "WRP team discussed with the individual his/her cultural preferences and concerns that may impact treatment." (11%) 5. "WRP team asked the individual for input in the evaluation

		<p>of progress in meeting each treatment objective. Each objective was reviewed with the individual in light of target dates, data from interventions, or need for new interventions." (28%)</p> <ol style="list-style-type: none"> 6. "WRP team discussions relate treatment progress to meeting discharge goals with identification of potential clinical and non-clinical barriers to discharge." (43%) 7. "Individuals have substantive input into the therapeutic and rehabilitation service planning process as evidenced by a choice of groups, By CHOICE points preferences and allocations, formulation of objectives and behavioral expectations to meet discharge criteria, and choice and types of therapy offered." (46%) 8. "The individual knows what he/she is to do for each objective." (31%) <p>NSH has data based on the chart audit tool (20% sample of charts). Data indicate 54% compliance with the requirement that the team includes the individual's life goals in the individual's own words and, when appropriate, links them to treatment, rehabilitation and enrichment.</p> <p>The Positive Behavior Supports (PBS) team at NSH has surveyed the individuals (17% sample) to determine their views regarding participation in the WRP process. Results are as follows: a) 63% stated that their life goals in their own words were included in the WRP; b) 65% stated that they had the opportunity to provide input into or to choose their small groups, individual or group therapy and enrichment activities that are assigned in the WRP; c) 51% stated they knew the objective they are working on in the WRPs ;and d) 69% stated that their WRP team asks for their input in evaluating the progress they have made in meeting each objective.</p>
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		<p>As mentioned in the previous section, this monitor's observations of the WRP team meetings indicate that WRP teams, in general, do not obtain meaningful input from the individuals in the process of review and revisions of the plans. The main deficiency is that the individual's input is obtained in the context of performing disciplinary assessments rather than interdisciplinary planning of the services necessary to meet the individual's assessed needs.</p> <p>Compliance: Partial.</p> <p>Recommendations: Continue and strengthen WRP training that focuses on the process of engaging the individual in providing substantive input.</p>
b	Therapeutic and rehabilitation service planning provides timely attention to the needs of each individual, in particular:	<p>Compliance: Partial.</p>
b.i	initial therapeutic and rehabilitation service plans (Admission-Wellness and Recovery Plan ("A-WRP")) are completed within 24 hours of admission;	<p>Findings: On July 1, 2006, three (out of nine) admission teams began implementing the initial WRP conferences within 24 hours of admission. The skilled nursing unit is yet to implement the WRP system.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Implement the A-WRP within the first 24 hours on all admission teams. 2. Develop and implement a chart audit to ensure timeliness, completeness and quality of documentation. 3. Ensure implementation by skilled nursing unit of C.2. bi through C.2. b.iii.
b.ii	master therapeutic and rehabilitation service plans ("Wellness and Recovery Plan" (WRP)) are completed	<p>Findings: On July 1, 2006, three (out of nine) admission teams began</p>

	within 7 days of admission; and	<p>implementing this requirement. In all other teams, the master WRP conferences are completed at 14 days after admission. The WRP Chart Audit Form has an item that addresses the requirement of this section.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Begin implementation of master WRPs within 7 days of admission in all units. 2. Implement an audit system to ensure timeliness, completeness and quality of documentation.
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 12 th monthly review is the annual review.	<p>Findings:</p> <p>On July 1, 2006, three (out of nine) admission teams began implementing this requirement. In all other teams, the reviews are conducted quarterly.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Begin implementation of the required WRP conference schedule on all admission and long-term teams. 2. Develop and implement an audit system to ensure timeliness, completeness and quality of documentation.
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;	<p>Findings:</p> <p>The DMH WRP manual (7.3. Case Formulation, 7.5 Discharge Criteria, 7.6 Focus of Hospitalization, 7.7 Objectives and 7.8 Interventions) contains the key elements in this section.</p> <p>NSH has monitoring data based on chart audits of a 20% sample. The data show patterns of deficiency that are relevant to the requirements of this item. The following is a summary of the most relevant data, including compliance rates:</p> <ol style="list-style-type: none"> 1. "The WRP includes a case formulation developed in the 6-p

		<p>format. The case formulation will consider biomedical, psychosocial and psychoeducational factors as clinically appropriate." (25%)</p> <ol style="list-style-type: none"> 2. "The present status of the case formulation includes assessment results and implications for treatment." (31%) 3. "The case formulation considers such factors as age, gender, culture, treatment adherence, and medication issues that may affect the outcomes o treatment and rehabilitation interventions." (17%) 4. "When substance abuse is diagnosed on Axis I, it is documented on focus 5 and there is at least one objective and intervention." (57%) <p>However, chart reviews by this monitor indicate that WRPs currently performed at NSH generally fail to comply with the key element in this section. For example, treatment, rehabilitation and enrichment services tend to ignore the needs of individuals suffering from a range of disorders that require specialized objectives and interventions. Examples include cognitive disorders (e.g. RT, DS, DA, BJ-203133-4, DB, CR) and substance abuse disorders (DB, TNG, TG, EL and KZ) Some individuals suffering from seizure disorders are not assessed for the need to minimize the negative impact of treatment on the cognitive, behavioral and life quality of the individual (e.g. TG). In addition, observation of mall activities and chart reviews (RL, DS, ES, SD, RB, JR, SW, RS and RP) show that mall facilitators do not utilize or have access to WRP and assessments/reassessments data in their evaluations of the individuals' needs and progress.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Continue and strengthen training of WRP teams to ensure
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		<p>that:</p> <ol style="list-style-type: none"> a. The case formulation includes appropriate review and analysis of assessments to identify the individual's needs in the psychiatric, medical and psychosocial domains, and b. Foci of hospitalization addresses all identified needs of the individual in the above domains. <ol style="list-style-type: none"> 2. Develop and implement audit items to ensure that cognitive disorders, if present, are documented as a focus and that individualized and appropriate objectives and interventions are provided. 3. Develop and implement audit items to ensure that substance abuse, if present, is documented as a focus and that individualized and appropriate objectives and interventions are provided. 4. Develop and implement audit items to ensure that seizure disorders, if present, are documented as a focus and that individualized and appropriate objectives and interventions are provided. The documentation needs to address the interface between seizure disorders (and its treatment), psychiatric status (and its treatment) and psychosocial functioning of the individual.
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:	<p>Compliance: Partial.</p>
d.i	be derived from analyses of the information gathered from interdisciplinary assessments, including diagnosis and differential diagnosis;	<p>Findings: NSH has developed but not yet implemented a WRP Case Formulation Monitoring Form. The monitoring tool contains the key requirements in C.2. d.i through C.2. d.iv.</p>

		<p>At present, NSH monitors some elements that relate to the basic requirement in this item. The WRP process observation data (10% sample of team meetings) show the following patterns of inconsistent practice, including compliance rates:</p> <ol style="list-style-type: none"> 1. "The team reviewed current risk factors e.g. suicide, AWOL. " (31%) 2. "If there has been a suicide threat, behavior or report by others since last WRP, then the findings of the completed suicide assessment and treatment implications was discussed." (17%) 3. "The WRP team updated present status of the case formulation and diagnosis based on current assessments, progress reviews and the individual's thoughts and concerns about treatment." (59%) <p>NSH has additional monitoring data that show deficiencies related to the key elements of this step. The data are based on chart audit of a 20% sample. The most relevant patterns, including compliance rates, are:</p> <ol style="list-style-type: none"> 1. "The WRP includes a case formulation developed in the 6-p format. The case formulation will consider biomedical, psychosocial and psychoeducational factors as clinically appropriate." (25%) 2. "The WRP includes information on all five axes." (23%) 3. "If the WRP includes a rule out or deferred diagnosis on Axis I or Axis II, it is not present for longer than 60 days from the day it was noted." (7%) <p>Chart reviews by this monitor show evidence of case formulations that, in general, are not based on careful analysis of the information in the assessments. As a result, these formulations do not provide the basis for proper delineation of diagnosis and development and finalization of</p>
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		<p>a differential diagnosis (e.g. CR, NJ, AA and KP). This finding is also applicable to C.2.d.ii through C.2.d.i.v.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Continue and strengthen training of the WRP teams to ensure that the case formulation includes adequate review and analysis of assessments to establish appropriate diagnosis and differential diagnosis. 2. Implement the newly developed case formulation monitoring instrument. This instrument should consolidate most of the items in the current variety of tools as well as provide a more meaningful process. It should serve as the main tool to assess quality of case formulations.
d.ii	include a review of: pertinent history; predisposing, precipitating and perpetuating factors; previous treatment history, and present status;	<p>Findings:</p> <p>As mentioned above, NSH currently monitors this item by conducting chart audits of a 20% sample. Data show 25% compliance with the requirements that the WRP includes a case formulation developed in the 6-p format and that the case formulation considers biomedical, psychosocial and psychoeducational factors, as clinically applicable, for each category.</p> <p>Recommendation:</p> <p>Continue and strengthen the implementation of the WRP by WRPTs to ensure that the case formulations are consistently completed in the 6-p format and that the content of different sections accords with the information in the DMH WRP manual.</p>
d.iii	consider biomedical, psychosocial, and psychoeducational factors, as clinically appropriate, for each category in § [III.B.4.b] above	Same as above.
d.iv	consider such factors as age, gender, culture, treatment adherence, and medication issues that may affect the	<p>Findings:</p> <p>As mentioned under C.2.c, NSH has data that demonstrate only 17%</p>

	outcomes of treatment and rehabilitation interventions;	<p>compliance with the requirement in this step.</p> <p>Recommendations: Same as in C.2.c.</p>
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	Same as in C.1.d.i and D.1.C.iii.
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.	<p>Findings: The new case formulation monitoring tool effectively addresses the key element in this section. NSH has yet to implement this monitoring system.</p> <p>Almost all the charts reviewed by this monitor demonstrate a pattern of significant deficiencies in the quality and completeness of case formulations. The key deficiencies include:</p> <ol style="list-style-type: none"> 1. The case formulations are not consistently completed in the 6-p format. 2. The linkages within different components of the formulations are often missing. 3. The formulations contain inadequate analysis of assessments and derivation of hypothesis regarding the individual's treatment, rehabilitation and enrichment needs. 4. There is inadequate linkage between the material in the case formulations and other key components of the WRP (e.g. foci of hospitalization, life goals, objectives and interventions). <p>These deficiencies are such that the current case formulations performed at NSH generally fail to address the key requirements in this step.</p>

		<p>Recommendations: Same as in C.1.d.i through C.1.d.iv.</p>
e	<p>The therapeutic and rehabilitation service plan specifies the individual's focus of hospitalization (goals), assessed needs (objectives), and how the staff will assist the individual to achieve his or her goals/objectives (interventions);</p>	<p>Findings: NSH has monitoring data that address important elements related to this item. Process Observation data (10% of WRP meetings) indicate 45% compliance with the following relevant items:</p> <ol style="list-style-type: none"> 1. "The WRP team reviewed and revised the individual's foci of hospitalization as needed;" and 2. "The WRP team revised or added new treatment objectives and/or interventions as needed." <p>The facility has data derived from other process observation items that do not clearly address the key elements.</p> <p>Chart audit data (20% sample) indicate the following patterns of deficiency, including compliance rates:</p> <ol style="list-style-type: none"> 1. "There was a documented rationale if a focus of hospitalization does not have objective and/or interventions." (7%) 2. "There is at least one objective and intervention for each focus of hospitalization." (29%) 3. "The WRP included interventions that are clearly linked to the objective and are written in terms of what the staff will do." (19%) 4. "The WRP included 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." (17%) <p>The facility has other chart audit data that do not address the key elements.</p>

		<p>Chart reviews by this monitor indicate that, in almost all cases, the foci of hospitalization are incomplete, usually limited to one or two areas, are identified in generic terms and do not offer meaningful targets for treatment, rehabilitation and enrichment of the individuals. Deficiencies are noted in the following areas:</p> <ol style="list-style-type: none"> 1. Identification of foci of hospitalization that address individuals' special needs (see monitor's findings in C.1.c and C.1.o). 2. Proper formulation and execution of objectives and interventions (see the monitor's findings in C.2.f.i, C.2.iv through C.2.v.iii). 3. Appropriate revision of foci and objectives (see the monitor's finding in C.2.g). <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Same as in C.1.c, C.1.o, C.2.f. and C.2.g. 2. Ensure that process observation and chart audit data are consolidated and aligned with the operational items spelled out in the Enhancement Plan.
f	<p>Therapeutic and rehabilitation service planning is driven by individualized needs, is strengths-based (i.e., builds on an individual's current strengths), addresses the individual's motivation for engaging in wellness activities, and leads to improvement in the individual's mental health, health and well being, consistent with generally accepted professional standards of care. Specifically, the interdisciplinary team shall:</p>	<p>Compliance: Partial.</p>
f.i	<p>develop and prioritize reasonable and attainable goals/objectives (e.g., at the level of each individual's</p>	<p>Findings: Data from NSH monitoring instruments indicate patterns of deficiency</p>

	<p>functioning) that build on the individual's strengths and address the individual's identified needs and, if any identified needs are not addressed, provide a rationale for not addressing the need;</p>	<p>that relate to the key elements in this cell. Process Observation data (10% sample) indicate 32% compliance with the requirement that "individual's strengths were utilized in the interventions for each objective." Chart audit data (20% sample) show 7% compliance with the requirement that "individual's strengths are used in the interventions to assist the individual to achieve an objective." Data presented from a number of other monitoring items do not clearly address the key elements in this step.</p> <p>Chart reviews by this monitor demonstrate a general trend of WRPs not meeting the key requirements of this cell (e.g. ST, TG, GF, NA, RF, VDB, RH, JS, EL and WJ). This finding also addresses C.2.f.ii and C.2.f.iii.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Continue and strengthen training of WRP teams to ensure that objectives and interventions are implemented in accordance with the requirements in the DMH WRP manual. 2. Assess the reason for (and correct) the discrepancies between process and audit data that address similar concepts and operations. 3. Develop and implement a monitoring system to assess if goals/objectives are reasonable and attainable, if they address the identified need and if there is a rationale for not addressing the need.
f.ii	<p>ensure that the objectives/ interventions address treatment (e.g., for a disease or disorder), rehabilitation (e.g., skills/supports, motivation and readiness), and enrichment (e.g., quality of life activities);</p>	<p>Findings:</p> <p>The current monitoring data presented by NSH do not clearly address the key requirement of this section.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Same as in recommendation #1 in C.2.f.i. 2. Develop and implement monitoring tools that clearly

		<p>address the key required elements.</p> <p>3. Same as in C.2.e.</p>
f.iii	<p>write the objectives in behavioral, observable, and/or measurable terms;</p>	<p>Findings: NSH has monitoring data that adequately address the key element in this cell. Process observation data (10% sample) indicate only 7% compliance with the requirement that "the team developed objectives for each focus of hospitalization that are behaviorally defined, observable and measurable." Chart audit data (20% sample) show only 10% compliance with the requirement that "the WRP plan includes observable, measurable, and behaviorally worded objectives written in terms of what the individual will do."</p> <p>This monitor's case examples provided in C.1.f.i corroborate the facility's data that show poor compliance.</p> <p>Recommendations: Same as in recommendation #1 in C.2.f.i.</p>
f.iv	<p>include all objectives from the individual's current stage of change or readiness for rehabilitation, to the maintenance stage for each focus of hospitalization, as clinically appropriate;</p>	<p>Findings: NSH has monitoring tools that adequately address the key elements in this cell. Chart audit data (20% sample) indicate the following relevant patterns, including compliance rates:</p> <ol style="list-style-type: none"> 1. "The WRP includes 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." (17%) 2. "The objectives are linked to the individual's stages of change, if appropriate." (60%) <p>The facility has process observation data that do not address the key elements.</p>

		<p>Chart reviews by this monitor (e.g. DF, JP and MA) indicate that NSH, in general, fails to meet compliance with this requirement. An occasional example of proper implementation of this element is found in the chart of VCB.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Same as in recommendations #1 in C.2.f.i. 2. Same as in C.2.e. 3. Assess the reason for (and correct) the discrepancies among audit data that address similar concepts and operations.
f.v	<p>ensure that there are interventions that relate to each objective, specifying who will do what, within what time frame, to assist the individual to meet his/her needs as specified in the objective;</p>	<p>Findings: NSH has chart audit data (20% sample) that adequately address the key element in this step. The data indicate the following patterns of deficiency, including compliance rates:</p> <ol style="list-style-type: none"> 1. "The WRP includes interventions that are clearly linked to the objectives and are written in terms of what the staff will do." (19%) 2. "The WRP plan includes names of specific staff responsible for implementing each intervention, type of intervention and frequency and duration of the intervention." (6%). <p>Chart reviews by this monitor confirm overall inadequate implementation of this element. Case examples include AA, RT, TM, VB and RP.</p> <p>Recommendations: Same as in recommendation#1 in C.2.f.i.</p>
f.vi	<p>implement interventions appropriately throughout the individual's day, with a minimum of 20 hours of active</p>	<p>Findings: NSH has monitoring data that adequately address this requirement.</p>

	<p>treatment per week. Individual or group therapy included in the individual's WRP shall be provided as part of the 20 hours of active treatment per week;</p>	<p>Chart audits (20% sample) indicate only 5% compliance with the requirement that "interventions include at least 20 hours of planned small groups or individual therapy that is linked to objectives". Another audit (19% sample) revealed that the average number of active treatment hours received per individual is only nine hours. Only one hour of individual psychotherapy was documented in this sample.</p> <p>NSH has developed and implemented a computerized process--"My Activity and Participation Plan (MAPP)"-- to provide data regarding hours of active treatment scheduled and hours attended.</p> <p>Chart reviews by this monitor indicate that most teams do not schedule their individuals for the required 20 hours. Examples include RF (12 hours), CR (nine hours), RP (nine hours) and ST (six hours).</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Assess and address the factors related to inadequate scheduling by the WRP teams and participation by individuals to ensure compliance with the requirement. 2. Continue efforts to monitor hours of active treatment (scheduled and attended).
f.vii	<p>maximize, consistent with the individual's treatment needs and legal status, opportunities for treatment, programming, schooling, and other activities in the most appropriate integrated, non-institutional settings, as clinically appropriate; and</p>	<p>Findings:</p> <p>NSH has chart audit (20% sample) data that adequately address this requirement. The data indicate 15% compliance with the requirement that "when legal status permits (e.g. civil commitments), the individual is scheduled for off ground activities for community integration (e.g. unemployment office, education, employment, recreation, skills development)."</p> <p>This monitor's review of the charts of civilly committed individuals does not show evidence of activities that meet the requirement in this item. Case examples include AA, MC, BJ and KP.</p>

		<p>Recommendation: Assess and correct factors related to lack of programs.</p>
f.viii	<p>ensure that each therapeutic and rehabilitation service plan integrates and coordinates all services, supports, and treatments provided by or through each State hospital for the individual in a manner specifically responsive to the plan's therapeutic and rehabilitation goals. This requirement includes but is not limited to ensuring that individuals are assigned to mall groups that link directly to the objectives in the individual's WRP and needs.</p>	<p>Findings: NSH has not developed a monitoring tool to assess compliance with the first element in this section.</p> <p>Chart reviews by this monitor (e.g. VB, SCT, JP, J JL and EW) demonstrate lack of compliance with this element.</p> <p>NSH has developed a monitoring form--"Mall Alignment Protocol"--to assess the second element of this section. However, this protocol does not address the key element of aligning objectives of mall groups with the objectives in the WRP.</p> <p>Chart reviews by this monitor (e.g. VDB, AA and RI) demonstrate lack of documentation that supports linkage between mall activities and objectives outlined in the WRP. Interviews with a sample of staff psychiatrists confirm disconnect between the WRP and interventions provided at the mall.</p> <p>Examples of adequate linkage between mall activities and WRP objectives are found only in the charts of individuals deemed incompetent to stand trial (e.g. JL) and those designated as sexual offenders (e.g. BH).</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a mechanism to ensure proper linkage between type and objectives of mall activities and objectives outlined in the WRP as well as documentation of this linkage.

		<ol style="list-style-type: none"> 2. Revise the ARP/mall alignment check protocol to address the key element in question. 3. Implement electronic progress note documentation by all mall and individual therapy providers.
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:	<p>Compliance: Partial.</p>
g.i	revise the focus of hospitalization, objectives, as needed, to reflect the individual's changing needs and develop new interventions to facilitate attainment of new objectives when old objectives are achieved or when the individual fails to make progress toward achieving these objectives;	<p>Findings: The DMH WRP manual does not include specific parameters for review and revision of the foci, objectives and interventions.</p> <p>The monitoring process at NSH includes data based on process observations (10% sample) that address elements relevant to this item. The following is an outline of the most relevant results, including compliance rates:</p> <ol style="list-style-type: none"> 1. "If there has been a suicide threat, behavior or report by others since last WRP then the findings of the completed suicide assessment and treatment implications were discussed." (45%) 2. "The team reviewed and revised the individual's Foci of Hospitalization as needed." (45%) 3. "The team revised or added new treatment objectives and/or interventions as appropriate. (45%) <p>NSH has chart audit data (20% sample) that monitor other elements relevant to the key requirements in this step. The data demonstrate the following patterns of deficiency, including compliance rates:</p>

		<ol style="list-style-type: none"> 1. "The WRP plan is evaluated and revised as necessary in response in instances of severe maladaptive behavior, use of seclusion and restraints, use of PRN medications or other outcome triggers (e.g. BMI, AWOL, suicide attempt." (24%) 2. "When the individual has not met the objective by the target date, either the objective or the intervention is changed or a justification for continuing without change is included in the WRP." (31%) <p>Charts reviewed by this monitor show examples of failure to revise foci (e.g. AG and ST) and objectives (e.g. AG and JP) as clinically needed in all four charts reviewed for this purpose.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that the DMH WRP manual contains specific requirements for review and revision of foci, objectives and interventions to address changes in the individual's status. 2. Continue and strengthen training to WRP teams to ensure that foci and objectives are reviewed and revised and that new interventions are developed and implemented as clinically needed.
g.ii	<p>review the focus of hospitalization, needs, objectives, and interventions more frequently if there are changes in the individual's functional status or risk factors (i.e., behavioral, medical, and/or psychiatric risk factors);</p>	<p>Findings: NSH has chart audit data (20% sample) that address the key element in this step. As mentioned earlier, the data show 24% compliance with the requirement that "the WRP is evaluated and revised, as necessary in response to instances of severe maladaptive behavior, use of seclusion and restraints, use of PRN medications or other outcome triggers (e.g. BMI, AWOL, suicide attempts, etc)."</p> <p>This monitor reviewed charts of individuals who have experienced</p>

		<p>seclusion and/or restraints in the past year. This review reveals evidence of failure to revise foci/needs, objectives and interventions in order to minimize the risk. Examples include MAP, JB and AG.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Same as above. 2. Revise current monitoring tool to include individuals whose functional status has improved.
g.iii	<p>ensure that the review process includes an assessment of progress related to discharge to the most integrated setting appropriate to meet the individuals assessed needs, consistent with his/her legal status; and</p>	<p>Findings:</p> <p>NSH has monitoring data regarding pertinent elements. The process observation data (10% sample) reveal the following inconsistent patterns of practice, including compliance rates:</p> <ol style="list-style-type: none"> 1. "A team member gave a summary report on the individual's progress on each treatment objective and progress in meeting discharge criteria." (4%) 2. "The WRP team discussion related treatment progress to meeting discharge goals with identification of potential clinical and non-clinical barriers to discharge." (43%) 3. "The WRP discussed with the individual the behavioral expectations to meet discharge criteria." (28%) <p>Chart reviews by this monitor indicate inconsistent implementation of this item. The charts of two individuals (DS and KP) show documentation of the WRP team's discussion of the individual's progress toward discharge. However, in the chart of one individual (NJ), no discharge criteria or discussion of progress towards discharge are found. The chart of another individual (RT) contains documentation of discharge criteria but no review of progress toward discharge.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Continue and strengthen training to WRP teams to ensure consistent implementation of this requirement.

		<p>2. Assess reason for (and correct) discrepancies in process observation data that address similar concepts and operations.</p>
g.iv	<p>base progress reviews and revision recommendations on data collected as specified in the therapeutic and rehabilitation service plan.</p>	<p>Findings: NSH has process observation data (10% sample) that address one element that has relevance to this cell. The data demonstrate 4% compliance with the requirement that "a team member gives a summary report on the individuals' progress on each treatment objective and progress in meeting discharge criteria (specific objective data was reviewed with the individual)." However, this monitoring item includes two separate team functions and it is not clear how compliance data is assessed in this situation.</p> <p>NSH has other process observation data that do not clearly address the required key element.</p> <p>Chart reviews by this monitor (CWP, NM, MWP and DS) demonstrate failure to conduct data-based reviews in the WRP.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Same as in C.2.g.i. 2. Same as recommendation #3 in C.2.f.viii. 3. Same as recommendation #2 in C.2.f.ii. 4. Ensure that each monitoring item addresses only one team function.
h	<p>Individuals in need of positive behavior supports in school or other settings receive such supports consistent with generally accepted professional standards of care.</p>	<p>Findings: NHS has established four PBS teams as part of its plan to provide a continuum of services to meet WRP goals within the Recovery Model. PBS teams were very open to fact finding when they met with the monitor.</p>

		<p>The PBS team members from all teams voiced their concerns and problems regarding their ability to develop and implement PBS plans because of systems barriers. Some of the team members voiced their frustration in not being able to function effectively. Interviews with unit staff and WRP team members and observations indicate that staff does not consistently implement the PBS plans or collect reliable and valid outcome data.</p> <p>The number of individuals on PBS plans (n=5) and behavior guidelines (n=60) is very small when compared to the number of individuals needing behavioral interventions for learned maladaptive behaviors (e.g. individuals who are repeatedly secluded or restrained due to learned maladaptive behaviors).</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that PBS psychologists have the authority to write orders for the implementation of PBS plans. 2. Ensure that all staff implement PBS plans and collect reliable and valid outcome data.
i	Adequate active psychosocial rehabilitation is provided, consistent with generally accepted professional standards of care, that:	<p>Compliance: Partial.</p>
i.i	is based on the individual's assessed needs and is directed toward increasing the individual's ability to engage in more independent life functions;	<p>Findings:</p> <p>The individual's needs for psychosocial rehabilitation are not carefully assessed to enable the WRP team to assign the individual to specific groups and individual therapy that will enhance more independent functional status. In almost all the charts reviewed by this monitor, the conclusions/recommendations of discipline-specific assessments</p>

		<p>were not clearly stated in terms of rehabilitation needs.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. All discipline-specific assessments should include a section that states the implications of the assessment for rehabilitation activities. 2. The WRP team should integrate these assessments and prioritize the individual's assessed needs 3. The WRP team 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.
i.ii	Has documented objectives, measurable outcomes, and standardized methodology	<p>Findings:</p> <p>In a majority of the charts reviewed, the objectives were stated but were not written in behavioral, observable or measurable terms (see findings in C.2.f.i). The outcomes expected of the individual were not clear. Often the objectives and interventions were confused—sometimes the objectives were written in terms of what the staff would do rather than what the individual will learn and how the learning outcome will be measured.</p> <p>The facility's self-assessment indicated that only 10% of the objectives were written in the required format as specified in the DMH WRP Manual. Further, the objectives were not clearly linked to the relevant foci.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that the objectives are written in behavioral, observable and/or measurable terms, as specified in the DMH WRP Manual. 2. Ensure that the learning outcomes are stated in measurable terms.

i.iii	Is aligned with the individual's objectives that are identified in the individual's Wellness and Recovery Plan	<p>Findings: NSH has established a psychosocial rehabilitation (PSR) mall concept for providing group and some individual therapy options for its individuals. This is a recovery-oriented system that should enable the facility to meet the treatment, rehabilitation and enrichment needs of the individuals. The PSR Mall is supposed to be run according to the PSR Mall manual. This is not the case. The Mall is fragmented and, for the most part, groups and other therapies are not aligned with the needs of the individuals.</p> <p>The objectives specified in the individuals' WRPs and the groups they are assigned to, as well as the contents of the groups, are not aligned with the individual's needs. There are two main problems: a) the objectives stated in the individuals' WRPs are not fully aligned with their assessed needs; and b) the content of groups the individuals attend frequently do not meet the assessed needs of the individuals.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that WRP teams 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.
i.iv	utilizes the individual's strengths, preferences, and interests;	<p>Findings: Chart reviews showed that less than 10% of the WRPs identified the individual's strengths, preferences, and interests in the interventions.</p> <p>Observations, staff interviews, and chart reviews showed that the group offerings in the PSR Mall typically did not show any evidence of incorporating individual strengths, interests, and preferences into activity planning. Some staff could not identify any strength that they</p>

		<p>could use with specific individuals.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that the individual's strengths, preferences, and interests are clearly specified in the interventions in the individual's WRP in accordance with the DMH WRP manual. 2. Ensure that the group facilitators and individual therapists know and use the individual's strengths, preferences and interests when delivering rehabilitation services.
i.v	<p>focuses on the individual's vulnerabilities to mental illness, substance abuse, and readmission due to relapse, where appropriate;</p>	<p>Findings:</p> <p>Review of WRPs and interviews with staff showed that the case formulation is inadequate in presenting or discussing an individual's vulnerabilities to mental illness and substance abuse (predisposing, precipitating and perpetuating factors).</p> <p>Chart audits and staff interviews revealed that case formulation using the 6-p format is uneven in quality, has almost no analysis, and does not follow the content guidelines established in the DMH WRP Manual. Most of the case formulations are a cut-and-paste from old notes, which defeats the intent of the formulation in serving as the functional bridge between the assessments and the WRP.</p> <p>NSH has developed a new training manual based on the trans-theoretical model of substance abuse for training group facilitators. This is an excellent manual. However, the manual does not cover all five stages of change. Further, the PSR Mall groups have begun using the Group Treatment for Substance Abuse: A Stages-of-Change Therapy Manual by Mary Velasquez, Gaylyn Gaddy Maurer, Cathy Crouch, and Carlo C. DiClemente. This is an excellent, evidence-based manual that should be used for all substance abuse groups. Other supplementary groups (e.g., AA, 12-Step) can be used as well but the staged model should provide the foundation for substance abuse</p>

		<p>groups. This is not in place at the hospital at the present time.</p> <p>Chart reviews show that there is not a clear focus of treatment on those factors that precipitated readmission due to relapse. The groups assigned are varied and often global. There is almost no reference in the case formulation to an individual's vulnerability to relapse. There is no subsequent focus on developing objectives and interventions that are related to these vulnerabilities.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Undertake clinical case formulation as a team rather than by assigning the task to a team member or to non-team members. 2. Include the individual's vulnerabilities in the case formulation under predisposing, precipitating, and perpetuating factors. 3. Include in the present status an update on 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 on Wellness Recovery Action Plan to all individuals to preempt relapse.
i.vi	is provided in a manner consistent with each individual's cognitive strengths and limitations;	<p>Findings:</p> <p>Groups in the mall are rarely assigned by cognitive levels.</p> <p>Staff interviews showed that group facilitators tend to judge an individual's cognitive status based on the individual's physical presentation and disabilities rather than on psychological testing.</p>

		<p>Recommendations:</p> <ol style="list-style-type: none"> 1. PSR Mall groups must address the assessed cognitive levels of the individuals participating in the groups. 2. Psychologists must assess all individuals suspected of cognitive disorders, mental retardation and developmental disabilities and other conditions that may adversely impact an individual's cognitive status.
i.vii	Provides progress reports for review by the Wellness and Recovery Team as part of the Wellness and Recovery Plan review process	<p>Findings: Mall providers began providing progress reports in July 2006 and the hospital's self-assessment shows that it occurs about 5% of the time. However, no supporting data were available to verify this self-assessment finding.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that all group and individual therapy providers provide the WRP teams 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 reports in a timely manner.
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;	<p>Findings: The PSR Mall does not provide enough groups for the individuals to choose from in order to fulfill the required elements. As mentioned earlier, the hospital's self-assessment shows that, on average, individuals receive only 9 hours of mall services per week. Mall services are provided five days a week, but not for four hours a day. Structured Mall services are not provided for two hours in the morning and two hours in the afternoon. Mall services provided in the afternoons or in the residential units are not structured and do not comport with current professional standards. Often, scheduled groups are not run and the individuals in these groups wander the corridors</p>

		<p>looking for the group provider.</p> <p>The hospital's own data show that there are not enough groups being run, with the stated reason being shortage of staff. However, the data show that except for rehabilitation therapists, none of the other disciplines are providing enough groups per clinician.</p> <p>Finally, the PSR Malls vary in session length from less than 20 minutes to 120 minutes. Sessions less than 20 minutes are not meaningful. Sessions for those with cognitive limitations can be varied within a session as indicated in the DMH WRP Manual.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Provide PSR Mall groups as required by the EP, five days a week, for a minimum of four hours a day (i.e., two hours in the morning and two hours in the afternoon each weekday), for each individual or two hours a day when the individual is in school, except days falling on state holidays. 2. Mandate that all staff at NSH, other than those who attend to emergency medical needs of individuals, will provide services at the PSR Mall. This includes clinical, administrative and support staff. 3. All Mall sessions must be 50 minutes in length. 4. Provide groups as needed by the individuals and written in the individuals' WRPs. 5. Add new groups as the needs are identified in new/revised WRPs.
i.ix	is provided to individuals in bed-bound status in a manner and for a period that is commensurate with their medical status;	<p>Findings:</p> <p>Many bed-bound individuals are not provided rehabilitation services commensurate with their needs. Many were observed to watch television as their primary rehabilitation therapy. There is minimal documentation of mall services provided to individuals in bed-bound</p>

		<p>status.</p> <p>When individuals in bed-bound status are taken to the Mall area within the unit, they do not receive any meaningful therapeutic interventions. Furthermore, when therapy is provided, not all individuals receive the services. For example, when physical therapy services were being provided in the Mall area in the SNF unit to one individual, the rest of the individuals were merely sitting in their chairs with the television on in the room.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Include individual skill-building activities with bed-bound individuals commensurate with their cognitive status, medical health, and physical limitations. 2. Therapy can be provided in any physical location within the hospital as long as the services are structured and consistent with scheduled Mall activities.
i.x	routinely takes place as scheduled;	<p>Findings:</p> <p>The PSR Mall does not monitor nor mandate that all groups and individual therapies must be provided as scheduled. Review of the hospital data, staff interviews, interviews with the individuals and observations showed that group facilitators determine how and when they provide the services, or when they will cancel groups without informing the Mall administrators. Further, Mall administrators noted that a large number of cancellations are due to the unavailability of staff.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Implement a more focused Mall program that is regularly scheduled, implemented, and provided within the individual's cognitive, medical, physical and functional status. 2. Ensure that Mall groups and individual therapies are

		cancelled rarely, if ever.
i.xi	includes, in the evenings and weekends, additional activities that enhance the individual's quality of life; and	<p>Findings: The hospital's self-assessment shows that the average number of hours of enrichment activity programming is about six hours. However, many individuals do not either receive any programming or do not participate in available programs.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop a list of all enrichment activities available along with staff names competent in facilitating the activities in accordance with generally accepted professional standards of care. 2. Plan and organize these activities such that there is minimal interruption, individuals are reinforced to participate regularly in these activities, and as much as possible eliminate competing activities that act as a barrier for individuals to participate in such activities 3. Increase the number of hours of enrichment activities per individual provided in the evenings and on weekends.
i.xii	is consistently reinforced by staff on the therapeutic milieu, including living units.	<p>Findings: The DMH WRP Manual contains information that captures this requirement. Chart reviews showed that some WPRs included therapeutic milieu in the intervention section but observations and staff interviews showed that this did not occur in the residential units. Further, there was little mention of the objectives and interventions during change of shift communication.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that all WPRs 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.
j	Adequate, individualized group exercise and recreational options are provided, consistent with generally accepted professional standards of care.	<p>Findings: Enrichment and MAPP schedules show that group exercises and recreational activities are provided but not in sufficient quantity to meet the needs of all individuals. The hospital reviewed a 20% sample of its individuals (#225) to determine the enrichment activities provided to individuals with BMI of more than 25 (#132). The data showed that 102 individuals did not have any enrichment interventions and that 30 individuals received, on average, six hours per week of these interventions.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Establish group exercise and recreational activities for all individuals. 2. Provide training to Mall facilitators to conduct the activities appropriately. 3. Track and review participation of individuals in scheduled group exercise and recreational activities. 4. Implement corrective action if participation is low.
k	Individuals who have an assessed need for family therapy services receive such services in their primary language, as feasible, consistent with generally accepted professional standards of care and that these services, and their effectiveness for addressing the indicated problem, are comprehensively documented in each individual's chart.	<p>Findings: NSH has initiated a family therapy database, family therapy monitor, and MAPP documentation for family therapy services. However, no data were available for review from this system. Efforts to assess need for family therapy services are minimal, and it was found that family therapy is not listed in the MAPP documentation of services.</p>

		<p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Conduct a needs assessment with individuals and/or their families. 2. Use individual discharge plan goals as a way to identify families that may need family therapy to help them assist and support their family members upon discharge. 3. Review pre-admission reports and services/treatments provided to identify the need for family therapy services.
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.	<p>Findings: NSH monitoring instrument does not include all the key elements of this requirement.</p> <p>Compliance: Partial.</p> <p>Recommendations: Develop and implement a monitoring and tracking system to address the key elements of this requirement.</p>
M	The children and adolescents it serves receive, consistent with generally accepted professional standards of care:	MSH only
m.i	Therapy relating to traumatic family and other traumatic experiences, as clinically indicated; and	
m.ii	reasonable, clinically appropriate opportunities to involve their families in treatment and treatment decisions.	

n	<p>Policies and procedures are developed and implemented consistent with generally accepted professional standards of care to ensure appropriate screening for substance abuse, as clinically indicated.</p>	<p>Findings: NSH has a draft Substance Abuse Screening policy and procedures, which is yet to be finalized. The policy provides guidelines and responsibilities for the appropriate screening of all individuals for substance abuse as clinically indicated. The procedures do not address one of the two main purposes of the policy, that is to ensure that screening and assessment of substance abuse is available and used to provide therapeutic and rehabilitation services that are consistent with generally accepted professional standards of care.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Revise the screening policy to address the above deficiency. 2. Finalize and implement the policy and procedure.
o	<p>Individuals who require treatment for substance abuse are provided appropriate therapeutic and rehabilitation services consistent with generally accepted professional standards of care.</p>	<p>Findings: NSH has initiated a substance abuse training program for its staff. An interdisciplinary committee developed a training curriculum based on the stages of change model. The program is informed by the "Group Treatment for Substance Abuse-A Stages of Change Manual" (by Mary Marden Velasquez et al.). As mentioned earlier, this manual contains current generally accepted professional standards in this area. The facility completed the curriculum for the stages of precontemplation, contemplation, preparation and action. So far, 50 members of the WRP teams have received competency-based training.</p> <p>NSH has an audit item that addresses whether Axis I diagnosis of</p>

		<p>substance abuse is documented as a focus. The same item also addresses the presence of least one objective and intervention if substance abuse was identified as a focus. The data show 57% compliance with this item. The facility does not monitor the quality or appropriateness of the objectives and interventions.</p> <p>NSH has data from a Substance Abuse Checklist that demonstrate 93% compliance with the identification of substance abuse in the 6-ps, 77% compliance with the identification of an objective and corresponding intervention under focus #5 and 66% compliance with the identification of stage of change in the WRP. The data also show 59% compliance with the requirement that "identified stage of change is consistent with corresponding objective(s) and intervention(s) under focus #5" and 39% compliance with "active treatment identified in the WRP matches what is reflected on the individual's MAPP schedule."</p> <p>Chart reviews by this monitor (DB, TNG, TG, EL and KZ) indicate the following key deficiencies:</p> <ol style="list-style-type: none"> 1. There is no evidence of recovery-based interventions due to failure to identify stages of change for the individual (e.g. DB, TNG and TG). This finding is inconsistent with the hospital's data regarding the high compliance rate with the identification of stages of change for individuals with substance abuse. 2. The diagnosis of substance abuse is not listed in the WRP and no objectives or interventions are listed despite reports, in the chart, that the individual has significant needs in this area (e.g. EL). 3. The WRP does not include substance abuse focus, objectives or interventions when the individual's schedule indicates that he/she attends substance abuse group (e.g. KZ). The chart does not include any mention of the individual's specific needs, objectives of the group and
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		<p>his/her progress.</p> <p>4. In all charts reviewed, the case formulations do not address the factors that precipitate relapse and readmission and the WRPs do not address the interventions needed to overcome these factors.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop a formalized substance recovery program with designated administrative and clinical leadership. 2. The substance recovery program should develop and utilize clinical outcomes for individuals and process outcomes for the program. 3. Assess the reason for (and correct) the discrepancy between facility's data regarding identification of stages of change and the monitor's findings from chart reviews. 4. Complete the training curriculum to address the maintenance phase of change. 5. Same as in recommendation #3 in C.2.c. 6. Ensure that substance abuse monitoring items are aligned with the principles outlines in the current training curriculum.
p	<p>Group facilitators and therapists providing therapeutic and rehabilitation services (in groups or individual therapy) are verifiably competent regarding selection and implementation of appropriate approaches and interventions to address therapeutic and rehabilitation services objectives, are verifiably competent in monitoring individuals' responses to therapy and rehabilitation, and receive regular, competent supervision.</p>	<p>Findings: The hospital's self-assessment was incomplete and provided data only on social workers. There are no data on the competency of group facilitators and therapists in providing services in PSR Malls. The facility has developed a monitoring tool but has not used it.</p> <p>Compliance: Noncompliance.</p>

		<p>Recommendations: Monitor the competency of group facilitators and therapists in providing rehabilitation services.</p>
q	Group facilitators and therapists providing therapeutic and rehabilitation services in the field of substance abuse should be certified substance abuse counselors.	<p>Findings: The hospital has trained providers for substance abuse groups using the new staged model of substance abuse services. The training included some of the early stages of change but not all of the five stages of change. The facility employs discipline-specific criteria for determination of staff competency (via the credentialing and privileging process). The criteria represent a combination of licensure, relevant clinical experience and continuing education requirements as well as peer recommendations. In general, these criteria are vague, complicated and not always linked to the current substance abuse training curriculum.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that all providers complete the NSH substance abuse training curriculum at NSH. 2. Clarify and streamline staff competency criteria to ensure their alignment with the current training curriculum. 3. Ensure that training includes all of the five stages of change. 4. Establish a review system to evaluate the quality of services provided by these trained facilitators.
r	Transportation and staffing issues do not preclude individuals from attending appointments.	<p>Findings: According to the hospital's self-evaluation data (MAS Medical Transcriber), about one percent of outside medical appointments were</p>

		<p>missed due to lack of staff or transportation. About four percent of internal medical appointments were also canceled due to lack of staff to accompany the individual or illness of the treating physician. A significant number of entries indicated that individuals refused to go for their appointments but no follow up was documented.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Review reasons for cancellations and assess and correct factors contributing to such events. 2. Complete and implement the Medical Scheduler. 3. Assess why individuals refuse medical appointments and find ways to resolve their concerns.
s	<p>Adequate oversight to treatment, rehabilitation and enrichment groups is provided to ensure that individuals are assigned to groups that are appropriate to their assessed needs, that groups are provided consistently and with appropriate frequency, and that issues particularly relevant for this population, including the use of psychotropic medications and substance abuse, are appropriately addressed, consistent with generally accepted professional standards of care.</p>	<p>Findings: There are no data to assess if the individuals are assigned to groups appropriate for their assessed needs. There are no data to show that the individuals benefit from the groups they actually attend. On average, the individuals receive only nine hours of active treatment, most of which do not appear to correspond with their assessed needs.</p> <p>Compliance: Partial.</p> <p>Recommendations: Develop and implement monitoring systems that address the required elements.</p>
†	<p>Treatment, rehabilitation and enrichment services are monitored appropriately against rational, operationally-defined target variables and revised as appropriate in light</p>	<p>Findings: NSH is yet to develop tracking and monitoring systems.</p>

	of significant developments, and the individual's progress, or lack thereof;	<p>Compliance: Noncompliance.</p> <p>Recommendation: Develop and implement needed instruments.</p>
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.	<p>Findings: At present, NSH does not have a formalized mechanism to ensure that individuals are educated about the purposes of their treatment, rehabilitation and enrichment activities. The facility has developed, but not yet implemented, a wellness and recovery mall group curriculum that include education about this requirement.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Implement the newly developed mall curriculum to ensure compliance with this item. 2. Develop and implement a monitoring tool to address the key elements. 3. Ensure that individuals are provided a copy of their WRP based on clinical judgment.
v	Staff educates individuals about their medications, the expected results, and the potential common and/or serious side effects of medications, and staff regularly asks individuals about common and/or serious side effects they may experience.	<p>Findings: Based on a 20% sample of MAPP database, NSH has data to show that only 11% of individuals attend mall groups that offer education regarding medication management. At this time, some mall groups offer education about medication management, but the number appears to be inadequate to meet the needs of individuals. The facility does not have a mechanism to ensure that the individuals' needs are assessed in this regard and to assist individuals to make choices based</p>

		<p>on both needs and available services.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Increase the number of mall groups that offer education regarding medication management. 2. The DMH WRP manual needs to include guidelines to WRP teams to assist individuals in making choices based on need and available services.
w	<p>Interdisciplinary teams review, assess, and develop positive clinical strategies to overcome individual's barriers to participation in therapeutic and rehabilitation services.</p>	<p>Findings: NSH has a number of audit items to assess this requirement but the items do not address the key elements.</p> <p>At present, the WRP teams do not have a methodology to assess individuals' barriers to participation. In addition, the WRP teams do not provide individuals with clinical strategies to help them achieve readiness to engage in group activities.</p> <p>NSH has not provided Key Indicator data regarding this item.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Provide Key Indicator data regarding individuals' non-adherence to interventions in the WRP. 2. Assess barriers to individuals' participation in their WRPs and provide strategies to individuals to facilitate participation. 3. Ensure that the DMH WRP manual includes guidelines to

		<p>WRP teams regarding assessment methodology and strategies, including cognitive interventions, to facilitate individuals' participation.</p> <p>4. Develop and implement monitoring tools to assess compliance with this item.</p>
D	Integrated Assessments	
	<p>Each State hospital shall ensure that, consistent with generally accepted professional standards of care, each individual shall receive, promptly after admission to each State hospital, an accurate and comprehensive assessment of the conditions responsible for the individual's admission, to the degree possible given the obtainable information at the time of admission. Thereafter, each individual shall receive an accurate and comprehensive reassessment of the reasons for the individual's continued hospitalization whenever there has been a significant change in the individual's status, or a lack of expected improvement resulting from clinically indicated treatment. The individual's interdisciplinary team shall be responsible for investigating the past and present medical, nursing, psychiatric, and psychosocial factors bearing on the individual's condition, and, when necessary, for revising assessments and therapeutic and rehabilitation plans in accordance with new information that comes to light. Each State hospital shall monitor, and promptly address deficiencies in the quality and timeliness of such assessments.</p>	<p>Summary of Progress:</p> <ol style="list-style-type: none"> 1. NSH is transitioning to a new system of integrated assessment. When fully implemented, the system provides comprehensive assessments of the individual's needs and serves as the basis for meaningful recovery model of service planning. 2. In general, the admission medical and psychiatric assessments, psychiatric reassessments on the long-term units and the transfer assessments are completed in a timely manner. 3. NSH has established a Forensic Review Panel, which provides needed oversight to improve the quality of court reports for individuals admitted under PC 1026 and PC 1370. 4. NSH has developed and in some cases implemented a variety of monitoring instruments that are aligned with the key requirements (e.g. inter-unit transfer assessments, psychological assessments and court assessments).
1	Psychiatric Assessments and Diagnoses	
	<p>Each State hospital shall provide all of the individuals it serves with routine and emergency psychiatric assessments and reassessments consistent with generally accepted professional standards of care; and,</p>	<p>Methodology: Interviewed Jeffrey Zwerin, D.O, Medical Director. Interviewed Scott Sutherland, D.O. Chief of Medical Staff. Interviewed seven staff psychiatrists.</p>

		<p>Reviewed charts of 53 individuals (WR, JC, NF, AB, FR, CS, RL, KL, SP, RS, HAS, WJ, RP, SB, AM, MD, MB, WJ, CC, JA, HM, EL, JN, RP, EPA, JG, JA, KL, HM, MP, RJ, JS, RP, QE, LH, MT, WZ, DB, JR, EV, RT, LS, CR, PJA, DB, KZ, CL, TH, SM, TK, RZ, GJ and AP).</p> <p>Reviewed a roster of all psychiatrists at NSH and their board certification status.</p> <p>Reviewed form regarding "NSH Medical Staff Application."</p> <p>Reviewed NSH form regarding "Medical Staff Criteria for Privileging/Reprivileging."</p> <p>Reviewed NSH form regarding "Medical Staff Delineation of Clinical Privileges."</p> <p>Reviewed "NSH Department of Psychiatry Quality Assurance-Record Review."</p> <p>Reviewed the "Initial Admission Assessment Monitoring Form."</p> <p>Initial Admission Assessment Monitoring summary data (Jan-June 2006).</p> <p>Reviewed "Napa Psychiatric Evaluation Monitoring Form."</p> <p>Reviewed Psychiatric Evaluation Monitoring summary data (Jan-June 2006).</p> <p>Reviewed "Psychiatric Progress Note (PPN) Monthly Monitoring Form."</p> <p>Monthly Psychiatry Progress Notes Monitoring summary data (Jan-June 2006).</p> <p>Reviewed Physician Transfer Summary Monitoring Form.</p> <p>Reviewed Physician Transfer Summary Monitoring summary data (Jan-June 2006).</p>
a	<p>Each State hospital shall use the diagnostic criteria in the most current Diagnostics and Statistical Manual of Mental Disorders ("DSM") for reaching the most accurate psychiatric diagnoses.</p>	<p>Findings:</p> <p>NSH provides copies of new DSM-IV-TR to all current and newly appointed psychiatrists and psychologists. The facility Medical Director states that all psychiatrists are aware of the need to use the most current diagnostic criteria in DSM to reach the most accurate diagnosis. However, the facility does not monitor whether psychiatric diagnoses are consistent with the criteria.</p>

		<p>Chart reviews by this monitor indicate that, by and large, psychiatric diagnoses are stated in terminology that is consistent with the current version of DSM. However, admission and integrated psychiatric assessments (see D.1.c.i through D.1.c.iii) are inconsistently completed and the information needed for adequate diagnostic formulations is either missing or does not provide the basis the reaching the most reliable diagnosis.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a monitoring instrument to assess accuracy of psychiatric diagnoses. 2. Address all recommendations in section D.1.
b	Each State hospital shall ensure that all psychiatrists responsible for performing or reviewing psychiatric assessments:	<p>Compliance: Partial.</p>
2.i	are certified by the American Board of Psychiatry and Neurology ("ABPN") or have successfully completed at least three years of psychiatry residency training in an Accreditation Counsel for Graduate Medical Education accreditation program, and	<p>Findings: At present, NSH employs 52 full-time psychiatrists. The facility has data to show that 56% of the staff is board certified and that all staff completed at least three years of psychiatry residency training in an accredited program. NSH requires that all applicants for psychiatry positions present documentation of satisfactory completion of psychiatry residency program approved by the ACGME Residency Review Committee (or osteopathic equivalent).</p> <p>Recommendations: Continue current practice and encourage all staff to obtain board certification.</p>

2.ii	<p>Are verifiably competent (as defined by privileging at initial appointment and thereafter by reprivileging for continued appointment) in performing psychiatric assessments consistent with each State Hospital's standard diagnostic protocols.</p>	<p>Findings: In the process of interviewing applicants for positions as psychiatrists, NSH has a Quality Appraisal Panel (QAP). The panel presents applicants with a standard questionnaire and the Medical Director documents the answers. The questionnaire involves vignettes of clinical situations that test assessment and diagnostic skills. The current criteria for privileging and reprivileging include scope of delineated privileges. However, the facility does not have a formalized system to ensure that data regarding assessment skills are being utilized in an ongoing basis in decisions regarding the privileging process.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that the reprivileging process incorporates a quality profile that includes competency in the diagnosis, assessment and reassessment of individuals. 2. Ensure that the medical staff manual includes orientation regarding the facility's expectations regarding competency in diagnosis, assessments and reassessments.
c	<p>Each State hospital shall ensure that:</p>	<p>Compliance: Partial.</p>
c.i	<p>Within 24 hours of an individual's admission to each State hospital, the individual receives an Admission Medical Assessment that includes:</p>	<p>Findings: NSH monitors this process using a statewide instrument--"Initial Admission Assessment Monitoring Form." NSH has data based on a review of 29 (out of 33) admissions to the facility during May 2006. The monitoring was completed by two peer staff psychiatrists and data show overall compliance rates of 93%.</p>

		<p>Chart reviews by this monitor indicate a much lower compliance rate. The medical assessment is present in most cases, but it is complete in only a few cases (e.g. WR and NF). Some important items in the physical examination are missing in too many cases, including genitalia, rectum and breast in male individuals (e.g. JC and AB) and lungs in some individuals (e.g. JC and AB). The examination of breasts, genitalia, and rectum in female individuals is usually deferred to OB/GYN (e.g. FR and CS) with no evidence in the chart that the examination is subsequently done (for up to a month after admission). In some charts (e.g. RL), there is no evidence of a medical assessment within the specified time frame.</p> <p>NSH's data regarding components of the initial medical examination, indicate compliance rates of 90% (review of systems), 93% (medical history), 93% physical examination, 93% (diagnostic impressions) and 86% (management of acute medical conditions).</p> <p>This monitor's reviews are concordant with these data regarding review of systems, medical history and diagnostic impressions. However, as mentioned earlier, a much lower compliance is noted regarding the presence of a complete physical examination. In all the charts reviewed by this monitor, there was evidence of a management plan when acute medical problems were identified.</p> <p>Recommendations:</p> <ol style="list-style-type: none">1. Ensure completeness of the admission medical examination within the specified time frame.2. Ensure that there is a rationale for deferral of items on the examination and that deferred items are subsequently addressed to ensure compliance with the intent of this item.3. Update the medical staff manual to include the requirements regarding D.1. c.i.1 through D.1.c.i.5.
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		4. Ensure that monitoring of the admission physical examination addresses completeness of the examination and that the overall compliance rate considers incomplete items.
c.i.1	a review of systems;	As above.
c.i.2	medical history;	As above.
c.i.3	physical examination;	As above.
c.i.4	diagnostic impressions; and	As above.
c.i.5	management of acute medical conditions	As above.
c.ii	within 24 hours of an individual's admission to each State hospital, the individual receives an Admission Psychiatric Assessment that includes:	<p>Findings: NSH utilizes the above-mentioned form and process to monitor this item. The facility's data show 100% overall compliance. The compliance rates for specific items include 93% (psychiatric history), 100% (mental status examination), 100% admission diagnosis, 86% (completed AIMS) and 100% for laboratory tests. The facility reports a rate of 55% of consultations ordered, but there is misinterpretation of how this item should be monitored.</p> <p>Chart reviews by this monitor demonstrate inconsistent practice with a lower compliance rate than that reported by the facility. There is evidence of incomplete mental status examination in many charts. Examples include WR, KL, SP, RS, HAS, WJ, RP, SB, AM, and AB. In some individuals, the missing components include such essential items as suicidality (e.g. HAS), aggression (e.g. AM), self-abuse (e.g. SB) and nature of delusions and/or auditory hallucination (e.g. SB).</p>

		<p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that the mental 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." 2. Update the medical staff manual to include the requirements regarding D.1. c.ii.1 through D.1.c.ii.6. 3. Ensure that monitoring of the admission psychiatric examination addresses completeness of the examination and that overall compliance rate accounts for the completeness of each item. 4. Ensure that monitoring of the item regarding consultations accounts for the intent of monitoring, i.e. compliance rate in only those cases where the reviewer felt that consultations were indicated.
c.ii.1	psychiatric history, including a review of presenting symptoms;	As above.
c.ii.2	complete mental status examination;	As above.
c.ii.3	admission diagnoses;	As above.
c.ii.4	completed AIMS;	As above.
c.ii.5	laboratory tests ordered; and	As above.
c.ii.6	consultations ordered.	As above.

c.iii	<p>within 7 days (60/72 hrs) of an individual's admission to each State hospital, the individual receives an Integrated Psychiatric Assessment that includes:</p>	<p>Findings:</p> <p>NSH monitors integrated assessment using the "Psychiatric Evaluation Monitoring Form." Data is based on a randomly selected sample of 40 charts of individuals who have been hospitalized for at least 60 days. The review was completed by two peer staff psychiatrists. The facility reports an overall compliance rate of 85%. The compliance rates for specific components are reported at 98% (psychosocial history), 93% (mental status examination), 88% (strengths), 65% (psychiatric risk factors), 85% (diagnostic formulation), 63% (differential diagnosis), 100% (current diagnosis), 30% (psychopharmacology plan) and 80% (management of identified risk).</p> <p>Chart reviews by this monitor show a much lower compliance rate. In too many charts, the integrated assessment is not present (e.g. RL, MD, SP, WJ and AM). The current integrated assessments include a variety of significant deficiencies. Examples are as follows:</p> <ol style="list-style-type: none"> 1. Important components are missing, including: <ol style="list-style-type: none"> a. Chief complaint (e.g. AB) b. History of present illness (e.g. AB) c. Past psychiatric and medical histories (e.g. SB) d. Psychosocial history from the individual (e.g. RS) or from collateral sources if the individual is unable to provide information (e.g. CC) e. Strengths (e.g. JA, HM, EL and AB) 2. Important components are inadequately assessed, including: <ol style="list-style-type: none"> a. History of present illness (e.g. JN and RP) b. Psychosocial history (e.g. AB) c. Many charts include assessment of strengths that are not meaningful for planning services (e.g. WR, RC and EPA) 3. Many assessments include incomplete mental status examination, including:
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		<ul style="list-style-type: none"> a. Auditory/visual hallucinations (e.g. EL) b. Appearance, motor activity, speech and mood/affect (e.g. AB) c. The assessment of the individual's insight and judgment tends to be vague and generic (e.g. EPA, JG, RS, JN, RP and CS) <p>4. Too many charts do not include diagnostic formulations or appropriate differential diagnosis (e.g. JA, RP, JN, CS and SB). This deficiency is noted even in individuals who are in most need for this assessment. Examples include:</p> <ul style="list-style-type: none"> a. Individuals who are receiving diagnoses listed as not otherwise specified (e.g. "psychotic disorder, NOS -JA and RP) b. Individuals who are assigned diagnoses that do not match the prescribed treatment (e.g. SB) <p>5. Although the risk assessments are present in almost all the charts that this monitor reviewed, these assessments, by and large, do not include important information regarding how recent the risk is, the relevance of risk to current dangerousness, the assessment of mitigating factors and planned interventions to reduce the risks.</p> <p>6. Most of the assessments are completed on the day of admission (e.g. KL, EPA, HM and EL). This is a significant deficiency because the practice does not permit the integration of data that becomes available during the first week of admission, thus defeating a key purpose of the integrated assessment.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ul style="list-style-type: none"> 1. Ensure completeness of the integrated assessment within
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		<p>the specified timeframe. The assessment must integrate information that cannot be obtained at the time of admission but becomes available during the first 7 days of admission.</p> <ol style="list-style-type: none"> 2. Update the medical staff manual to include the requirements regarding D.1. c.iii.1 through D.1.c.iii.10. 3. Ensure that monitoring of the integrated psychiatric examination addresses completeness of the examination and that overall compliance rate accounts for the completeness of each item. 4. Ensure that monitoring of the integrated assessment addresses the practice of conducting the assessments so early that the purpose is defeated.
c.iii.1	psychiatric history, including a review of present and past history;	As above.
c.iii.2	psychosocial history;	As above.
c.iii.3	mental status examination;	As above.
c.iii.4	strengths;	As above.
c.iii.5	psychiatric risk factors;	As above.
c.iii.6	diagnostic formulation;	As above.
c.iii.7	differential diagnosis;	As above.
c.iii.8	current psychiatric diagnoses;	As above.
c.iii.9	psychopharmacology treatment plan; and	As above.
c.iii.10	management of identified risks.	As above.

d	Each State hospital shall ensure that:	<p>Compliance: Partial.</p>
d.i	Clinically justifiable diagnoses are provided for each individual, and all diagnoses that cannot be clinically justified for an individual are discontinued no later than the next review;	<p>Findings: NSH conducted a review of a randomly selected sample of 30 charts by two peer staff psychiatrists. The facility modified the statewide monitoring instrument--"Psychiatric Progress Note (PPN) Monitoring Form" (Psychiatry)--to address the requirements in d.i through d.iv. Data indicate 90% compliance with the question of whether the current diagnosis is clinically justifiable. Data also show zero percent compliance with a question about changes or elimination of unjustifiable diagnoses.</p> <p>Chart reviews by this monitor show a pattern of inadequate justification and updates of a variety of diagnostic categories, mostly in the area of cognitive functioning. Examples include established diagnoses of cognitive disorder, NOS (MP), mild mental retardation and substance-induced persisting dementia (RJ), alcohol-induced persisting dementia (JS) dementia NOS (RP and QE), PDD and mild mental retardation (LH and MT) and personality change due to encephalitis (WZ). Other examples include diagnoses such as R/O psychotic disorder, NOS (e.g. CR).</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Provide continuing medical education to psychiatry staff to improve competency in the area of assessment of cognitive and other neuropsychiatric disorders. 2. Revise current monitoring tool to address justification of diagnosis, differential diagnosis, as clinically indicated, and

		appropriate updates of diagnosis.
d.ii	The documented justification of the diagnoses is in accord with the criteria contained in the most current DSM (as per DSM-IV-TR Checklist);	<p>Findings: NSH has data from the above monitoring system that show 17% compliance with this item. This result appears to conflict with the hospital's above-mentioned finding of 90% compliance with justification of diagnosis. The criteria in DSM-IV-TR should constitute the basis for justification of the diagnosis.</p> <p>Recommendations: Assess reason for (and correct) discrepancies in results of monitoring of items that contain similar concepts.</p>
d.iii	Differential diagnoses, "deferred," or "rule-out" diagnoses, and diagnoses listed as "NOS" ("Not Otherwise Specified") are timely addressed (i.e., within 60 days), through clinically appropriate assessments, and resolved in a clinically justifiable manner; and	<p>Findings: Data from the above monitoring show that eight of the 30 charts included a deferred/rule/out/NOS diagnosis. In only 25% of those cases, the monthly progress notes included a plan for resolution or confirmation of the diagnosis.</p> <p>Chart reviews by this monitor confirm this low compliance rate. There is evidence of failure to finalize diagnoses of cognitive disorder NOS (e.g. MP and RS), psychotic disorder NOS (e.g. JA, EL, DB, RS and JR), R/O psychotic disorder NOS (e.g. CR) and R/O cognitive disorder NOS (DB) in a timely manner</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Update the medical staff manual to include the requirements in this cell. 2. Ensure regular monitoring of an adequate sample of charts.
d.iv	"no diagnosis" is clinically justified and documented.	<p>Findings: NSH's data also show that only one of the 30 charts included this</p>

		<p>diagnosis and that the chart included adequate justification. Chart reviews by this monitor did not show any diagnosis listed as "no diagnosis."</p> <p>Recommendation: Continue current practice.</p>
e	<p>Each State hospital shall ensure that psychiatric reassessments are conducted at a frequency that reflects the individual's clinical needs. At a minimum the reassessments are completed weekly for the first 60 days on the admissions units and monthly on other units.</p>	<p>Findings: NSH utilized the above monitoring process to assess this item. The facility's data show a 62% compliance rate with the requirement for monthly notes. Out of the sample, only individual was hospitalized for less than 60 days.</p> <p>This monitor reviewed charts of several individuals on the acute admissions unit. In most of these charts, there was no evidence of a weekly psychiatric note. Examples include MD, SP and DB. Chart reviews of individuals on long-term units indicate compliance with the requirement of monthly notes (EV, RT, LS and CR).</p> <p>Compliance: Partial.</p> <p>Recommendations: Assess and correct factors related to non-compliance with the requirement for weekly progress notes on the admission teams.</p>
f	<p>Each State hospital shall ensure that psychiatric reassessments are documented in progress notes that address the following:</p>	<p>Findings: NSH utilized the above-mentioned process to monitor compliance with this item. Data show compliance rates of 62% (f.i), 44% (f.ii), 30% (f.iii), 73% (f.iv), 67% (f.v), 0% (f.vi) and 33% (f.vii). The process adequately assesses corresponding items f.i through f.vi. The assessment of item f.vii that pertains to the integration of behavioral and pharmacological interventions is limited to whether or not the</p>

psychiatrist has reviewed the behavioral plan and has discussed it with the psychologist.

In almost all the charts reviewed by this monitor, there is a pattern of reassessments that do not meet the required elements. These reviews indicate compliance rates that are concordant with the facility's data in item f.vi but are much lower in all other items. In general, the reassessments show the following deficiencies:

1. The assessment of interval events is lacking and does not adequately cover significant clinical developments. Most of the reassessments are cross-sectional and more oriented towards current crisis events.
2. The diagnoses are not updated in a timely manner. As mentioned earlier, there is little justification for diagnoses listed as not otherwise specified and the diagnostic formulations and differential diagnoses are not adequate when needed. There is little or no documentation to indicate that the psychiatrist has used information regarding the individual's response to specific treatments as data to refine diagnosis.
3. The risks and benefits of current treatments are not reviewed in a systematic manner.
4. The assessment of risk factors is limited to some documentation of crises that lead to use of restrictive interventions. There is no evidence of proactive evaluation of risk factors or timely and appropriate modification of interventions in order to minimize the risk on an ongoing basis.
5. There is limited or no documentation of actual and/or potential side effects of benzodiazepines, anticholinergic medications and/or new generation antipsychotics. This pattern is noted even when these medications are used in individuals who are particularly vulnerable to the risks.

		<ol style="list-style-type: none"> 6. There is no review of the specific indications for the use of PRN or stat medication, the circumstances for the administration of these medications, the individual's response to this use or modification of treatment based on this review. 7. When behavioral interventions are provided, there is no documentation to indicate an integration of pharmacological and behavioral modalities. In addition, there is little or no discussion of the contextual basis and functional significance of the current symptoms. 8. There is no documentation of the goals of individual psychotherapy and of the individual's progress in treatment when the WRP indicates that the psychiatrist is providing this intervention. <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a standardized format for psychiatric reassessments that address and correct the deficiencies identified above. 2. When the individuals receive both pharmacological and behavioral interventions, the reassessments need to address the following specific items: <ol style="list-style-type: none"> a. Review of behavioral plans prior to implementation as documented in progress notes and/or behavioral plan; b. Review of individual's progress in behavioral treatment; c. Differentiation, as clinically appropriate, of learned behaviors from behaviors that are targeted for pharmacological treatment; and
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		<p>d. Modification, as clinically appropriate, of diagnosis and/or pharmacological treatment based on above reviews/assessments.</p> <p>3. Update the medical staff manual to specify requirements regarding documentation of psychiatric reassessments.</p> <p>4. Ensure that monitoring instruments are aligned with the above expectations.</p>
f.i	significant developments in the individual's clinical status and of appropriate psychiatric follow up;	As above.
f.ii	Timely and justifiable updates of diagnosis and treatment, as clinically appropriate;	As above.
f.iii	Analyses of risks and benefits of chosen treatment interventions;	As above.
f.iv	Assessment of, and attention to, high-risk behaviors (e.g., assaults, self-harm, falls) including appropriate and timely monitoring of individuals and interventions to reduce risks;	As above.
f.v	Responses to and side effects of prescribed medications, with particular attention to risks associated with the use of benzodiazepines, anticholinergic medications, polypharmacy (use of multiple drugs to address the same condition), and conventional and atypical antipsychotic medications;	As above.
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	As above.
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	As above.

	<p>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.</p>	
9	<p>When individuals are transferred between treatment teams, a psychiatric transfer note shall be completed addressing: review of medical and psychiatric course of hospitalization, including medication trials; current target symptoms; psychiatric risk assessment; current barriers to discharge; and anticipated benefits of transfer.</p>	<p>Findings: NSH modified the statewide "Physician Transfer Summary Monitoring Form to monitor inter-unit transfers. The revised instrument adequately addresses all key elements. A randomly selected sample of 32 individuals who have required inter-unit transfer was reviewed by one psychiatrist not involved in the care of any of these individuals. The process focused on the psychiatrists' review of main components of the assessment. The compliance rates were 56% (reason for transfer), 6% (psychiatric course), 38% (medical course), 16% (medication trials), 25% (current target symptoms), 3% (psychiatric risk factors), 9% (current barriers to dc) and 13% (anticipated benefits of the transfer).</p> <p>This monitor reviewed charts of some individuals who required inter-unit transfers for psychiatric indications (e.g. RV, JM, BS and MT). An inter-unit transfer assessment was present in all charts. However, the reviews indicate that the required components of the assessment are either inconsistently addressed (e.g. reason for transfer, psychiatric and medical course, medication trials, medication trials and current target symptoms) or almost consistently missing (e.g. psychiatric risk factors/interventions to reduce the risk, barriers to discharge, anticipated benefits of the transfer). The assessments of individuals who are being transferred for administrative reasons (e.g. JM) are particularly inadequate. One individual (BS) is routinely transferred every quarter with no apparent clinical rationale. Such practice renders the implementation of a PBS plan almost obsolete, thus depriving an individual who has been refractory to all current</p>

		<p>interventions from a key therapeutic intervention that has not been attempted.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Update the medical staff manual to include requirements regarding inter-unit transfer assessments. 2. Continue to monitor using current instrument. 3. Refrain from the practice of administrative transfers that have no clinical rationale. 4. 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.
2	Psychological Assessments	
		<p>Methodology:</p> <p>Interviewed Dr. Jim Jones, Acting Chief Psychology. Interviewed Dr. Kathleen Patterson, psychologist. Interviewed Dr. Kenneth Lakritz, psychologist. Interviewed Dr. Ann Hoff, psychologist. Reviewed charts of 23 individuals (RL, DS, ES, SD, WB, JM, MB, BM, BS, ET, DR, AZ, GM, JC, RP, RW, MC, AG, HJ, MM, PF, SA and BC). Chart reviews were conducted with Dr. Jim Jones, Chief Psychologist. Reviewed DMH WRP Manual (Draft July 2006). Reviewed DMH psychology monitoring form. Reviewed Psychology Staff Manual. Reviewed DSM-IV-TR Checklists. Reviewed database on psychologists verifying education, training, privileges, certification and licensure. Reviewed psychological and neurological assessments.</p>

		<p>Reviewed NSH behavior guidelines. Reviewed NSH self-assessment data. Reviewed hospital organizational chart. Reviewed Compliance Checklists on five Psychological Assessments. Reviewed Integrated Assessment Training Record. Reviewed PBS Technical Manual. Reviewed Clinical Services Review (CSR) Compliance Checklist for Qualitative Standards for Psychological Assessment. Requested Dr. Jones, and Dr. Patterson to complete Clinical Service checklists on selected number of psychological assessments. Reviewed NSH Hospital Inventory of Assessments. Reviewed Documentation of Assessments Referred and Completed (January-June 2006).</p>
a	<p>Each State hospital shall develop and implement standard psychological assessment protocols, consistent with generally accepted professional standards of care. These protocols shall address, at a minimum, diagnostic neuropsychological assessments, cognitive assessments, and I.Q./achievement assessments, to guide psychoeducational (e.g., instruction regarding the illness or disorder, and the purpose or objectives of treatments for the same, including medications), educational, rehabilitation, and habilitation interventions, and behavioral assessments (including functional assessment of behavior in schools and other settings), and personality assessments, to inform positive behavior support plans and psychiatric diagnoses.</p>	<p>Findings: NSH psychology department has compiled a psychology staff manual. This manual addresses policies and guidelines, privileging procedures, quality assessments, services and standard of practice and service delivery, and ethics. The manual does not contain all of the elements required by EP, or present the elements with sufficient information required to achieve compliance with the Enhancement Plan by reading it. Not all required elements are being fully implemented at this time, but the acting director of psychology department has plans to achieve compliance with the EP.</p> <p>Interviews with psychologists, chart reviews, and observations showed great inconsistency among psychologists in their understanding of the required elements, such as integrated assessments, clinically indicated assessments, diagnostic assessments, development and implementation of interventions in the PSR Malls, and monitoring of outcomes.</p> <p>Compliance: Partial.</p>

		<p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a statewide psychology manual that codifies the requirements of the EP. 2. The manual should include: <ol style="list-style-type: none"> a. A generic section that applies to all hospitals, and b. Orientation information for newly hired psychologists and clinical practices that is specific to each hospital.
b	<p>Each State hospital shall require the completion of cognitive and academic assessments within 30 days of admission of all school-age and other individuals, as required by law, unless comparable testing has been performed within one year of admission and is available to the interdisciplinary team.</p>	<p>Findings:</p> <p>The hospital has about 50 individuals under the age of 22 who fulfill this criterion. However, no cognitive or academic assessments were found for these individuals. Further, it appears that no hospital staff knew of this requirement.</p> <p>The hospital's self-assessment reported similar findings and compliance.</p> <p>Compliance: Noncompliance.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Implement this requirement of the EP. 2. Develop and implement monitoring and tracking instruments to assess the key requirement of this step.
c	<p>Each State hospital shall ensure that all clinicians responsible for performing or reviewing psychological assessments and evaluations are verifiably competent in the methodology required to conduct the assessment.</p>	<p>Findings:</p> <p>A review of the credentialing list showed that all the psychologists in the department have the appropriate education and credentialing as defined by their job responsibilities. All the psychologists have provisional, affiliate, or active credentials. Although not all</p>

		<p>psychologists showed competency in the content of actual assessments, they showed competency in the methodology required for conducting the assessment.</p> <p>Compliance: Substantial.</p> <p>Recommendation: Continue current practice.</p>
d	Each State hospital shall ensure that all psychological assessments, consistent with generally accepted professional standards of care, shall:	<p>Compliance: Partial.</p>
d.i	expressly state the clinical question(s) for the assessment;	<p>Findings: This monitor reviewed six psychological assessments (DS, JH, MM, PF, AS and BC), four of them with Dr. Jim Jones, the Acting Chief Psychologist. The psychological assessments reviewed were generally adequate. Most assessments, except for one (BC), failed to link summary and conclusions to specific interventions plans, or recommend individuals to available therapy groups within NSH. Only CB's assessment had recommendations that referred to his participation in the By CHOICE program, level of care upon discharge, and other relevant support for CB to improve in his identified target behaviors. Other psychological assessments, reviewed in the context of assessing WRPs, showed a great variability in content and quality. Further, no assessments could be located in several charts.</p> <p>The reviewed psychological assessments contained statements regarding the reason for the referral. A number of the reasons for referral/reason for assessment/referral question sections but did not clearly specify the clinical question. Three of them had pointed sentences clearly defining the statement.</p>

		<p>Recommendation: Ensure that statement of reason for referral is clear and brief.</p>
d.ii	include findings specifically addressing the clinical question(s), but not limited to diagnoses and treatment recommendations;	<p>Findings: All psychological assessments reviewed met this requirement.</p> <p>Recommendation: Continue current practice.</p>
d.iii	Specify whether the individual would benefit from individual therapy or group therapy in addition to attendance at mall groups;	<p>Findings: The hospital's self-evaluation showed only 38% compliance on 24 focused assessments. This monitor found that only one of the assessments reviewed made an attempt to specify if the individual would benefit from individual or group therapy. This finding corroborates the hospital's monitoring data.</p> <p>Recommendation: Ensure that all psychological assessments specify whether the individual would benefit from individual therapy or group therapy.</p>
d.iv	be based on current, accurate, and complete data;	<p>Findings: The psychological assessments reviewed met this requirement.</p> <p>Recommendation: Continue current practice.</p>
d.v	determine whether behavioral supports or interventions (e.g., behavior guidelines or mini behavior plans) are warranted or whether a full positive behavior support plan is required;	<p>Findings: The hospital's self-assessment showed only 13% compliance on 24 focused assessments. Only one of the assessments reviewed by this monitor met this criterion</p>

		<p>Recommendation: Ensure that all psychological assessments of individuals with maladaptive behavior meet this requirement.</p>
d.vi	include the implications of the findings for interventions;	<p>Findings: The hospital's self-assessment showed 75% compliance on 24 focused assessments.</p> <p>This monitor's review showed that the implications of the psychological findings were not consistently specified, and often the implications were not related to the type of groups that would be most appropriate for the psychological status of the individual.</p> <p>Recommendation: Ensure that all focused psychological assessments include the implications of the findings for interventions, especially psychosocial rehabilitation.</p>
d.vii	identify any unresolved issues encompassed by the assessment and, where appropriate, specify further observations, records review, interviews, or re-evaluations that should be performed or considered to resolve such issues; and	<p>Findings: The hospital's self-assessment showed only 56% compliance on 16 focused assessments.</p> <p>This monitor found that, in general, the assessments reviewed did not sufficiently address issues that needed clarification or further testing.</p> <p>Recommendation: Ensure that all focused psychological assessments meet this requirement.</p>
d.viii	Use assessment tools and techniques appropriate for the individuals assessed and in accordance with the American Psychological Association Ethical Standards	<p>Findings: The assessments reviewed used appropriate assessment tools relevant to the individual's cognitive level and reading ability. It could not be</p>

	and Guidelines for testing.	<p>determined from the charts and assessments if the testing was in accordance with the American Psychological Association Ethical Standards and Guidelines for testing.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Continue current practice. 2. Abide by the American Psychological Association Ethical Standards and Guidelines for testing.
e	Each State hospital shall ensure that all psychological assessments of all individuals residing at each State hospital who were admitted there before the Effective Date hereof shall be reviewed by qualified clinicians with demonstrated current competency in psychological testing and, as indicated, revised to meet the criteria in § [IV.B.1 and IV.B.2], above.	<p>Findings:</p> <p>The hospital's self-assessment showed 71% compliance on Integrated Psychological Assessments and 29% compliance on the focused assessments. The monitor's review of more than 25 assessments showed less than 10% compliance.</p> <p>Recommendation:</p> <p>Ensure that psychological tests are completed as required.</p>
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:	<p>Compliance:</p> <p>Partial.</p>
f.i	before an individual's therapeutic and rehabilitation service plan is developed, a psychological assessment of the individual shall be performed that will:	<p>Findings:</p> <p>The hospital's self-assessment used focused assessments as the basis for their investigation. However, the issue is the Integrated Assessment conducted by psychologists before the master WRP is developed on the seventh day of admission. The hospital instituted</p>

		<p>Integrated Psychological Assessments in May 2005. The hospital's self-assessment data showed that 31 out of 43 (72%) of the charts reviewed met this criterion. This monitor's reviews showed that 53% of the charts met this criterion.</p> <p>Recommendation: Ensure that integrated psychological assessments are conducted in a timely manner as required.</p>
f.i.1	address the nature of the individual's impairments to inform the psychiatric diagnosis; and	<p>Findings: Fewer than 10% of the charts reviewed by this monitor contained the Integrated Assessment that addressed the nature of the individual's impairments to inform the psychiatric diagnosis.</p> <p>Recommendation: Ensure that integrated psychology assessments address the nature of the individual's impairments to inform the psychiatric diagnosis.</p>
f.i.2	provide an accurate evaluation of the individual's psychological functioning to inform the therapeutic and rehabilitation service planning process;	<p>Findings: Review of the DMH Psychology Monitoring Form showed 88% of the assessments met this criterion for focused psychological assessments. However, the evaluations were not performed on Integrated Assessments. This monitor's review of integrated assessments showed that less than 30% provided sufficient data on the individual's psychological functioning that would inform the WRP process.</p> <p>Recommendation: Ensure accurate evaluation of psychological functioning that informs the WRP team of the individual's rehabilitation service needs.</p>
f.ii	if behavioral interventions are indicated, a structural and functional assessment shall be performed, consistent with generally accepted professional	<p>Findings: This monitor's review confirmed the hospital's self-evaluation data. No structural and functional assessments were evident in any of the</p>

	<p>standards of care, by a professional having demonstrated competency in positive behavior supports; and</p>	<p>charts reviewed when an individual had a learned maladaptive behavior.</p> <p>Recommendation: Ensure appropriate structural and functional assessments are undertaken by a qualified psychologist when an individual has learned maladaptive behavior.</p>
f.iii	<p>additional psychological assessments shall be performed, as appropriate, where clinical information is otherwise insufficient, and to address unresolved clinical or diagnostic questions, including differential diagnosis, "rule-out," "deferred," "no-diagnosis" and "NOS" diagnoses.</p>	<p>Findings: The hospital's self-assessment showed 20% compliance on this criterion. The hospital's self-assessment included this monitoring item: "The statement "No diagnosis on Axis II" was not included in these findings because no diagnosis means no diagnosis." This item fails to address the requirement.</p> <p>This monitor's review showed that unresolved clinical or diagnostic questions are rarely addressed by the psychological assessments and that these issues were left to the psychiatrists to resolve. The findings in D.1.c through D.1.f indicate that psychiatric assessments and reassessments do not resolve these issues either. This seems to indicate that individuals with unresolved diagnostic issues are either treated for a diagnosis they do not have or not treated for a diagnosis they may have.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that additional psychological assessments are performed, as appropriate, where clinical information is otherwise insufficient, and address unresolved clinical or diagnostic questions, including differential diagnosis, "rule-out," "deferred," "no-diagnosis" and "NOS" diagnoses. 2. Ensure that the facility's monitoring instrument that address "no diagnosis" are aligned with the key requirement, i.e. that "no diagnosis" is backed up by clinical data, especially in individuals with forensic issues.

g	<p>For individuals whose primary language is not English, each State hospital shall endeavor to assess them in their own language; if this is not possible, each State hospital will develop and implement a plan to meet the individuals' assessment needs, including, but not limited to the use of interpreters in the individual's primary language and dialect, if feasible.</p>	<p>Findings: The hospital's self-assessment data showed that four out of 16 (25%) charts reviewed of individuals with other than English as their preferred language met this criterion.</p> <p>A review of the Documentation of Assessments Referred and Completed (January-June 2006) showed that at least three individuals' assessments were not completed because they were Spanish speakers. A review of NSH documentation showed that 49 individuals in the facility had identified non-English as their preferred language, with Spanish being the most preferred among this group of individuals.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that examiners consider cultural aspects when choosing assessment instruments with individuals whose preferred language is not English. 2. Ensure that psychological assessments are provided in the individual's preferred language using interpreters.
3	Nursing Assessments	
		<p>Methodology: Interviewed Ann Rust, MSN, Nursing QI Coordinator. Interviewed Eve Arcala, Assistant Nursing Coordinator. Interviewed Kevin Allen, unit staff. Interviewed Dorothy Pencelly, unit staff. Interviewed Paul Games, N.P. Toured units A4, T18, T17, Q9, Q11, Q 5&6. Attended shift report for unit Q 5&6. Reviewed charts of eight individuals (KH, VH, AG, MP, GB, ES, JB and</p>

		<p>JA).</p> <p>Reviewed Nursing Process Documentation Review Audit summary data (Jan-June 2006).</p> <p>Reviewed Medication Pass and Treatment Administration Review (Jan-June 2006).</p> <p>Reviewed Nursing Education Orientation Competency Checklist.</p> <p>Reviewed Nursing policies and procedures manual.</p> <p>Reviewed Medication Treatment Records (MTR) on 3 units (A4, Q11, Q5&6).</p> <p>Reviewed Controlled Drug log on 3 units.</p> <p>Reviewed 30 new nursing/psychiatric technician personnel files.</p> <p>Reviewed hiring packet.</p> <p>Interviewed Candida Asuncion, Supervising RN for skilled nursing unit.</p> <p>Reviewed Nursing Table of Organization.</p> <p>Reviewed Noc audit tool.</p> <p>Reviewed Special Order (SO) for Minimum Nursing Staff to Patient Ratios.</p> <p>Reviewed Administrative Directive for Nursing Services dated June 23, 2005.</p> <p>Reviewed procedure for Nightly Audits.</p> <p>Reviewed New Hire Orientation Competency Validation Tracking System Report.</p> <p>Reviewed PRN & STAT Progress Notes Monitoring Form and data.</p> <p>Reviewed Administrative Directive for Unit Staffing of Nursing Personnel.</p> <p>Reviewed Medication Variance Data Report for March and April 2006.</p> <p>Reviewed Initial Nursing Assessment Quality Control Summary (Jan-June 2006).</p> <p>Reviewed Nursing Weekly Note Review data (May 2001 to June 2006).</p>
a	Each State hospital shall develop standard nursing assessment protocols, consistent with generally accepted professional standards of care. These protocols shall	<p>Compliance: Partial.</p>

	address, at a minimum:	
a.i	a description of presenting conditions;	<p>Findings: NSH has identified that there was not a specific requirement regarding this key element included in the Nursing policy and procedures.</p> <p>NSH does not have a monitoring and tracking instrument addressing the key elements of a.i, a.ii, a.iii, a.iv, a.v, a.vi, a.vii, a.viii, and a.ix.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement monitoring and tracking instruments to measure the key elements of this requirement (a.i, a.ii, a.iii, a.iv, a.v, a.vi, a.vii, a.viii, and a.ix). 2. Develop, update, revise, and implement policies and procedures addressing the key elements of this requirement.
a.ii	current prescribed medications;	As above.
a.iii	vital signs;	As above.
a.iv	allergies;	As above.
a.v	pain;	As above.
a.vi	use of assistive devices;	As above.
a.vii	activities of daily living;	As above.
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	As above.

a.ix	conditions needing immediate nursing interventions.	As above.
b	Nursing may use a systems model (e.g., Johnson Behavioral System Model) for the nursing evaluation.	<p>Findings: NSH has identified that the Nursing Assessment uses the Johnson Model but needs to be revised to include WRP language.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Revise policies and procedures to include WRP language. 2. Implement WRMMS Nursing Assessments and Integrated Nursing Assessments.
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.	<p>Findings: NSH data reported 100% compliance with this requirement.</p> <p>From my review of 30 personnel files, I found 100% compliance with license and verification of license elements.</p> <p>Compliance: Full compliance.</p> <p>Recommendations: Continue current system to ensure that all nurses who are employed at NSH shall have graduated from an approved nursing program, shall have passed the NCLEX-RN and shall have a license to practice in the State of California.</p>
d	Each State hospital shall ensure that nursing assessments are undertaken on a timely basis, and in particular, that:	<p>Compliance: Partial.</p>

d.i	Initial nursing assessments are completed within 24 hours of the individual's admission;	<p>Findings: NSH data indicated 89% compliance with this requirement.</p> <p>Recommendations: Develop and implement a system that reviews, monitors, and tracks this requirement daily.</p>
d.ii	Further nursing assessments are completed and integrated into the individual's therapeutic and rehabilitation service plan within seven days of admission; and	<p>Findings: NSH data reports 31% of case formulations include assessment results and implications for treatment. This process has only recently begun.</p> <p>NSH has not yet implemented the requirement for completion of initial plan within seven days.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Continue implementation of WRP. 2. Provide on-going Wellness and Recovery training to all staff. 3. Implement appropriate timeframes for key element of this requirement. 4. Develop and implement a monitoring system address the key elements of this requirement.
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.	<p>Findings: NSH had identified that Nursing policies and procedures do not include the key elements in this requirement. The process of revisions has begun.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Revise policies and procedures to include provisions that Nursing assessments are reviewed every 14 days during the first 60 days of admission and every 30 days thereafter

		<p>and updated as appropriate. The third monthly review shall be a quarterly review and the 12th monthly review shall be the annual review.</p> <p>2. Develop and implement a monitoring system to address the key elements of this requirement.</p>
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4	Rehabilitation Therapy Assessments	
		<p>Methodology:</p> <p>Observed adaptive equipment used by individuals on unit A4.</p> <p>Observed the following individuals on unit 4A: HP, SS, DR, MG, LH, AF, TR.</p> <p>Interviewed Karen Zanetell, Chief of Rehabilitation.</p> <p>Interviewed Margaret Lalich, SLP/Special education teacher.</p> <p>Interviewed Joesph Atley, Audiologist/Special education teacher.</p> <p>Interviewed Karen Breckenridge, PT.</p> <p>Interviewed Candida Asuncion, SRN for unit A4.</p> <p>Interviewed Maelinda Holliman, OT.</p> <p>Reviewed charts for seven individuals (VL, JH, JM, SP, DS, TR, and WM).</p> <p>Reviewed the Rehabilitation Therapy Professional Practice Group Operations Manual.</p> <p>Reviewed Physical Therapy Department Policies and Procedures.</p> <p>Reviewed Proctors Orientation Checklist.</p> <p>Reviewed training schedule for July 2006.</p> <p>Reviewed orientation schedule for August 2006.</p> <p>Reviewed Annual Mandated Training list.</p> <p>Reviewed Rehab therapist training roster for July 1, 2006.</p> <p>Reviewed the list of individuals who require adaptive equipment.</p> <p>Reviewed physical therapy monitoring tools.</p> <p>Reviewed rehabilitation monitoring data.</p> <p>Reviewed list of individuals admitted before June 1, 2006 that had Integrated Rehabilitation Assessments completed.</p>

		<p>Reviewed credentialing documents. Reviewed Rehabilitation Therapy Documentation Monitoring Tool data. Reviewed Rehabilitation therapy services staffing.</p>
a	<p>Each State hospital shall develop standard rehabilitation therapy assessment protocols, consistent with generally accepted professional standards of care, for satisfying the necessary components of a comprehensive rehabilitation therapy assessment.</p>	<p>Findings: NSH has developed standard rehabilitation therapy assessment protocols consistent with generally accepted professional standards of care. However, most of the rehabilitation therapy assessments this monitor reviewed were not comprehensive and did not address all of the individuals' needs. The facility is currently in the process of revising the rehabilitation therapy assessments.</p> <p>NSH data indicated that RT Operations Manual (facility and state), AD for Rehabilitation Therapy Services, and Client Leisure Interest Survey do not include Wellness and Recovery language.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Continue process of revising, reassessing and developing integrated rehabilitation therapy assessments to ensure that they are comprehensive and meet the individuals' needs. 2. Revise, update, and implement policies, procedures, operations manuals and ADs to address this requirement.
b	<p>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:</p>	<p>Compliance: Partial.</p>
b.i	<p>Is accurate and comprehensive as to the individual's functional abilities;</p>	<p>Findings: NSH data indicated 49% compliance with the presence of an Integrated Rehabilitation Therapy Assessment with the required key</p>

		<p>elements. A majority of assessments did not address the skills and supports need to facilitate transfer to the next level of care, life goals stated in quotes, motivation for engaging in wellness activities, and the lack of interview of the individual during the assessment process.</p> <p>NSH data indicated a compliance rate of 60% for the presence of a CERT-Psych/R (annual assessment) with required elements.</p> <p>In addition, from my observations of individuals on the units and review of the rehabilitation assessments, there are several individuals who have significant unmet rehabilitation needs in the areas of OT, PT, and Speech therapy regarding dysphagia, positioning, and wheelchairs that do not promote appropriate body alignment.</p> <p>Recommendations:</p> <ol style="list-style-type: none">1. Revise appropriate policies, procedures, and manuals to include the required key elements.2. Train RT staff regarding changes implemented.3. Develop and implement a system for monitoring and tracking the key elements of this requirement.4. Secure a consultant with expertise in the area of dysphagia to assist the teams in assessments and the development of 24-hour, proactive WRPs for individuals at-risk and high-risk for aspiration.5. Provide on-going training to all team members regarding dysphagia.6. Obtain a wheelchair specialist to assist the teams in assessing the mobility needs and fabricating individual wheelchairs that promote appropriate body alignment for individuals who depend on the use of wheelchairs for the majority of their mobility.7. Streamline the process of obtaining adaptive equipment.8. Provide and document training to individuals and staff
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		<p>regarding the appropriate use of adaptive equipment.</p> <ol style="list-style-type: none"> 9. Develop a monitoring system to ensure that individuals have access to their adaptive equipment and that it is in proper working condition, and that it is being used appropriately. 10. Re-evaluate the adaptive equipment at least annually or in response to individuals' status changes to ensure that it is meeting the individuals' needs. 11. Develop a collaborative relationship with developmental specialists for assistance with positioning and wheelchair fabrication.
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	As above.
b.iii	Identifies the individual's life goals, strengths, and motivation for engaging in wellness activities.	As above.
c	Each State hospital shall ensure that all clinicians responsible for performing or reviewing rehabilitation therapy assessments are verifiably competent in performing the assessments for which they are responsible	<p>Findings: NSH does not have a system in place for monitoring and tracking this requirement.</p> <p>Compliance: Partial.</p> <p>Recommendations: Develop and implement a system for monitoring and tracking the key elements of this requirement.</p>
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.	<p>Findings: NSH has developed a list of individuals who will require a rehabilitation therapy assessment. They are in the process of completing these assessments to include all the required elements.</p>

		<p>Compliance: Partial.</p> <p>Recommendations: Continue the process of reassessing and developing integrated rehabilitation therapy assessments for individuals who were admitted before 6/1/06.</p>
5	Nutrition Assessments	
	<p>Each State hospital shall provide nutrition assessments, reassessments, and interventions consistent with generally accepted professional standards of care. A comprehensive nutrition assessment will include the following:</p>	<p>Methodology: Reviewed the Statewide Nutrition Care Monitoring Tool (NCMT). Reviewed the Statewide Nutrition Care Monitoring data Jan-June 2006. Reviewed Napa State Hospital Dietetics Department Procedure Manual. Reviewed Napa State Hospital Diet Manual. Reviewed Napa State Hospital Administrative Directive for Wellness and Recovery Plan (WRP) dated August 26, 2004. Reviewed Dysphagia/Choking Precaution List. Reviewed Enteral Feeding List. Reviewed list of individuals admitted directly into the medical-surgical unit (none). Reviewed list of individuals directly admitted into the skilled nursing facility (none). Reviewed list of individuals who were new admissions with identified nutrition triggers. Reviewed list of individuals at risk acuity levels. Reviewed list of individuals with BMI over 25 or under 18. Observed mealtime for building T. Interviewed Wen Pao, Clinical Dietician. Conducted chart reviews.</p>

a	<p>For new admissions with high risk referral (e.g., type I diabetes mellitus, enteral/parenteral feeding, dysphagia/recent choking episode), or upon request by physician, a comprehensive Admission Nutrition Assessment will be completed within 24 hours of notification to the dietitian.</p>	<p>Findings: At the time of this review, there were no individuals that met this criterion based on the facility's self assessment data (review of 12% sample).</p> <p>Compliance: Not applicable.</p> <p>Recommendations: Develop and implement a high-risk referral monitoring and tracking system to identify individuals who meet this criterion to ensure that they receive adequate nutrition assessments.</p>
b	<p>For new admissions directly into the medical-surgical unit, a comprehensive Admission Nutrition Assessment will be completed within 3 days of admission.</p>	<p>Findings: One individual met this criterion (VL). The Admission Nutrition Assessment was completed within three days of admission.</p> <p>The percentage of compliance with this criterion from the Napa Self-Assessment was reported as being only 71%. However, upon review, I noted that this score represented the total score for the NCMT, not for Assessment Type B, Item 1.</p> <p>However, the quality of the assessment was inadequate. Pertinent objective nutrition information was not accurately addressed; goals were not individualized or related to the nutrition diagnosis, and were not realistic and measurable; the Nutritional Status Type (NST) was incorrectly assigned to reflect acuity level and date of next review; and approved abbreviations were not used in the assessment.</p> <p>Compliance: Partial.</p>

		<p>Recommendations:</p> <ol style="list-style-type: none"> 1. Report scores for self-assessment tool broken down by items as well as overall scores to provide more specific and accurate data regarding strengths and problem areas. 2. Retrain appropriate staff regarding deficiencies and appropriate procedures for Admission Nutrition Assessments. 3. Document the above as corrective action including date(s) completed.
c	For new admissions directly into the skilled nursing facility unit, a comprehensive Admission Nutrition Assessment will be completed within 7 days of admission.	<p>Findings: At the time of this review, there were no individuals that met this criterion based on the facility's self assessment data (review of 12% sample).</p> <p>Compliance: Not applicable.</p> <p>Recommendations: Develop and implement a monitoring and tracking system for individuals directly admitted into the skilled nursing facility to identify individuals who meet this criterion to ensure that they receive adequate nutrition assessments.</p>
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	<p>Findings: Three individuals were found to meet this criterion (MA, CR, DF). Of the three Admission Nutrition Assessments, two were not completed within seven days of admission.</p> <p>The percentage of compliance with this criterion from the Napa Self-Assessment was reported at 65 %. However, upon review, this monitor</p>

	<p>completed within 7 days of admission.</p>	<p>noted that this score represented the total score for the NCMTs, not for Assessment Type D, Item 1.</p> <p>In addition, there were a number of problems related to the quality of the assessments. These problematic areas included estimating daily needs, using approved abbreviations, addressing nutrition goals, addressing food and fluid consistency needs for risk of aspiration/dysphagia, transitioning to oral feeding regimens, addressing pertinent objective nutrition information, and responding to nutrition interventions.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that Admission Nutrition Assessments for Assessment Type Ds are completed in a timely manner. 2. Report scores for self-assessment tool broken down by items as well as overall scores to provide more specific and accurate data regarding strengths and problem areas. 3. Retrain appropriate staff regarding deficiencies and appropriate procedures for Admission Nutrition Assessments. 4. Document the above as corrective action including date(s) completed.
e	<p>For new admissions with therapeutic diet orders for medical reasons, a comprehensive Admission Nutrition Assessment will be completed within 7 days of admission.</p>	<p>Findings: This monitor reviewed 12 individuals (JE, MM, VW, RD, YD, CP, PI, PV, DG, IL, AG and DG). Of these twelve Admission Nutrition Assessments, eight were not completed within seven days of admission.</p> <p>The percentage of compliance with this criterion from the Napa Self-</p>

		<p>Assessment was reported at 71%. However, upon review, I noted that this score represented the total score for the NCMTs, not for Assessment Type E, Item 1.</p> <p>In addition, there were a number of problems related to the quality of the assessments. These problematic areas included the provision of nutrition education, assignment of NST, legibility of assessment, monitoring of progress, developing complete and appropriate recommendations, utilizing findings, estimating daily needs, using approved abbreviations, addressing nutrition goals, addressing pertinent objective nutrition information, and responding to nutrition interventions.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that Admission Nutrition Assessments for Assessment Type Es are completed in a timely manner. 2. Report scores for self-assessment tool broken down by items as well as overall scores to provide more specific and accurate data regarding strengths and problem areas. 3. Retrain appropriate staff regarding deficiencies and appropriate procedures for Admission Nutrition Assessments. 4. Document the above as corrective action including date(s) completed.
f	<p>For individuals with therapeutic diet orders for medical reason after admission, a comprehensive Admission Nutrition Assessment will be completed within 7 days of the therapeutic diet order but no later than 30 days of admission.</p>	<p>Findings: Twelve individuals were reviewed who met this criterion (JE, MM, VW, RD, YD, CP, PI, PV, DG, IL and AG, DG). Of the twelve Admission Nutrition Assessments, eight were not completed within seven days of admission.</p>

		<p>The percentage of compliance with this criterion from the Napa Self-Assessment was reported at 71%. However, upon review, I noted that this score represented the total score for the NCMTs, not for Assessment Type E, Item 1.</p> <p>In addition, there were a number of problems related to the quality of the assessments. These problematic areas included the provision of nutrition education, assignment of NST, legibility of assessment, monitoring of progress, developing complete and appropriate recommendations, utilizing findings, estimating daily needs, using approved abbreviations, addressing nutrition goals, addressing pertinent objective nutrition information, and responding to nutrition interventions.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that Admission Nutrition Assessments for Assessment Type Es are completed in a timely manner. 2. Report scores for self-assessment tool broken down by items as well as overall scores to provide more specific and accurate data regarding strengths and problem areas. 3. Retrain appropriate staff regarding deficiencies and appropriate procedures for Admission Nutrition Assessments. 4. Document the above as corrective action including date(s) completed.
g	For all other individuals, a comprehensive Admission Nutrition Assessment will be completed within 30 days of admission.	<p>Findings: This monitor reviewed 25 five individuals were reviewed who met this criterion (NP, TH, RM, DG, SW, RG, RP, MCC, JTF, DB, LR, DB unit Q6,</p>

		<p>BD, LB, HT, RT, WD, DR, MP, GT, AO, KC, DH, TH unit T13 and AA,). Of these 25 Admission Nutrition Assessments, one was not completed within 30 days of admission.</p> <p>The percentage of compliance with this criterion from the Napa Self-Assessment was reported at 71%. However, upon review, I noted that this score represented the total score for the NCMTs, not for Assessment Type G, Item 1.</p> <p>In addition, there were a number of problems related to the quality of the assessments. These problematic areas included addressing subjective concerns, assignment of NST, legibility of assessments, missing signatures, response to interventions, addressing food and fluid consistency for risk of aspiration/dysphagia, transitioning to oral feeding, the provision of nutrition education, monitoring of progress, developing complete and appropriate recommendations, utilizing findings, using approved abbreviations, addressing nutrition goals, addressing pertinent objective nutrition information, and responding to nutrition interventions.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Continue to monitor Admission Nutrition Assessments for Assessment Type Gs to ensure that they are completed in a timely manner. 2. Report scores for self-assessment tool broken down by items as well as overall scores to provide more specific and accurate data regarding strengths and problem areas. 3. Retrain appropriate staff regarding deficiencies and appropriate procedures for Admission Nutrition Assessments.
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		4. Document the above as corrective action including date(s) completed.
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.	<p>Findings: From my review of 46 Admission Nutrition Assessments, 12 did not correctly assign the acuity level and date of next review (Item 12 on NCMT).</p> <p>The percentage of compliance with this criterion from the Napa Self-Assessment was reported as being 60 %. (86 out of 141 audits were assigned the NST acuity level correctly).</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Report scores for self-assessment tool broken down by items as well as overall scores to provide more specific and accurate data regarding strengths and problem areas. 2. Retrain appropriate staff regarding the Nutritional Status Type (NST) classifications. 3. Document the above as corrective action including date(s) completed.
i	The frequency of a comprehensive Nutrition Assessment Update will be determined by the NST. Updates should include, but not be limited to: subjective data, weight, body-mass index ("BMI"), waist circumference, appropriate weight range, diet order, changes in pertinent medication, changes in pertinent medical/psychiatric problems, changes in nutritional problem(s), progress toward goals/objectives, effectiveness of interventions, changes in goals/plan, recommendations, and follow-up as needed.	<p>Findings: The current NCMT does not address all the key elements included in this requirement.</p> <p>Compliance: Partial.</p> <p>Recommendations: Develop and implement tracking and monitoring systems related to the</p>

		elements of Nutrition Assessment Updates.
j.i	Individuals will be reassessed when there is a significant change in condition.	<p>Findings: The Nutrition Assessments were reviewed for 17 individuals who were either a post-admit consult/high-risk referral (Assessment Type I) or a non-administrative transfer to the medical/surgical unit or skilled nursing facility unit (Assessment Type J). (EA, DT, GL, SN, NJ, JK, BH, DHB, ML, VS, MW, EM, CL, RJ, LS, DL, HP). Two were not completed in a timely manner. In addition, there were significant problems noted in the quality of the assessments for all 17 individuals.</p> <p>The current NCMT does not adequately identify items pertinent to this population.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a system to ensure that individuals who have a significant change in condition will be reassessed. 2. Develop and implement monitoring system to ensure that these individuals are adequately reassessed and in a timely manner. 3. Provide training on components of an adequate assessment for changes in conditions.
j.ii	Every individual will be assessed annually.	<p>Findings: Forty-seven individuals' Nutritional Assessments were reviewed. Of the 47, seven did not have a timely annual assessment.</p> <p>The percentage of compliance with this criterion from the Napa Self-</p>

		<p>Assessment was reported as being 56%. However, upon review, I noted that this score represented the total score for the NCMTs, not for Assessment Type K, Item 1.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that each individual is nutritionally assessed annually. 2. Report scores for self-assessment tool broken down by items as well as overall scores to provide more specific and accurate data regarding strengths and problem areas. 3. Retrain appropriate staff regarding deficiencies and appropriate procedures for Admission Nutrition Assessments. 4. Document the above as corrective action including date(s) completed.
6	Social History Assessments	
	<p>Each State hospital shall ensure that each individual has a social history evaluation that, consistent with generally accepted professional standards of care:</p>	<p>Methodology: Interviewed Ann Long, LCSW, Chief of Social Work Services. Interviewed Jane Adams, WRP Training Officer. Reviewed charts of 16 individuals (RB, JR, CW, RP, CD, RB, PM, RS, RP, RG, RW, TF, TL, RG, FP and CW). Reviewed Social Work Integrated 5 day Monitoring Form. Reviewed Integrated Social Work Assessment Form. Reviewed Social Work Integrated Assessment Instructional Manual. Reviewed Social Work 30-Day Psychosocial Assessment Monitoring Form. Reviewed Social Work 30-Day Psychosocial Assessment Instructional Manual.</p>

		<p>Reviewed Social Work Annual Assessment Monitoring Form.</p> <p>Reviewed Integrated Social Work Assessment Monitoring Form.</p> <p>Reviewed DMH Social Work Monitoring summary data (January-June 2006).</p> <p>Observed team meetings.</p>
a	Is, to the extent reasonably possible, accurate, current and comprehensive;	<p>Findings:</p> <p>The hospital's self-assessment showed 88% compliance on all integrated assessments, 92% compliance on psychosocial assessments, and 82% compliance on annual assessments. There was a range from 62% to 90% on the timeliness of the social histories.</p> <p>This monitor's chart review corroborated the facility's data. However, the monitor found only 60% compliance on the annual evaluations in the charts. It is noted that the self-assessments are focused on timeliness and content rather than quality. The quality indicators are vague and do not adequately address required elements.</p> <p>Compliance:</p> <p>Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Include quality indicators in the Social Work monitoring instruments. 2. Implement the 30-day social history reviews. 3. Develop and implement monitoring of the 30-day social history evaluations. 4. Develop, finalize and implement statewide annual social history evaluations. 5. Align monitoring tools with the Evaluation Plan.
b	Expressly identifies factual inconsistencies among sources, resolves or attempts to resolve inconsistencies, and	<p>Findings:</p> <p>The hospital's self-assessment showed 25% of the social histories</p>

	explains the rationale for the resolution offered;	<p>reviewed had evidence of factual inconsistencies. This monitor's review showed a similar percentage.</p> <p>Compliance: Partial.</p> <p>Recommendations: Ensure that social workers identify and address the inconsistencies in current assessments.</p>
c	Is included in the 7-day integrated assessment and fully documented by the 30 th day of an individual's admission; and	<p>Findings: The hospital's self-assessment showed only 76% of the evaluations was completed within the required 30 days. Four of six charts (66%) reviewed by the monitor were deficient in the 30-day evaluation.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure all SW Integrated assessments are completed and available to the WRP team before the 7-day WRPC. 2. Ensure that all 30-day social histories are completed and available to the individual's WRP team members by the 30th day of admission.
d	Reliably informs the individual's interdisciplinary team about the individual's relevant social factors and educational status.	<p>Findings: The hospital's self-assessment showed a compliance rate of 85% on this criterion. This monitor's review showed about 76% compliance but the quality of the evaluations varied by the same social worker and between social workers.</p> <p>Compliance: Partial.</p>

		<p>Recommendation: Ensure that social histories reliably inform the individual's WRP team about the individual's relevant social factors and educational status.</p>
7	Court Assessments	
		<p>Methodology: Interviewed Robin Broadman, M.D. Chair, Forensic Review Panel. Interviewed Katie Cooper, Psych D, Director, Program II (PC 1026). Reviewed court reports submitted for ten individuals (PJA, DB, TH, CL, KZ, TK, RZ, GJ, SM and AP). Reviewed AD "Forensic Admissions." Reviewed AD #765 "Forensic Review Process for Not Guilty by Reason of Insanity (PC 1026) and Incompetent to Stand Trial (PC 1370) Commitments." Reviewed Court Report Monitoring Form for PC 1026. Reviewed Court Report Monitoring for PC 1026 summary data (Jan-June 2006). Reviewed Court Report Monitoring Form for PC 1370. Reviewed Court Report Monitoring summary data (Jan-June 2006). Reviewed Minutes of Forensic Panel meetings January to June 2006. Reviewed Forensic Report checklists.</p>
a	Each State hospital shall develop and implement policies and procedures to ensure an interdisciplinary approach to the development of court submissions for individuals adjudicated "not guilty by reason of insanity" ("NGI") pursuant to Penal Code Section 1026, based on accurate information, and individualized risk assessments. The forensic reports should include the following, as clinically indicated:	<p>Compliance: Partial.</p>
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	<p>Findings: NSH has developed and approved an AD (#765) that describes the format requirements for submission of court reports relevant to</p>

	crime (i.e., instant offense);	<p>individuals adjudicated NGRI. The facility has a monitoring form that is aligned with the criteria in items D.7.a.i through D.7. a.ix. Utilizing this form, the facility reviewed 64 reports (out of 65 that were presented to the Medical Director in May 2006). A compliance rate of 70% was reported for this item.</p> <p>However, review by this monitor of charts of five individuals adjudicated NGRI indicate that most reports (PJA,DB, KZ and CL) partially address this criterion. The report in the chart of TH does not address the item.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that the FRP reviews all PC 1026 reports and provide feedback to the WRP teams to achieve compliance. 2. Address the reason(s) for any significant discrepancy between findings of the monitor and the facility's data. 3. Clarify presentation of monitoring data in terms of sample size, how sample was selected, and corresponding results.
a.ii	acts of both verbal and physical aggression and property destruction during the past year of hospitalization and, if relevant, past acts of aggression and dangerous criminal behavior;	<p>Findings: Facility's data show compliance rate of 72% for this item. This monitor's reviews indicate non-compliance in the charts of PJA, DB, TH and CL and substantial compliance in the chart of KZ.</p> <p>Recommendations: Same as above.</p>
a.iii	understanding of potential for danger and precursors of dangerous/criminal behavior, including instant offense;	<p>Findings: The compliance rate reported by NSH for this item is 56%. This monitor's reviews show that the reports in most charts (PJA, DB, KZ and TH) do not address this criterion. One chart (CL) contains a report that partially addresses the criterion.</p>

		<p>Recommendations: Same as above.</p>
a.iv	<p>acceptance of mental illness and understanding of the need for treatment, both psychosocial and biological, and the need to adhere to treatment;</p>	<p>Findings: NSH reports a compliance rate of 59% for this item. This monitor's review show compliance in one chart (PJA), partial compliance in two (CL and TH) and non-compliance in two (DB and KZ).</p> <p>Recommendations: Same as above.</p>
a.v	<p>development of relapse prevention plan (i.e., Personal Wellness Recovery Plan or Wellness Recovery Action Plan) for mental illness symptoms, including the individual's recognition of precursors and warning signs and symptoms and precursors for dangerous acts;</p>	<p>Findings: NSH reports a compliance rate of 58% for this item. Chart reviews by this monitor demonstrate non-compliance in three charts (PJA, DB KZ), partial compliance in one (TH) and compliance in one (CL).</p> <p>Recommendations: Same as above.</p>
a.vi	<p>willingness to achieve understanding of substance abuse issues and to develop an effective relapse prevention plan (as defined above);</p>	<p>Findings: The compliance rate, based on the facility's monitoring data, is 41%. This monitor's review of charts shows non-compliance in three charts (DB, KZ and CL) and partial compliance in one (TH). This item is not applicable to PJA.</p> <p>Recommendations: Same as above.</p>
a.vii	<p>previous community releases, if the individual has had previous CONREP revocations;</p>	<p>Findings: The facility reports a compliance rate of 83% for this item. This monitor's reviews indicate that three charts (DB, KZ and CL) comply with this criterion and one chart (PJA) does not. The item does not apply to TH.</p>

		<p>Recommendations: Same as above.</p>
a.viii	<p>social support, financial resources, family conflicts, cultural marginalization, and history of sexual and emotional abuse, if applicable; and</p>	<p>Findings: The compliance rate reported by NSH is 26%. The reviews by this monitor show noncompliance in three charts (PJA, CL and TH), compliance in one chart (DB) and partial compliance in one (KZ).</p> <p>Recommendations: Same as above.</p>
a.ix	<p>relevant medical issues, all self-harm behaviors, risks for self harm and risk of harm to others, to inform the courts and the facility where the individual will be housed after discharge.</p>	<p>Findings: NSH reports a compliance rate of 47% for this item. This monitor found noncompliance in four charts (PJA, DB, CL and TH) and partial compliance in one (KZ).</p> <p>Recommendations: Same as above.</p>
b	<p>Each State hospital shall develop and implement policies and procedures to ensure an interdisciplinary approach to the development of court submissions for individuals admitted to the hospital pursuant to Penal Code Section 1370, "incompetent to stand trial" ("IST"), based on accurate information and individualized risk assessments. Consistent with the right of an individual accused of a crime to a speedy trial, the focus of the IST hospitalization shall be the stabilization of the symptoms of mental illness so as to enable the individual to understand the legal proceedings and to assist his or her attorney in the preparation of the defense. The forensic reports should include the following:</p>	<p>Compliance: Partial.</p>

b.i	relevant clinical description of initial presentation, if available, which caused the individual to be deemed incompetent to stand trial by the court;	<p>Findings: AD #765 describes the format requirements for submission of court reports relevant to individuals admitted under PC 1370. The facility has a monitoring form that is aligned with the criteria in items D.7.b.i through D.7. b.iv. Utilizing this form, the facility reviewed all 49 reports that were presented to the Medical Director in May 2006. A compliance rate of 67% is reported for this item.</p> <p>This monitor reviewed court reports in five charts of individuals that were admitted under PC 1370. There was noncompliance in three charts (TK, RZ and GJ) and compliance in two (SM and AP).</p> <p>Recommendations: Same as under D.7.a.i</p>
b.ii	clinical description of the individual at the time of admission to the hospital;	<p>Findings: The facility reports compliance rate of 92%. This monitor found compliance in three charts (SM, TK and GJ), partial compliance in one (AP) and noncompliance in one (RZ).</p> <p>Recommendations: Same as above.</p>
b.iii	course of hospital stay, describing any progress or lack of progress, response to treatment, current relevant mental status, and reasoning to support the recommendation; and	<p>Findings: NSH reports compliance rates for different sub-items of this criterion. The rates are: 84% (describing any progress or lack of progress), 82% (response to treatment), 65% (current relevant mental status) and 76% (reasoning to support the recommendation). Overall compliance rate of 77% was reported. Reviews by this monitor indicate overall compliance in two charts (205356-9 and 206179-4), partial compliance in two (205448-4 and 205949-1) and noncompliance in one (206183-6).</p>

		<p>Recommendations: Same as above.</p>
b.iv	<p>all self-harm behaviors and relevant medical issues, to inform the courts and the facility where the individual will be housed after discharge.</p>	<p>Findings: The compliance rate, based on the facility's data, is 35%. This monitor found noncompliance in four charts (SM, TK, RZ and AP) and partial compliance in one (GJ).</p> <p>Recommendations: Same as above.</p>
c	<p>Each State hospital shall establish a Forensic Review Panel (FRP) to serve as the internal body that reviews and provides oversight of facility practices and procedures regarding the forensic status of all individuals admitted pursuant to Penal Code 1026 and 1370. The FRP shall review and approve all forensic court submissions by the Wellness and Recovery Teams and ensure that individuals receive timely and adequate assessments by the teams to evaluate changes in their psychiatric condition, behavior and/or risk factors that may warrant modifications in their forensic status and/or level of restriction</p>	<p>Findings: NSH established a Forensic Review Panel with functions and responsibilities outlined in AD #765. The duties and responsibilities are consistent with the requirements of this section. The panel has held several meetings since January 2006 to address administrative aspects of its functioning and has developed individual trends based on the current monitoring tool. The panel just began the task of reviewing all reports submitted to the court and providing clinical and administrative feedback to practitioners to improve the quality of reports. The facility developed and implemented monitoring forms and checklists that incorporate the required elements.</p> <p>Compliance: Partial.</p> <p>Recommendations: Ensure that the panel performs the primary function of reviewing all court reports for individuals admitted under penal codes 1026 and 1370. The panel must provide feedback to WRP teams to ensure compliance with all above requirements.</p>

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.	<p>Findings: The current membership of the panel consists of a forensic psychiatrist as Chair, Medical Director, Chief of Psychology, Chief of Forensic Liaison Department and a psychologist with forensic training.</p> <p>Compliance: Partial.</p> <p>Recommendations: Improve interdisciplinary input by including, as members, Chief of Nursing Services or designee and Chief of Rehabilitation Services or designee.</p>
E	Discharge Planning and Community Integration	
		<p>Summary of Progress:</p> <ol style="list-style-type: none"> 1. NHS has correctly recognized that discharge planning focus begins from the individual's first day of admission. 2. NSH is focused on meeting the criteria on appropriate and timely discharge and community integration of the individuals in their facility 3. NSH has adopted the WRP as an essential tool towards addressing the individual's rehabilitation needs and preparation of the individual for discharge and community integration. 4. Social workers are provided training in the discharge process.
	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	<p>Methodology: Interviewed Ann Long, LCSW, Chief of Social Work Services. Reviewed charts of eight individuals (RW, NF, CW, TL, VM, PR, JB, and DP). Reviewed WRP Chart Audit Form. Reviewed WRP Chart Audit Data Summary. Reviewed documentation of individuals who met discharge criteria but</p>

	appropriate, that is consistent with each individual's needs.	are still in the hospital. Observed WRP team meetings to review three individuals (AS, LZ and CS).
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:	<p>Findings: Data from the WRP Chart Audits showed severe deficiency on this objective—achieving only 8% compliance on issues dealing with quality of the reports, expectations of the individual's performance for discharge, and identification of the placement setting. Three of the eight charts (38%) reviewed by this monitor were deficient on this criterion.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Achieve continuity of the discharge process from admission to discharge through the WRP and WRP team process. 2. Involve the individual in the discharge process through discussion of discharge criteria and how to meet them by attending relevant PSR Mall groups, individual therapy (as needed), and by practicing newly acquired skills in the therapeutic milieu. 3. Social workers must review discharge status with the WRP team and the individual at all scheduled WRP conferences involving the individual.
1a	those factors that likely would foster successful discharge, including the individual's strengths, preferences, and personal life goals;	<p>Findings: The hospital's WRP Chart Audit data on item # 23 dealing with individual's strengths evidenced only 7% compliance with this objective. Four of the five charts (80%) reviewed by this monitor failed to meet one or more criteria (e.g., addressing the individual's life goals,</p>

		<p>strengths, and preferences) of this objective.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that the individual's strengths and preferences are utilized to achieve discharge goals. These should be linked to the interventions that impact the individual's discharge criteria. 2. The individual's life goals should be linked to one or more focus of hospitalization, with associated objectives and interventions.
1b	the individual's level of psychosocial functioning;	<p>Findings: According to Ms. Ann Long, the HIMD tracks GAF entries on admission and upon every Annual Psychiatric Evaluation. Data from the WRP chart audit item dealing with GAF on evaluations had 23% compliance; and WRP Process Observation item dealing with present status and individual participation had 59% compliance. Three of the four (75%) charts reviewed failed to meet compliance. None of the charts reviewed included appropriate updates of the functional status (i.e. progress on assigned groups and individual therapies) in the present status section of the case formulation.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that the level of psychosocial functioning (functional status) is included in the individual's present status section of the case formulation section of the WRP.

		2. Implement the DMH WRP Manual in developing and updating the case formulation.
1c	any barriers preventing the individual from transitioning to a more integrated environment, especially difficulties raised in previously unsuccessful placements; and	<p>Findings: Review of the WRP Chart Audit data relating to case formulation showed a 75% deficiency on this objective. Three of the four charts (75%) reviewed by this monitor failed to meet the requirement in this step.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that discharge barriers, especially difficulties in previously unsuccessful placements, are discussed with the individual at scheduled WRPC. 2. Include skill training and supports in the WRP so that the individual can overcome the stated barriers. 3. Report to the WRP team, on a monthly basis, the individual's progress made in overcoming the barriers to discharge.
1d	the skills and supports necessary to live in the setting in which the individual will be placed.	<p>Findings: Review of the WRP Chart Audit data dealing with an individual's discharge criteria, expectations, and identification of the next setting showed only 8% of the charts reviewed met this criteria. Three out of the four charts (75%) reviewed by this monitor failed to meet compliance.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Assess the skills and supports that will be needed by the

		<p>individual for a successful transition to the identified setting.</p> <ol style="list-style-type: none"> 2. Assess skills and supports deficits the individual may have for the intended placement. 3. Include these skills and supports in the individual's WRP at the next scheduled conference.
2	<p>Each State hospital shall ensure that, beginning at the time of admission and continuously throughout the individual's stay, the individual is an active participant in the discharge planning process, to the fullest extent possible, given the individual's level of functioning and legal status.</p>	<p>Findings: NSH has emphasized in its SW procedural document the importance of discharge planning as an important goal from the day of the individual's admission to its facility. The state's DMH WRP process is based on the WRP as a discharge plan.</p> <p>The WRPC meetings that this monitor attended (e.g., AS, LZ and CS) indicated that the teams at some point addressed this objective with the individual. However, more often than not, the objective was not fully explicated before moving on to the next item/agenda/topic. Many times there were digressions either by the individual and the team reacted to the individual instead of directing the individual to focus on the objective, or a member of the WRP team interjected about something else. The process of WRP outlined in the WRP Manual was not followed and the individuals in the observed WRPCs left without discussing fully their current discharge status and what they should be doing to hasten their discharge to the next level of care.</p> <p>The hospital's data on this objective using their WRP Process Observation form for this objective regarding an individual's participation in his or her discharge planning showed 58% compliance. From the monitor's limited observations, this appears to be a rather generous finding.</p> <p>Compliance: Partial.</p>

		<p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that the individual is an active participant in the discharge planning process. 2. Implement the DMH WRP Manual on discharge process. 3. Prioritize objectives and interventions related to the discharge process.
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:	<p>Findings: The hospital's self-assessment showed only 8% compliance on this criterion. As mentioned earlier, the hospital is focused on discharge planning from the individual's first day of admission. However, this is not evident in the individuals' charts. The hospital's Social Service Department's procedures emphasize the need for proper documentation of discharge planning processes. However, this documentation is a significant deficiency at NSH. This appears to be related to the disconnect between various programs and therapy groups and inadequate implementation of the principles and practice requirements in the DMH WRP.</p> <p>Recommendation: Follow the established WRP process for discharge planning to ensure that each individual has a professionally developed discharge plan that is integrated within the individual's WRP.</p>
3a	measurable interventions regarding these discharge considerations;	<p>Findings: NSH's self-assessment data indicate only 8% compliance in documenting individual discharge plans written in behavioral terms specifying expected behaviors, achievement, and identification of next placement. This monitor's chart reviews confirm this deficiency.</p> <p>Compliance: Partial.</p>

		<p>Recommendation: Write all interventions, including those dealing with discharge criteria, in behavioral and measurable terms as outlined in the DMH WRP Manual.</p>
3b	the staff responsible for implement the interventions; and	<p>Findings: The hospital's own evaluation showed only 19% compliance with this criterion. This monitor's chart reviews showed that two (KP and VC) of seven WRPs (JM, VC, JL, KP, and BS) had specific staff identified for the PSR groups and individual therapies.</p> <p>Recommendation: For each intervention in the Mall or for individual therapy, clearly state the name of the staff member responsible.</p>
3c	the time frames for completion of the interventions.	<p>Findings: The hospital's self-evaluation showed 60% compliance with this criterion. The review by this monitor showed that six of nine WRPs (67%) had a time frame for completion of interventions, and also showed that many WRPs have interventions with the same completion dates, regardless of the difficulty of the interventions.</p> <p>Compliance: Partial.</p> <p>Recommendation: For each intervention in the Mall or for individual therapy, clearly state the time frame for the next scheduled review. This review should be the same as the individual's scheduled WRPC.</p>
4	Each State hospital shall provide transition supports and services consistent with generally accepted professional	<p>Compliance: Partial.</p>

	standards of care. In particular, each State hospital shall ensure that:	
4a	individuals who have met discharge criteria are discharged expeditiously, subject to the availability of suitable placements; and	<p>Findings: According to information provided by Ms. Ann Long and document review, the hospital does not at present have an established mechanism to track length of delay for individuals deemed ready for discharge by their WRP team. Twenty-three individuals referred for discharge during the period from January 31, 2005 to January 31, 2006 are still in the hospital as of July 27, 2006.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Reduce the overall number of individuals still hospitalized after referral for discharge has been made. 2. Identify and resolve system factors that act as barriers to timely discharge. 3. Develop and implement a tracking and monitoring system for obtaining data on all individuals delayed from their discharge.
4b	individuals receive adequate assistance in transitioning to the new setting.	<p>Findings: By policy, the hospital's responsibilities end when an individual is discharged from the facility. There is no clear way of identifying from the current documentation system if an individual was provided with adequate assistance when transitioning to a new setting.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a monitoring and tracking system to address the key elements of this requirement. 2. Ensure and document that individuals receive adequate assistance when they transition to the new setting.

5	For all children and adolescents it serves, each State hospital shall:	Only MSH
5a	develop and implement policies and protocols that identify individuals with lengths of stay exceeding six months; and	
5b	establish a regular review forum, which includes senior administration staff, to assess the children and adolescents identified in § V.E.1 above, to review their treatment plans, and to create an individualized action plan for each such child or adolescent that addresses the obstacles to successful discharge to the most integrated, appropriate placement as clinically and legally indicated.	
F	Specific Therapeutic and Rehabilitation Services	
		<p>Summary of Progress:</p> <ol style="list-style-type: none"> 1. NSH has a medication management system that includes reviews by a Pharmacy and Therapeutics Committee (P & T Committee) and a Therapeutics Review Committee (TRC). 2. NSH collects data regarding some adverse drug reactions (ADRs). 3. NSH has a medication variance reporting (MVR) system. 4. NSH has data that demonstrate a steady decrease in some categories of polypharmacy in recent years. 5. NSH has developed and implemented a variety of monitoring instruments to assess high-risk medication uses, including PRN and Stat medications, benzodiazepines, anticholinergics and polypharmacy. These instruments are aligned with the key requirements.
1	Psychiatric Services	<p>Methodology:</p> <p>Interviewed Jeffrey Zwerin, D.O., Medical Director. Interviewed Lee Bufalini, Pharm D., Assistant Director. Interviewed seven staff psychiatrists. Reviewed charts of 45 individuals (JS, BJ-203133-4, MT, RF, TG, MC, CS, KS, CB, CD, KH, SN, MJ, HTS, DB, BJ-206582-9, RP, MAP, GCB,</p>

		<p>VTD, RF, BTM, JRS, LV, QW, JW, MT, PL, MG, AF, QT, LK, JD, NG, BD, BAP, JRS, FG, JT, AH, PR, FG, JT, AH and RR).</p> <p>Reviewed DMH Medication Guidelines.</p> <p>Reviewed list of all individuals at the facility, including current medications, diagnoses and attending physicians.</p> <p>Reviewed "NSH: PRN & Stat Progress Notes Monitoring Form-Psychopharmacology."</p> <p>Reviewed PRN & Stat Progress Notes Psychopharmacology Monitoring Summary Data (Jan-June 2006).</p> <p>Reviewed Benzodiazepine Data Collection Sheet July 2006.</p> <p>Reviewed Benzodiazepine summary data (Jan-Jun 2006).</p> <p>Reviewed Anticholinergic Data Collection Sheet.</p> <p>Reviewed Anticholinergic Summary Data (Jan-Jun 2006).</p> <p>Reviewed Polypharmacy Data Collection Sheet.</p> <p>Reviewed Polypharmacy Summary Data (Jan-Jun 2006).</p> <p>Reviewed NSH data regarding number of individuals taking four psychotropic medications June 2004 to June 2006.</p> <p>Reviewed NSH data regarding number of individuals taking five psychotropic medications April 2004 to June 2006.</p> <p>Reviewed NSH data regarding number of individuals taking six or more psychotropic medications September 2003 to June 2006.</p> <p>Reviewed New Generation Antipsychotics Data Collection Worksheet.</p> <p>Reviewed New Generation Antipsychotics Summary Data (Jan-June 2006).</p> <p>Reviewed list of individuals diagnosed with tardive dyskinesia (TD).</p> <p>Reviewed TD Monitoring Form.</p> <p>Reviewed TD Monitoring summary data (Jan-Jun 2006).</p> <p>Reviewed Policy and procedure regarding Adverse Drug Reactions (ADR).</p> <p>Reviewed ADR data collection sheet.</p> <p>Reviewed randomly selected ADR reports (#10).</p> <p>Reviewed medication variance reporting (MVR) data collection sheet.</p> <p>Reviewed randomly selected medication variance reports (#10).</p>
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		<p>Reviewed P&T Committee Minutes (Jan-Jun 2006). Reviewed Therapeutic Review Committee Minutes (Jan-Jun 2006). Reviewed PPN Monthly Monitoring Form: Psychopharmacology. Reviewed PPN Monthly Psychopharmacology Monitoring summary data (Jan-Jun 2006). Reviewed Substance Abuse Checklist. Reviewed Substance Abuse Checklist summary data (Jan-Jun 2006). Reviewed Department of Psychiatry meeting minutes (Jan-Jun 2006). Reviewed Department of Medicine meeting minutes (Jan-Jun 2006). Reviewed Medical Executive Committee meeting minutes (Jan-Jun 2006).</p>
1a	<p>Each State hospital shall develop and implement policies and procedures to ensure system-wide monitoring of the safety, efficacy, and appropriateness of all psychotropic medication use, consistent with generally accepted professional standards of care. In particular, policies and procedures shall require monitoring of the use of psychotropic medications to ensure that they are:</p>	<p>Findings: NSH has yet to develop policies and procedures to ensure compliance with the requirements listed in F.1.a through F.1. At present, the facility utilizes the Department of Mental Health Medication Guidelines. The guidelines provide some general information on the use of psychotropic medications including antipsychotics, antimanics, antidepressants, anxiolytic and hypnotic agents, stimulants, anticonvulsants, and antiparkinsonians. These guidelines are incomplete and not consistent with current generally accepted professional standards of care.</p> <p>The facility developed and implemented a monitoring system based on peer review of 95 charts. An overall compliance rate of 85% was reported. Compliance rates for each sub-item (except for 1.a.ii) were reported as follows:</p> <p>85% (1.a.i) 94% (1.a.iii) 78% (1.a.iv) 67% 1.a.v 91% 1.a.vii</p>

		<p>39% 1.a.vii 32% 1.a.viii</p> <p>This process did not utilize guidelines that include information regarding indications, contraindications, screening and outcome criteria and that are derived from current literature, relevant experience and professionally accepted guidelines. In addition, the deficiencies listed under Psychiatric Assessments (C.1.c), Diagnosis (C.1.d) and Reassessments (C.1.d) are such that monitoring by NSH of this item is not based on meaningful criteria. As a result, the facility is not in compliance with items F.1.a.i through F.1.a.viii.</p> <p>Compliance: Noncompliance.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop individualized medication guidelines that include specific information regarding indications, contraindications, clinical and laboratory monitoring and adverse effects for all psychotropic and anticonvulsant medications in the formulary. The guidelines must be derived from current literature, relevant clinical experience and current generally accepted professional practice guidelines. 2. Implement recommendations listed in C.1.c, C.1.d and C.1.e.
1a.i	specifically matched to current, clinically justified diagnoses or clinical symptoms;	As above.
1a.ii	prescribed in therapeutic amounts, as dictated by the needs of the individual served;	As above.
1a.iii	tailored to each individual's symptoms;	As above.
1a.iv	monitored for effectiveness against clearly identified	As above.

	target variables and time frames;	
1a.v	monitored appropriately for side effects;	As above.
1a.vi	modified based on clinical rationales;	As above.
1a.vii	are not inhibiting individuals from meaningfully participating in treatment, rehabilitation, or enrichment and educational services as a result of excessive sedation; and	As above. Also refer to item C.1.e.
1a.viii	properly documented.	As above. Also, see item C.1.e. and C.1.f.
b	Each State hospital shall monitor the use of PRN and Stat medications to ensure that these medications are administered in a manner that is clinically justified and are not used as a substitute for appropriate long-term treatment of the individual's condition.	<p>Findings: NSH developed a monitoring instrument--"PRN & Stat progress notes monitoring form-Psychopharmacology." The form adequately addresses the requirements in this item. Utilizing this form, the facility conducted review by peer psychiatrists and by department of standards compliance of 191 charts. An overall compliance rate of 37% was reported for this item</p> <p>As mentioned in C.1.f, there is a pervasive trend of poor documentation of PRN and/or Stat medication use. The following are the main deficiencies:</p> <ol style="list-style-type: none"> 1. There is inadequate review of the administration of PRN and Stat medications, including the circumstances that required the administration of drugs, the type and doses of drugs administered or the individual's response to the drugs. 2. PRN medications are prescribed for generic indications, typically "agitation" without specific information on the nature of behaviors that require the drug administration. 3. At times, more than one drug is ordered on a PRN basis without specification of the circumstances that require the administration of each drug.

		<ol style="list-style-type: none"> 4. There is no evidence of a face-to-face assessment by the psychiatrist within one hour of the administration of Stat medication. 5. There is no evidence of a critical review of the use of PRN and/or Stat medications in order to modify scheduled treatment based on this use. 6. PRN medications are frequently ordered when the individual's condition, as documented in psychiatric progress notes, no longer requires this intervention. <p>Compliance: Noncompliance.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Update the medical staff manual to include all requirements regarding high-risk medication uses, including PRN and/or Stat medications. 2. Continue to monitor the use of PRN and Stat medications to ensure correction of the above deficiencies. 3. Consolidate the monitoring processes for PRN and/or Stat medications and for psychiatric reassessments (progress notes).
c	<p>Each State hospital shall monitor the psychiatric use of benzodiazepines, anticholinergics, and polypharmacy to ensure clinical justification and attention to associated risks.</p>	<p>Findings: NSH has developed monitoring systems for the use of benzodiazepines, anticholinergics and polypharmacy. These systems address the key requirements in this item.</p> <p>In May-June 2006, two peer psychiatrists reviewed the charts of 24 individuals (out of 49 receiving lorazepam facility-wide at that time). The results showed patterns of deficiency summarized as follows. The compliance rates for each criterion is indicated:</p>

		<ol style="list-style-type: none"> 1. "The latest team conference has a DSM IV diagnosis of an anxiety disorder." (0%). 2. "The documentation justifies the regular use of lorazepam for anxiety or other disorder." (28%) 3. "When benzodiazepines are used regularly, there is documentation of the risks of sedation (16%), drug dependence (11%) or cognitive decline (7%)." 4. "Benzodiazepines used for individuals with alcohol /drug use problems are justified in PPN documentation." (15%) 5. "Benzodiazepines used for individuals with cognitive disorders are justified in the progress note documentation." (6%). 6. "When benzodiazepines are used for more than two months continuously, there is clear documentation of the risks for sedation (11%), drug dependence (11%) or cognitive decline (11%)." 7. "Treatment is modified in an appropriate and timely manner to ensure proper indications and minimize risk." (32%) <p>Chart reviews by this monitor demonstrate a trend of inadequate monitoring of individuals regarding the risks of benzodiazepine treatment, including for individuals with diagnoses of substance abuse (e.g. JS, BJ, MT,RF, TG, MC, CS,KS, CB, CD and KH) and with various cognitive disorders (e.g. SN, MJ, HTS and DB)</p> <p>The facility also reviewed the charts of all individuals receiving treatment with anticholinergic medications (benztropine, diphenhydramine and trihexyphenidyl). In this process, 76 charts (out of 114 individuals receiving these medications) were reviewed. Results revealed inconsistent practice patterns summarized as follows. The compliance rates are indicated for each criterion.</p> <ol style="list-style-type: none"> 1. "Documentation justifies the regular use." (48%)
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		<ol style="list-style-type: none"> 2. "Documentation includes EPS indications." (35%) 3. "Anticholinergic use for elderly individuals clearly documents in the PPN risks of sedation (18%), cognitive decline (4%), or gait unsteadiness/falls (0%)." 4. "Anticholinergic use for more than two months continuously includes documentation of the risks of cognitive decline (5%) and other risks (15%)." 5. "Treatment is modified in an appropriate and timely manner to ensure proper indications and minimize risks." (23%) <p>This monitor reviewed charts of individuals receiving anticholinergic treatment as a scheduled modality. The review showed a pattern of inadequate justification of treatment and monitoring of individuals for the risks of treatment (e.g. BAJ, RP, MAP, GCB, VTD, RF, BTM, JRS and LV). My review of the charts of elderly individuals receiving this modality (BAP, JRS and MAP) demonstrates the same pattern.</p> <p>NSH has data that demonstrate steady decline in the use of polypharmacy (four or more psychotropic medications) in recent years. The data show significant decreases in the number of individuals taking four psychotropic medications from June 2004 to June 2006. Data also show decrease in the number of individuals taking five psychotropic medications (from April 2004 to June 2006) and in the number of individuals taking six or more psychotropic medications (from September 2003 to June 2006).</p> <p>The facility reviewed the charts of 75 individuals (out of 193 on more than four psychotropic medications) to monitor both intra-class and inter-class polypharmacy. The results showed the following patterns of deficiencies. Compliance rates are included for each category.</p> <ol style="list-style-type: none"> 1. "Documentation justifies intra-class polypharmacy." (26%) 2. "Documentation justifies inter-class polypharmacy." (34%)
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		<ol style="list-style-type: none"> 3. "Use of intra- or inter-class is accompanied by documentation in the PPN of drug-drug interactions and their risks." (12%) 4. "Polypharmacy use is modified in a timely manner to ensure proper indications and minimize risks." (37%) <p>This monitor's findings of the deficiencies in C.1.f indicate that the psychiatric reassessments by and large do not provide the basis for accurate monitoring of the item.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Update the Medical Staff Manual to include all requirements regarding high-risk medication uses, including benzodiazepines, anticholinergics and polypharmacy. 2. Develop Medication Guidelines for benzodiazepines and anticholinergics. The guidelines must specify risks of use and clinical monitoring requirements to minimize these risks. 3. Continue to use current monitoring instruments regarding the use of benzodiazepines, anticholinergics and polypharmacy. Ensure that the justification of use is consistent with current generally accepted standards. 4. Consolidate the process of monitoring of all individual medications within the Drug Utilization Evaluation (DUE) Process.
d	Each State hospital shall ensure the monitoring of the metabolic and endocrine risks associated with the use of new generation antipsychotic medications.	<p>Findings: NSH reviewed 88 charts of individuals receiving new generation antipsychotic medications. The monitoring form addressed the main requirements related to this item. However, as mentioned earlier, the</p>

		<p>facility does not have medication guidelines that codify facility standards in the monitoring process. The following is an outline of results, with compliance rates for each criterion indicated:</p> <ol style="list-style-type: none">1. "Use of medications is based on documentation of benefits and tolerability." (77%)2. "New generation antipsychotics are not used for individuals with diagnoses of dyslipidemia (31%), diabetes (46%) or obesity (35%) without documented justification in the PPN."3. "Risperidone used for individuals with hyperprolactinemia only with documented justification." (17%)4. "There is appropriate baseline and periodic monitoring of family/personal risk factors (31%), Body Mass Index (66%), waist circumference (21%), triglycerides (76%), cholesterol (80%), fasting blood glucose (76%), glycosylated HgbA1c (31%), menstrual cycle (36%) and breast signs (13%)."5. "There is appropriate baseline and periodic monitoring of EKG for individuals receiving ziprasidone (50%) and, as indicated, other new generation antipsychotics. (21%)6. "There is appropriate baseline and periodic monitoring for postural hypotension for individuals receiving quetiapine 41%, ziprasidone, 60% olanzapine (IM) (33%), and risperidone (53%)."7. "There is appropriate baseline and periodic monitoring of blood counts (100%) and vital signs (100%) for individuals receiving clozapine."8. "Psychiatric progress notes document potential and actual risks for each medication used (32%)."9. "There is evidence of timely/appropriate modification of treatment to address identified risks (60%)."
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e	<p>Each State hospital shall ensure regular monitoring, using a validated rating instrument (such as AIMS or DISCUS), of tardive dyskinesia (TD); a baseline assessment shall be performed for each individual at admission with subsequent monitoring of the individual every 12 months while he/she is receiving antipsychotic medication, and every 3 months if the test is positive, TD is present, or the individual has a history of TD.</p>	<p>Findings: NSH has a neurology-run movement disorders clinic that provides specialized consultation services for individuals diagnosed with a variety of movement disorders. The State Department of Mental Health has a database that lists all individuals diagnosed with TD. NSH reviewed the charts of all 36 individuals listed in the database and 28 additional charts for other individuals followed at the movement disorders clinic. The criteria listed on the monitoring form address the key requirements in this item. The data demonstrate the following patterns of inconsistent practice, and the compliance rate is listed for each criterion:</p> <ol style="list-style-type: none"> 1. "If a conventional antipsychotic is used, is there

		<p>documented justification?" (13%)</p> <ol style="list-style-type: none"> 2. "Was an AIMS done on admission?" (71%) 3. "Was an annual AIMS done at the time of the last annual physical examination?" (77%) 4. "If this patient has TD, was a new AIMS done every three months?" (0%) 5. "If the individual has a history of TD, was a new AIMS done every three months?" (0%) 6. "Do monthly progress notes for the past three months indicate that antipsychotic treatment has been modified for individuals with TD, history of TD or positive AIMS test?" (15%) <p>This monitor's review of the charts of individuals with documented diagnosis or history of TD confirms the facility's data regarding noncompliance with AIMS assessments. In addition, some charts include evidence that the WRP either fails to list TD as a diagnosis or as one of the foci of hospitalization (e.g. LK, JD and NG), or includes the diagnosis as a focus but does not provide any related treatment and/or rehabilitation objectives/interventions (e.g. BD)</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that Medical Staff manual includes required criteria for monitoring of individuals with TD. 2. Ensure that the diagnoses listed on the WRP are aligned with those listed in psychiatric documentation. 3. Ensure that TD is recognized as one of the foci of hospitalization and that appropriate objectives and interventions are identified for treatment and/or rehabilitation.
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f	Each State hospital shall ensure timely identification, reporting, data analyses, and follow up remedial action regarding all adverse drug reactions ("ADR").	<p>Findings:</p> <p>NSH has a policy and procedure regarding ADR reporting. The ADR data collection tool includes generally adequate criteria, including the generally accepted Naranjo algorithm for probability assessment of suspected ADRs. However, the current system is ineffective due to the following deficiencies:</p> <ol style="list-style-type: none"> 1. ADRs are underreported. Review of the summary report of suspected ADRs prepared by the Assistant Director of Pharmacy indicates a total of 57 ADRs submitted from November 2005 through February 2006. This indicates serious underreporting of ADRs, given that the facility provides services to approximately 1200 individuals, most of whom suffer from serious illnesses. 2. NSH does not aggregate or analyze ADR data. 3. NSH does not provide adequate instruction to its clinical staff regarding the proper reporting and investigation and analysis of ADRs. Specifically, the facility does not provide information or have written guidelines regarding the requirements for : <ol style="list-style-type: none"> a. Classification of reporting discipline; b. Proper description of details of the reaction; c. Additional circumstances surrounding the reaction, including how reaction was discovered, relevant history, allergies, etc; d. Review of all medications that the individual was actually receiving at the time of the ADR; e. Information about all medications that are suspected or could be suspected of causing the reaction; f. A probability rating if more than one drug is suspected of causing the ADR;
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		<ul style="list-style-type: none"> g. Information about type of reaction (e.g. dose-related, withdrawal, idiosyncratic, allergic, etc); h. Information regarding future screening; i. Physician notification and review of the ADR; and j. Information on the clinical review process, including the clinical review person or team, determination of need for intensive case analysis and other actions. <ul style="list-style-type: none"> 4. NSH does not have a formalized system of intensive case analysis based on established ADR-related thresholds. 5. NSH does integrate data regarding ADRs in the current system of psychiatric peer review. 6. NSH does not provide analysis of individual and group practitioner trends and patterns regarding ADRs. 7. NSH has not provided educational programs to address trends in the occurrence of ADRs. <p>Compliance: Partial.</p> <p>Recommendations:</p> <ul style="list-style-type: none"> 1. Provide instruction to all clinicians regarding significance and proper methods in reporting of ADRs. 2. Increase reporting of ADRs. 3. Revise current policy and procedure and develop guidelines to staff to improve attention to the items described above. 4. Develop and implement tracking log and data analysis systems. 5. Develop and implement an intensive case analysis procedure based on established severity/outcome thresholds. The analysis must include proper discussion of history/circumstances, preventability, contributing factors and recommendations.
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g	<p>Each State hospital shall ensure drug utilization evaluation ("DUE") occurs in accord with established, up-to-date medication guidelines that shall specify indications, contraindications, and screening and monitoring requirements for all psychotropic medications; the guidelines shall be in accord with current professional literature.</p> <p>A verifiably competent psychopharmacology consultant shall approve the guidelines and ensure adherence to the guidelines.</p>	<p>Findings: NSH does not have a DUE system that evaluates adherence to established individualized guidelines. As mentioned earlier, the facility does not have individualized medication guidelines that are consistent with current generally accepted standards.</p> <p>Compliance: Noncompliance.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Same as recommendation #1 in F.1.a.. 2. Develop and implement a DUE system based on established individualized medication guidelines. 3. Ensure systematic review of all medications, with priority give to high-risk, high-volume uses. 4. Determine the criteria by which the medications are evaluated, the frequency of evaluation, the indicators to be measured, the DUE data collection form, the sample size, and acceptable thresholds of compliance. 5. Ensure that the individualized medication guidelines are continually updated to reflect current literature, relevant clinical experience and current professional practice guidelines.
h	<p>Each State hospital shall ensure documentation, reporting, data analyses, and follow up remedial action regarding actual and potential medication variances ("MVR") consistent with generally accepted professional standards of care.</p>	<p>Findings: NSH has a data collection tool for medication variance reporting. The facility provides information on variances in the administration category.</p> <p>The current system of MVR is ineffective due to the following deficiencies:</p>

		<ol style="list-style-type: none">1. The system provides information on limited categories of variances, and ignores other possible categories that include prescription, documentation, ordering, procurement and storage of medications as well as medication security.2. NSH does not give proper instruction to the clinical staff regarding the appropriate methods of reporting medication variances and of providing information that aid in the investigation and analysis of the variances. Specifically, the facility does not provide information or have written guidelines to staff regarding:<ol style="list-style-type: none">a. Classification of reporting discipline;b. Proper description of details of the variance;c. Additional facts involving the variance, including how the variance was discovered, how the variance was perpetuated, relevant individual history, etc.;d. Description of the full chain of events involving the variance;e. Classification of potential and actual variances;f. All medications involved and their classification;g. The route of medication administration;h. Critical breakdown points;i. All possible outcome categories; andj. Outline and analysis of contributing factors.3. NSH does not aggregate or analyze MVR data.4. NSH does not have a formalized system of intensive case analysis based on established MVR-related thresholds.5. NSH does not integrate data regarding MVR in the current system of psychiatric peer review.6. NSH does not provide analysis of individual and group practitioner trends and patterns regarding MVR.7. NSH has not provided educational programs to address trends in the occurrence of MVR.
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		<p>8. The current system of MVR is not integrated in any meaningful fashion in the activities of the P & T Committee, the MRC, the Department of Psychiatry or the Department of Medicine.</p> <p>Overall, the above deficiencies render the current system seriously inadequate for performance improvement purposes.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Provide instruction to all clinicians regarding significance of and proper methods in MVR. 2. Develop a policy and procedure regarding MVR that includes a revised data collection tool. The procedure and the revised tool must address the deficiencies identified above. 3. Develop and implement tracking log and data analysis systems. 4. Develop and implement an intensive case analysis procedure based on established severity/outcome thresholds. The analysis must include proper discussion of history/ circumstances, preventability, contributing factors and recommendations. 5. Ensure that MVR is a non-punitive process.
i	<p>Each State hospital shall ensure tracking of individual and group practitioner trends, including data derived from monitoring of the use of PRNs, Stat medications, benzodiazepines, anticholinergics, and polypharmacy, and of ADRs, DUE, and MVR consistent with generally accepted professional standards of care.</p>	<p>Findings: The Medical Director has tracked individual practitioner trends re use of lorazepam, clonazepam, PRN anticholinergic medications, scheduled anticholinergic meds, and the number of patient on four or more psychotropic medications.</p> <p>The above mentioned deficiencies in F.1.a through F.1.h must be</p>

		<p>addressed and corrected prior to the development of meaningful practitioner trend data. In addition to these deficiencies, the facility does not have designated leadership structure and oversight system for the psychiatry department. This deficiency is a critical gap in a facility that employs 64 staff psychiatrists providing services as attending physicians.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Same as in F.1.a. through F.1.h. 2. Improve IT resources to the pharmacy to facilitate the development of databases regarding medication use.
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.	<p>Findings: The deficiencies identified in F.1.a through F.1. h must be addressed and corrected prior to any meaningful assessment of this item.</p> <p>Compliance: Noncompliance.</p> <p>Recommendations: Same as above.</p>
k	Each State hospital shall ensure integration of information derived from ADRs, DUE, MVR, and the Pharmacy & Therapeutics, Therapeutics Review, and Mortality and Morbidity Committees consistent with generally accepted professional standards of care.	<p>Findings: Same as above.</p> <p>Compliance: Noncompliance.</p> <p>Recommendations: Same as above.</p>

l	<p>Each State hospital shall ensure that all physicians and clinicians are verifiably competent, consistent with generally accepted professional standards of care, in appropriate medication management, interdisciplinary team functioning, and the integration of behavioral and pharmacological treatments.</p>	<p>Findings: NSH does not have a data-driven process to address this requirement. The findings outlined in team leadership (C.1.b), interdisciplinary functioning (C.1.c.), the integration of behavioral and pharmacological treatments (D.1.f.v.iii.) and medication management (F.1.a through F.1.h.) are applicable to this item.</p> <p>The medical staff participates in the WRP planning, but the training is not competency-based at this time.</p> <p>At present, the facility does not have a designated leadership structure and oversight system for the psychiatry department. This deficiency is a critical gap in a facility that employs 64 staff psychiatrists providing services as attending physicians.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Same as in C.1.b., C.1.c., D.1.f.viii. and F.1.a. through F.1.h. 2. Develop and implement a formalized supervisory system for the psychiatry department to ensure clinical and administrative support to staff, proper oversight and development, implementation and coordination of monitoring, educational and peer review systems. Specifically, the facility should consider creating a dedicated position for Chief of Psychiatry and positions for a lead psychiatrist for each of the programs.
m	<p>Each State hospital shall review and ensure the appropriateness and safety of the medication treatment, consistent with generally accepted professional standards</p>	<p>Compliance: Partial.</p>

	of care, for:	
m.i	all individuals prescribed continuous anticholinergic treatment for more than two months;	<p>Findings: The findings of deficiencies listed in F.1.c indicate that the current system of clinical monitoring and systematic oversight is inadequate.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Same as in F.1.c. 2. Ensure that this practice is triggered for TRC review and follow through.
m.ii	all elderly individuals and individuals with cognitive disorders who are prescribed continuous anticholinergic treatment regardless of duration of treatment;	Same as above.
m.iii	all individuals prescribed benzodiazepines as a scheduled modality for more than two months;	Same as above.
m.iv	all individuals prescribed benzodiazepines with diagnoses of substance abuse or cognitive impairments, regardless of duration of treatment; and	Same as above.
m.v	all individuals with a diagnosis or evidencing symptoms of tardive dyskinesia.	<p>Findings: The findings listed in F.1.e indicate that NSH does not have a system that ensures systematic monitoring of individuals suffering from TD and the recognition of TD as one of the foci of hospitalization that require specialized treatment and/or rehabilitation objectives and interventions.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Same as in F.1.e. 2. Revise the current monitoring mechanism to ensure the proper identification and management of TD as well as proper frequency of clinical assessments.

m.vi	all individuals diagnosed with dyslipidemia, and/or obesity, and/or diabetes mellitus who are prescribed new generation antipsychotic medications	<p>Findings: NSH does not monitor this requirement. My review of charts of individuals diagnosed with these conditions and receiving new generation antipsychotics (FG, JT, AH and RR) shows appropriate justification and/or monitoring in FG and AH and lack thereof in JT and RP.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Same as in F.1.g. 2. Develop and implement DUE monitoring system based on individualized medication guideline.
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.	<p>Findings: NSH reviewed a random sample of 52 charts, utilizing a statewide substance abuse checklist form. This review does not address the key requirement in this item.</p> <p>The findings of deficiency in F.1.c indicate that NSH does not meet this requirement.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that the monitoring instrument addresses the key requirement. 2. Same as in F.1.m.iii. 3. Ensure that medication management for these individuals is triggered for review by the TRC and follow through.

o	Metropolitan State Hospital shall provide a minimum of 16 hours per year of instruction, through conferences, seminars, lectures and /or videotapes concerning psychopharmacology. Such instruction may be provided either onsite or through attendance at conferences elsewhere.	Only MSH
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:	<p>Methodology:</p> <p>Attended PBS team meeting. Observed virtual Mall sessions. Observed unit Mall sessions. Observed WPR team conferences (CS,AS and ZL). Interviewed Jim Jones, Ph.D., Chief Psychologist. Interviewed Dr. Anthony Rabin, PBS psychologist. Interviewed Dr. Patricia White, PBS psychologist. Interviewed PBS ensemble staff. Interviewed Dr. Kathleen Patterson, PBS psychologist. Interviewed Dr. Kenneth Lakritz, PBS psychologist. Interviewed Dr. Ann Hoff, staff psychologist. Interviewed many individuals served by NSH staff. Interviewed 20 unit staff. Interviewed Dr. Nicole Aviles-Galberth, By CHOICE Coordinator. Interviewed Ms. Wyona Jordan, By CHOICE, Office Assistant. Reviewed charts of 29 individuals (JH, TB, JF, AL, AG, JK, ET, AM, KZ, FT, IL, GF, RS, AL, AD, RS, RB, AR, JM, JL, KP, BD, SP, AC, AJ, CM, RM, MW, and HM). Reviewed Behavioral Guidelines of AR, RT, JS, BM, MR, NJ, GL, MM, KS, ZQ, PK, TG, AS, LJ, LK, BC, HS, BS, MS, and JT. Reviewed 58 PBS charts (BM, LG, SC, DR, MR, JW,TS, BS, FM, CC, JH, LJ, JW, DB, HM, CP, MW,DT, AL, LW, JE,TO, GB, HP, LT,SC,RW,GR, GR, DH, MP, JR, FT, JR, MM, TM, NJ, LH, EG, KH, LL, RR, PG, VC, FT,</p>

		<p>SC, AG, EH, TO, MT, RW, MC, CS, CP, WB, EW, CG, and AF). Reviewed Memberships of PBS Teams. Reviewed PBS Team Assignments. Reviewed AD for Psychology Services. Reviewed NSH Psychology Department Manuals. Reviewed PBS Manual. Reviewed APA Ethics Standards of Practice. Reviewed Mall Curriculum. Reviewed Psychology Protocols and Assessment Tools. Reviewed BCC treatment plans. Reviewed DMH audit forms. Reviewed WRP audit forms. Attended PBS team meeting. Observed virtual Mall sessions. Observed unit Mall sessions. Observed WPR team conferences (CS, AS and ZL). Reviewed By CHOICE Manual Visited By CHOICE stores Reviewed Hospital Organizational Chart. Reviewed NSH Psychology Department Organizational Chart. Reviewed individuals x program x unit needing behavioral interventions. Reviewed list of individuals on PBS plans. Reviewed personnel CVs. Reviewed personnel certification and licensure documents. Reviewed PBS monitoring form. Reviewed PBS-BCC summary sheets and checklist. Reviewed training records for four PBS plans (MC, JH, CS and CC).</p>
a	<p>Each State hospital shall ensure that it has positive behavior support teams (with 1 team for each 300 individuals, consisting of 1 clinical psychologist, 1 registered nurse, 2 psychiatric technicians (1 of whom may be a behavior specialist), and 1 data analyst (who may be a</p>	<p>Findings: The State has established guidelines on the composition, duties, responsibilities and regulations governing the PBS teams. The guidelines are aligned with the requirements of the EP.</p>

	<p>behavior specialist) that have a demonstrated competence, consistent with generally accepted professional standards of care, in the following areas:</p>	<p>The PBS manual is a draft, has redundant content and does not provide clear guidelines for the PBS teams.</p> <p>The hospital currently has four fully staffed PBS teams. They are short one full PBS team. Their current team to individual ratio is approximately 1:400 instead of 1:300 as required by the EP.</p> <p>The team composition criterion is met but the competency criterion is not. Specifically, interviews with all 4 PBS teams indicated that all staff of the 4 teams did not demonstrate competence in their understanding of current generally accepted standards in Positive Behavior Supports. Two of the four teams are using an older model of behavior programming that is not consistent with current standards. Further, the RNs, PTs and data analysts for each team were not able to articulate sufficient knowledge of the instruments/interviews (i.e., QABF, FAI, scatterplot, behavior analytic methods) used for obtaining and analyzing reliable data for the development of a PBS plan.</p> <p>A review of the CVs revealed that the four PBS psychologists have not had sufficient competency-based training in Positive Behavior Supports at the university level. Two of the four PBS leaders have held positions that included the development of behavior assessments and behavior plans prior to joining the PBS team in November of 2005. These positions, however, did not employ the Positive Behavior Supports Model. The other two psychologists have had no work experience with behavioral supports, but are rapidly acquiring the needed skills on the job.</p> <p>Based on interviews with Drs. Jones and Patterson, and discussion with the PBS team members, this monitor concurs with the hospital's self-evaluation findings that the referral process to the PBS team does not utilize clear criteria. In addition, it appears that each PBS team has different criteria for accepting referrals.</p>
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		<p>The PBS-BCC Checklist has not been used as the pathway for referrals to the PBS teams or the BCC.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Revise the statewide PBS manual to include clear guidelines on the referral process (i.e., what triggers a referral, who is responsible for making the referral and what is expected once a referral is made, timelines). 2. Include in the PBS manual clear guidelines on how structural and functional assessments are to be performed. 3. Identify in the manual specific evidence-based tools to use for each type of assessment. 4. Use the terms of behavior guidelines and PBS plans instead of Type A and Type B plans, which are not meaningful to staff or the individuals. 5. Recruit additional PBS team. 6. Ensure that all four PBS psychologists use the PBS model as currently identified in the literature. 7. Provide Positive Behavior Supports training to all PBS team members. The PBS Psychologist should provide training to the RNs, PTs and data analysts. Specifically, train these members on the reliable use of evidence-based tools (QABF, FAI, ABC Observations, Maladaptive Behavior Record, scatterplots, etc.). 8. Standardize the referral system and the format for developing PBS structural and functional assessments across all facilities.
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	<p>Findings:</p> <p>All four PBS teams demonstrate inadequate an understanding of the linkage between PBS and the Recovery Model. In fact, all four teams did not demonstrate a clear understanding of either model.</p>

	<p>program implementation, and, as appropriate, revising or terminating the program; and</p>	<p>All four Type B plans lacked adequate structural and functional assessment. One assessment was started several months after the plan was developed and implemented.</p> <p>All four structural/functional assessments failed to meet criteria for generally accepted professional standards.</p> <p>Evidence-based tools were not consistently or reliably used.</p> <p>All four Type B plans fell well below 50% in achieving criterion on the PBS Monitoring Tool. This monitor identified the following patterns of deficiency:</p> <ol style="list-style-type: none"> 1. The individual's Wellness and Recovery Plan (WRP) Team is involved in the assessment and intervention process—100% showed partial compliance. 2. Broad goals of intervention were determined—0% in compliance. 3. At least one specific behavior of concern was defined in clear, observable and measurable terms—100% showed partial compliance. 4. Baseline estimate of the maladaptive behavior was established in terms of objective measure—25% showed full compliance and 75% partial compliance. 5. Pertinent records were reviewed—25% in full compliance, 75% in partial compliance. 6. Structural assessments (e.g., ecological, sleep, medication
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		<p>effects, mall attendance, etc) were conducted, as needed, to determine broader variables affecting the individual's behavior—25% in full compliance, 75% in partial compliance.</p> <ol style="list-style-type: none">7. Functional assessment interviews were conducted with people (e.g., individual, parents and family members, therapists and care staff, teachers) who often interact with the individual within different settings and activities—100% in partial compliance.8. Direct observations were conducted across relevant circumstances (e.g., multiple settings, over time) and by more than one observer, as appropriate—25% in complete compliance, 75% in partial compliance.9. Other assessment tools (e.g., rating scales, checklists) were used to produce objective information regarding events preceding and following the behavior of concern, as well as ecological and motivational variables that may be affecting the individual's behavior. 25% in complete compliance, 75% in partial compliance.10. Patterns were identified from the data collected that included (1) circumstances in which the behavior was most and least likely to occur (e.g., when, where, and with whom) and (2) specific functions the behavior appeared to serve for the individual (i.e., what the individual gets or avoids by engaging in the behaviors of concern).—25% partial compliance, 50% not in compliance, 25% n/a.11. Broader variables (e.g., activity patterns, curriculum) that may be affecting the individual's behavior were identified—100% in partial compliance.
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		<p>12. Patterns were summarized into written hypotheses based on structural and/or functional assessments. These statements were clear, concise, and based on data—75% in partial compliance, 25% not in compliance.</p> <p>13. Intervention strategies were clearly linked to the hypotheses derived from the structural and/or functional assessments—75% in partial compliance, 25% not in compliance.</p> <p>14. The individual's PBS Team designed a positive behavior support plan (PBS plan) collaboratively with the individual's WRP Team that includes: Description of the behavior, patterns identified through the structural and functional assessments and goals of intervention—25% in full compliance, 75% in partial compliance.</p> <p>15. Modifications to the social, environmental or cultural milieu that may prevent the behavior and/or increase the likelihood of alternative appropriate behavior(s)—100% in partial compliance.</p> <p>16. Specific behaviors (skills) to be taught and/or reinforced that will: (i) achieve the same function as the maladaptive behavior, and (ii) allow the individual to cope more effectively with his/her circumstances—100% in partial compliance.</p> <p>17. Strategies for managing consequences so that reinforcement is (i) maximized for positive behavior and (ii) minimized for behavior of concern, without the use of aversive or punishment contingencies—0% in compliance.</p>
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		<p>18. The PBS plan is clearly specified in the Objective and Intervention sections of the individual's Wellness and Recovery Plan. The PBS Plan itself need not be included in the individual's WRP—25% in full compliance, 75 % not in compliance.</p> <p>19. If necessary to insure safety and rapid de-escalation of the individual's maladaptive behavior, crisis management procedures and criteria for their use and termination were determined and documented—50% in partial compliance, 25% not in compliance, 25% n/a.</p> <p>20. Everyone working with the individual on a regular basis is familiar with the PBS plan and implements its strategies with high degree of fidelity (>90%)—0% in compliance.</p> <p>21. Implementation of the PBS plan is monitored to insure that strategies are used consistently across all intervention settings—0% in compliance.</p> <p>22. Objective information is collected to evaluate the effectiveness of the PBS plan. This information includes decreases in maladaptive behavior—50 % in full compliance 25%, partial compliance, 25% not in compliance.</p> <p>23. Increases in replacement skills and/or alternative behaviors—25% in partial compliance, 75% not in compliance.</p> <p>24. Achievement of broader goals—0% in compliance.</p> <p>25. Durability of behavior change—50% partial compliance,</p>
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		<p>25% not in compliance, 25% n/a.</p> <p>26. The individual's WRP team reviews, at scheduled Wellness and Recovery Plan Conferences, the individual's progress and a PBS Team member or the WRP Team psychologist makes necessary adjustments to the PBS plan, as needed—50% partial compliance, 50% not in compliance.</p> <p>The PBS teams self-analysis (as documented in the four PBS charts) using the PBS Monitoring tool was inconsistent with the monitor's review, reporting higher compliance rates.</p> <p>Training of line staff to implement these plans consists only of a verbal review of the PBS plan. This is not in accordance with the State's Special Order on PBS. When staff members were interviewed on the units, they were consistently unable to verbalize or demonstrate the components of the plan.</p> <p>Three of the four PBS plans were not revised in response to outcome data.</p> <p>Data analysis did not indicate whether the PBS plan was a variable that impacted treatment outcomes.</p> <p>In the review of the charts for the four PBS plans, two of the four charts had more than one version of the plan in the chart. One plan was completely missing from the chart. Evidence of a review of the monthly or quarterly outcome data was not found in any of the four charts.</p> <p>The majority of the cases referred to the PBS teams end up in Crisis Intervention Plans. Of these plans, the majority were in the chart for over a year with no revisions. Crisis Intervention Plans are not</p>
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		<p>Behavior Guidelines or PBS plans, and should be developed by the WRP team psychologists in consultation with PBS team members. PBS teams were unable to state who was responsible for monitoring, revising or discontinuing these plans.</p> <p>The PBS teams and the BCC chair were unclear about their roles and responsibilities in BCC consultation. In fact, very few BCCs have been held and the PBS-BCC checklist has not been utilized for referral to the BCC.</p> <p>The PBS teams and the hospital do not currently use any trigger system to determine when it is appropriate to make a referral to PBS.</p> <p>Given the high numbers of episodes and hours of Seclusion and Restraint in the hospital, it is a significant deficiency that there were only four PBS plans in place. The PBS teams reported that this is due to the teams working 1:1 with the WRP teams on a weekly basis; however, further interviews revealed that two PBS teams do not feel that they are successful in working with the WRP teams.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that all PBS staff members receive systematic training in all aspects of the PBS plans, including the relationship between PBS and recovery principles. 2. Conduct treatment implementation fidelity checks regularly. 3. Senior Psychologists should be assigned to review Type A plans and Crisis Intervention plans for content and appropriateness. 4. PBS team leaders need to develop a systematic way of
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		<p>evaluating treatment outcomes and reporting those outcomes.</p> <ol style="list-style-type: none"> 5. Revision of treatment plans should be directly related to the outcome data and reported at all scheduled WRPC of the individual. 6. PBS teams and WRP teams need to follow the PBS-BCC checklist for all referrals to the BCC. 7. The PBS teams, WRP teams and the BCC require further training to fully understand their roles, agenda at the BCC and tracking of referrals made to the BCC. 8. 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. 9. 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. 10. Develop a training protocol for all PBS plans to ensure that all staff who will be responsible for implementing the plan are consistently and appropriately trained prior to implementation of the plan (i.e., behavioral rehearsals, demonstrations, role plays, modeling). 11. Integrate a response to triggers in the referral process. 12. Ensure that team psychologists and PBS psychologists are trained in the WRP process. The DMH WRP manual outlines the requirements for including PBS programs in the Objectives and Interventions of an individual's WRP.
a.ii	the development and implementation of a facility-wide behavioral incentive system, referred to as "By CHOICE" that encompasses self-determination and	<p>Findings: The hospital has implemented the statewide BY CHOICE incentive program. There is a statewide BY CHOICE manual, and associated</p>

	<p>choice by the individuals served.</p>	<p>training materials for staff and individuals for implementing the program facility-wide. The hospital has taken a long time to begin implementing the BY CHOICE program and it is still not being used facility-wide.</p> <p>Dr. Aviles-Galberth is the BY CHOICE program coordinator, a psychologist by training. She is currently actively involved in training staff and putting together a system that will make the BY CHOICE program meaningful and effective. However, she does not have a supervisory role, which may pose a barrier in fully implementing the program especially considering the fact that the structure and organization of the program are still evolving and the program is not fully functional.</p> <p>According to the BY CHOICE coordinator, some of the barriers include: (a) staff not filling out cards in each cycle; (b) often the cards are filled in all at one time; (c) at times the cards are filled in even when the individual has not earned the points; and (d) staff say that they find it stressful when individuals come up to them to fill cards all day long. Further, contrary to the instructions in the BY CHOICE Manual, individuals do not carry their own cards; rather the cards are left at the nursing station. These appear to be training issues and developmental pains of a new program.</p> <p>The current implementation of the BY CHOICE program also has the following deficiencies:</p> <ol style="list-style-type: none"> 1. The BY CHOICE cards and the BY CHOICE orientation handouts are in English only. 2. The incentive stores are open only during lunch and dinner times. This is a problem because a large number of individuals crowd the store and is difficult to serve them in a timely manner. Further, the incentive stores are supposed to be like community shops (e.g., 7-Eleven) that are open for extended hours so that individuals at increasing levels of recovery can
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		<p>avail themselves of the option of "shopping" when they choose to do so.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Fully implement the BY CHOICE program. 2. Train all staff in correctly implementing the BY CHOICE program. 3. Implement the program as per the manual. 4. Ensure that the program has additional resources, including computers and software that will assist in running the system smoothly. 5. Assure that the individuals have the final choice in allocating points per cycle, ranging from 0 to 100 per cycle. 6. BY CHOICE point allocation should be determined by the individual at the individual's WRPC, with facilitation by the staff. 7. Report BY CHOICE point allocation in the Present Status section of the individual's case formation and update at every scheduled WRPC.
<p>b</p>	<p>Each State Hospital shall ensure that the Chief of Psychology has the clinical and administrative responsibility for the Positive Behavior Supports Team and the By CHOICE incentive program.</p>	<p>Findings: Dr. Jim Jones, Acting Chief of Psychology, is currently responsible for the administration of the PBST and the BY CHOICE incentive program</p> <p>The State's Special Order contains all the required elements of PBS. In addition, NSH has a PBS AD, which is in a draft form.</p> <p>Compliance: Partial.</p>

		<p>Recommendations:</p> <ol style="list-style-type: none"> 1. Use the Special Order as the NSH AD. 2. Implement the AD.
c	Each State Hospital shall ensure that:	<p>Compliance:</p> <p>Partial.</p>
c.i	behavioral assessments include structural and functional assessments and, as necessary, functional analysis;	<p>Findings:</p> <p>PBS teams and Acting Chief of Psychology were unable to produce the list of individuals needing behavioral interventions and were unsure of how they would produce it in the future.</p> <p>Of the four PBS plans and assessments reviewed by this monitor, 0% met compliance on the DMH Psychology Monitoring Tool Item #27 due to the quality of the assessments not meeting generally accepted professional standards.</p> <p>Five of the 18 Behavior Guidelines reviewed were appropriate for PBS referral for an assessment and possible PBS plan development and implementation.</p> <p>The PBS-BCC checklist had been used for only five of the PBS referrals and had not been used appropriately, thus making it difficult to determine when an individual may require a referral to PBS for an assessment.</p> <p>Staff's knowledge of the various functional assessment methods is inadequate.</p> <p>Dr. Jim Jones concurred with these findings.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Train all PBS team members in functional assessment, data

		<p>collection, data analysis, graphing, plan implementation and data interpretation.</p> <ol style="list-style-type: none"> 2. Develop a system for identifying and tracking individuals in the hospital who are in need of behavioral interventions. 3. Use the PBS-BCC checklist for all consultations. 4. Senior Psychologists should be utilized to monitor the appropriateness of Behavior Guidelines, Crisis Intervention Plans and the need for a referral to PBS teams.
c.ii	hypotheses of the maladaptive behavior are based on structural and functional assessments;	<p>Findings: The plans reviewed by this monitor (MC, JH, CS and CC) were not based on any behavioral hypotheses. Dr. Jones concurred with this finding.</p> <p>Recommendation: Ensure that hypotheses of the maladaptive behavior are based on structural and functional assessments and clearly stated in the PBS documentation.</p>
c.iii	There is documentation of previous behavioral interventions and their effects;	<p>Findings: Only two of the 29 charts reviewed by this monitor met this criterion. In three instances, there was documentation of a PBS plan but it was not clear whether the plan was active and there was no data on the plan's effectiveness. Dr. Jones indicated that there are very few reports/plans that review past interventions or their effects. Review of DMH Psychology Monitoring Tool data (Item # 29) further supports these findings.</p> <p>Recommendation: Document previous behavioral interventions.</p>
c.iv	behavioral interventions, which shall include positive behavior support plans, are based on a positive	<p>Findings: Only four of the 18 Behavior Guidelines included aversive or</p>

	behavior supports model and do not include the use of aversive or punishment contingencies;	<p>punishment contingencies and none were based on a positive behavior supports model.</p> <p>None of the four PBS plans included aversive or punishment contingencies; however none were based on a positive behavior supports model.</p> <p>Recommendation: Ensure that all behavioral interventions are based on a positive behavior supports model and do not include the use of aversive or punishment contingencies</p>
c.v	behavioral interventions are consistently implemented across all settings, including school settings;	<p>Findings: None of the four PBS plans showed evidence that interventions were being consistently implemented across settings. Unit-based training is the only environment addressed. One of the four PBS plans considered appropriate settings for training on the PBS plan in the assessment. Dr. Jones and Dr. Patterson reported that interventions were not always consistently implemented across all settings</p> <p>Mall staff reported not knowing when an individual had a behavior plan, not receiving a copy of the plan and not receiving training on the plan.</p> <p>Recommendation: Ensure that all behavioral interventions are consistently implemented across all settings, including mall, vocational and education settings</p>
c.vi	triggers for instituting individualized behavioral interventions are specified and utilized, and that these triggers include excessive use of seclusion, restraint, or psychiatric PRN and Stat medication for behavior control;	<p>Findings: The trigger data are not being considered in referring individuals with maladaptive behavior to the PBS teams.</p> <p>Recommendation: The hospital should have a system for using their trigger data to</p>

		obtain PBS consultation for appropriate individuals.
c.vii	positive behavior support teams and team psychologists integrate their therapies with other treatment modalities, including drug therapy;	<p>Findings: This is not a practice at this time. Only one of 30 charts reviewed had documented evidence of other treatments being integrated with the behavioral interventions.</p> <p>Recommendation: Integrate all behavioral interventions with other treatment modalities, including drug therapy.</p>
c.viii	all positive behavior support plans are specified in the objectives and interventions sections of the individual's Wellness and Recovery Plan;	<p>Findings: Only one of four PBS plans was specified in the objectives and interventions sections of the individual's WRP. Interview with PBS team leaders identified a lack of understanding of this requirement by the PBS team and by the unit psychologists.</p> <p>Dr. Jones agreed that this objective is not being met at this time.</p> <p>Recommendation: Specify PBS plans in the objectives and interventions sections of the individual's WRP Plan as outlined in the DMH PBS Manual.</p>
c.ix	all positive behavior support plans are updated as indicated by outcome data and reported at least quarterly in the Present Status section of the case formulation in the individual's Wellness and Recovery Plan	<p>Findings: Review of the four PBS plans showed that this criterion was not met for any of them.</p> <p>Report by Dr. Jones and by PBS team leaders indicated that a few charts have updates on the results of the PBS plans but the data were subjective and not reliable for accurate tracking of treatment outcome.</p>

		<p>Recommendation: Update all PBS plans as indicated by outcome data and document it at every scheduled WRPC in the Present Status section of the individual's case formulation.</p>
c.x	<p>all staff has received competency-based training on implementing the specific behavioral interventions for which they are responsible, and performance improvement measures are in place for monitoring the implementation of such interventions.</p>	<p>Findings: None of the four PBS plans showed evidence of the use of performance improvement measures for monitoring the implementation of the interventions.</p> <p>Recommendation: 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.</p>
c.xi	<p>all positive behavior support team members shall have as their primary responsibility the provision of behavioral interventions;</p>	<p>Findings: Some team members offer group therapies, but this is done by choice of the members.</p> <p>Recommendation: Ensure that all PBS team members provide PBS services fulltime until the needs of all individuals requiring behavioral interventions is met.</p>
c.xii	<p>the By CHOICE point allocation is updated monthly in the individual's Wellness and Recovery Plan.</p>	<p>Findings: None of five charts reviewed showed an update of By CHOICE allocation in the WRP. By CHOICE program is not fully operational in all units.</p> <p>Recommendation: Ensure that By CHOICE point allocation is updated monthly in the individual's Wellness and Recovery Plan.</p>

d	<p>Each State hospital shall ensure that it has at least one developmental and cognitive abilities team (DCAT; consisting of 1 clinical psychologist, 1 registered nurse, 1 social worker, 1 psychiatric technician, and 1 data analyst (who may be a behavior specialist) who have a demonstrated competence, consistent with generally accepted professional standards of care, in assessing individuals with cognitive disorders/challenges; developing therapeutic interventions (including positive behavior supports); advising therapy and rehabilitation providers on the implementation of interventions at the cognitive level of the individuals; and managing discharge processes for individuals with developmental disabilities and cognitive disorders/challenges,. This team shall assume some of the functions of the positive behavior support teams if the individuals they serve also need positive behavioral supports.</p>	<p>Findings: Dr. Lakritz's PBS team performs both as a PBS team and as the developmental and cognitive abilities team (DCAT). As such, it fails to fulfill either function.</p> <p>Compliance: Noncompliance.</p> <p>Recommendation: Develop and implement a DCAT.</p>
e	<p>Each State Hospital shall develop and implement a Behavioral Consultation Committee (BCC), chaired by the Chief of Psychology, and co-chaired by the Chief of Psychiatry, to review the Wellness and Recovery Plan and maladaptive behavior(s) of the individuals who have not made timely progress on positive behavior support plans. The Chief of Psychology is responsible for the functions of this committee, together with members of the positive behavior support team (in functions of the committee that relate to individuals under the care of those team members). The committee membership shall include all clinical discipline heads, including the medical director, as well as the clinical administrator of the facility.</p>	<p>Findings: The hospital has a Behavior Consultation Committee (BCC) that is co-chaired by Dr. Jones (Chief of Psychology) and Dr. Eisenstark, (Associate Medical Director). BCC meeting attendance record shows poor attendance by standing committee members at these meetings. Four meetings have been held since January of 2006. Attendance at these meetings ranged from 41% to 68%.</p> <p>No referral has been received by the BCC for individuals who have a Type A (i.e., behavior guidelines) or Type B (i.e., full PBS plans). Given the number of individuals with learned maladaptive behaviors at this hospital, especially those who end up in seclusion and restraints and 1:1 observations, one would expect several referrals a week.</p> <p>There is a PBS-BCC checklist that lists the sequence of steps that</p>

		<p>ought to be followed for the BCC process.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. The Chief of Psychology should chair this committee as required by the EP. 2. Use the PBS-BCC checklist to define the sequence of steps for referrals to the BCC. 3. Ensure that all standing members of the BCC attend every meeting.
f	<p>Each State Hospital shall ensure that it has sufficient neuropsychological services for the provision of adequate neuropsychological assessment of individuals with persistent mental illness.</p>	<p>Findings: Dr. Jones indicated that the psychology department is short-staffed and that he is in the process of filling those positions. However, none of these psychology vacancies are specifically allocated to neuropsychology. At present there is one FTE neuropsychologist employed by the facility. This is insufficient to provide the testing needed in a facility with hundreds of individuals with cognitive disorders and substance abuse as well as individuals with specific psychological deficits, such as traumatic Brain Injury (TBI). In addition, the WRP teams currently underutilize the neuropsychological services by not referring appropriate cases for evaluation.</p> <p>The neuropsychology sub-section of the psychology department does not provide cognitive remediation and cognitive retraining groups in the PSR Mall.</p> <p>Compliance: Partial.</p>

		<p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that WRP teams, especially psychologists, make referrals that are appropriate for neuropsychological assessments. 2. Ensure that neuropsychologists provide cognitive remediation and cognitive retraining groups in the PSR Mall. 3. Increase the number of neuropsychologists to meet the anticipated demand for neuropsychological services.
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.	<p>Findings: The hospital's psychologists currently do not have the authority to write orders.</p> <p>Compliance: Noncompliance.</p> <p>Recommendation: The hospital and/or state must provide psychologists the authority to write orders as specified in the Enhancement Plan.</p>
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.	<p>Methodology: Interviewed Ann Rust, MSN, Nursing QI Coordinator. Interviewed Eve, Assistant Nursing Coordinator. Interviewed Kevin Allen, unit staff. Interviewed Dorothy Pencelly, unit staff. Interviewed Paul Games, N.P. Toured units A4, T18, T17, Q9, Q11, Q 5&6. Attended shift report for unit Q 5&6. Observed mealtime for unit T. Reviewed charts of eight individuals (KH, VH, AG, MP, GB, ES, JB and</p>

		<p>JA).</p> <p>Reviewed Nursing Process Documentation Review Audit summary data (Jan-June 2006).</p> <p>Reviewed Medication Pass and Treatment Administration Review (Jan-June 2006).</p> <p>Reviewed Nursing Education Orientation Competency Checklist.</p> <p>Reviewed Nursing policies and procedures manual.</p> <p>Reviewed Medication Treatment Records (MTR) on 3 units (A4, Q11, Q5&6).</p> <p>Reviewed Controlled Drug log on 3 units.</p> <p>Reviewed 30 new nursing/psychiatric technicians' personnel files.</p> <p>Reviewed hiring packet.</p> <p>Interviewed Candida Asuncion Supervising RN for skilled nursing unit</p> <p>Reviewed Nursing Table of Organization.</p> <p>Reviewed Noc Audit tool.</p> <p>Reviewed Special Order for Minimum Nursing Staff to Patient Ratios.</p> <p>Reviewed Administrative Directive for Nursing Services dated June 23, 2005.</p> <p>Reviewed procedure for Nightly Audits.</p> <p>Reviewed New Hire Orientation Competency Validation Tracking System Report.</p> <p>Reviewed PRN & STAT Progress Notes Monitoring Form and data.</p> <p>Reviewed Administrative Directive for Unit Staffing of Nursing Personnel.</p> <p>Reviewed Medication Variance Data Report for March and April 2006.</p> <p>Reviewed Initial Nursing Assessment Quality Control Summary (January-June 2006).</p> <p>Reviewed Nursing Weekly Note Review data (May 2001 to June 2006).</p>
a	<p>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</p>	<p>Compliance: Partial.</p>

	generally accepted professional standards of care, to ensure:	
a.i	safe administration of PRN medications and Stat medications;	<p>Findings: The facility has reviewed and submitted drafts of policies and procedures for Medication Administration: General Information; Medication Administration; Documentation; Administration of PRN Meds for Pain and Psychiatric Symptom Management. I did not see a draft addressing the use of Stat medications.</p> <p>In addition, the facility has drafted a policy addressing the use of the MOSES (Monitoring of Side Effects System) tool.</p> <p>Recommendation: Continue to develop and implement policies and procedures that ensure the safe administration of PRN medications and Stat medications.</p>
a.ii	documentation of the circumstances requiring PRN and Stat administration of medications;	<p>Findings: From my review of eight charts of individuals who have received PRN and Stat medications, I noted that there were significant problems regarding the documentation of circumstances requiring these medications in all eight charts. In all cases of PRN medication administration, the progress notes indicated that the patient asked for the medication for "anxiety" or "aggression." However, there was no documentation indicating that the staff tried alternative interventions or exploring why the individual was anxious or feeling aggressive.</p> <p>In addition, the documentation for Stat medications indicated that there were no interventions tried at the time the individual was becoming agitated. In some cases, the documentation indicated that the staff member was engaged in a power struggle with the individual, which precipitated the need for the Stat medication.</p> <p>My review of documentation contained in the records did not support</p>

		<p>the findings of the NSH: PRN & Stat Progress Notes Monitoring Form data that reported this item was at 65% compliance.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Provide training to staff regarding the use of alternative therapeutic strategies to assist individuals to deal with emotions. 2. Ensure staff documents the attempts to use these strategies prior to PRN and/or Stat medication administration. 3. Clarify and specify criteria regarding what should be included in the progress notes for item b.c on the NSH: PRN & Stat Progress Notes Monitoring Form to ensure accurate data.
a.iii	documentation of the individual's response to PRN and Stat medication.	<p>Findings:</p> <p>The data from the NSH: PRN & Stat Progress Notes Monitoring Form indicated that the individual's response to PRN medication was at 70% compliance and for Stat medication it was 77%.</p> <p>From my review of eight charts, I found that seven of eight charts only recorded only one word ("effective") in the progress regarding the individual's response to PRN medications. The documentation was more specific to behaviors and symptoms for the response to Stat medications.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Provide staff training regarding the documentation of specific indicators describing an individual's response to PRN and Stat medications. 2. Clarify and specify criteria regarding what should be included in the progress notes for item b.d on the NSH: PRN & Stat Progress Notes Monitoring Form to ensure

		accurate data.
b	Each State hospital shall ensure that all failures to properly sign the Medication Treatment Record (MTR) or the controlled medication log are treated as medication variances, and that appropriate follow-up occurs to prevent recurrence of such variances.	<p>Findings: From my review of the MTRs and the controlled medication logs on units A4, Q11, and Q5&6, I found blanks on the MTRs and the controlled medication logs for July 2006. The staff on each unit was unaware that these failures to properly sign were medication variances.</p> <p>The facility is in the process of revising the Medication Error Report Form, the 24-Hour Medication Audit, and the Medication Administration Monitoring Tool to include the failure to properly sign the MTR and/or the Controlled Medication Log as a medication variance.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Complete the revision of the necessary report forms and monitoring tools. 2. Revise policies and procedures regarding medication variances to include failure to properly sign MTR and Controlled Medication Log as a reportable medication variance. 3. Provide training to staff regarding the above.
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	<p>Findings: The process of integrating all nursing interventions into the WRP has only recently begun. From my review, I noted that many of the "old" and inappropriate nursing interventions such as "will monitor" or "give medications as prescribed" were carried over to the WRP. It appears that the old system is just being implanted into the new system</p>

	<p>measurable terms. No nursing care plans other than the nursing interventions integrated in the therapeutic and rehabilitation service plan are required. No nursing diagnoses other than as specified in the therapeutic and rehabilitation service plan, in terms of the current DSM criteria, are required.</p>	<p>without applying the principles of the Wellness and Recovery Model.</p> <p>I also noted that there was no clinical objective data generated from most of the interventions. Interventions that included "monitoring" did not specify what was to be monitored, how often, where it would be documented, when it would be reviewed and by who. Without this clinical objective data, it is difficult if not impossible to determine if individuals are better or worse related to the team's interventions.</p> <p>Also, I noted that many of the interventions were not written in observable, behavioral, and/or measurable terms.</p> <p>In addition, I found little to no proactive interventions for individuals who were identified at risk for certain issues. For example, individuals who have been identified for being at risk for falls have no additional interventions than individuals who are not at risk for falls.</p> <p>I found several individuals who were obese but did not have it listed as a medical condition. I reviewed the records for a sample of 30 individuals with a BMI over 28 and found only seven had obesity identified as a medical condition. Consequently, there were no interventions in place to address this issue for 23 individuals.</p> <p>The current monitoring and tracking tools do not reflect specific criteria for appropriate interventions.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Provide on-going training regarding the WRP and the Wellness and Recovery Model. 2. Ensure that interventions are written in observable,
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		<p>behavioral, and/or measurable terms.</p> <ol style="list-style-type: none"> 3. Develop and implement proactive interventions related to the individuals needs. 4. Revise appropriate monitoring and tracking instruments to ensure accurate data. 5. Revise policies and procedures to reflect the key elements in this requirement.
d	All nursing staff working with an individual shall be familiar with the goals, objectives and interventions for that individual.	<p>Findings: From observations of 15 staff members, 33% were heard acknowledging individuals' strengths and abilities, 0% were observed discussing mall activities with individuals, and 60% were knowledgeable about a WRP.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Provide on-going training regarding recovery-focused interactions with individuals. 2. Provide positive reinforcement to staff familiar with the goals, objectives, and interactions of individuals.
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.	<p>Findings: As noted above in c., there is a significant lack of clinical objective data available to review for baseline data and for comparison to determine if an individual's symptoms, target variables, and health and mental status are better or worse. The lack of this data hampers the timely detection of changes in status and modifications to interventions and the WRP.</p> <p>I attended a shift report for unit Q 5&6 and found that there was very little information shared during this time. In fact, there were</p>

		<p>several individuals who only had their names read without any status given. I noted that situations where there were staff/patient conflicts precipitated the most discussion. However, there was no resolution and the usual consensus was that the individual was at fault.</p> <p>In addition, I observed a mealtime for unit T18 where the following individuals were identified as being at risk for choking and/or aspiration: JB, DB, JC, LD, VH, KH, RH, AM, DS, JS, LS, JS, JW, AND JS. I noted that there were no specific interventions initiated for these individuals compared to others who were not identified as being at risk. During the meal DB was noted to be coughing. The staff initiated no interventions until I asked that his lung sound be assessed. It was reported that he was experiencing significant wheezing.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none">1. Develop and implement systems to generate individualized, clinical, objective data.2. Develop and implement specific criteria for reporting for shift reports.3. Develop and implement monitoring and tracking instruments to measure the key elements of this requirement.4. Develop and implement individualized interventions for patients who are at risk for choking and/or aspiration.5. Develop and implement a monitoring and tracking system to ensure that the above interventions are consistently initiated.6. Obtain prethickener packets for individuals requiring thickened fluids to ensure the consistency of fluids is consistent.
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f	Each State hospital shall develop and implement a system to monitor nursing staff while administering medication to ensure that:	Compliance: Partial.
f.i	nursing staff are knowledgeable regarding each individual's prescribed medications;	<p>Findings: Only five Medication Pass and Treatment Administration Reviews were conducted from January-July 2006. The results indicated that there was only 60% compliance in staff demonstrating knowledge of individuals' prescribed medications.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Increase the number of Medication Pass and Treatment Administration Reviews to at least 20% per program per quarter. 2. Provide on-going training for staff regarding medications.
f.ii	education is provided to individuals during medication administration;	<p>Findings: The results from the Medication Pass and Treatment Administration Reviews indicated that there was only 60% compliance with providing education during medication administration.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Increase the number of Medication Pass and Treatment Administration Reviews to at least 20% per program per quarter. 2. Provide on-going training for staff regarding medications.
f.iii	nursing staff are following the appropriate medication administration protocol; and	<p>Findings: From the small sample from the Medication Pass and Treatment Administration Reviews, it was noted that the unit does procedure was not followed and that there was a hand-washing deficit.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Increase the number of Medication Pass and Treatment

		<p>Administration Reviews to at least 20% per program per quarter.</p> <ol style="list-style-type: none"> 2. Provide on-going training for staff regarding medication administration procedures.
f.iv	<p>medication administration is documented in accordance with the appropriate medication administration protocol.</p>	<p>Findings: There was no data contained in the Medication Pass and Treatment Administration Reviews that addressed medication administration documentation. However, from my review of three units' MTR and Controlled Medication Logs, I noted blanks on each for all three units.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Include medication administration documentation requirements on the Medication Pass and Treatment Administration Reviews. 2. Provide on-going training for staff regarding medication administration procedures. 3. Increase the number of Medication Pass and Treatment Administration Reviews to at least 20% per program per quarter.
g	<p>Each State hospital shall ensure that individuals remain in a "bed-bound" status only for clinically justified reasons.</p>	<p>Findings: Data from NSH indicated that clinical justification was not found for individuals who are in a bed-bound status.</p> <p>This monitor received the names of 14 bed-bound individuals from units A2, A3, and A4. (LS, JC, CR, CL, SG, JW, JM, JMa, SP, QE, JS, SS, JF and VL). I found no clinical justifications for this status documented in the medical records.</p> <p>Compliance: Noncompliance.</p>

		<p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a system to ensure that clinical justification is documented in the medical records for individuals who are in a "bed-bound" status. 2. Initiate interventions in WRP to integrate bed-bound individuals into milieu activities both in and out of their rooms.
h	Each State hospital shall ensure that, before they work directly with individuals, all nursing and psychiatric technicians have successfully completed competency-based training regarding:	<p>Compliance: Partial.</p>
h.i	mental health diagnoses, related symptoms, psychotropic medications and their side effects, monitoring of symptoms and target variables, and documenting and reporting of the individual's status;	<p>Findings: Of 53 nursing staff hired between March-May 2006, 45 had completed the required competency-based training. In addition, there is not an adequate tracking system to ensure that all staff have completed orientation classes.</p> <p>In addition, the preceptorship for nurses after orientation is only 3-5 days. However, for other disciplines such as physical therapists, it is 12 months.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Evaluate the need to extend the nursing preceptorship. 2. Develop and implement a reliable system to monitor and track staff who have not completed orientation classes and annual mandatory training. 3. Assign responsibility for follow-up for attendance at orientation classes and other required training. 4. Ensure completion of classes and skill demonstration prior to competency validation.

h.ii	the provision of a therapeutic milieu on the units and proactive, positive interventions to prevent and de-escalate crises; and	<p>Findings: Although all staff that were hired from April 2005 to April 2006 had received MAB 1 training prior to working with individuals, the facility has implemented additional training such as Aggression Reduction Training (ART), Alternative Dispute Resolution (ADR).</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Implement additional training as recommended. 2. Develop and implement a reliable system to monitor and track staff attendance at training classes.
h.iii	positive behavior support principles.	<p>Findings: Of 53 new staff hired from March-May 2006, 32 have completed positive behavior support (PBS) training. The 21 remaining staff were not able to complete the training due to the unavailability of the PBS team to teach the class.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that PBS team is available to conduct training. 2. Develop and implement a reliable system to monitor and track staff attendance at training classes.
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.	<p>Findings: The data provided by NSP does not address the key element of this requirement; competency-based training on the completion of the MTR and the Controlled Medication Log.</p> <p>However, other deficiencies were recognized including noting that the Psychotropic Medication class was not a mandatory class and that there was not a requirement for remediation class for staff with unsatisfactory performance on Medication Pass audits.</p>

		<p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement monitoring tools that address the key required elements. 2. Initiate Psychotropic Medication class as mandatory 3. Require remediation classes for staff with unsatisfactory performance on Medication Pass audits. 4. Develop and implement an annual Medication Administration competency-based class.
4	Rehabilitation Therapy Services	
	<p>Each State hospital shall provide adequate, appropriate, and timely rehabilitation therapy services to each individual in need of such services, consistent with generally accepted professional standards of care.</p>	<p>Methodology: Observed adaptive equipment used by individuals on unit A4. Reviewed charts for ten individuals: (VL, JH, JM, SP, DS, TR, WM SS, HP and DR). Reviewed the Rehabilitation Therapy Professional Practice Group Operations Manual. Reviewed rehabilitation therapy. Reviewed Physical Therapy Department Policies and Procedures. Reviewed Proctors Orientation Checklist. Reviewed training schedule for July 2006. Reviewed orientation schedule for August 2006. Reviewed Annual Mandated Training list. Reviewed rehab therapist training roster for July 1, 2006. Reviewed the list of individuals who require adaptive equipment. Reviewed physical therapy monitoring tools. Reviewed rehabilitation monitoring data. Reviewed list of individuals admitted before June 1, 2006 that had Integrated Rehabilitation Assessments completed. Reviewed credentialing documents. Reviewed Rehabilitation Therapy Documentation Monitoring Tool data.</p>

		<p>Reviewed rehabilitation therapy services staffing. Interviewed Karen Zanetell, Chief of Rehabilitation. Interviewed Margaret Lalich, SLP/Special education teacher. Interviewed Joesph Atley, Audiologist/Special education teacher. Interviewed Karen Breckenridge, PT. Observed individuals on unit A4. Interviewed Candida Asuncion, SRN for unit A4. Interviewed Maelinda Holliman, OT. Reviewed charts for ten individuals: (VL, JH, JM, SP, DS, TR, WM SS, HP and DR).</p>
a	Each State hospital shall develop and implement policies and procedures, consistent with generally accepted professional standards of care, related to the provision of rehabilitation therapy services that address, at a minimum:	<p>Compliance: Partial.</p>
a.i	the provision of direct services by rehabilitation therapy services staff; and	<p>Findings: NSH's current rehabilitation therapy services policies and procedures do not include the principles and language of the Wellness and Recovery Model.</p> <p>Recommendations: Revise policies and procedures to include principles and language of the Wellness and Recovery Model.</p>
a.ii	the oversight by rehabilitation therapists of individualized physical therapy programs implemented by nursing staff.	<p>Findings: At the current time, there is no oversight provided by the rehabilitation therapists of individualized physical therapy programs that are implemented by nursing staff.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a system to provide regular oversight by rehabilitation therapists to nursing staff implementing individualized physical therapy programs.

		<p>2. Develop and implement a monitoring system to ensure that oversight by rehabilitation therapists of individualized physical programs implemented by nursing staff is occurring.</p>
b	<p>Each State hospital shall provide competency-based training to nursing staff, as appropriate, on the use and care of adaptive equipment, transferring, and positioning, as well as the need to promote individuals' independence.</p>	<p>Findings: Although the rehabilitation staff report that training does occur for each of these key elements, it is not consistently documented nor is it consistently competency-based.</p> <p>There is currently no monitoring system in place for these required elements.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a system to provide and document competency-based training on the key elements of this requirement. 2. Develop and implement a monitoring system to ensure that competency-base training is provided for the key elements of this requirement.
c	<p>Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.</p>	<p>Findings: There is no monitoring system in place to ensure compliance with the key elements of this requirement. NSH has recently reviewed the timeliness of physical therapy referrals. However, there is no system in place to review this on a regular basis or to review the adequacy of rehabilitation therapy services.</p> <p>Compliance: Partial.</p>

		<p>Recommendations: Develop and implement a system to monitor the key elements of this requirement.</p>
d	<p>Each State hospital, consistent with generally accepted professional standards of care, shall ensure that each individual who requires adaptive equipment is provided with equipment that meets his/her assessed needs and promotes his/her independence, and shall provide individuals with training and support to use such equipment.</p>	<p>Findings: There is no monitoring system in place to ensure compliance with the key elements of this requirement. For example, there is currently no tracking or monitoring of individuals who require and have been given hearing aids or adaptive equipment. In addition, there is no system in place to ensure that adaptive equipment is accessible to individuals, is in good working order, and is cleaned on a regular basis, e.g. wheelchairs.</p> <p>Compliance: Partial.</p> <p>Recommendations: Develop and implement a system to monitor the key elements of this requirement.</p>
5	Nutrition Services	
	<p>Each State hospital shall provide the individuals it serves, particularly those experiencing weight-related problems, adequate and appropriate dietary services consistent with generally accepted professional standards of care.</p>	<p>Methodology: Reviewed the Statewide Nutrition Care Monitoring Tool (NCMT). Reviewed the Statewide Nutrition Care Monitoring data Jan-June 2006. Reviewed Napa State Hospital Dietetics Department Procedure Manual. Reviewed Napa State Hospital Diet Manual. Reviewed Napa State Hospital Administrative Directive for Wellness and Recovery Plan (WRP) dated August 26, 2004. Reviewed Dysphagia/Choking Precaution List. Reviewed Enteral Feeding List.</p>

		<p>Reviewed list of Individuals admitted directly into the medical-surgical unit (none).</p> <p>Reviewed list of Individuals directly admitted into the skilled nursing facility (none).</p> <p>Reviewed list of Individuals who were new admissions with identified nutrition triggers.</p> <p>Reviewed list of Individuals at risk acuity levels.</p> <p>Reviewed list of Individuals with BMI over 25 or under 18.</p> <p>Reviewed WRP for 30 individuals with BMI over 28.</p> <p>Observed mealtime for building T.</p> <p>Interviewed Wen Pao, Clinical Dietician.</p> <p>Conducted chart reviews.</p>
a	<p>Each State hospital shall modify policies and procedures to require that the therapeutic and rehabilitation service plans of individuals who experience weight problems and/or related health concerns include adequate strategies and methodologies to address the identified problems and that such strategies and methodologies are implemented in a timely manner, monitored appropriately, and revised, as warranted, consistent with generally accepted professional standards of care.</p>	<p>Findings:</p> <p>There is currently no monitoring system in place for these key elements of this requirement. NSH does have a list of individuals' BMI. However, from my chart review, I found few medical conditions listing obesity and very few WRPs adequately addressing this issue. The NSH data indicated that this was at 0% compliance.</p> <p>Compliance:</p> <p>Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a system to monitor the key elements of this requirement. 2. Retrain staff regarding medical conditions to be listed in the WRP. 3. Develop and implement creative mall activities addressing weight and health issues.
b	<p>Each State hospital shall ensure that one or more treatment team members demonstrate competence in the</p>	<p>Findings:</p> <p>NSH's NCMT Item 22, addresses the competency I dietary and</p>

	<p>dietary and nutritional issues affecting the individuals they serve and the development and implementation of strategies and methodologies to address such issues.</p>	<p>nutritional issue key element. The NSH data indicated that this was at 0% compliance.</p> <p>There is no monitoring system in place to address the other key elements of this requirement.</p> <p>Compliance: Noncompliance.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a competency-based curriculum to ensure that team members demonstrate competence in the dietary and nutritional issues and the development and implementation of strategies and methodologies to address such issues, 2. Develop and implement a system to monitor the key elements of this requirement.
c	<p>Each State hospital shall develop and implement policies and procedures to address the needs of individuals who are at risk for aspiration or dysphagia, including but not limited to, the development and implementation of assessments and interventions for mealtimes and other activities involving swallowing.</p>	<p>Findings: The current NSH policies and procedures regarding risk of aspiration and dysphagia are inadequate to guide the provision of safe care to this population. The SLPs, nurses, dieticians, physical therapists, and occupational therapists at the facility have little expertise in this area. There is no system in place to ensure that a comprehensive 24-hour dysphagia care plan is developed and implemented.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Secure the assistance of a consultant who specializes in dysphagia to ensure the key elements of this requirement is met.

		<ol style="list-style-type: none"> 2. Revise policies and procedures in accordance with generally accepted standards of practice regarding risk of aspiration/dysphagia. 3. Develop and implement 24-hour, individualized dysphagia care plans with the assistance of a consultant with expertise in this area. 4. Provide competency-based training to staff regarding risk of aspiration/dysphagia. 5. Provide competency-based training on individualized, 24-hour dysphagia care plans to staff working with individuals at risk of aspiration/dysphagia. 6. Develop and implement a monitoring system of the key elements of this requirement.
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.	<p>Findings: NSH's NCMT Item 20, addresses this key element. The data indicated that there was 0% compliance. There has been no competency-based training regarding aspiration/dysphagia.</p> <p>Compliance: Noncompliance.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Secure a consultant with expertise in aspiration/dysphagia to assist in developing and implementing competency-based training for this key element of the requirement. 2. Develop and implement a monitoring system to ensure the key elements of this requirement.
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	<p>Findings: NSH's NCMT Item 14 addresses one of the key elements of this requirement.</p>

	utilized, to determine the feasibility of returning them to oral intake status.	<p>The data indicated that there was 0% compliance for Item 14, "transition to oral feeding regimen is addressed for enteral/parenteral nutrition support."</p> <p>The data indicated that there was 100% compliance for Item 21, "Nutrition Services has current policies/procedures on enteral/parenteral nutrition support." However, this item does not address the key element requiring treatment of the underlying causes for feeding tube placement.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Revise policies and procedures to reflect key elements of this requirement. 2. Develop and implement a system to monitor all the key elements of this requirement.
6	Pharmacy Services	
	Each State hospital shall provide adequate and appropriate pharmacy services consistent with generally accepted professional standards of care. Each State hospital shall develop and implement policies and procedures that require:	<p>Methodology: Interviewed John Banducci, Pharmacy Director. Interviewed Lee V. Bufalini, Assistant Pharmacy Director. Interviewed Pamela Moe, Assistant Pharmacy Director. Reviewed charts of 13 individuals (VL, JH, JM, SP, DS, JB, JA, KH, VH, AG, MP, GB, and ES). Reviewed Physician's Orders System (POS) Manual. Reviewed NSH Pharmacy Manual and Drug Formulary. Reviewed New Medication Orders (January-June 2006).</p>
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	<p>Findings: The NSH Pharmacy Department currently has 8 full-time and 3 part-time pharmacists. They have 3.5 full-time vacancies, which affect the services that they are able to deliver to the facility. The department</p>

	<p>interactions, side effects, and need for laboratory work and testing; and</p>	<p>has been conducting more reviews than required—on a monthly basis rather than quarterly.</p> <p>NSH does not have a monitoring system in place for key elements of this requirement or an established database.</p> <p>NSH reported 0% compliance with documentation of drug-drug interactions, 0% compliance with documentation of side effects of new medications ordered, and 4% compliance with documentation of laboratory tests and work.</p> <p>In my review of the above listed medical records, I found no documentation related to the key elements of this requirement.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a system to monitor the key elements of this requirement. 2. Develop, update and/or revise and implement policies and procedures to address key elements of this requirement. 3. Establish an appropriate database to monitor key elements of this requirement.
b	<p>Physicians to consider pharmacists' recommendations, and for any recommendations not followed, document in the individual's medical record an adequate clinical justification.</p>	<p>Findings: There is no procedure in place at NSH addressing this requirement.</p> <p>Compliance: Noncompliance.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a system to address this required

		<p>element.</p> <ol style="list-style-type: none"> 2. Develop and implement policies and procedures regarding this requirement. 3. Develop and implement a system to monitor the key elements of this requirement. 4. Establish appropriate database to monitor key elements of this requirement.
7	General Medical Services	
		<p>Methodology: Interviewed Scott Anderson, M.D, PhD. Chief of Medical Ancillary Services. Interviewed William Kocsis, M.D., staff physician. Interviewed Abishi Rumano, staff physician. Interviewed Hong-Shen Yeh, M.D. staff physician. Interviewed Edward Goldstein, M.D., staff physician. Interviewed Emmanuel Obanor, D.O., staff physician. Interviewed Paul Games, Nurse Practitioner. Reviewed charts of five individuals (VW, DB, LD, QWL, and FS). Reviewed Medical Quality Management Monitor: Urgent and Emergent Care; Reviewed Medical Quality Management Monitor: Asthma/COPD Reviewed Medical Quality of Care Monitor: Diabetes Mellitus. Reviewed Medical Ancillary Services Manual (available upon request) Reviewed Initial Admission Assessment Monitoring Form: Medical Reviewed Credentialing and privileging documents for non-psychiatric physicians. Reviewed Physical Health trigger summary data (January-June 2006) Reviewed Department of Medicine meeting minutes (January-June 2006) Reviewed List of individuals requiring hospitalization, E.R. care and/or medical emergency response. Reviewed AD "Medical Procedure on Admission and Annually".</p>

		<p>Reviewed AD "Pain Management".</p> <p>Reviewed AD "Off-grounds Medical or Administrative Transportation and Transfer".</p> <p>Reviewed AD "Back-up Medical Coverage for PM's and NOC's".</p> <p>Reviewed AD "Gynecological Examinations, Routine".</p> <p>Reviewed AD "Medical/Surgical Services".</p>
a	<p>Each State hospital shall provide adequate, appropriate, and timely preventive, routine, specialized, and emergency medical care to all individuals in need of such services, consistent with generally accepted professional standards of care. Each State hospital shall ensure that individuals with medical problems are promptly identified, assessed, diagnosed, treated, monitored and, as monitoring indicates is necessary, reassessed, diagnosed, and treated, consistent with generally accepted professional standards of care.</p>	<p>Findings:</p> <p>The medical ancillary (medical surgical) service employs 16 full-time physicians. The physicians provide regular coverage of each program as well as on-call coverage of the facility at all times. In addition, the facility has a range of on-site specialty clinics, including general/internal medicine, podiatry, optometry, OB GYN, neurology, hematology/oncology, infectious diseases, ENT, ophthalmology, and urology. NSH also has contractual arrangements with a variety of outside consultants who provide on-site services and are privileged by the facility as well as off-site consultants in cardiology, gastroenterology, endocrinology, and dermatology. The facility transfers individuals who require a hospital level of care not available on-site to Queen of the Valley Hospital and, occasionally, to Saint Helena Hospital (for cardiac conditions) and the medical centers of the University of California at San Francisco and the University of California at Davis (for a variety of interventions, including pain management).</p> <p>NSH has a medical unit on-site to provide care for individuals with conditions that cannot be managed in their units but do not require specialized hospital services (e.g. pneumonias, dehydration, urinary tract infections, etc).</p> <p>There is a medical officer of the day (MOD) who provides on-call services from 8:30 am to 4:30 pm. Three full-time physicians ensure</p>

		<p>on-call coverage from 4:30 pm to 8:30 am.</p> <p>All physicians at NSH are licensed and have completed at least one year of internship in medicine. Many physicians have completed approved residency training in family or general practice and some are board-certified in a variety of specialties.</p> <p>The emergency medical response at NSH is provided by a team of paramedics working for the fire department on-site and the response is limited to first aid/basic CPR and transfer to Queen of the Valley Hospital.</p> <p>At this time, the medical service at NSH has adequate staffing levels and a range of consultation services and contractual arrangements that can meet the needs of the individuals served.</p> <p>The facility conducted self-assessment of its compliance with this step. Based on a review of 20 charts, NSH identified five aspects of medical care. The following is a summary of the data, including compliance rates for each item:</p> <ol style="list-style-type: none">1. Timeliness of the admission medical assessment (76%);2. Ordering of appropriate laboratory tests upon admission (88%);3. Appropriate referrals of individuals for specialty care upon admission, when applicable (50%);4. Timeliness of the annual history and physical examination (6%);5. Ordering of annual laboratory tests (6%); and6. Referrals of individuals for specialty care during hospitalization (22%). <p>The facility's current monitoring data indicate serious inconsistencies</p>
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		<p>that require prompt corrective action. At present, the facility does not monitor the timeliness, completeness and quality of ongoing medical assessments and management of changes in the physical status of the individuals as well as timeliness and quality of consultation services. In this venue, the facility has developed monitoring instruments regarding the transfer of individuals during emergencies and the management of individuals with asthma/COPD and diabetes mellitus.</p> <p>This monitor reviewed charts of several individuals that required hospitalization at an outside facility, care at the medical unit of NSH upon return transfer and specialty care at NSH (e.g. VW, DB, LD, QWL, and FS). The reviews indicate timely and appropriate care in these aspects of medical services.</p> <p>NSH does not have a policy and procedure that outlines standards and expectations regarding the following areas:</p> <ol style="list-style-type: none">1. Timeliness and documentation requirements of initial assessments;2. Timeliness and documentation requirements regarding medical attention to changes in the status of individuals;3. Requirements for preventive health screening of individuals;4. Proper physician-nurse communications and physician response with timeframes that reflect the urgency of the condition;5. Emergency medical response, including drill practice;6. Communication of needed data to consultants;7. Timely review and filing of consultation and laboratory reports;8. Follow-up on consultant's recommendations;9. Assessment and documentation of medical risk factors that are relevant to the individual in a manner that facilitates and integrates interdisciplinary interventions needed to
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		<p>reduce the risks,</p> <p>10. Parameters for physician participation in the WRP process to improve integration of medical and mental health care; and</p> <p>11. Proper documentation of changes in the medical status of individuals in the WRP.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement policy and procedure to codify facility's standards and expectations regarding the areas outlined above. 2. Ensure that monitoring instruments are aligned with the policy and procedure and that the data address not only timeliness and completeness of medical assessments but also quality of assessments and management interventions. 3. Ensure easy access by physicians to the laboratory information system, radiology data/reports, chart notes and consultation reports. 4. Address physicians' concerns regarding the status of equipment and environmental conditions at the consultation clinics to ensure proper functioning of these clinics. 5. Same as in C.1.c.i
b	Each State hospital shall develop and implement protocols and procedures, consistent with generally accepted professional standards of care, that:	<p>Compliance: Partial.</p>
b.i	require the timely provision of initial and ongoing assessments relating to medical care, including but not	<p>Findings: The facility's self-assessment data address only the percentages of</p>

	limited to, vision care, dental care, and laboratory and consultation services;	<p>individuals that are seen in medical and specialty clinics (ophthalmology, respiratory therapy and podiatry) compared to those scheduled to be seen. The data does not address the requirements in this step. Findings in F.7.a also apply to this step.</p> <p>Recommendations: As above.</p>
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;	<p>Findings: The facility's monitoring data do not address the key requirements in this step. The development of monitoring instruments regarding transfers of individuals during emergencies and the management of individuals with asthma/COPD and diabetes mellitus are steps in the right direction.</p> <p>Recommendations: As above.</p>
b.iii	define the duties and responsibilities of primary care (non-psychiatric) physicians;	<p>Findings: The current medical staff duty statement outlines the duties and responsibilities, but does not clearly or adequately address the standards and expectations in the specific areas outlined in F.7.a.</p> <p>Recommendations: Ensure that the duty statement outlines the performance standards and expectations as above.</p>
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	<p>Findings: NSH has an adequate system for after-hours coverage by psychiatrists and primary care physicians.</p> <p>Recommendations: Continue current practice.</p>

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.	<p>Findings: NSH has a mechanism to address this requirement. The facility holds a joint meeting with staff from Queen of the Valley Hospital quarterly to discuss continuity of care issues and address identified barriers. This meeting includes representatives from medical and nursing staff and leadership of NSH.</p> <p>This monitor's review of charts indicates that the medical discharge records from Queen of the Valley Hospital were available in a timely manner. The chief of the medical ancillary service indicates that the quarterly meeting has helped improve continuity of care concerns, but that the availability of records from the outside hospitals has been variable.</p> <p>Recommendations: Continue current practice and increase efforts to ensure consistency in the availability of needed records.</p>
c	Each State hospital shall ensure that physicians monitor each individual's health status indicators in accordance with generally accepted professional standards of care, and, whenever appropriate, modify their therapeutic and rehabilitation service plans to address any problematic changes in health status indicators.	<p>Findings: The facility has monitoring data based on the physicians' adherence to practice guidelines at NSH. These data do not address the key requirements in this step.</p> <p>This monitor's chart reviews indicate that, in general, the foci of hospitalization, objectives and interventions are not modified to reflect changes in the physical status of individuals. As mentioned earlier, this deficiency is also noted in the services provided to individuals suffering from cognitive disorders, substance abuse and seizure disorders.</p> <p>Compliance: Partial.</p>

		<p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement monitoring and tracking instruments to ensure that the foci of hospitalization address current assessed medical needs and that foci, objectives and interventions are modified in a timely basis to address the changes in the physical status of the individuals. 2. Improve integration of medical staff into the interdisciplinary functions of the WRP.
d	<p>Each State Hospital shall monitor, on a continuous basis, outcome indicators to identify trends and patterns in the individual's health status, assess the performance of medical systems, and provide corrective follow-up measures to improve outcomes.</p>	<p>Findings: At present, NSH monitors transfers to higher level of care, appropriate eye and foot care, laboratory testing and antiplatelet therapy for individuals suffering from diabetes mellitus and the management of individuals with asthma/COPD. The facility does not have a formalized system that addresses health care outcomes for the individuals and process outcomes for the medical service. Review of the Key Indicators indicates that the facility currently does not have data on the identified triggers (see introduction).</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a formalized physician peer review system that utilizes indicators aligned with the standards and expectations outlined in F.7.a. 2. Collect data on the medical triggers identified in the Key Indicators. The facility may establish additional indicators of outcome to the individuals and the medical systems of care. 3. Identify trends and patterns based on clinical and process outcomes.

		<p>4. Provide corrective actions to address problematic trends and patterns.</p> <p>5. Expedite efforts to automate data systems to facilitate data collection and analysis.</p>
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.	<p>Methodology: Interviewed Bob Kolker, RN, Public Health Nurse. Reviewed Infection Control Committee Meeting minutes (Jan-June 2006). Reviewed Medical Executive Committee Meeting minutes (Jan-June 2006). Reviewed CDC Guidelines.</p>
a	Each State hospital shall establish an effective infection control program that:	<p>Compliance: Partial.</p>
a.i	actively collects data regarding infections and communicable diseases;	<p>Findings: NSH does not have a monitoring system in place for key elements of this requirement.</p> <p>From my interview with Mr. Bob Kolker, the department does collect data on TB, rubella and varicella antibody, Hepatitis A, B, and C serology, HIV screenings, MRSA cultures and STD lab work. However, infection and immunization reporting from the units is inconsistent and data is unreliable. In addition, employee reporting of communicable illness is inadequate and limited.</p> <p>On-site laboratory and radiology reporting of communicable illness is adequate. However, lab and x-rays obtained while an individual is hospitalized in the community is inconsistently forwarded to the Public Health Department.</p>

		<p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a system to monitor the key elements of this requirement. 2. Develop and implement a system for consistent unit reporting of appropriate information. 3. Develop and implement a system to ensure that community labs and x-rays are forwarded to the public health department. 4. Develop and implement systems to monitor and track unit reporting and accessibility of community labs and x-rays.
a.ii	assesses these data for trends;	<p>Findings: NSH does not have a monitoring system in place for key elements of this requirement. Data regarding trend analysis was not found in the minutes of the Infection Control Committee meetings.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a system to monitor the key elements of this requirement. 2. Develop and implement a system to document identified trends, interventions/corrective actions, and follow-up.
a.iii	initiates inquiries regarding problematic trends;	<p>Findings: NSH does not have a monitoring system in place for key elements of this requirement.</p> <p>Recommendations: As above.</p>
a.iv	identifies necessary corrective action;	As above.
a.v	monitors to ensure that appropriate remedies are	As above.

	achieved; and	
a.vi	integrates this information into each State hospital's quality assurance review.	As above.
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.	<p>Methodology: Interviewed Debbie Bordeaux, Dental Assistant. Interviewed Scott Anderson, MD, PhD, Chief of Medical Ancillary Services. Interviewed Ronaldo Chavez, DDS. Reviewed list of dental staff. Reviewed documentation regarding Committee on Dental Auxilliarities. Reviewed patient/dentist ratios. Reviewed draft of Napa State Hospital Dental Policies and Procedures. Reviewed Staffing Guidelines. Reviewed California Department of Mental Health Special Order Regarding Hiring of Physicians, Psychologists, Podiatrists, and Dentists. Reviewed Dental Service. Reviewed Dental Refusal Patient List (June 2005-May2006). Reviewed AD for Medical Procedures on Admission and Annually, dated September 22, 2005. Reviewed SO for Consent for Dental Care dated May 22, 1995. Reviewed draft of MH5505 Dental Record. Reviewed Dental Clinics Form. Reviewed Memorandum for Intervention Request. Reviewed Individual's Refusal of Dental Treatment Form.</p>
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;	<p>Findings: NSH does not have a monitoring system in place for key elements of this requirement.</p> <p>Information provided by NSH indicated that the dentist to patient</p>

		<p>ratio was 1 D.D.S./500 patients. The facility employs two staff dentists and one Chief Dentist. From the review of the dental appointment books, there is a two to four month wait for dental appointments, similar to community standards. The dental auxiliary staff includes one dental assistant and one vacant dental hygienist position, two registered dental assistants, and one psych tech assistant (PTA).</p> <p>There is no available data to indicate if timely and appropriate dental care and treatment is provided.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a system to monitor the key elements of this requirement. 2. Evaluate the need for an additional dentist, dental assistant, dental hygienist, a PTA, and a clerical staff position to cover 1200 patients.
b	Each State hospital shall develop and implement policies and procedures that require:	<p>Compliance: Partial.</p>
b.i	comprehensive and timely provision of dental services;	<p>Findings: NSH does not have a monitoring system in place for key elements of this requirement.</p> <p>NSH has recognized that the current Dental Manual needs to be revised. Drafts of Dental Department policies and procedures have been developed.</p> <p>The data from NSH indicated from a review of 10% of a stratified</p>

		<p>sample that 76% of admission dental exams were performed within the first 90 days of admission and annual exams were performed 62% of the time during or before the anniversary month. However, there is no data indicating reasons why exams were not completed. As noted above, NSP needs a monitoring tool for required elements for dental services to provide regular, consistent, and accurate data.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a system and a database to monitor the key elements of this requirement. 2. Revise Dental Manual. 3. Finalize and implement Dental Department policies and procedures.
b.ii	documentation of dental services, including but not limited to, findings, descriptions of any treatment provided, and the plans of care:	<p>Findings:</p> <p>NSH does not have a monitoring system in place for key elements of this requirement.</p> <p>NSH reported that a review was conducted on a sample of patient dental records. However, the data not available for review.</p> <p>The dental has revised the Patient Dental Record and is awaiting approval for implementation.</p> <p>I did note that patient dental records are kept in the Dental Clinic, not in the medical records. Consequently, individuals' Wellness and Recovery teams do not have access to the information contained in these records regarding dental health and hygiene issues.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a system to monitor the key elements of this requirement. 2. Consider placing patient dental records in medical records

		<p>or on a facility computerized system for staff to have accessibility to this health care information.</p> <p>3. Implement revised Patient Dental Record.</p>
b.iii	<p>use of preventive and restorative care whenever possible; and</p>	<p>Findings: NSH does not have a monitoring system in place for key elements of this requirement</p> <p>Percentages of patients receiving preventative and restorative care were not included in the self-assessment data report.</p> <p>The Dental Department has been putting much effort in providing dental treatments to individuals who are incompetent and/or are refusing dental treatment. The department has gone through the individual's conservator and the court system to obtain consent for treatment to be performed under general anesthesia.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a system to monitor the key elements of this requirement. 2. Evaluate staffing needs as outlined in recommendation #2.a. in providing adequate preventative and restorative dental care. 3. Develop and implement database to monitor and track care and use of general anesthesia.
b.iv	<p>tooth extractions be used as a treatment of last resort, which, when performed, shall be justified in a manner subject to clinical review.</p>	<p>Findings: NSH does not have a monitoring system in place for key elements of this requirement.</p> <p>NSH reported that from a 20% of a stratified sample of dental records of individuals who had a dental extraction, 100% included justification in the dental record. The monitoring tool used assess this</p>

		<p>data was not provided. However, many of the recommendations contained in the Napa State Hospital Self- Assessment tool in section F,9 Dental Services b.iv appear to be appropriate, specific criteria to include in the monitoring of this key element.</p> <p>Recommendations: Develop and implement a system to monitor the key elements of this requirement.</p>
c	<p>Each State hospital shall ensure that dentists demonstrate, in a documented fashion, an accurate understanding of individuals' physical health, medications, allergies, and current dental status and complaints.</p>	<p>Findings: NSH does not have a monitoring system in place for key elements of this requirement.</p> <p>NSH reported that a sample of dental records was assessed to review this key element. However, the data and results were not provided in the self-assessment report.</p> <p>Compliance: Partial.</p> <p>Recommendations: As above.</p>
d	<p>Each State hospital shall ensure that transportation and staffing issues do not preclude individuals from attending dental appointments, and individuals' refusals are addressed to facilitate compliance.</p>	<p>Findings: NSH does not have a monitoring system in place for key elements of this requirement.</p> <p>NSH reported that from a sample of individuals found on the "Missed Dental Appointment" form indicated that outside appointments were missed due to patient refusal (6%), staff issues (7%), and transportation issues (1%). In-house appointments were missed due to patient refusals (no data reported), staffing issues (no data reported), and transportation issues (0%).</p>

		<p>Compliance: Partial.</p> <p>Recommendations: Develop and implement a system to monitor the key elements of this requirement.</p>
e	<p>Each State hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to overcome individual's refusals to participate in dental appointments.</p>	<p>Findings: NSH does not have a monitoring system in place for key elements of this requirement.</p> <p>NSH reviewed a sample of individuals who refuse appointments by using the "Missed Dental Appointment" form. The self-assessment data indicated that each Dental Clinic is using the form to notify Unit Supervisors and Program Directors when two appointments are refused. However, there is no indication from the self-assessment if the interdisciplinary teams are reviewing, assessing, and developing strategies for refusals as outlined in the key elements of this requirement.</p> <p>The Dental Department has developed an Intervention Request form and Individual's Refusal of Dental Treatment form to activate desensitization for the individual. This is a very positive intervention to implement at the facility.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a system to monitor the key elements of this requirement. 2. Develop and implement a facility-wide system to facilitate

		communication with Dental and the Wellness and Recovery teams regarding individualized strategies to address refusals of dental appointments and treatments.
10	Special Education	
	Each State hospital shall provide the school-age and other residents, as required by law, who qualify for special education ("students"), individualized educational programs that are reasonably calculated to enable these students to receive educational benefits, as defined by applicable law.	Only MSH
a	Each State hospital shall develop and implement uniform systems for assessing students' individual educational needs and monitoring their individual progress.	
b	Each State hospital shall ensure that all Individual Education Plans ("IEPs") are developed and implemented consistent with the Individuals with Disabilities Education Act, 20 U.S.C. § 1400 <i>et seq.</i> (2002) ("IDEA").	
c	Each State hospital shall ensure that teachers providing instruction to students at each State hospital have completed competency-based training regarding teaching and academic instruction, behavioral interventions, monitoring of academic and behavioral progress and incident management and reporting.	
d	Each State hospital shall ensure that students receive instruction and behavioral supports appropriate to their learning abilities and needs, consistent with generally accepted professional standards of care.	
e	Each State hospital shall provide appropriate literacy instruction, consistent with generally accepted professional standards of care, for students who show deficits in one or more common areas of reading (e.g., decoding or comprehending).	
f	Each State hospital shall on admission and as statutorily	

	required thereafter, assess each student's capacity to participate, with appropriate supports and services, in an integrated, non-institutional, education environment, and provide access to an integrated education environment for those students who can participate in one with appropriate supports and services.	
g	Each State hospital shall ensure that all students receive their education in the least restrictive setting pursuant to the requirements of the IDEA, consistent with their legal and clinical status.	
G	Documentation	
		<p>Summary of Progress:</p> <ol style="list-style-type: none"> 1. NSH is in the beginning stages of the documentation of the Wellness and Recovery Model and making significant efforts to move the process in a positive direction. 2. The DMH WRP manual includes criteria for the proper documentation of the main components of the new model. 3. NSH has implemented new formats for the documentation of admission and integrated assessments and the WRP. 4. In general, NSH ensures documentation of transfer assessments upon the inter-unit transfer of individuals.
	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	<p>Findings:</p> <p>The previously mentioned findings of deficiencies in the documentation of admission and integrated assessments (D.1. through D.7) and the main components of integrated therapeutic and rehabilitation services (C.2.b through C.2.i) and specific therapeutic and rehabilitation services (F.1 through F.7) indicate that the documentation of these systems is generally inadequate.</p> <p>Compliance:</p> <p>Partial.</p>

	<p>expectation that such records include meaningful, accurate, and coherent assessments of the individual's progress relating to treatment plans and treatment goals, and that clinically relevant information remains readily accessible.</p>	<p>Recommendations:</p> <ol style="list-style-type: none"> 1. Revise, update, and implement policies and procedures related to documentation to include specific criteria required. 2. Develop and implement a system to monitor and track the quality of documentation addressing the required elements in the Plan. 3. Provide on-going training regarding documentation requirements.
H	Restraints, Seclusion, and PRN and Stat Medication	
		<p>Summary of Progress:</p> <ol style="list-style-type: none"> 1. NSH has identified needed revisions in its policies and procedures regarding seclusion, restraints, PRN and stat medications and is in the process of making these revisions. 2. Monitoring systems are being put in place to ensure that proper procedures are being implemented. 3. NSH is committed to decreasing the use of seclusion/restraints and PRN and Stat medications. 4. NSH has adopted the Wellness and Recovery Model to guide its provision of services to individuals with serious mental illness. 5. NSH has identified many of its deficits through the process of self-assessment. 6. Many of the NSH staff members are invested in making the needed changes to enhance the lives of the individuals residing at NSH.
	<p>Each State hospital shall ensure that restraints, seclusion, psychiatric PRN medications, and Stat medications are used consistent with generally accepted professional standards of care.</p>	<p>Methodology: Reviewed California Department of Mental Health Special Order for Seclusion and Behavioral Restraint dated May 15, 2006. Reviewed Administrative Directive for Behavioral Seclusion or Restraint dated October, 26, 2005.</p>

		<p>Reviewed NSH Nursing Policy for Behavioral Seclusion or Restraint. Reviewed Nursing Quality Improvement Seclusion And Restraint Review tool. Reviewed NSH Emergency Intervention Reports. Reviewed Positive Behavior Supports Program Monitoring Form. Reviewed NSH Behavioral Seclusion or Restraint Observation Record. Reviewed Nightly Audit Checklist and procedure. Reviewed NSH Unit Weekly S&R Reduction Meeting Minutes for May 2006 Reviewed Side Rail Usage list. Reviewed the following medical records: KH, VH AG, MP, GB, ES, JB, and JA.</p>
1	<p>Each State hospital shall revise, as appropriate, and implement policies and procedures regarding the use of seclusion, restraints, psychiatric PRN medications, and Stat Medications consistent with generally accepted professional standards of care. In particular, the policies and procedures shall expressly prohibit the use of prone restraints, prone containment and prone transportation and shall list the types of restraints that are acceptable for use.</p>	<p>Findings: NSH has identified several problematic issues with specific policies and procedures regarding the use of seclusion, restraints, psychiatric PRN medications, and Stat medication. They are in the process of revising these policies and procedures.</p> <p>Compliance: Partial.</p> <p>Recommendations: Revise implement, and retrain staff regarding policies and procedures addressing the use of seclusion, restraints, psychiatric PRN medications, and Stat medication in accordance with generally, accepted standards of practice.</p>
2	<p>Each State hospital shall ensure that restraints and seclusion:</p>	<p>Compliance: Partial.</p>
a	<p>are used in a documented manner and only when individuals pose an imminent danger to self or others and after a</p>	<p>Findings: NSH does not have a monitoring system in place for key elements of</p>

	<p>hierarchy of less restrictive measures has been considered in a clinically justifiable manner or exhausted;</p>	<p>this requirement.</p> <p>NSH has identified policies and procedures that do not adequately address using a hierarchy of less restrictive measures prior to the use of restraints and seclusion.</p> <p>From my review of eight individuals who were placed in seclusion and/or restraints, there was no indication from the documentation that less restrictive measures were tried prior to the use of restraints and/or seclusion.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a system to monitor the key elements of this requirement. 2. Revise policies and procedures to include implementing seclusion and restraints only after a hierarchy of less restrictive measures has been considered in a clinically justifiable manner or exhausted with supporting documentation to be logged in the medical record. 3. Retrain staff regarding new policies and procedures regarding the use of seclusion and restraint. 4. Revise forms used to document use of seclusion and restraint to include documentation of less restrictive measures used prior to restrictive procedures being implemented.
b	<p>are not used in the absence of, or as an alternative to, active treatment, as punishment, or for the convenience of staff;</p>	<p>Findings:</p> <p>NSH does not have a monitoring system in place for key elements of this requirement.</p> <p>NSH reviewed a sample of Emergency Intervention Reports and physician orders, and noted that the HSS provides oversight for seclusion and restraints and concluded that there was no evidence that</p>

		<p>restrictive procedures were used in the absence of, or as an alternative to, active treatment, as punishment, or for the convenience of staff.</p> <p>From my review of the medical records noted above, my findings do not support the findings of NSH. Several of the notes I reviewed indicated that there were power struggles between the staff and the individual, which led to escalation, resulting in the use of a chemical restraint and/or physical restraints. The documentation in conjunction with my observation of a shift report on unit Q5&6 (see Nursing Services E.) indicates that restrictive procedures are used in the absence of active treatment, as a punishment, and for the convenience of staff.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a system to monitor the key elements of this requirement. 2. Provide on-going training for staff regarding therapeutic interactions and interventions. 3. Increase the number of therapeutic mall activities to provide adequate treatment options to individuals.
c	are not used as part of a behavioral intervention; and	<p>Findings:</p> <p>NSH data indicated that seclusion and/or restraints were not included as a behavioral intervention in the WRPs for a sample of individuals that were placed in seclusion and/or restraints.</p> <p>From my review of a number of WRPs, I found no documentation indicating that seclusion and/or restraints were used as part of behavioral interventions.</p> <p>Recommendations:</p> <p>Continue ongoing monitoring to ensure compliance with this key</p>

		element.
d	are terminated as soon as the individual is no longer an imminent danger to self or others.	<p>Findings: NSH data indicted that 75% of records reviewed demonstrated that seclusion/restraints were terminated as soon as the individual was no longer an imminent danger to self or others.</p> <p>There is no monitoring tool in place to identify specific issues related to this key element such as staffing issues or documentation to identify problematic trends in need of corrective action.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Continue on-going monitoring to ensure compliance with this key element. 2. Develop and implement a monitoring system to identify specific problematic trends related to this key element to ensure effective plans of correction.
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.	<p>Findings: NSH data indicated 96% compliance with individuals being seen within an hour by a physician or RN while in seclusion/restraints. In addition, the NSH data indicated that 85% of PTAs have completed the return demonstration for the restraint/seclusion class. However, the data from NSH does not address all the key elements of this requirement regarding continuous monitoring by competency-based trained staff.</p> <p>Compliance: Partial.</p> <p>Recommendations: Develop and implement a system to monitor and ensure compliance the key elements of this requirement.</p>

4	<p>Each State hospital shall ensure the accuracy of data regarding the use of restraints, seclusion, psychiatric PRN medications, or Stat medications.</p>	<p>Findings: NSH has a fairly extensive but manual review of data for seclusion and restraint. However, at the current time, there is little to no automated data available, making reviews less than timely and prone to error.</p> <p>In addition, NSH has identified problems regarding the accuracy of data addressing psychiatric PRN medications and Stat medications. Consequently, there is no way to ensure the accuracy of the data being collected to guide the initiation of appropriate corrective actions.</p> <p>Compliance: Partial.</p> <p>Recommendations: Develop and implement an automated system to ensure accuracy of data regarding the use of restraints, seclusion, psychiatric PRN medications, or Stat medications.</p>
5	<p>Each State hospital shall revise, as appropriate, and implement policies and procedures to require the review within three business days of individuals' therapeutic and rehabilitation service plans for any individuals placed in seclusion or restraints more than three times in any four-week period, and modification of therapeutic and rehabilitation service plans, as appropriate.</p>	<p>Findings: NSH has identified deficits in their policies and procedures regarding this requirement. They are in the process of revising the appropriate policies and procedures.</p> <p>There is no monitoring system in place to ensure that there is a review within three business days of individuals' therapeutic and rehabilitation service plans for any individuals placed in seclusion or restraints more than three times in any four-week period, and modification of therapeutic and rehabilitation service plans, as appropriate.</p> <p>Compliance: Partial.</p>

		<p>Recommendations:</p> <ol style="list-style-type: none"> 1. Revise appropriate policies and procedures to ensure compliance with this requirement. 2. Develop and implement a monitoring system to ensure that there is a 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.
6	Each State hospital shall develop and implement policies and procedures consistent with generally accepted professional standards of care governing the use of psychiatric PRN medication and Stat medication, requiring that:	<p>Compliance: Partial.</p>
a	such medications are used in a manner that is clinically justified and are not used as a substitute for adequate treatment of the underlying cause of the individual's distress.	<p>Findings: The findings in C.1.b indicate that the use of PRN and Stat medication does not conform to the requirements of the Enhancement Plan. At this time, NSH does not have a policy/procedure or any formalized system to ensure appropriate use.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Same as in C.1.b 2. Develop and implement policy/procedure to outline facility's standards regarding PRN/Stat medication use. 3. Develop and implement triggers for review by TRC and follow through.
b	PRN medications, other than for analgesia, are prescribed for specified and individualized behaviors.	Same as above.
c	PRN medications are appropriately time limited.	Same as above.

d	<p>nursing staff assess the individual within one hour of the administration of the psychiatric PRN medication and Stat medication and documents the individual's response.</p>	<p>Findings:</p> <p>NSH identified deficiencies and inconsistencies in the policies and procedures addressing this requirement. They are in the process of correcting and revising the appropriate policies and procedures.</p> <p>NSH data indicated 68% compliance with documentation indicating that a face-to-face assessment was conducted within one hour of administration of a Stat medication.</p> <p>From my review of the records, nursing did not consistently document an assessment of individuals within one hour of the administration of the psychiatric PRN medication and Stat medication.</p> <p>As noted previously, from my review of eight charts, I found that seven of eight charts only recorded "effective" in the progress regarding the individual's response to PRN medications. The documentation was more specific to behaviors and symptoms for the response to Stat medications.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Revise appropriate policies and procedures to ensure compliance with this requirement. 2. Develop and implement a monitoring system to ensure that 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. 3. Provide staff training regarding policies/procedure changes and the documentation of specific indicators describing an individual's response to PRN and Stat medications. 4. Clarify and specify criteria regarding what should be included in the progress notes for item b.d on the NSH: PRN & STAT Progress Notes Monitoring Form to ensure accurate data.
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e	<p>A psychiatrist conducts a face-to-face assessment of the individual within 24 hours of the administration of a Stat medication. The assessment shall address reason for Stat administration, individual's response, and, as appropriate, adjustment of current treatment and/or diagnosis.</p>	<p>Findings: NSH does not monitor this requirement as stated.</p> <p>This monitor's review of the chart of LS indicates that a psychotropic medication was administered as Stat on two occasions without documentation of a psychiatrist's face-to-face assessment within 24 hours of the administration. The chart of LK includes evidence of Stat administration of psychotropic medication on at least four separate occasions (within a one-week period) without evidence of a psychiatrist's documented face-to-face assessment within 24 hours. In both cases, there was no evidence that the diagnosis and/or scheduled treatment were modified in a timely basis as a result of Stat medication use.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a monitoring instrument to address this requirement. 2. Same as in recommendation #2 in H.6.a.
7	<p>Each State hospital shall ensure that all staff whose responsibilities include the implementation or assessment of seclusion, restraints, psychiatric PRN medications, or Stat medications successfully complete competency-based training regarding implementation of all such policies and the use of less restrictive interventions.</p>	<p>Findings: NSH has identified deficits in determining compliance with training courses due to issues with the program for the training database. In addition, there has been no competency-based training for each of the applicable policies.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Improve and update training database to ensure compliance with this requirement. 2. Develop and implement competency-based training on the

		key elements of this requirement.
8	Each State hospital shall:	<p>Compliance: Partial.</p>
a	develop and implement a plan to reduce the use of side rails as restraints in a systematic and gradual way to ensure individuals' safety; and	<p>Findings: NSH does not have a monitoring system in place for key elements of this requirement.</p> <p>NSH has indicated that if the facility had low beds available for individuals who warrant them, they could reduce the use of side rails. There has been no action taken on this issue for a number of years.</p> <p>From my review of the medical records (SG, CR, TR, LS, LC, LH), I found no indication that individuals had a plan in place to reduce the use of side rails.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a system to monitor the key elements of this requirement. 2. Evaluate, obtain, and maintain appropriate equipment needs for those individuals that warrant the use of side rails. 3. Develop, implement, and regularly review individualized plans for the reduction of side rails.
b	ensure that, as to individuals who need side rails, their therapeutic and rehabilitation service plans expressly address the use of side rails, including identification of the medical symptoms that warrant the use of side rails, methods to address the underlying causes of such medical symptoms, and strategies to reduce the use of side rails, if appropriate.	<p>Findings: NSH does not have a monitoring system in place for each key element of this requirement.</p> <p>NSH has indicated that documentation addressing medical symptoms necessitating the use of side rails, alternatives implemented, and results of actions were not addressed.</p>

		<p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a system to monitor the key elements of this requirement. 2. Provide training to appropriate staff regarding individuals who need side rails, including identification of the medical symptoms that warrant the use of side rails, methods to address the underlying causes of such medical symptoms, and strategies to reduce the use of side rails, if appropriate.
I	Protection From Harm	
	Each State hospital shall provide the individuals it serves with a safe and humane environment and ensure that these individuals are protected from harm.	<p>Summary of Progress:</p> <ol style="list-style-type: none"> 1. Mechanisms are in place for the investigation of Special Incidents by a Special Incident investigator, a member of the Hospital Police. The chief of the Hospital Police reviews these investigations upon completion. 2. Mechanisms are in place for the reporting of programmatic changes initiated as a result of a Special Incident Investigation. 3. NSH and the state have developed policies for the protection of individuals and their rights.
1	Incident Management	
	Each State hospital shall develop and implement across all settings, including school settings, an integrated incident management system that is consistent with generally accepted professional standards of care.	<p>Methodology:</p> <p>Interviewed Patients' Rights Advocate (PRA). Interviewed Standards Compliance Director and Coordinator. Interviewed Director of Human Resources. Interviewed Hospital Administrator. Interviewed Assistant Hospital Administrator. Interviewed a Special Investigator. Interviewed the Hospital Clinical Administrator. Interviewed the Program Director for Program II. Interviewed several unit staff.</p>

		<p>Interviewed twenty individuals served using a structured interview format.</p> <p>Reviewed abuse/neglect data base,</p> <p>Reviewed PRA database.</p> <p>Reviewed 16 SIR investigations.</p> <p>Reviewed four hospital police investigations of sexual contact between individuals and nine death investigations.</p> <p>Reviewed the latest semi-annual and monthly reports for the last six months of incidents.</p> <p>Reviewed training records and personnel files for six staff members.</p> <p>Reviewed numerous Administrative Directives and facility self-monitoring tools.</p> <p>Compared abuse/neglect data to actual investigations conducted for January—June 2006.</p> <p>Attended Mortality Review Committee Meeting on July 25, 2006.</p>
a	Each State hospital shall review, revise, as appropriate, and implement incident management policies, procedures and practices that are consistent with generally accepted professional standards of care. Such policies, procedures and practices shall require:	<p>Compliance:</p> <p>Partial.</p>
a.i	that each State hospital not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of individuals;	<p>Findings:</p> <p>AD 435 states: Employees are required to immediately report incidents of employee misconduct.</p> <p>AD 437 states: The NSH workforce are mandated reporters of elder or dependent adult/child abuse. All staff is required to report any incident of abuse or suspected abuse that they witness or that is reported to them.</p> <p>Recommendations:</p> <p>Insert into the ADs cited (and wherever else appropriate) a strong</p>

		statement that the hospital will not tolerate abuse or neglect.
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;	<p>Findings: Special Order (SO) #227.05, effective Sept. 15, 2005 identifies the categories and definitions of Special Incidents and Headquarters Reportable Incidents. Special incidents are reported to hospital administration. Special incidents include, but are not limited to, physical and verbal aggression between individuals, all types of staff to individual abuse, suicides, deaths, escapes, criminal activity and violations of patient's rights. Special Incidents are reported on a standardized form.</p> <p>Recommendation: Continue current practice.</p>
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;	<p>Findings: AD 435 states: Depending on the circumstances, the employee may be placed on administrative leave (with or without pay) or temporarily reassigned. These arrangements (unless the reassignment is within the same program/department) are made through the Personnel Officer.</p> <p>Several investigation files reviewed contained notice that the staff member involved had been placed on paid administrative leave or had been moved to another work area. This information appeared on the Special Incident Report (SIR). In separate interviews, a Program Director and the Human Resource Director indicated that the decision to place a staff member on administrative leave or to reassign him/her is made collaboratively between the two of them.</p> <p>The ADs related to incident and investigation management do not specifically instruct staff to attend to the safety needs of the individual first, including removing the alleged perpetrator from contact with the alleged victim.</p>

		<p>Recommendations:</p> <ol style="list-style-type: none"> 1. Revise ADs to include the instruction to attend to the safety of the individual first, including removing the alleged perpetrator from contact. 2. Ensure information about attending to the safety of the individual first is included on all Special Incident Reports alleging staff misconduct causing physical or psychological harm. 3. Include a copy of the Special Investigation Report in all investigation files. This will allow the facility to ensure proper actions were taken initially. 4. Add a cell to the Investigation Compliance Monitoring Form monitoring checklist tool that checks for the presence of the SIR in the investigation case file. 5. Include a copy of the Special Investigation Report in all investigation files. This will allow the facility to ensure proper actions were taken. 6. Add a cell to the Investigation Compliance Monitoring Form monitoring checklist tool that checks for the presence of the SIR in the investigation case file.
a.iv	adequate competency-based training for all staff on recognizing and reporting potential signs and symptoms of abuse or neglect, including the precursors that may lead to abuse;	<p>Findings:</p> <p>Attachment B to AD 437 identifies indicators of child and dependent adult abuse. Presently A/N training is not competency-based and is provided only at orientation for one hour. Beginning August 2, 2006, this training will be expanded to two hours. Presently 15–20 minute refresher training is conducted on the unit periodically at the inter-shift meeting. According to the Director of Human Resources, this short refresher is supposed to be provided annually in February. A review of the personnel records of six staff revealed that all had had the hour-long training, but only three had received the refresher annually.</p>

		<p>The hospital maintains a training database that can track by staff member name and can identify persons who have not had the required training or refresher course.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Add a meaningful competency component to the A/N orientation training within six months. 2. Ensure training clarifies the definition and common examples of neglect and the reporting responsibilities for neglect, as well as abuse. 3. Within one year, ensure formal competency-based training regarding abuse and neglect is provided to staff annually.
a.v	<p>notification of all staff when commencing employment and adequate training thereafter of their obligation to report abuse or neglect to each State hospital and State officials. All staff persons who are mandatory reporters of abuse or neglect shall sign a statement that shall be kept with their personnel records evidencing their recognition of their reporting obligations. Each State hospital shall not tolerate any mandatory reporter's failure to report abuse or neglect;</p>	<p>Findings:</p> <p>The obligation to report is part of the orientation training and is included in the ADs cited above. A review of several personnel records indicated that staff had signed the mandatory reporter forms indicating their understanding of their reporting responsibilities.</p> <p>The "NSH New Hire Monitoring Tool" is adequate to assess compliance with this requirement.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Increase the frequency of training and ensure, through testing, understanding of the material. [In conversation about this topic, I suggested that when a staff member fails the competency test, he/she receive tutoring on the problem subject area(s), not tutoring on how to answer the questions correctly), and then retake the entire test.] 2. Add a check box in the personnel database for "delayed reporting" and design a report query. Include "delayed reporting" under "charges" in the same database.

a.vi	mechanisms to inform individuals and their conservators how to identify and report suspected abuse or neglect;	<p>Findings:</p> <p>The handbook provided to individuals admitted under LPS status at the time of admission advises the individual that he/she has the right to be free from abuse, neglect or harm, including unnecessary or excessive physical restraint, isolation or medication. It further advises the individual to report these occurrences to a staff member and/or to the PRA. (The PRA's name and number are on the booklet and the individual is advised that he/she can call (toll-free) and request the assistance of the PRA.)</p> <p>The Notification of Rights flyer provided to Non-LPS Patients informs the individual of the right to be free from harm including abuse or neglect, and unnecessary or excessive medication, restraint, seclusion or protective or administrative isolation. It further notes the right of the individual to access the services of a PRA, but does not explain the function/role of a PRA.</p> <p>Neither of the rights notices described above advise the individual what actions constitute abuse and neglect nor do they note the right to be free of retaliation for reporting staff misconduct.</p> <p>Individuals sign a statement on admission that they have been advised of their rights.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop and use a sign off sheet where private conservators indicate that they have been advised of the rights of individuals in care and have received a copy of the "How to File a Complaint" procedures. 2. Add a cell on the Admission and Annual Audit form to indicate that the conservator had been made aware of the rights of individuals served and how to file a complaint.
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		<p>3. Augment the rights information given to individuals and conservators that includes information on how to recognize abuse and neglect, asserts the right to be free from retaliation for reporting and explains procedures for reporting retaliation. Use easy to understand language. Provide this information in the individual's language of choice.</p>
a.vii	posting in each living unit and day program site a brief and easily understood statement of individuals' rights, including information about how to pursue such rights and how to report violations of such rights;	<p>Findings: A patients' rights poster in Spanish and English was secured to the wall in each living unit I visited. It listed individuals' rights and the name, phone number (a toll-free number) and hours of operation of the Patient Rights Advocates Office.</p> <p>Recommendation: Continue current practice.</p>
a.viii	procedures for referring, as appropriate, allegations of abuse or neglect to law enforcement; and	<p>Findings: All allegations that constitute staff-to-individual abuse, neglect, or any criminal activity are to be reported and investigated by the hospital police. Special Order 112 directs the Special Investigator to report rape to the local legal authority.</p> <p>Recommendation: Continue current practice.</p>
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	<p>Findings: An AD entitled "Prohibition from Retaliation for Persons who Report Illegal Acts" is nearly ready for finalization. It directs staff to report retaliation (for good faith reporting of staff misconduct) to the Executive Director, the State Personnel Board or the EEO office.</p>

	incident in an appropriate or timely manner.	<p>Recommendations: Establish a protocol within the AD cited above whereby any entity receiving a complaint of retaliation will inform the Director of Human Resources who will keep a log of these complaints.</p>
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:	<p>Compliance: Partial.</p>
b.i	require investigations of all deaths, as well as allegations of abuse, neglect, serious injury, and theft. The investigations shall be conducted by qualified investigator(s) who have no reporting obligations to the program or elements of the facility associated with the allegation and have expertise in conducting investigations and working with persons with mental disorders;	<p>Findings: There is presently no system in place to ensure that all allegations of abuse, neglect, serious injury and theft are reported to one central location, logged in, and sent on to a Special Investigator for investigation. In addition, there is a need to define a procedure that insures that at the conclusion of an incident investigation, all material related to the investigation is collected into one case file. This would include documentation of all corrective actions (disciplinary and programmatic) recommended and implemented, so that eventually a system will be developed to track corrective measures and implementation. Presently programmatic corrective actions are documented on Special Incident Briefing forms and communications between the Program Director and the Hospital Clinical Administrator, while the work of the Special Investigator is documented in a separate file.</p> <p>The hospital has yet to determine a method for investigating serious injuries. Will this responsibility fall to the hospital police or to another body?</p> <p>The Special Investigator reports of death investigations reviewed were complete.</p>

		<p>The Mortality Review Committee is not current in reviewing deaths. There have been 12 deaths thus far in 2006; the Mortality Review Committee minutes reflect discussion of six. The minutes cite deficiencies in care, if any, and "opportunities to improve care." There is no information identifying what measures were actually taken to avoid the recurrence of these contributing factors.</p> <p>The Special Investigators working at NSH are qualified by training and experience to conduct police-type investigations.</p> <p>The training record for the course titled, "Special Investigator's Manual," attended by both Special Investigators, does not include the date, time, location or instructor.</p> <p>The following recommendations are consistent with expectations expressed in Special Order 227.05, which states that final reports for Headquarters Reportable Special Incidents shall "describe the incident and give a detailed account of immediate actions taken by staff, long-term actions taken by the program, and indicate whether system changes were made in the hospital or psychiatric program."</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Route all Special Incidents and Headquarters Reportable Special Incidents through the Standards Compliance office for tracking. 2. Give "read only" rights to this database to the Hospital Police and Special Investigators. The Hospital Police may maintain a separate data collection system if it chooses. 3. Write a procedure that ensures that all allegations related to abuse, neglect, serious injury or theft that are made to the PRA are put onto a Special Incident report form and entered into the Standards Compliance database. 4. Ensure the PRA is advised in writing of the determination
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		<p>at the close of an investigation, so that she can advise the complainant.</p> <ol style="list-style-type: none">5. Create a complete case file at the close of an investigation. This will include the Special Investigator's report, the Special Incident Report and all Special Incident Briefing forms and communication between the Program Director and the Hospital Clinical Administrator.6. Train Program Directors to complete Special Incident Briefing forms and communications with the Hospital Clinical Administrator at the close of an investigation, identifying all corrective in succinct, bulleted or numbered form. This will permit the collection of data without having to read through long narratives and pull out the corrective actions taken. It may be helpful to redesign the form so that it prompts the writer to complete it this way. Later, the facility will use these briefing forms as the source of information to create a database (or add to the existing data base) for tracking the effective implementation of the corrective actions.7. Identify the best way to compile information on corrective measures, so that it is useful for identifying patterns and which also facilitates checks on implementation, in anticipation of creation of a database.8. Ensure that in determining how best to investigate serious injuries, the input of medical professionals is sought when the circumstances of an injury require it. For example, in determining if an injury matches the description of how it occurred, in determining the age of bruises, in identifying any medical conditions that may impact on an individuals bruising or gait, etc.9. Change the format of the Mortality Review minutes to identify specifically actions taken to improve care. Consider the use of a table that identifies the case, the
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		<p>deficiency or "opportunity to improve care," the specific actions implemented and the date.</p> <p>10. Complete training rosters with essential information.</p>
b.ii	<p>ensure that only the State Hospital staff who have successfully completed competency-based training on the conduct of investigations be allowed to conduct investigations of allegations of petty theft and all other unusual incidents;</p>	<p>Findings: According to staff interviews, the Hospital Administrator, the Hospital Clinical Administrator and the Program Directors are among the staff who received 5-6 hours of investigation training. Since the first response to incidents lies with the Program Directors and they conduct a preliminary review of the circumstances of all Special Incidents, such training is essential for them.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure all staff persons reviewing incident reports and conducting investigations, particularly Program Directors, have had this investigation training. 2. Ensure the training has a test of competency.
b.iii	<p>investigations required by paragraph I.1.b.i, (above) provide for the safeguarding of evidence;</p>	<p>Findings: I have no evidence to suggest problems in the safeguarding of evidence.</p> <p>Recommendation: Continue current practice.</p>
b.iv	<p>investigations required by paragraph I.1.b.i, (above) require the development and implementation of standardized procedures and protocols for the conduct of investigations that are consistent with generally accepted professional standards. Such procedures and protocols shall require that:</p>	<p>Findings: The Special Investigator stated that investigations are conducted using a standard protocol authorized in the Long Term Care Services State Hospital Special Investigations Manual.</p> <p>Recommendation: Review the manual to identify revisions that may be necessary to bring it into compliance with the Enhancement Plan.</p>

<p>b.iv.1</p>	<p>investigations commence within 24 hours or sooner, if necessary, of the incident being reported</p>	<p>Findings: The review of 16 Special Investigations conducted since January 2006 indicates that they are often not begun in a timely manner. This monitor determined the date the investigation commenced using the first date mentioned in the report where an action was taken, e.g. the date of the first interview. In some instances it appears that the incident was not reported to the Special Investigator in a timely fashion. In other instances, there is no rationale provided in the investigation report for the substantial lapses in time between the filing of the incident report and the first actions by the Special Investigator reported in their investigation report.</p> <p>Of the 14 relevant investigation reports reviewed (two were determined not to meet the definition of abuse and not to require investigation), the investigation was initiated in a timely manner in five. In the remaining 9 reports, the time between the date the incident was reported and the beginning of the investigation ranged from 4 to 30 days. Six of the 9 showed delays of 10 days or more. Examples include:</p> <table border="1" data-bbox="1012 971 1898 1239"> <thead> <tr> <th>Individual's Initials</th> <th>Date Incident Reported</th> <th>Date Inv. Begun</th> </tr> </thead> <tbody> <tr> <td>ML</td> <td>4/21/06</td> <td>4/25/06</td> </tr> <tr> <td>DS</td> <td>1/08/06</td> <td>1/13/06</td> </tr> <tr> <td>LS</td> <td>1/20/06</td> <td>2/07/06</td> </tr> <tr> <td>DA</td> <td>5/19/06</td> <td>5/30/06</td> </tr> <tr> <td>HP</td> <td>4/6/06</td> <td>4/20/06</td> </tr> <tr> <td>LL</td> <td>3/18/06</td> <td>4/14/06</td> </tr> </tbody> </table> <p>A review of Special Investigator caseloads for the period January-June 2006 does not suggest a workload issue, unless other duties are interfering with investigation activities. During that period the highest workload for any month was 10 new cases for the two Special</p>	Individual's Initials	Date Incident Reported	Date Inv. Begun	ML	4/21/06	4/25/06	DS	1/08/06	1/13/06	LS	1/20/06	2/07/06	DA	5/19/06	5/30/06	HP	4/6/06	4/20/06	LL	3/18/06	4/14/06
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		<p>Investigators, and the total caseload during that period was 31 cases.</p> <p>The Investigation Compliance Monitoring Form states that in 28 of the 30 relevant cases the investigation commenced within 24 hours of the incident being reported. My findings do not agree.</p> <p>**This monitor was provided aggregate results of the Investigation Compliance Monitoring Forms for a sample of 31 cases for the period January to June 2006. There is a substantial difference, with compliance rated much higher in the material I was given than that provided in the self-assessment material in the binder. I have insufficient information to determine if the same sample of 31 was used for both. NSH should review this issue. The numbers I have used throughout this section in referencing the hospital's own monitoring are from the aggregate data I was provided.</p> <p>Recommendations:</p> <p>Track the date the Special Investigator receives notice of the incident (and put this date on the investigation report as well) and the date the first investigation steps are taken, to identify the source of the problem and take appropriate corrective actions.</p>															
<p>b.iv.2</p>	<p>investigations be completed within 30 business days of the incident being reported, except that investigations where material evidence is unavailable to the investigator, despite best efforts, may be completed within 5 business days of its availability;</p>	<p>Findings:</p> <p>In six of the Special Investigations reviewed, the investigation was completed beyond the 30-day limit. Often the delay in completing the investigation within the time limit was related to the late start of the investigation.</p> <table border="1" data-bbox="1010 1227 1900 1421"> <thead> <tr> <th>Initials of Individual</th> <th>Date Reported</th> <th>Date Inv. Closed</th> </tr> </thead> <tbody> <tr> <td>JA and AH</td> <td>3/24/06</td> <td>5/10/06</td> </tr> <tr> <td>LL</td> <td>4/4/06</td> <td>5/16/06</td> </tr> <tr> <td>RM (death)</td> <td>2/5/06</td> <td>4/25/06</td> </tr> <tr> <td>KH</td> <td>2/15/06</td> <td>4/21/06</td> </tr> </tbody> </table>	Initials of Individual	Date Reported	Date Inv. Closed	JA and AH	3/24/06	5/10/06	LL	4/4/06	5/16/06	RM (death)	2/5/06	4/25/06	KH	2/15/06	4/21/06
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RC	5/19/06	6/28/06						
LL	3/18/06	5/3/06						
b.iv.3	<p data-bbox="296 833 982 1045">each investigation result in a written report, including a summary of the investigation, findings and, as appropriate, recommendations for corrective action. The report's contents shall be sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly and separately:</p>	<p data-bbox="1012 833 1896 1122">Findings: Each of the 14 relevant investigations was summarized in a written report that included findings. The Special Investigations Report reviewed contained recommendations only for referral to Human Resources for appropriate disciplinary action, if indicated. In an interview, a Special Investigator stated it was not part of his duties to make recommendations. Documentation of the programmatic response to an incident follows a separate track.</p> <p data-bbox="1012 1166 1245 1230">Recommendations: Same as b.i.</p>						
b.iv.3(i)	<p data-bbox="348 1276 884 1308">each allegation of wrongdoing investigated;</p>	<p data-bbox="1012 1276 1881 1416">Findings: Each Special Investigation identified the violation, citing the relevant law, and indicated the type of allegation, e.g. verbal abuse, physical abuse.</p>						

		<p>Recommendations: Continue current practice.</p>
b.iv.3(ii)	the name(s) of all witnesses;	<p>Findings: One cannot be sure that all witnesses are identified, in some measure because of the time lag between the actual incident and the initiation of a Special Investigation. In only one instance in the 14 investigations reviewed did the investigator look beyond the names of persons identified by victim or the alleged perpetrator as witnesses to identify other possible witnesses.</p> <p>The Investigation Compliance Monitoring Form states that the investigation reports of 28 of the 29 relevant investigations set forth the names of all witnesses. My findings are not in agreement.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. List witnesses (name and title/position) at the beginning of the investigation report, where the allegation, alleged perpetrator and victim are identified. 2. Consider during supervisory review of investigations whether the report indicates any efforts/questioning to identify other possible witnesses, including staff on duty and individuals served.
b.iv.3(iii)	the name(s) of all alleged victims and perpetrators;	<p>Findings: All Special Investigations reviewed clearly identified alleged victims and perpetrators.</p> <p>Recommendation: Continue current practice.</p>

b.iv.3(iv)	the names of all persons interviewed during the investigation;	<p>Findings: The names of persons interviewed are identified in separate paragraphs as the investigator states the content of their interviews.</p> <p>Recommendation: Include a list of persons interviewed (with title/position) at the beginning of the investigation with the other identifying information.</p>
b.iv.3(v)	a summary of each interview;	<p>Findings: A short summary of each interview was included in each investigation report. In some instances, it was impossible to tell whether information was in response to a question, the form of the question or was offered independently.</p> <p>Recommendations: Provide a fuller interview summary, indicating questions asked and the response.</p>
b.iv.3(vi)	a list of all documents reviewed during the investigation;	<p>Findings: None of the investigation reports reviewed listed documents reviewed by investigators. In some cases, documents were included in the investigation file and one would assume that they had been reviewed. In other instances, the report referenced a document, for example, nurse's note, but a copy of the referenced material was not in the investigation file.</p> <p>The Investigation Compliance Monitoring Form indicates that documents reviewed were explicitly and separately listed in 26 of the 30 investigation reports. My findings are not in agreement.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Photocopy the relevant portions of all documents reviewed

		<p>and include these in the investigation file.</p> <p>2. List all documents reviewed with the other identifying information at the beginning of the report.</p>
b.iv.3(vii)	<p>all sources of evidence considered, including previous investigations and their results, involving the alleged victim(s) and perpetrator(s);</p>	<p>Findings: The Special Investigator interviewed stated that he can access information concerning the past incident history of an individual served and any staff member by searching under the person's last name. He cannot run a report, however, but needs to scroll through all entries and take notes on the number and type of incidents. Several investigations reviewed indicated that an individual served had a history of making allegations against staff, but there was no source cited for this information. None of the investigations reviewed contained incident history on an alleged staff perpetrator or specific information on the incident history of the individual served.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Document in the investigation that the incident history of the victim and the alleged perpetrator was reviewed and indicate the findings from this search. 2. See also the recommendations in b.i, which would facilitate the retrieval of this historical information.
b.iv.3(viii)	<p>the investigator's findings, including findings related to the substantiation of the allegations as well as findings about staff's adherence to programmatic requirements; and</p>	<p>Findings: Not all investigations reviewed contained a clear synopsis of relevant findings that lead the investigator to his determination of substantiated or unfounded.</p> <p>For example, in an incident reported on 4/4/06 in which LL alleged his arms and wrists were twisted when he was put into restraints, the restraints were too tight, and he was not allowed to urinate when in restraint, there is no indication in the investigation file that the</p>

		<p>Special Investigator reviewed the restraint documentation. Nonetheless, the Special Investigator determined the allegation was unfounded.</p> <p>In another incident, KH alleged in February that she was slammed into the floor and broke a tooth while she was being taken to Time Out. The investigation report makes no mention of trying to determine whether, in fact, KH had broken a tooth. (She had refused medical evaluation at the time of the incident.) The same investigation report included an IDT note that states that KH was assaulting her roommate and was on 1:1 status. There is no mention in the investigation report of consideration of the actions or lack of action on the part of the assigned staff member to prevent the assault.</p> <p>The general lack of attention in the Special Investigator's reports to staff's adherence to programmatic requirements stems, in good measure, from the division of investigation responsibilities between the Special Investigator and the Program Director.</p> <p>Recommendations: Begin development of an integrated incident investigation system as described in b.i.</p>
a.iv.3(ix)	the investigator's reasons for his/her conclusions, including a summary indicating how potentially conflicting evidence was reconciled; and	<p>Findings: In several investigations reviewed, there was no discussion of conflicting evidence, other than to assert that staff were telling the truth, and the individual's account was erroneous.</p> <p>For example, in the incident reported on January 8, 2006 by DS in which she alleged that staff threatened to "bash her head in if she hurt anyone else," the investigator cited the positive work history of the employee involved, but made no assessment of DS's credibility based on past performance and concluded, "the likelihood of DS's</p>

		<p>allegation having any validity is nil.”</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Include in investigation reports a rationale for determinations that expressly weighs potentially conflicting evidence. 2. Conclude that an allegation is “undetermined” when the investigator cannot produce a convincing rationale for a determination of substantiated or unfounded.
b.iv.4	<p>staff supervising investigations review the written report, together with any other relevant documentation, to ensure that the investigation is thorough and complete and that the report is accurate, complete, and coherent. Any deficiencies or areas of further inquiry in the investigation and/or report shall be addressed promptly. As necessary, staff responsible for investigations shall be provided with additional training and/or technical assistance to ensure the completion of investigations and investigation reports consistent with generally accepted professional standards of care.</p>	<p>Findings:</p> <p>All of the investigations reviewed were signed by the Chief of the Hospital Police or by his designee. I saw no indication in any of the investigation reports that the supervisor identified deficiencies in the investigations.</p> <p>Recommendations:</p> <p>Review again the requirements of the Enhancement Plan with a more critical eye to compliance.</p>
c	<p>Each State Hospital shall ensure that whenever disciplinary or programmatic action is necessary to correct a situation or prevent reoccurrence, each State hospital shall implement such action promptly and thoroughly, and track and document such actions and the corresponding outcomes.</p>	<p>Findings:</p> <p>NSH has a Personnel database that tracks disciplinary actions. Programmatic changes in response to incidents are indicated on the SIR and on the Special Incident Briefing forms and in communications between the Program Director and the Hospital Clinical Administrator. Presently there is no mechanism for compiling and tracking corrective actions and outcomes.</p> <p>I reviewed the Personnel records of six staff members determined to have engaged in misconduct. Two staff members were terminated for bringing in contraband and the other four received two-step pay</p>

		<p>reductions for 12 months.</p> <p>Compliance: Substantial.</p> <p>Recommendation: Continue current practice.</p>
d	Each State hospital shall have a system to allow the tracking and trending of investigation results. Trends shall be tracked by at least the following categories:	<p>Compliance: Partial.</p>
d.i	type of incident;	<p>Findings: While NSH has the capacity to track investigations by type of incident, there exists a more fundamental problem that calls into the question the integrity of the entire abuse/neglect database and consequently any trend data that may be derived from it. A comparison of the 10 abuse investigations I reviewed with a report generated from the data base of all abuse allegations from January - June 2006 reveals that five of the 10 investigations reviewed did not appear in the report.</p> <p>Until the abuse and neglect database accurately reflects the investigations conducted, any reports that have been generated are not useful and are not discussed in this report.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Determine the source of the problem. If the problem is that Standards Compliance is not receiving all abuse SIR reports and investigations, designate Standards Compliance as the first stop for the Serious Incident Report (This is not intended to discourage the circulation of copies to persons who need to know quickly or any other forms of communicating that the incident has occurred that the

		<p>hospital may determine necessary) and assign Standards Compliance the responsibility for the maintenance of the hospital data base for Special Incidents, as recommended in b.i..</p> <p>2. When the problem is corrected, begin to run reports on closed cases on the variables which the database can presently track. These include type of incident, location, date and time, alleged victim and alleged perpetrator.</p>
d.ii	staff involved and staff present;	<p>Findings: The hospital has the capacity to generate reports on staff persons alleged to be perpetrators in a Special Incident. It cannot identify staff otherwise involved and present.</p> <p>Recommendation: Continue to work on the capacity to generate useful reports on a regular basis.</p>
d.iii	individuals directly and indirectly involved;	<p>Findings: The hospital does not have the capacity to generate reports on the individuals who were involved in Special Incidents, unless identified as the alleged victim or alleged perpetrator.</p> <p>Recommendation: Continue to work on the capacity to produce useful reports on a regular basis.</p>
d.iv	location of incident;	<p>Findings: The hospital has the capacity to generate reports on the location of Special Incidents.</p> <p>Recommendation: Continue current practice.</p>

d.v	date and time of incident;	<p>Findings: The facility has the capacity to generate reports on the date and time of Special Incidents.</p> <p>Recommendation: Continue current practice.</p>
d.vi	cause(s) of incident; and	<p>Findings: The facility database does not identify the cause of the incident.</p> <p>Recommendation: Identify a list of common causes of incidents to form the basis of a drop-down menu. The terminology used should be determined in collaboration with the hospital police and be consistent with the Aggression Reduction Training.</p>
d.vii	outcome of investigation.	<p>Findings: The hospital can generate reports by outcome of the investigation, i.e. substantiated, not substantiated, etc.</p> <p>Recommendation: Continue current practice.</p>
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	<p>Findings: The hospital keeps a fingerprint log that tracks the date the fingerprints were sent out, the date the report was returned and whether the prints were cleared for hire or disapproved.</p> <p>I have no information on the supervision of volunteers.</p> <p>The New Hiring Monitoring Tool adequately addresses this issue.</p>

	facility shall ensure that a staff person or volunteer may not interact with individuals at each State hospital in instances where the investigation indicates that the staff person or volunteer may pose a risk of harm to such individuals.	<p>Compliance: Substantial (based on limited information).</p> <p>Recommendation: None.</p>
2	Performance Improvement	
	Each State hospital shall develop, revise as appropriate, and implement performance improvement mechanisms that enable it to comply fully with this Plan, to detect timely and adequately problems with the provision of protections, treatment, rehabilitation, services and supports, and to ensure that appropriate corrective steps are implemented. Each State hospital shall establish a risk management process to improve the identification of individuals at risk and the provision of timely interventions and other corrective actions commensurate with the level of risk. The performance improvement mechanisms shall be consistent with generally accepted professional standards of care and shall include:	<p>Methodology: Interviewed Standards Compliance Director. Interviewed Hospital Administrator. Interviewed Hospital Clinical Administrator Interviewed several individuals served. Review of Key Indicator data.</p>
a	Mechanisms for the proper and timely identification of high-risk situations of an immediate nature as well as long-term systemic problems. These mechanisms shall include, but not be limited to:	<p>Compliance: Partial.</p>
a.i	data collection tools and centralized databases to capture and provide information on various categories of high-risk situations;	<p>Findings: The hospital has in place mechanisms to collect some of the data required and is actively identifying the sources of other information and the best methods for collecting it.</p> <p>Recommendation: Be mindful that the purpose of the collection of this information is to identify persons and situations that place individuals at risk of harm. Communicate the name of persons who reach Key indicator triggers to the units and to the Hospital Clinical Director so that they can take</p>

		action.
a.ii	establishment of triggers and thresholds that address different levels of risk, as set forth in Appendix A; and	<p>Findings: NSH began the process of identifying key indicators related to issues such as falls, escapes, suicides, STAT and PRN meds, seclusion and restraint, several medical conditions, seizure management, hospitalizations, deaths, 1:1 observation, medication errors, ECT, falls, homicide, combined pharmacotherapy, weight, abuse and neglect, aggression toward self and aggression toward others. Data entry began in April 2006. Of the 18 broad categories, there is at least some data for parts or all of 16 categories. Medical data is the most difficult to capture.</p> <p>The facility has created a crosswalk between existing policies and the Key Indicators. It has not been determined whether any of the policies specifically address what is to occur when an individual reaches a particular "high risk" indicator.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Review the existing ADs related to the Key Indicators. Revise these as necessary to reflect the appropriate additional attention to be provided to an individual who has reached a trigger. 2. Establish a system whereby the unit is notified when an individual has reached trigger criteria and the unit responds in writing with corrective actions and target and/or completion date. 3. Determine the best way to augment the present database to include corrective measures and dates of completion. May want to consider a drop down menu for standard responses (as identified in the ADs), using some of the same actions presently listed in the Special Incident data

		<p>base (under Actions and Clinical Response) and adding additional ones, as well as space for a narrative for more individualized responses.</p> <p>4. See introduction.</p>
a.iii	<p>identification of systemic trends and patterns of high risk situations.</p>	<p>Findings: Based on the evidence of under-reporting, the problems with the abuse and neglect database, and the absence of information on programmatic changes made in response to Special Incidents, I believe the hospital is not able to identify high-risk situations.</p> <p>Recommendations: See recommendations suggested in earlier sections of this report.</p>
b	<p>Mechanisms for timely interventions and other corrective actions by teams and disciplines to prevent or minimize risk of harm to individuals. These mechanisms shall include, but not be limited to:</p>	<p>Compliance: Partial.</p>
b.i	<p>a hierarchy of interventions by clinical teams that correspond to triggers and thresholds;</p>	<p>Findings: As noted above, the facility has not yet identified specific interventions to correspond to the key indicators. Thus, there is no way to know if all persons who have reached a trigger are provided at least the same minimum response from the team caring for them.</p> <p>Recommendations: Same as I.2. a.ii.</p>
b.ii	<p>timely corrective actions by teams and/or disciplines to address systemic trends and patterns;</p>	<p>Findings: Since there is at most three months data available on any of the QI, it is early to identify trends. One could identify some patterns. For example, there are a total of six incidents of aggression to self in the three-month period April-June. Are any of the six incidents related to the same person? Same circumstance? Same method of self-injury?</p>

		<p>This kind of analysis is not yet being done.</p> <p>This monitor has serious questions related to aggression between individuals data; it is simply incompatible with what individuals reported to me and quite low for a population with the characteristics of NSH.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Review individuals' records, logs, and other documentation looking for under-reporting. 2. Establish a system of unannounced, frequent visits on the units by administrators. 3. Interview individuals served using a standard interview format, review the information gathered for patterns, and follow-up on issues raised.
b.iii	formalized systems for the notification of teams and needed disciplines to support appropriate interventions and other corrective actions;	<p>Findings:</p> <p>There is presently no mechanism in place to notify units and disciplines that an individual has reached a trigger and action is required.</p> <p>Recommendations:</p> <p>Same as in I.2.a.ii.</p>
b.iv	formalized systems for feedback from teams and disciplines to the standards compliance department regarding completed actions; and	<p>Findings:</p> <p>The hospital does not presently have the capacity to receive, record and analyze feedback from the units regarded completed actions taken in response to an individual meeting trigger criterion.</p> <p>Recommendations:</p> <p>Same as above.</p>
b.v	monitoring and oversight systems to support timely implementation of interventions and corrective actions and appropriate follow up.	<p>Findings:</p> <p>As above, the hospital has not yet developed the capacity to monitor the implementation of corrective measures.</p>

		<p>Recommendations: Same as I.2.a.ii.</p>
c	Utilize, on an ongoing basis, appropriate performance improvement mechanisms to assess and address the facility's compliance with its identified service goals.	<p>Findings: The self-assessment undertaken earlier was very helpful in identifying work that needs to be done. Throughout this report, the Court Monitoring Team has identified effective monitoring tools and has made recommendations to improve others or to review the subject area more critically.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Identify how the self-assessment and the accompanying tools are to be used moving forward. 2. Make any changes to the instruments as needed. 3. Broaden the reviews to include reviewers (staff) who are not directly responsible for the issue under review.
3	Environmental Conditions	
	Each State hospital shall develop and implement a system to review regularly all units and areas of the hospital to which individuals being served have access to identify any potential environmental safety hazards and to develop and implement a plan to remedy any identified issues, consistent with generally accepted professional standards of care. Such a system shall require that:	<p>Methodology: Conducted environmental inspections of six units. Interviewed individuals served about environmental conditions and attention to personal care needs. Reviewed the individual environmental reports for T-4 and T-7 from June 05 forward.</p>
a	Potential suicide hazards are identified and prioritized for systematic corrective action, and such action is implemented on a priority basis as promptly as feasible;	<p>Findings: No environmental reports reviewed revealed any suicide hazards. My environmental reviews revealed no suicide hazards. Environmental modifications include: Wardrobes have piano hinges, there are no bars in wardrobes. Shower heads are flush, plumbing under sinks is</p>

		<p>enclosed, and there is no gap between the wall and grab bars.</p> <p>Compliance: Substantial.</p> <p>Recommendations: Continue current practice.</p>
b	<p>All areas of the hospital that are occupied by individuals being served have adequate temperature control and deviations shall be promptly corrected;</p>	<p>Findings: During extremely hot weather during the Court Monitoring Team's tour, one unit visited did not have a thermometer with which to monitor temperature. The temperature in one bedroom on T-4, with the bedroom door open, was 84 degrees. Individuals sleep with bedroom doors closed. All units visited that did not have air conditioning, had large fans in the halls. All units visited were supplying individuals with ice and extra fluids. Extra fluids were served at meals.</p> <p>Abbreviated reviews of environment are supposed to be done each month and a thorough review done annually. My review of the environmental reviews done on T-4 and T-7 indicate that the comprehensive review was completed in January 2006, but the most recent monthly review prior to that time was completed in May 2005. The reviews pay insufficient attention to the personal care needs of individuals. In several units visited, there was an insufficient supply of toothbrushes or no toothbrushes at all. Many beds lacked a full set of linens and some had no linens at all. Some mattresses and pillows were ripped. Tobacco littered bedroom floors, nightstands and was in bedding. One nightstand had several pieces of rotten fruit in it.</p> <p>Compliance: Partial.</p>

		<p>Recommendations:</p> <ol style="list-style-type: none"> 1. Supply each unit with a digital thermometer and collect information on common area and bedroom temperatures when the outdoor temperature reaches health-endangering range. Hospital to determine that specific temperature. 2. Specify and circulate instructions to staff on how to respond to extremely warm temperatures. 3. Determine circumstances under which standard procedures may be waived in extreme situations. 4. Identify criteria for determining individuals particularly at high risk during extremely hot weather and appropriate interventions. 5. Enforce procedures for the unannounced review of environmental conditions monthly. 6. Establish a short check-list to ensure the availability of necessary supplies and acceptable unit conditions at the change of shift.
<p>c</p>	<p>Each State hospital reviews, revises, as appropriate, and implements procedures and practices so that individuals who are incontinent are assisted to change in a timely manner;</p>	<p>Findings: According to staff interviewed, individuals who are incontinent are checked and changed every 2-3 hours, if they are not able to take care of their own needs. Others are reminded to use the bathroom and are asked to change if there is an accident. One woman who needs assistance to get to the bathroom explained in an interview that staff is responsive when she calls for assistance.</p> <p>Compliance: Partial (based on limited information).</p> <p>Recommendation: Maintain a list of individuals with problems with incontinence on each unit with check and change information, so that for those individuals</p>

		<p>where bladder control might be regained, there is data to determine if progress is being made.</p>
d	<p>Each State hospital thoroughly reviews and revises, as appropriate, its policy and practice regarding sexual contact among individuals served at the hospital. Each State hospital shall establish clear guidelines regarding staff response to reports of sexual contact and monitor staff response to incidents. Each State hospital documents comprehensively therapeutic interventions in the individual's charts in response to instances of sexual contact; and</p>	<p>Findings: NSH's AD 774 "Sexuality and the Safety of Individuals" became effective February 28, 2006. It addresses the assessment of sexual issues upon admission and identifies "appropriate protective/preventative measures to prevent sexual exploitation of vulnerable individuals." It permits, under most circumstances, expressions of caring that do not involve intimate body parts. Unprotected sex, sex that is physically or psychologically injurious to either partner, non-consensual sexual activity, sexual behavior to pay a debt or solicit a favor and publicly erotically stimulating, teasing or threatening sexual behaviors require staff intervention. Condoms are available at the nurses' station for all individuals for health-related purposes and to avoid pregnancy.</p> <p>Review of the record of one very sexually active woman on T-4 indicated that the clinical team was responding appropriately to her. The medical doctor was following her claims of pregnancy (she has had several during her time at NSH). Staff was keeping watch on her interactions (but not imposing unreasonable restrictions) with males, although she claims to be able to circumvent their surveillance and have intercourse.</p> <p>Individuals interviewed said they believe they are not supposed to have sex with others. Two men specifically noted the availability of condoms at the nurses' station, and I found condoms in one nightstand during an environmental review.</p> <p>Administrators stated they are grappling with the question of providing private space for consenting couples.</p>

		<p>Present monitoring tool adequately addresses the requirements of the EP.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Continue honest discussion on how to accommodate consenting couples, including in the dialogue individuals served who are part of the Cooperating Council. 2. Consider a mall "training" option for consenting couples on accommodations for intimate relationships, how to say "no" to specific act, etc.
e	<p>Each State hospital develops and implements clear guidelines stating the circumstances under which it is appropriate to utilize staff that is not trained to provide mental health services in addressing incidents involving individuals. Each State hospital ensures that persons who are likely to intervene in incidents are properly trained to work with individuals with mental health concerns.</p>	<p>Findings: All non level-of-care employees who plan to provide mall services will receive training in Preventive Management of Assaultive Behavior, CPR, First Aid, Recovery Model, By Choice program.</p> <p>Compliance: Partial Compliance, since this training has not yet been implemented.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Add training providing basic information on mental illness. 2. Create a separate personnel category for non-level of care staff who provides mall services in order to be able to track their training records. 3. Ensure critical trainings have a test of competency.
J	First Amendment and Due Process	
		<p>Summary of Progress:</p> <ol style="list-style-type: none"> 1. The hospital has policies and procedures that identify rights related to free speech, include policies and procedures protecting the privacy of mail, telephone calls,

		<p>and visits and calls to the PRA and to attorneys.</p> <ol style="list-style-type: none"> 2. These rights are listed in Patients Rights information provided on admission and annually.
	<p>Each State hospital unconditionally permits individuals to exercise their constitutional rights of free speech, including the right to petition the government for redress of grievances without State monitoring, and provides them due process.</p>	<p>Methodology: Interviewed individuals served and staff members on various units. Reviewed Patients' Rights documents.</p> <p>Findings: The Patients' Rights materials clearly articulate the right to free speech, including due process arrangements for appeals of rights violations. I heard several times from individuals served that mail has been opened when they were not present (and sometimes money is missing), mail is held on the units for days and not distributed and then sometimes lost, and confidential correspondence to the PRA is not delivered to her.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Include on the Environmental Monitoring form an item to look for mail on the unit, with the goal of determining if mail is not being distributed in a timely fashion or not leaving the unit in a timely fashion. 2. Include on the individual interview form questions about the mail, communication with the PRA, and privacy during phone calls.
<p>MES 082606</p>		