REPORT 6

NAPA STATE HOSPITAL

January 26-30, 2009

THE HUMAN POTENTIAL CONSULTING GROUP
ALEXANDRIA, VIRGINIA

NOTE

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

The Court Monitor is not in any way responsible for the services provided at Napa State Hospital or for outcomes of these services for any individual resident at the facility during or following the tenure of the Enhancement Plan. Neither the Court Monitor nor his experts are in any way responsible for the administration of the facility, the day-to-day clinical management of the individuals served, clinical outcomes for any individual, staffing, outcomes for staff providing services at the facility or any other aspect of the operations of Napa State Hospital. All decisions regarding the facility, its clinical and administrative operations and the individuals it serves are made independently from the Court Monitor.

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Acronyms used in Court Monitor reports:

AA	Alcoholics Anonymous
ACT	Administrative Clinical Team
AD	Administrative Directive
ADCAP	Audit-Driven Corrective Action Plan
ADR	Adverse drug reaction
AIMS	Abnormal Involuntary Movement Scale
A/N	Abuse/Neglect
ASH	Atascadero State Hospital
ASI	Addiction Severity Index
A-WRP	Admission Wellness and Recovery Plan
BCC	Behavioral Consultation Committee
BMI	Body Mass Index
CA	Clinical Administrator
CAC	Cooperative Advisory Council
CASAS	Comprehensive Adult Student Assessment Systems
CCA	Clinical Chart Auditing
CDPH	California Department of Public Health
CET	Consistent Enduring Team
CEU	Continuing Education Units
CHF	Congestive heart failure
CIS	Clinical Information System
CIPRTA	Comprehensive Integrated Physical Rehabilitation Therapy Assessment
CM	Court Monitor
CON	Clinical Oversight Nurse
COPD	Chronic Obstructive Pulmonary Disease
COT	Community Outpatient Treatment
C-PAS	Central Psychological Assessment Services
CPR	Cardio-pulmonary resuscitation
CRG	Council Representative Group
CRIPA	Civil Rights of Institutionalized Persons Act

CV	Curriculum vitae (i.e. resumé)
DBT	Dialectical behavioral therapy
DCAT	Developmental and Cognitive Abilities Team
DMH	Department of Mental Health
DOJ	Department of Justice
DPH	Department of Public Health
DPS	Department of Police Services
DSM-IV-TR	Diagnostic and Statistical Manual of Mental Disorders—Fourth Edition (Text Revision)
DTR	Dietetic Technician, Registered
DUE	Drug Utilization Evaluation
EAP	Employee Assistance Program
EKG	Electrocardiogram
EMS	Emergency Medical Service
EP	Enhancement Plan
EPPI	Enhancement Plan Performance Improvement
EPS	Extrapyramidal symptoms
ETRC	Enhanced Trigger Review Committee
FRP	Forensic Review Panel
FSP	Family Services Program
FSSW	Family Services Social Worker
FTE	Full time employee, full time equivalent
GAF	Global Assessment of Functioning [Score]
H&P	History and Physical [Examination]
HAC	Hospital Advisory Council
HAI	Hospital-associated infection
HAR	Hospital administrative resident
HIMD	Health Information Management Department
HIV	Human Immunodeficiency Virus
HSS	Health Services Specialist
IA-RTS	Integrated Assessment—Rehabilitation Therapy Section
IC	Infection Control
ICA	Intensive Case Analysis

ICF	Intermediate Care Facility
IDN	Inter-Disciplinary Note
IMRC	Incident Management Review Committee
INPOP	Individualized Nursing Physical/Occupational Plan
IPA	Integrated Assessment: Psychology section
IRC	Incident Review Committee
IT	Information Technology
LTBI	Latent tuberculosis infection
LVN	Licensed Vocational Nurse
MAPP	My Activity and Participation Plan
MAR	Medication Administration Record
MIRC	Mortality Interdisciplinary Review Committee
MMSE	Mini Mental Status Examination
MNT	Medical Nutrition Training
MOD	Medical Officer of the Day
MPPN	Monthly Physician's Progress Note
MRMC	Medical Risk Management Committee
MRSA	Methicillin-resistant Staphylococcus aureus
MSH	Metropolitan State Hospital
MTR	Medication and Treatment Record
MVR	Medication Variance Report
NA	Narcotics Anonymous
N/A	Not applicable
NAC	North Activity Center
NAMI	National Alliance on Mental Illness
NCHPPD	Nursing care hours per patient day
NCMT	Nutrition Care Monitoring Tool
NCS	Neuropsychological Consultation Service
NGA	New generation antipsychotic
NOC	Nocturnal shift
NOS	Not otherwise specified
NP	Nursing Policy; Nurse Practitioner

NPO	Nulla per Os (nothing by mouth)
NRT	Narrative Restructuring Therapy
NSH	Napa State Hospital
NST	Nutritional Status Type
OA	Office Assistant
OSI	Office of Special Investigations
OT	Occupational Therapy/Therapist
P&P	Policy and Procedure/Policies and Procedures
P&T	Pharmacy and Therapeutics [Committee]
PAC	Psychopharmacology Advisory Committee
PBS	Positive Behavior Support
PC	Penal Code
PCP	Primary Care Physician
PFA	Psychology Focused Assessment
PHN	Public health nurse
PIO	Public Information Officer
PMAB	Prevention and Management of Assaultive Behavior
PMHNP	Psychiatric Mental Health Nurse Practitioner
PMOD	Psychiatric Medical Officer of the Day
POS	Physician Order System
POST	Physical, Occupational, and Speech/Language Pathology
PPD	Purified Protein Derivative (skin test for tuberculosis)
PPN	Physician's Progress Note
PRA	Patient Rights Advocate
PRC	Program Review Committee
PRN	Pro re nata (as needed)
PSH	Patton State Hospital
PSR	Psychosocial Rehabilitation
PSS	Psychology Specialty Services
PSSC	Psychology Specialty Services Committee
PT	• Physical Therapy/Therapist (in Sections D.4 and F.4) • Psychiatric Technician (in Sections D.3 and F.3)

PTA	Psychiatric Technician Assistant
R&R	Rule(s) and Regulation(s)
RD	Registered Dietician
RIAT	Rehabilitation Integrated Assessment Team
RMS	Record Management System; Recovery Mall Services
RN	Registered nurse
RNA	Restorative Nursing Assistant
R/O	Rule out
S&R	Seclusion and Restraint
SA	Substance abuse
SAMHSA	Substance Abuse and Mental Health Services Administration
SCD	Standards Compliance Department
SLP	Speech Language Pathology/Pathologist
SNF	Skilled Nursing Facility
SO	Special Order
S/P	Status post
S/R	Seclusion/restraint
SRA	Suicide Risk Assessment
SSI	Supervising Special Investigator
TB	Tuberculosis
TD	Tardive dyskinesia
TSI	Therapeutic Strategies and Interventions
TST	Tuberculin skin test
WaRMSS	Wellness and Recovery Model Support System
WRAP	Wellness and Recovery Action Plan
WRP	Wellness and Recovery Plan
WRPC	Wellness and Recovery Planning Conference
WRPT	Wellness and Recovery Planning Team

Introduction

A. Background Information

The evaluation team, consisting of Court Monitor (Mohamed El-Sabaawi, MD) and four expert consultants (Vicki Lund, PhD, MSN, ARNP; Ramasamy Manikam, PhD; Elizabeth Chura, MSRN; and Monica Jackman, OTR/L) visited Napa State Hospital (NSH) from January 26 to 30, 2009 to evaluate the facility's progress regarding compliance with the Enhancement Plan (EP). The evaluators' objective was to develop a detailed assessment of the status of compliance with all action steps of the EP.

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

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

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

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

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

B. Methodology

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

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

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

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

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

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

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

C. Statistical Reporting

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

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

As needed, this monitor re-characterized the facility's data in this report, usually by naming the process or group that was audited/monitored and providing a summary of the relevant monitoring indicators and corresponding compliance rates.

D. Findings

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

1. Key Indicator Data

The following points are observations made upon review of key indicator data prior to the tour:

a. There was a marked increase in aggression towards others in December 2008. For example, peer-to-peer aggression resulting in major injury had averaged five incidents per month for the 12 months prior to December 2008, then there were 32 incidents in December 2008 alone. (The data was subsequently determined to be in error; the facility corrected the data during the tour.)

b. Similarly, there was a sharp increase in allegations of abuse/neglect. For the 12 months leading up to December 2008 (December 2007 through November 2008), there were on average seven allegations per month. There were 27 allegations in December 2008. (The data was subsequently determined to be in error; the facility corrected the data during the tour.)
c. Also, the incidents of escape/walkaway rose sharply in December, from a trailing-twelve-month average of 1.3 incidents per month to 14 incidents in December. (The data was subsequently determined to be in error; the facility corrected the data during the tour.)
d. There was a notable spike in falls in July 2008; the count has since declined.
e. In the last two months of 2008, there was a steep rise in the number of individuals whose weight had risen more than 10% over the past six months.
f. Medication variances in general tend to be lower at NSH than at two of its peer facilities on a fairly consistent basis. However, it is impossible to determine whether this is due to superior practices or difference in data collection.
g. Medication variances due to documentation errors continued to show significant month-to-month variability.
h. There was a jump in diagnoses of aspiration pneumonia (three each in October and November to eight in December). The facility has never reported more than five cases and usually averages two.
i. There has been a 21% increase in Hepatitis C diagnoses between October and December (224 diagnoses to 271).
j. MRSA diagnoses climbed from 35 to 47 in November, and the facility reports that one new diagnosis of MRSA was made. The implication seems to be that 11 individuals were admitted with existing MRSA infection.
k. There were no unexpected deaths during the period and two expected deaths.

The court monitor's team used common sense and curiosity—not any complex or unusually sophisticated approach—to identify several of the observations listed above as problematic or worthy of further inquiry. The team raised questions on site about these trends and asked for explanation of the trend or for resolution of questions that arose when key indicator data was contradicted by data presented by the facility during the tour. As readers of this report will learn, in a number of instances this data was subsequently determined to be inaccurate. The time is well past for the facilities to generate and distribute data that outsiders can identify as potentially questionable. The significance and application of the key indicator data has been discussed repeatedly and at length in previous reports and should be reviewed again by those who are still unclear.

2. Monitoring, mentoring and self-evaluation

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

a. NSH has refined most of the structures and processes that are required for implementation of the EP. The facility has made progress in reviewing the self-assessment data and this monitor's findings to ensure consistent feedback to the WRPTs and disciplines, identify trends and patterns and implement targeted corrective actions. The facility has to make further progress in utilizing these processes to improve the quality of care to its individuals.
b. Regarding the process of self-assessment, this monitor has requested the following:
   i. For data demonstrating compliance rates of less than 90% with the main indicators, all facilities should provide the following information:
      - Comparison of the mean compliance rates for the main indicator in the entire review period from the current to the previous periods;
      - Comparison of the mean compliance rates for the main indicators and sub-indicators (if they were presented) from the last month of the current review period to the last month of the previous review period;
      - A review of the facility's assessment of barriers towards compliance; and
      - A plan of correction.
   ii. For data demonstrating compliance rates of 90% or more with the main indicators, all facilities should provide comparison of mean compliance rates with the main indicators for the entire review period from the current to the previous periods.
   iii. For data derived from the DMH standardized auditing tools, all facilities should present their data using the same configuration of indicators/sub-indicators for each corresponding requirement of the EP.
c. NSH has presented data comparing the compliance rates from this review period to the previous period and from the month of the current review period to the last month of the last review period as requested. In addition, the facility presented information on the barriers towards compliance, as indicated and plans of correction, as applicable.
d. With few exceptions (e.g. the admission medical assessment), the DMH has standardized the auditing tools required for self-monitoring across state facilities. NSH has utilized these tools for all applicable sections of the EP.
e. The DMH currently has sufficient monitoring tools to ensure meaningful self-assessment of EP implementation. With few exceptions, there appears to be no need to develop new monitoring tools this stage. However, the existing monitoring tools should be viewed as dynamic instruments that continually respond to realities of clinical practice and updates in current standards of care.
f. All facilities must ensure that discipline chiefs and senior executives review the monitoring data on a monthly basis at the facility level and that results of these reviews are used to enhance service delivery within each facility. As mentioned in earlier reports by this monitor, the monitoring data across hospitals should be reviewed quarterly by the State with its Chief CRIPA Consultant so that the aggregate data can be used to enhance the mental health services provided throughout the DMH system.
g. The DMH has yet to ensure that the tools and data collection are automated.

3. Implementation of the EP

   a. Since the last review period, NSH has made further progress in the implementation of requirements of the EP. This progress is summarized in each corresponding section in the body of the report.
   b. NSH has yet to make significant progress to address the process deficiencies in medical and nursing care. The DMH has finalized Special Order (SO), Provision of Medical Care to Individuals and medical and nursing care templates and protocols. These tools contain appropriate mechanisms that, if properly implemented, can improve the processes of nursing and medical care and strengthen the facility's efforts to achieve compliance with the EP in these areas.
   c. The DMH has finalized SO, Risk Management that provides adequate mechanisms in the identification of triggers and thresholds regarding high-risk behavior, establishment of levels of interventions corresponding to the level of risk and appropriate notification, follow up and oversight mechanisms. The facility had yet to implement these mechanisms at the time of the tour as the SO was published on December 29, 2008.
   d. Given that the EP provides the basis for the mental health services delivered in the California DMH State Hospitals, it is the monitor's recommendation that the DMH seriously consider standardizing across all hospitals the Administrative Directives that impact these services.
   e. Functional/clinical outcomes of the current structural changes have yet to be finalized and implemented to guide further implementation.
   f. A well-functioning PSR Mall that meets the specific needs of the individuals is the centerpiece of the Wellness and Recovery Planning model. Progress remains to be made towards this goal, specifically in the areas of:
      i. Mall hours: Several disciplines in the acute service provided the required number of facilitation/therapy hours on average during the review period, as did several non-clinical classifications. Progress remains to be made regarding the Mall contributions of disciplines in the long-term service, psychiatry in general, and nursing. Nursing hours of service provided in the Mall were minimal, even taking the nursing position vacancy rate into account.

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

         (Please see next page)

DMH PSR MALL HOURS REQUIREMENTS

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

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

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

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

ii. **Progress notes**: NSH has yet to ensure that providers of mall groups and individual therapy complete and make available to each individual's Wellness and Recovery Planning Team (WRPT) the DMH-revised PSR Mall Facilitator Monthly Progress Note prior to regularly scheduled WRPCs. Without the information in the monthly progress notes, the WRPT has almost no basis for revising an individual's objectives and interventions. All hospitals must fully implement the PSR Mall Facilitator Monthly Progress Note in their PSR Malls for all groups and individual therapies.

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

The cognitive screening protocol will also provide information for the WRPT psychologist to determine whether a referral to the DCAT and/or neuropsychological service is required. All State hospitals must ensure that cognitive screening has been completed for all individuals and that their Mall groups are aligned with their cognitive levels.

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

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

4. Staffing

NSH's clinical staffing pattern as of January 1 is as follows:

Napa State Hospital Vacancy Totals as of January 1, 2009

Identified Clinical Positions	Budgeted Positions	Filled Positions	Vacancies	Vacancy Rate
Assistant Coordinator of Nursing Services	5.0	4.0	1.0	20.0%
Assistant Director of Dietetics	4.0	3.0	1.0	25.0%
Chief Dentist	1.0	1.0	0.0	0.0%
Chief Physician & Surgeon	1.0	0.0	1.0	100.0%
Chief Psychologist	1.0	1.0	0.0	0.0%
Clinical Dietician	10.0	6.0	4.0	40.0%
Clinical Laboratory Technologist	3.0	4.0	-1.0	-33.3%
Clinical Social Worker	61.4	55.3	6.1	9.9%
Coordinator of Nursing Services	1.0	0.0	1.0	100.0%
Dental Assistant	3.0	4.0	-1.0	-33.3%
Dental Hygienist	1.0	1.0	0.0	0.0%
Dentist	2.0	2.0	0.0	0.0%
Food Service Technician I	90.0	91.0	-1.0	-1.1%
Hospital Worker	5.0	5.0	0.0	0.0%
Health Record Technician I	11.0	11.0	0.0	0.0%
Health Record Technician II Sp	1.0	1.0	0.0	0.0%

Napa State Hospital Vacancy Totals as of January 1, 2009				
Identified Clinical Positions	**Budgeted Positions**	**Filled Positions**	**Vacancies**	**Vacancy Rate**
Health Record Technician II Sup	1.0	1.0	0.0	0.0%
Health Record Technician III	1.0	0.0	1.0	100.0%
Health Services Specialist	29.0	27.0	2.0	6.9%
Institution Artist Facilitator	1.0	1.0	0.0	0.0%
Licensed Vocational Nurse	53.0	48.8	4.2	7.9%
Medical Transcriber	7.0	6.0	1.0	14.3%
Sr. Medical Transcriber	3.0	3.0	0.0	0.0%
Nurse Instructor	9.0	6.0	3.0	33.3%
Nurse Practitioner	7.0	7.0	0.0	0.0%
Nursing Coordinator	9.0	7.0	2.0	22.2%
Office Technician	40.5	40.5	0.0	0.0%
Pathologist	1.0	0.0	1.0	100.0%
Pharmacist I	13.5	7.0	6.5	48.1%
Pharmacist II	2.0	0.0	2.0	100.0%
Pharmacy Services Manager	1.0	1.0	0.0	0.0%
Pharmacy Technician	15.0	12.0	3.0	20.0%
Physician & Surgeon	20.8	18.4	2.4	11.5%
Podiatrist	1.0	1.0	0.0	0.0%
Program Assistant	5.0	3.0	2.0	40.0%
Program Consultant (RT, PSW)	2.0	0.0	2.0	100.0%
Program Director	7.0	5.0	2.0	28.6%
Psychiatric Nursing Education Director	2.0	1.0	1.0	50.0%
Psychiatric Technician*	310.5	270.6	39.9	12.9%
Psychiatric Technician Assistant	239.0	228.5	10.5	4.4%

Napa State Hospital Vacancy Totals as of January 1, 2009				
Identified Clinical Positions	**Budgeted Positions**	**Filled Positions**	**Vacancies**	**Vacancy Rate**
Psychiatric Technician Instructor	3.0	3.0	0.0	0.0%
Psychologist-HF, (Safety)	60.8	52.55	8.25	13.6%
Public Health Nurse II/I	3.0	3.0	0.0	0.0%
Radiologic Technologist	2.0	2.0	0.0	0.0%
Registered Nurse**	400.8	377.8	23.0	5.7%
Registered Nurse, Pre-Registered	0.0	0.0	0.0	0.0%
Rehabilitation Therapist	67.2	65.7	1.5	2.2%
Special Investigator	4.0	4.0	0.0	0.0%
Supervising Special Investigator	1.0	1.0	0.0	0.0%
Sr. Psychiatrist	15.3	7.0	8.3	54.2%
Sr. Psychologist	19.7	11.0	8.7	44.2%
Sr. Psychiatric Technician (Safety)	70.0	63.0	7.0	10.0%
Sr. Voc. Rehab. Counselor/Voc. Rehab.	1.0	1.0	0.0	0.0%
Staff Psychiatrist	64.9	51.9	13.0	20.0%
Supervising Psychiatric Social Worker	5.0	0.0	5.0	100.0%
Supervising Registered Nurse	17.0	15.0	2.0	11.8%
Supervising Rehabilitation Therapist	5.0	0.0	5.0	100.0%
Teacher-Adult Educ./Vocational Instructor	9.1	6.0	3.1	34.1%
Unit Supervisor	31.0	25.0	6.0	19.4%
Vocational Instructor/Carpentry	1.0	1.0	0.0	0.0%
Vocational Instructor/Upholstery	1.0	1.0	0.0	0.0%

The Hourly Intermittent FTE is not included in filled column.

* Plus, Psychiatric Technician – 26.4 hourly FTE Psychiatric Technicians

** Plus Registered Nurse – 19 hourly FTE Registered Nurses

Since the prior report, the staffing pattern has been modestly reallocated with the primary effect of increasing the number of budgeted positions in Nursing (17 new RN and seven new Senior Psychiatric Technician positions) and Psychology (five Psychologist positions). Since the previous report, significant changes in staffing include the filling of six Senior Psychiatrist positions and two Pharmacist positions. These are positive developments but vacancies remain in both of those positions. Other significant vacancies include Senior Psychologists and Clinical Dieticians.

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

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

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

E. Monitor's Evaluation of Compliance

The status of compliance is assessed considering the following factors:

1. An objective review of the facility's data and records;
2. Observations of individuals, staff and service delivery processes;
3. Interviews with individuals, staff, facility and State administrative and clinical leaders;
4. An assessment of the stability of the facility's current structure and functions in terms of potential for self-sustenance in order adequately meet the needs of individuals currently and in the future;
5. Assessment of trends and patterns of change rather than single and/or temporary occurrences of compliance or noncompliance that are inconsistent with these patterns and trends;

6. When no instance requiring implementation of a specific requirement was found in the baseline assessment, the compliance was rated as Not Applicable for this evaluation.
7. At least two of the hospitals (i.e., PSH and ASH) have reached substantial compliance in one section of the EP. Once a hospital reaches substantial or full compliance in a section of the EP, the CM begins maintenance evaluation of that section for 18 consecutive months. If the hospital maintains substantial or full compliance during the 18-month period, the CM's evaluation of that section will cease, and it will be up to DMH to provide oversight evaluation and ensure future maintenance. Thus, DMH should be prepared to assume this responsibility in terms of trained personnel to assume this responsibility as each section of the EP achieves maintenance status at each hospital.

F. Next Steps

1. The Court Monitor's team is scheduled to reevaluate Napa State Hospital July 20-24, 2009.
2. The Court Monitor's team is scheduled to tour Metropolitan State Hospital March 9-13, 2009 for a follow-up evaluation.
3. All compliance reports should be reviewed and utilized, as applicable, by all facilities to guide implementation efforts regardless of the schedule of facility-specific assessments.

C. Integrated Therapeutic and Rehabilitation Services Planning		
	Each State hospital shall provide coordinated, comprehensive, individualized protections, services, supports, and treatments (collectively "therapeutic and rehabilitation services") for the individuals it serves, consistent with generally accepted professional standards of care. In addition to implementing the therapeutic and rehabilitation planning provisions set forth below, each State hospital shall establish and implement standards, policies, and practices to ensure that therapeutic and rehabilitation service determinations are consistently made by an interdisciplinary team through integrated therapeutic and rehabilitation service planning and embodied in a single, integrated therapeutic and rehabilitation service plan.	**Summary of Progress:** 1. NSH has continued to provide WRP training to its WRPTs. The training included new courses based on the MSH modules, a new module to improve linkages between the assessments and different sections of the WRP and discipline-focused training to address the roles of each discipline (psychology, social work, nursing and rehabilitation therapy) in the WRP process. 2. NSH has appointed a senior psychiatrist for each of its five programs and trained all senior psychiatrists on the WRP model. 3. Overall, NSH has improved the content of the WRPs in the following areas: a. Strengths formulation; b. Organization of the present status section of the case formulation; c. Development of enrichment foci, objectives and interventions; d. Development of learning-based objectives for individuals suffering from seizure disorders; e. Stages of change; and f. Development of specified interventions. 4. NSH has increased the number of recreational/supplemental leisure activities. Some of the activities occur outside the facility.

1. Interdisciplinary Teams		
C.1	The interdisciplinary team's membership shall be dictated by the particular needs and strengths of the individual in the team's care. At a minimum, each State Hospital shall ensure that the team shall:	**Methodology:** Interviewed: 1. Carmen Caruso, Clinical Administrator 2. [redacted], RN, MBA, EdD, Executive Director 3. Karen Phillips, PhD, Master WRP Trainer 4. Katie Cooper, PsyD, Enhancement Plan Coordinator Reviewed: 1. NSH Physician's Manual 2. NSH WRP Content and Process Overview (training outline) 3. NSH Informal Checklist for Engaging Individuals in WRPC 4. NSH Cultural Issues (training outline) 5. NSH Cognitive and Developmental Issues Examples 6. NSH Case Formulation Help List 7. NSH Substance Abuse Objectives (training outline) 8. NSH Nursing Interventions (training outline and examples) 9. NSH Focus 10 Examples 10. NSH Strengths (training outline) 11. NSH WRP Preparation Worksheet 12. NSH WRPC Checklists 13. NSH WRP Linkages (lesson plan) 14. DMH WRP Process Observation Monitoring Form 15. DMH WRP Process Observation Monitoring Form Instructions 16. NSH WRP Process Observation Monitoring summary data (June to November 2008) 17. DMH Clinical Chart Auditing Form 18. DMH Clinical Chart Auditing Form Instructions 19. NSH Clinical Chart Auditing summary data (June to November 2008) 20. DMH WRP Team Facilitator Observation Monitoring Form 21. DMH WRP Team Facilitator Observation Monitoring Instructions 22. NSH WRP Team Facilitator Observation Monitoring summary data

		(June to November 2008) 23. NSH data regarding staffing ratios on admissions and long-term units (June to November 2008) <u>Observed</u>: 1. WRPC (Program I, unit T-5) for quarterly review of DBG 2. WRPC (Program I, unit T-8) for monthly review of RJ 3. WRPC (Program II, unit Q-11) for quarterly review of BB 4. WRPC (Program II, unit Q-11) for monthly review of MPC 5. WRPC (Program II, unit T-2) for monthly review of PDR 6. WRPC (Program II, unit T-2) for monthly review of TEF 7. WRPC (Program III, unit T-11) for annual review of KNZ 8. WRPC (Program III, unit Q-11) for monthly review of TL 9. WRPC (Program III, unit Q-11) for monthly review of BAS 10. WRPC (Program IV, unit A-2) for monthly review of AT 11. WRPC (Program V, unit T-4) for monthly review of JF
C.1.a	Have as its primary objective the provision of individualized, integrated therapeutic and rehabilitation services that optimize the individual's recovery and ability to sustain himself/herself in the most integrated, appropriate setting based on the individual's strengths and functional and legal status and support the individual's ability to exercise his/her liberty interests, including the interests of self determination and independence.	**Current findings on previous recommendations:** **Recommendation 1, July 2008:** Implement the MSH WRP training modules, update these modules as needed and provide a specific outline of any updates and additions to these modules. **Findings:** Since the previous review, NSH has implemented the following actions: 1. The facility implemented a revised version of the MSH WRP training modules in September 2008. Most of the revisions were minor changes in wording and formatting; however, one substantive change was made: the exercises were removed from the Case Formulation, Foci/ Objectives and Interventions and Mall Integration modules. The WRP Master Trainer indicated that the facility intends to develop a

		practical (vs. didactic) training that will include the MSH exercises. 2. The WRP master trainer developed and implemented a new module, Linkage Training, which emphasizes the critical linkages within the case formulation and methods to improve the linkages between assessments, foci, objectives and interventions. 3. The facility developed Discipline-Focused WRP Trainings for Psychology, Social Work, Rehabilitation Therapy and Nursing. These trainings focused on each discipline's specific responsibilities at the WRPC. **Recommendation 2, July 2008:** Ensure that training on the process of WRP addresses and corrects the deficiencies listed by this monitor above. **Findings:** The facility implemented three pathways of training/mentoring to address the noted deficiencies: 1. The WRP Master Trainer completed in vivo training/mentoring with each of the Senior Psychiatrists in order to improve their training and mentoring of their supervisees. 2. Each of the WRP trainers was assigned to mentor 12-14 WRPTs. The trainers attended the WRPCs and provided in vivo WRPC mentoring as well as written feedback. The facility plans to increase the pool of WRPT mentors by February 2009 by training the Supervising Seniors to serve as mentors. 3. The WRP trainers continued to offer the WRP Learning Lab, which serves as a "hotline" for WRPTs' questions regarding WRP process and content. 4. The facility continues to provide the WRP Content and Process (Overview) training on a monthly basis for all new employees.

		Recommendation 3, July 2008: Ensure that Senior Psychiatrists are assigned to all programs in the facility. **Findings:** A Senior Psychiatrist is currently assigned to each of the facility's five programs. **Recommendation 4, July 2008:** Ensure that all senior clinicians have received training based on the MSH modules as well as training in the clinical Chart Auditing process. **Findings:** Since the previous review, NSH has completed the following trainings: 1. 100% of the Chiefs and Seniors within Psychology, Social Work and Rehabilitation Therapy were trained on each of the WRP modules and the Clinical Chart Auditing (CCA) process. 2. Senior Psychiatrists completed training on the WRP Content and Process (Overview) Module and CCA process. The facility intends to train the Psychiatry Seniors on the remaining WRP modules in February 2009. 3. The EP Coordinator and the WRP Master Trainer initiated the CCA Consultation Group in September 2008. The group serves as a forum for continued training on the methodology of the CCA and on-going inter-rater reliability checks. Discipline Seniors and WRP trainers are required to attend a minimum of monthly. **Recommendation 5, July 2008:** Provide data regarding competency-based training to all WRPTs in the facility.

Findings:
NSH continued training the WRP Process Content (Overview) module and initiated the Linkages and Discipline-Specific trainings during this review period. The facility provided data on the percentages of WRPT members who successfully completed (passed the WRP Knowledge Assessment) these trainings during this review period. The following table summarizes the data:

Discipline	Content and Process Training	Linkage Training	Discipline-Specific Training
MD	85	36	
PhD	81	53	85
SW	32	45	81
RT	94	53	100
RN	34	26	61
PT	23	6	

NSH also provided information on the types of training that other staff completed during this review period, summarized below:

1. Clinical Dieticians and POST staff were trained on WRP Content and Process (Overview) and WaRMSS related to using the WRP module in October 2008. This training was aimed at enabling these staff members who are not core members of the WRPT to provide timely input on assessed needs, foci, objectives and interventions.
2. Clinical Oversight Nurses (83%) completed the WRP Linkages Training.

Recommendation 6, July 2008:
Monitor this requirement using the DMH Clinical Chart Auditing Form based on at least a 20% sample and provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).

Findings:
NSH used the DMH WRP Clinical Chart Auditing Form to assess compliance with this requirement. The facility reviewed an average sample of 15% of the quarterly and annual WRPs due each month (June to November 2008). This is an improvement from an average of 8% during the previous review. The following table summarizes the data:

1.	*Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary and appropriate psychiatric and medical care.*	56%
2.	*Treatment, rehabilitation and enrichment services are goal-directed, individualized and informed by a thorough knowledge of the individual's psychiatric, medical and psychosocial history and previous response to such services.*	70%

Comparative data showed improvement since the prior review period:

	Previous period	Current period
Mean compliance rate		
1.	5%	56%
2.	40%	70%
Compliance rate in last month of period		
1.	9%	88%
2	52%	91%

Recommendation 7, July 2008:
Provide a summary outline of any improvements in practice made as a result of review by the facility of internal monitoring data.

		Findings: The facility has addressed (or will address) the results of the internal monitoring data with the following actions: 1. Current WRP training programs will continue and refinements will be made based on specific deficiencies noted in the audit results. 2. Audit results will be reviewed monthly by the Clinical Management Team; 3. Beginning in January 2009, Supervising Seniors will review audit results with their supervisees to provide ongoing mentoring and retraining as necessary; and 4. A motivational program for WRPTs achieving compliance has been initiated. **Other findings:** 1. The facility continues to have five full-time WRP Trainer positions. At the current time, four out of five are filled. NSH anticipates the vacancy will filled in February 2009. 2. Dr. Karen Phillips (Senior Psychologist) continues as the WRP Master Trainer. 3. The monitor and his consultants attended 11 WRPCs. The monitor found that the facility has maintained progress in the following areas: a. Timeliness of the meetings; b. Attendance by core members, with few exceptions; c. Team leadership by the team psychiatrists or covering psychologists; d. Review of WRP attachments and task tracking forms; e. Update of the present status section of the case formulation in the following areas: symptoms, interventions and response, risk factors, cultural factors, functional status, barriers to discharge, behavioral guidelines/PBS plan, as indicated, By Choice status and results of MOSES. f. Update of other sections of the case formulation prior to the

		meeting; g. Engagement of the individual during the meetings; h. Review of the diagnosis, objectives and interventions with the individual's participation; i. Update of the individual's life goals; j. Attempts to review the individual's attendance (and participation) at the assigned groups; and k. Revision of foci, objectives and interventions. However, the meetings showed process deficiencies in the following areas: 1. Consistent attendance by core members, particularly PTs; 2. Identification of key questions or issues to be discussed with the individual prior to the individual's arrival; 3. Presentation of assessment results by WRPTs prior to the individual's arrival ; 4. Review of risk factors prior to the individual's arrival; 5. Review of the individual's participation in active treatment using the PSR Mall progress notes; 6. Review of progress towards discharge using individualized criteria; 7. Revision of objectives and Mall interventions to ensure proper alignment; and 8. Use of updated life goals and strengths in the development/revision of objectives and interventions. **Compliance:** Partial. **Current recommendations**: 1. Report any process or content modifications (additions, deletions and/or revisions) to current trainings. Include information on both MSH modules and other WRP trainings developed at NSH. 2. Reinstitute exercises from the MSH WRP modules.

		3. Consider consolidation of Content and Process (Overview) and additional modules based on training needs of WRPT members. 4. Continue current trainings and report on the proportion of staff (per discipline) trained to competency. Compare data to the previous review period. 5. Formalize a mentoring system that ensures that each WRPT receives adequate mentoring, including provision of feedback. 6. Monitor this requirement using the DMH Clinical Chart Auditing Form based on at least a 20% sample and provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). 7. Provide a summary outline of any improvements in practice made as a result of review by the facility of internal monitoring data.
C.1.b	Be led by a clinical professional who is involved in the care of the individual.	**Current findings on previous recommendations:** **Recommendations 1 and 2, July 2008:** • Monitor this requirement using WRP Process Observation and Team Leadership Monitoring Forms based on samples of 20% and 100%, respectively. • Continue data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). **Findings:** NSH used the DMH WRP Observation Monitoring Form to assess compliance. The average sample was 26% of the WRPCs held each month (June to November 2008). The following table summarizes the data: 1. *Each team is led by a clinical professional who is involved in the care of the individual:* 26% 1.a *The clinical professional is a core team member for* 78%

	the individual.	
1.b	*This person is the identified facilitator or the team leader appointed a team facilitator.*	28%

The mean compliance rate for the indicator decreased from the previous review. The same trend was noted for the compliance rates between the last month of the previous and current review periods. The following is an outline of comparative data:

	Previous period	Current period
Mean compliance rate		
1.	47%	26%
Compliance rate in last month of period		
1.	52%	28%
1.a	92%	80%
1.b	54%	29%

The facility also used the DMH WRP Team Facilitator Observation Monitoring Form to assess compliance (June to November). The facility revised this tool since the previous review to ensure that only those indicators that were directly influenced by the facilitator's function were included.

The current review was based on an average sample of 6% of the WRPCs held during the month. The previous recommendation was to review an average sample of 100% of the expected reviews (two reviews per WRPT psychiatrist per month.) The following table summarizes the data:

1.	*Psychiatrist was present.*	98%
2.	*Psychiatrist elicited the participation of all disciplines.*	23%
3.	*Psychiatrist ensured the "Present Status" section in*	18%

	the Case Formulation was updated.	
4.	*Psychiatrist ensured that the interventions were linked to the measurable objectives.*	13%

Comparative data showed modest improvement in compliance with most items as follows:

	Previous period	Current period
Mean compliance rate		
1.	100%	98%
2.	32%	23%
3.	13%	18%
4.	10%	13%
Compliance rate in last month of period		
1.	100%	100%
2.	32%	55%
3	15%	27%
4.	13%	10%

NSH reported that the facility's data analysis of the WRP Process Observation and DMH WRP Team Facilitator Observation Monitoring Forms, in regards to the identification of a team facilitator, indicated that the scores may have resulted from an auditing error. As a result, the WRP audits were streamlined in November 2008 and oversight shifted to the Enhancement Plan Coordinator to ensure reliability and validity of audits.

Recommendation 3, July 2008:
Develop and implement a peer mentoring system to ensure competency in team leadership skills.

		Findings: See C.1.a for a description of mentoring/training systems that the facility has implemented during this review period. **Recommendation 4, July 2008:** Finalize the draft Medical Staff Manual and ensure alignment with EP requirements. **Findings:** The facility has completed the Napa State Hospital Physician's Manual in an effort to align it with EP requirements. **Compliance:** Partial. **Current recommendations**: 1. Monitor this requirement using WRP Observation and WRP Team Facilitator Observation Monitoring Forms based on samples of 20% of WRPs completed each month and 100% of expected reviews (two per WRPT psychiatrist per month), respectively. 2. Continue data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period. 3. Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data. 4. Same as Recommendation 5 in C.1.a related to formalizing mentoring system.
C.1.c	Function in an interdisciplinary fashion.	**Current findings on previous recommendations:** **Recommendations 1 and 2, July 2008:** • Monitor this requirement using process observation based on at least a 20% sample.

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

Findings:
NSH used the DMH WRP Observation Monitoring Form to assess compliance with this requirement. The average sample was 26% of the WRPCs held each month (June to November 2008). The following table summarizes the data:

2.	*Each team functions in an interdisciplinary fashion.*	2%
2.a	*The core team members participate by presenting or updating discipline-specific and or holistic assessment data.*	7%
2.b	*The team reviews and updates the DMH WRPC Task Tracking Form.*	44%
2.c	*Team members present their assessments and consultations as listed in the Task Tracking Form.*	20%
2.d.	*Team members discuss the individual's specific outcomes for the WRP review period.*	10%

Compliance rates for the indicator and sub-indicators increased modestly from the previous review. The following is an outline of comparative data:

	Previous period	Current period
Mean compliance rate		
2.	1%	2%
Compliance rate in last month of period		
2.	1%	3%
2.a	8%	9%
2.b	32%	58%

		2.c 14% 31% 2.d 4% 13% The facility's review of this indicator and sub-indicators found that the lack of PT attendance at WRPCs caused the low compliance for these items. Across the facility, PTs participate in only 13% (on average) of the conferences. The EP Coordinator reported that the facility plans to change the times at which WRPCs are scheduled to facilitate PT attendance. **Compliance:** Partial. **Current recommendations**: 1. Monitor this requirement using the DMH WRP Observation Monitoring Form based on at least a 20% sample. 2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). 3. Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.
C.1.d	Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary, and appropriate psychiatric and medical care.	**Current findings on previous recommendations:** **Recommendations 1 and 2, July 2008:** • Monitor this requirement using the Clinical Chart Audit form based on at least a 20% sample. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). **Findings:** NSH used the DMH WRP Clinical Chart Auditing Form to assess

compliance with this requirement. The average sample was 15% of the quarterly and annual WRPCs held each month (June to November 2008). The following table summarizes the data:

1.	*Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary, and appropriate psychiatric and medical care.*	56%
1.a	*The present status and previous response to treatment sections of the case formulation are aligned with the assessments (focused assessment of compliance)*	67%
1.b	*A review of assessments, WRP and WRP attachments indicate that the information in the WRP is supported by the assessments and DMH PSR Mall Facilitator Monthly Progress Notes (Global assessment of compliance)*	60%

Compliance rates increased significantly from the previous review. The following is an outline of comparative data:

	Previous period	Current period
Mean compliance rate		
1.	4%	56%
Compliance rate in last month of period		
1.	9%	88%
1.a	31%	92%
1.b	10%	88%

The facility plans to improve compliance in this area with the mentoring/training outlined in C.1.a above.

		Compliance: Partial. **Current recommendations**: 1. Monitor this requirement using the Clinical Chart Audit form based on at least a 20% sample. 2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). 3. Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.
C.1.e	Ensure that each member of the team participates appropriately in competently and knowledgeably assessing the individual on an ongoing basis and in developing, monitoring, and, as necessary, revising the therapeutic and rehabilitation services.	**Current findings on previous recommendations:** **Recommendation 1, July 2008:** Ensure recruitment of senior clinicians to fill current vacancies. **Findings:** As of November 2008, there were no senior clinician vacancies. **Recommendations 2 and 3, July 2008:** • Monitor this requirement using the DMH WRP Observation Monitoring Form based on at least a 20% sample. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). **Findings:** NSH used the DMH WRP Observation Monitoring Form to assess compliance with this requirement. The average sample was 26% of the WRPCs held each month (June to November 2008). The following table summarizes the data:

3.	*Each member of the team participates appropriately in competently and knowledgeably assessing the individual on an ongoing basis and in developing, monitoring, and, as necessary revising the therapeutic and rehabilitative services.*	0%
3.a	*Each team member presents relevant and appropriate content for the discipline-specific assessments. The Psychiatric Technician presents global observations of the individual for the WRP review period.*	2%
3.b	*Team members present their assessments and consultations as listed in the Task Tracking Form.*	16%
3.c	*Team members discuss the individual's specific outcomes for the WRP review period.*	8%

Compliance rates remained low or improved only modestly since the prior review. The following is an outline of comparative data:

	Previous period	Current period
Mean compliance rate		
3.	0%	0%
Compliance rate in last month of period		
3.	0%	0%
3.a	3%	3%
3.b	14%	25%
3.c	6%	10%

NSH reported that audit data analysis indicated two primary findings:

1. WRPTs continued to utilize NSH Consultation Binders rather than the

		Task Tracking Form as monitored on the Observation Monitoring Form, Item 3.b. 2. PTs did not consistently attend WRPCs as monitored on the Observation Monitoring Form, Item 3.a. In response to these findings, the facility plans to institute the WRPC Task Tracking Form and modify the time of conferences as described in C.1.c. **Compliance:** Partial. **Current recommendations**: 1. Monitor this requirement using the DMH WRP Observation Monitoring Form based on at least a 20% sample. 2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). 3. Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.
C.1.f	Ensure that assessment results and, as clinically relevant, consultation results, are communicated to the team members, along with the implications of those results for diagnosis, therapy and rehabilitation by no later than the next review.	**Current findings on previous recommendations:** **Recommendations 1 and 2, July 2008:** • Monitor this requirement using the WRP Observation Monitoring Form based on at least a 20% sample. • Provide data analysis addressing sub-items of this requirement. The analysis must evaluate areas of low compliance and delineate areas of relative improvement. **Findings:** NSH used the DMH Observation Monitoring Form to assess compliance and reported a mean compliance rate of 3% for this requirement. This is

		similar to the rate (2%) reported during the last review period. **Findings:** The facility reported that PTs did not consistently attend WRPCs as monitored on the Observation Monitoring Form, Item 4 and that auditing errors complicated the interpretation of data. As a corrective action, the facility plans to shift the oversight of the Observation Monitoring form to the EP Coordinator to ensure ongoing inter-rater reliability and implement the mentoring/training described in C.1.a. **Compliance:** Partial. **Current recommendations**: 1. Monitor this requirement using the DMH WRP Observation Monitoring Form based on at least a 20% sample. 2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). 3. Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.
C.1.g	Be responsible for the scheduling and coordination of assessments and team meetings, the drafting of integrated treatment plans, and the scheduling and coordination of necessary progress reviews.	**Current findings on previous recommendations:** **Recommendation 1, July 2008:** • Monitor this requirement using the WRP Observation Monitoring Form based on at least a 20% sample. • Provide data analysis addressing sub-items of this requirement. The analysis must evaluate areas of low compliance and delineate areas of relative improvement.

Findings:
NSH used the DMH WRP Observation Monitoring Form to assess compliance with this requirement. The average sample was 26% of the WRPCs held each month (June to November 2008). The following table summarizes the data:

5.	*The team identified someone to be responsible for the scheduling and coordination of assessments and team meetings, the drafting of integrated treatment plans, and the scheduling and coordination of necessary progress reviews.*	8%
5.a	*There is an identified WRP recorder who is responsible for the scheduling and coordination of assessments and WRPCs. This person typically records the WRP.*	93%
5.b	*The identified recorder drafts the WRP on the computer and obtains all necessary signatures on the completed WRP, schedules the next conference date and time, fills out the appointment card for the next WRPC for the individual and fills out the WRPC Task Tracking form at the conference.*	8%

The mean compliance rates for the indicator did not change from the previous review. However, there was modest improvement in sub-indicator compliance from the last month of the prior review period to the last month of the current review period. The following is an outline of comparative data:

	Previous period	Current period
Mean compliance rate		
5.	8%	8%
Compliance rate in last month of period		
5.	9%	13%
5.a	87%	92%
5.b	9%	13%

NSH reported that data analysis indicated two areas for improvement:

1. WRPTs did not consistently provide individuals with appointment cards to schedule the next conference.
2. As in C.1.e, WRPTs did not utilize the Task Tracking Form.

As corrective actions, the facility plans to retrain staff on the appointment card requirement and implement mentoring/training as delineated in C.1.a and C.1.e.

Compliance:
Partial.

Current recommendations:
1. Monitor this requirement using the DMH WRP Observation Monitoring Form based on at least a 20% sample.
2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).
3. Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.

C.1.h	Consist of a stable core of members, including at least the individual served; the treating psychiatrist, treating psychologist, treating rehabilitation therapist, the treating social worker; registered nurse and psychiatric technician who know the individual best; and one of the individual's teachers (for school-age individuals), and, as appropriate, the individual's family, guardian, advocates, attorneys, and the pharmacist and other staff.	**Current findings on previous recommendations:** **Recommendation 1, July 2008:** Continue to monitor attendance by all core members of the WRPTs. **Findings:** NSH has provided data that address the above recommendation. The data were based on a mean sample of 25% of the scheduled WRPCs per month. Data showed that all core members' attendance rates have decreased since the last review period. The following is a summary of the data for the last three review periods:

	Jul-Dec 2007	Jan-May 2008	Jun-Nov 2008
Individual	72%	81%	66%
Psychiatrist	68%	82%	73%
Psychologist	74%	84%	75%
Social Worker	61%	76%	68%
Rehabilitation Therapist	65%	80%	73%
Registered Nurse	55%	82%	77%
Psychiatric Technician	4%	16%	13%

The inconsistency between the 73% psychiatrist attendance rate reported here and the 98% psychiatrist attendance rate reported in C.1.b is likely due to the small sample size reported in C.1.b.

Recommendation 2, July 2008:
Address and correct factors related to low attendance rates of Psychiatric Technicians.

Findings:
The facility reported that the times of conferences will be rescheduled to facilitate PT attendance and attendance rates will be presented to

<table>
<tr>
<td></td>
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<td>discipline chiefs at Clinical Management Team meetings until attendance improves.

Compliance:
Partial.

Current recommendation:
Aggressively address core team members' low attendance rates at WRPCs.</td>
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<tr>
<td>C.1.i</td>
<td>Not include any core treatment team members with a case load exceeding 1:15 in admission teams (new admissions of 90 days or less) and, on average, 1:25 in all other teams at any point in time.</td>
<td>Current findings on previous recommendation:

Recommendation, July 2008:
Continue current practice and provide data regarding staffing ratios on the admissions and long-term units.

Findings:
Except for Social Workers, each core team discipline's mean staffing ratio was above the expected ratio of 1:15 for admission teams due to an increase in the number of admissions. The following is a summary of the facility's data for this review period:
<table>
<tr><th></th><th>Mean Ratios Previous Period</th><th>Mean Ratios Current Period</th></tr>
<tr><td>MDs</td><td>1:15</td><td>1:17</td></tr>
<tr><td>PhDs</td><td>1:14</td><td>1:17</td></tr>
<tr><td>SWs</td><td>1:13</td><td>1:15</td></tr>
<tr><td>RTs</td><td>1:14</td><td>1:17</td></tr>
<tr><td>RNs</td><td>1:15</td><td>1:17</td></tr>
<tr><td>PTs</td><td>1:15</td><td>1:17</td></tr>
</table>

All disciplines except for Psychiatry and Social Work met the expectation of 1:25 on non-admission units. The following is a summary of the facility's data for this review period:</td>
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<table>
<tr><td></td><td>Mean Ratios Previous Period</td><td>Mean Ratios Current Period</td></tr>
<tr><td>MDs</td><td>1:26</td><td>1:26</td></tr>
<tr><td>PhDs</td><td>1:26</td><td>1:25</td></tr>
<tr><td>SWs</td><td>1:27</td><td>1:29</td></tr>
<tr><td>RTs</td><td>1:25</td><td>1:25</td></tr>
<tr><td>RNs</td><td>1:23</td><td>1:22</td></tr>
<tr><td>PTs</td><td>1:23</td><td>1:22</td></tr>
</table>

Compliance:
Partial.

Current recommendation:
Ensure that staffing ratios are met.
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</tr>
<tr>
<td>C.1.j</td>
<td>Not include staff that is not verifiably competent in the development and implementation of interdisciplinary wellness and recovery plans.</td>
<td>
Current findings on previous recommendations:

Recommendation 1, July 2008:
Same as in C.1.a through C.1.f.

Findings:
Same as in C.1.a through C.1.f.

Recommendation 2, July 2008:
Ensure accuracy of data regarding competency-based training of WRPT members as measured by the WRP Knowledge assessment test.

Findings:
Data presented at this review were consistent with those provided in C.1.a above.
</td>
</tr>
</table>

		Compliance: Partial. **Current recommendation**: Same as in C.1.a through C.1.f.

2. Integrated Therapeutic and Rehabilitation Service Planning (WRP)		
	Each State hospital shall develop and implement policies and protocols regarding the development of therapeutic and rehabilitation service plans, referred to as "Wellness and Recovery Plans" [WRP]) consistent with generally accepted professional standards of care, to ensure that:	**Methodology:** Interviewed: 1. Alisha McPherson, RN, HSS, WRP Trainer 2. Anita Sachdev, MD, Psychiatrist 3. Beverly Lynn, Acting Senior Rehabilitation Therapist 4. Camille Gentry, Acting Senior Rehabilitation Therapist 5. Carmen Caruso, Clinical Administrator 6. Catherine Michaels, Assistant Mall Director 7. Chandandeep Chahal, MD, Psychiatrist 8. Charlie Oncea, PD, RA, Interim Mall Director 9. Cindy Black, Director of Standards Compliance 10. Craig Saewong, Registered Dietitian 11. Cynthia Rozensky, CSW 12. Dana M. Scruggs, Registered Dietitian 13. Deborah Feichtinger, PsyD 14. Deborah G. Davidson, LCSW 15. Diane Chapman, PT, By Choice Incentive Store Staff 16. Dolly Matteucci, Hospital Administrator 17. [redacted], RN, MBA, EdD, Executive Director 18. Edna Mulgrew, PhD, Senior Supervising Psychologist, BCC 19. Emiko Taki, Registered Dietitian 20. Heidi Voglesang, Registered Dietitian 21. Jack Aamot, PsyD, Psychologist 22. Jatinder Singh, LVN, Psychiatric Technician 23. Jeffrey Pouncey, PsyD, Director of Substance Recovery Services 24. Joane Merrill, Registered Dietitian 25. Jocelyn Ricafort, RN, Psychiatric Nurse Practitioner 26. John Wyman, LCSW, Senior Social Worker 27. Judy Wick, CSW, Social Work 28. Karen Phillips, PhD, Master WRP Trainer 29. Katie Cooper, PsyD, Enhancement Plan Coordinator

		30. Kumiko Kato, Registered Dietitian 31. Lea Dario, RN, Psychiatric Nurse Practitioner 32. Lynn Wurzel, Registered Dietitian 33. Michelle Bower, SRN, NC 34. Miwako Tan, RT 35. Monique Jansma, LCSW, Senior Social Worker 36. Patty Lamb, PsyD, Psychologist 37. Phyllis Moore, Acting Senior Rehabilitation Therapist 38. Reggie Ott, Chief of Rehabilitation Services 39. Robert Newman, RT, Acting Senior Rehabilitation Therapist, Supplemental Activity Coordinator 40. Robin Carboni, Registered Dietitian 41. Scott Sutherland, DO, Staff Psychiatrist 42. Terese Mesa, PT, WRP Trainer 43. Veronica Oteyza, Registered Dietitian 44. Wen Pao, Registered Dietitian <u>Reviewed</u>: 1. The charts of the following 146 individuals: ABN, AC-1, AC-2, AC-3, ADS, AH, AJS, AN, ANA, ARC, ARL-1, ARL-2, AVN, AWL, BDA, BFL, BJB, BMS, BPJ, BSC, BT, CC, CDK, CEC, CEG, CG, CHH, CM, CMD, CMG, CMS, CWR, DBC, DCB, DF, DL, DM, DML, DN, DN-2, DP, DP, DPA, DR, DS, DSY, DWH, EAB, EB, ELH, ERM, ETR, EV, FBG, FG, FK, FLK-1, FLK-2, FM, FP, FTP, GAB, GAF, GAR, GB, GM, GMT-1, GMT-2, HDE, HLA, HMS, IL, ILL, JAH, JAO, JC, JDT, JEB, JH, JH, JHM, JJR, JR-1, JR-2, JSC, JT, JTC-1, JTC-2, JWM, JWS, KDP, LLH, LTH, MAG, MAK, MAW, MBB, MER, MKS, MM-1, MM-2, MPP, NAJ, NJ, NMB, OH, OJR, PEM-1, PEM-2, PG-1, PG-2, PV, PVW, PW, PWL, RDS, RDZ, RGW, RJA, RJH, RL, RLM-1, RLM-2, RM, RW, SCL, SMS, SP, SPP, SSB, SSP, SVP, TJ, TJM, TL, TM, TR, TTR, UBH, VH, WAB, WBM, WFO, WLV, YJL and YL 2. DMH WRP Process Observation Monitoring Form 3. DMH WRP Process Observation Monitoring Form Instructions

		4. NSH WRP Process Observation Monitoring summary data (June to November 2008) 5. DMH Clinical Chart Auditing Form 6. DMH Clinical Chart Auditing Form Instructions 7. NSH Clinical Chart Auditing Form summary data (June to November 2008) 8. DMH WRP Substance Abuse Monitoring Form 9. DMH WRP Substance Abuse Monitoring Form Instructions 10. NSH Substance Abuse Monitoring summary data (June to November 2008) 11. NSH MAPP data regarding active treatment hours scheduled and attended (June to November 2008) 12. DMH revised template of the Mall Facilitator Progress Note 13. Completed Mall Progress Notes 14. List of individuals assessed to need family therapy 15. List of individuals with substance disorders 16. List of Substance Recovery providers at NSH 17. List of leisure activities offered at NSH 18. List of Mall courses offered at NSH 19. List of new enrichment activities/groups offered over the last six months 20. List of off-ground field trips (individuals in Program IV) 21. List of scheduled exercise groups 22. List of scheduled vs cancelled/missed appointments 23. Mall Group/Activity Requests in the last six months 24. Psychosocial Enrichment activity list 25. Substance Recovery Enhancing Motivation lesson plans <u>Observed</u>: 1. WRPC (Program I, unit T-5) for quarterly review of DBG 2. WRPC (Program I, unit T-8) for monthly review of RJ 3. WRPC (Program II, unit Q-11) for quarterly review of BB 4. WRPC (Program II, unit Q-11) for monthly review of MPC

		5. WRPC (Program II, unit T-2) for monthly review of PDR 6. WRPC (Program II, unit T-2) for monthly review of TEF 7. WRPC (Program III, unit T-11) for annual review of KNZ 8. WRPC (Program III, unit Q-11) for monthly review of TL 9. WRPC (Program III, unit Q-11) for monthly review of BAS 10. WRPC (Program IV, unit A-2) for monthly review of AT 11. WRPC (Program V, unit T-4) for monthly review of JF 12. PSSC/ETRC meeting 13. Shift Lead Meeting 14. Life Skills Mall Group 15. Reality Orientation Mall Group 16. Relaxation Technique Mall Group 17. Substance Abuse/Recovery Mall Group
C.2.a	Individuals have substantive input into the therapeutic and rehabilitation service planning process, including but not limited to input as to mall groups and therapies appropriate to their WRP.	**Current findings on previous recommendations:** **Recommendation 1, July 2008:** Continue current training and mentoring regarding engagement of individuals and initiate training using the MSH module regarding engagement of the individuals. **Findings:** See C.1.a. Additionally, during the current review period the facility focused efforts on increasing individual's engagement in two pathways: 1. Training with staff: a. WRP Trainers provided competency-based training on the MSH Engagement Module to the Psychology, Social Work and Rehabilitation Therapy Seniors in September 2008. The facility intends to complete this training with Psychiatry Seniors in February 2009. b. Senior Supervisors in each discipline are expected to ensure that their supervisees are trained to competency on the MSH

Engagement Module in February 2009.

2. Training with individuals:
   a. NSH developed and piloted Personal Wellness groups in Program III. These groups focused on the role of the individual in the WRP process and are designed to empower the individual to fully participate in his/her treatment planning.
   b. The facility intends to implement these groups in all programs during February 2009.
   c. Starting in January 2009, each individual will review his/her WRP weekly with one of the core team members to promote increased participation in the WRP process.

Recommendation 2, July 2008:
Monitor this requirement using process observation based on at least a 20% sample.

Findings:
NSH used the DMH WRP Observation Monitoring Form (June to November 2008) to assess compliance with this requirement. The average sample was 25% of the WRPCs held each month. The following table summarizes the data:

6.	*Individuals have substantive input into the therapeutic and rehabilitation service planning process, including but not limited to input as to mall groups and therapies appropriate to their WRP.*	10%
6.a	*The WRPT asks the individual for his or her input into the evaluation of progress on each objective, as clinically indicated.*	16%
6.b	*When the individual has achieved an objective, at the current WRPC, the WRPT discusses with the individual the groups available for the next objective. The individual makes a choice from*	12%

	several equivalent options.	
6.c	*The WRPT reviews the By Choice points, preferences and allocation with the individual. The individual determines how he or she will allocate the points between WRPCs.*	37%
6.d	*When the individual identifies cultural preferences, the team updates the case formulation and may incorporate them into the individual's WRP objectives and interventions, as relevant.*	33%

The mean compliance rate for the indicator improved modestly during this review period, while changes in compliance rates between the last months of the current and previous review periods were mixed. The following is an outline of comparative data:

	Previous period	Current period
Mean compliance rate		
6.	6%	10%
Compliance rate in last month of period		
6.	7%	12%
6.a	20%	16%
6.b	15%	7%
6.c	34%	45%
6.d	35%	49%

Recommendation 3, July 2008:
Provide data analysis that evaluates low compliance and delineates areas of relative improvement (during the reporting period and compared to the last period).

		Findings: NSH reported that the WRPTs did not have access to the current Mall catalog, which impacted compliance for item 6.b. Based on these findings, NSH reported that the facility has planned the following actions: 1. Increase monitoring and mentoring of the specific programs with lower compliance; and 2. Implement use of Course Outline WaRMSS module to provide teams and individuals access to information on available groups within Foci that are specific to objectives and interventions. **Compliance:** Partial. **Current recommendations**: 1. Monitor this requirement using the DMH WRP Observation Monitoring Form based on at least a 20% sample. 2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). 3. Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.
C.2.b	Therapeutic and rehabilitation service planning provides timely attention to the needs of each individual, in particular:	Please see sub-cells for compliance findings.
C.2.b.i	initial therapeutic and rehabilitation service plans (Admission-Wellness and Recovery Plan ("A-WRP") are completed within 24 hours of admission;	**Current findings on previous recommendation:** **Recommendation, July 2008:** Continue to monitor this requirement.

		Findings: NSH used the DMH Chart Auditing Form (June to November 2008) to assess compliance with this requirement. The average sample was 95% of the A-WRPs due each month. The facility reported a compliance rate of 92% for this requirement. This is consistent with the previous review period's compliance rate of 96%. **Other findings:** This monitor reviewed the charts of 10 individuals (AJS, ARC, ARL-1, BDA, DCB, DWH, FP, NAJ, PV and TJM) who were admitted during this review period. The review found compliance in all charts except one (TJM). **Compliance:** Substantial. **Current recommendation**: Continue to monitor this requirement.
C.2.b.ii	master therapeutic and rehabilitation service plans ("Wellness and Recovery Plan" (WRP)) are completed within 7 days of admission; and	**Current findings on previous recommendation:** **Recommendation, July 2008:** Continue to monitor this requirement and ensure a sample size of at least 20%. **Findings:** NSH used the DMH Chart Auditing Form (June to November 2008) to assess compliance with this requirement. The average sample was 20% of the 7-day WRPs due each month. The facility reported a compliance rate of 72% for this requirement. This is a decrease from the compliance rate of 90% during the previous review period.

		Other findings: NSH reported that WRPCs continue to be scheduled within the appropriate time frames. However, WRPT members have reportedly rescheduled conferences, resulting in the WRPs not being completed within required timelines. The facility indicated that beginning in February 2009, a staff person would be assigned to monitor the scheduling of WRPCs and to assist WRPTs with the rescheduling of conferences. Reviews by this monitor found compliance in the charts of 10 individuals who were admitted during this reporting period (AJS, ARC, ARL-1, BDA, DCB, DWH, FP, NAJ, PV and TJM). **Compliance:** Partial. **Current recommendation**: Ensure that WRPs are completed in accordance with this requirement.
C.2.b.iii	therapeutic and rehabilitation service plan reviews are performed every 14 days during the first 60 days of hospitalization and every 30 days thereafter. The third monthly review is a quarterly review and the 12th monthly review is the annual review.	**Current findings on previous recommendations:** **Recommendation 1, July 2008:** Monitor this requirement using process observation based on at least a 20% sample. **Findings:** NSH used the DMH Chart Auditing Form (June to November 2008) to assess compliance with this requirement. The following is a summary of the facility's data:

WRP Review	Mean sample size	Mean compliance rate
14-Day	33%	59%
Monthly	19%	54%
Quarterly	22%	53%
Annual	25%	74%

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

14-Day Review:

	Previous period	Current period
Mean compliance rate		
3.	10%	59%
Compliance rate in last month of period		
3.	8%	88%

Monthly Review:

	Previous period	Current period
Mean compliance rate		
3.	29%	54%
Compliance rate in last month of period		
3.	55%	73%

Quarterly Review:

	Previous period	Current period
Mean compliance rate		
3.	28%	53%
Compliance rate in last month of period		
3.	50%	58%

Annual Review:

	Previous period	Current period
Mean compliance rate		
3.	22%	74%
Compliance rate in last month of period		
3.	50%	81%

Recommendation 2, July 2008:
Provide data analysis that evaluates low compliance and delineates areas of relative improvement (during the reporting period and compared to the last period).

Findings:
See C.2.b.ii above for the facility's analysis of the issue and corrective actions.

Other findings:
This monitor found compliance in the charts of 10 individuals who had been admitted during this reporting period (AJS, ARC, ARL-1, BDA, DCB, DWH, FP, NAJ, PV and TJM).

		Compliance: Partial. **Current recommendations**: 1. Monitor this requirement using the DMH Chart Auditing Form based on at least a 20% sample. 2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). 3. Provide a summary outline of any improvements in practice made as a result of review by the facility of internal monitoring data.
C.2.c	Treatment rehabilitation and enrichment services are goal-directed, individualized, and informed by a thorough knowledge of the individual's psychiatric, medical, and psychosocial history and previous response to such services;	**Current findings on previous recommendations:** **Recommendation 1, July 2008:** Continue and strengthen the WRP training curriculum to ensure that: a. The case formulation includes appropriate review and analysis of assessments to identify the individual's needs in the psychiatric, medical and psychosocial domains, and b. Foci of hospitalization addresses all identified needs of the individual in the above domains. **Findings:** See C.1.a for a review of recent modifications to NSH's trainings. **Recommendations 2 and 3, July 2008:** • Monitor this requirement using the Clinical Chart Auditing Form based on at least a 20% sample. • Provide data analysis that evaluates low compliance and delineates areas of relative improvement (during the reporting period and compared to the last period).

Findings:
NSH used the DMH WRP Clinical Chart Auditing Form (June to November 2008) to assess compliance with this requirement. The average sample was 15% of the quarterly and annual WRPCs held each month. This sample was not based on the number of individuals (N) who were diagnosed with the disorders specified in items 2.a through 2.d. The following table summarizes the data:

2.	*Treatment rehabilitation and enrichment services are goal-directed, individualized, and informed by a thorough knowledge of the individual's psychiatric, medical, and psychosocial history and previous response to such services.*	69%
2.a	*When a cognitive disorder is identified on Axis I, it is written in Focus I, and has at least one objective with an appropriately linked intervention.*	55%
2.b	*When substance abuse is identified on Axis I, it is written in Focus 5, and has at least one objective with an appropriately linked intervention.*	77%
2.c	*When mental retardation is identified on Axis II, all interventions are aligned with the cognitive functioning level of the individual.*	56%
2.d	*When seizure disorder is identified on Axis III, it is written in Focus 6, and has at least one objective with an appropriately linked intervention.*	53%

The mean compliance rate increased from the previous review. This trend was also noted in the change in compliance between the last months of the current and previous review periods, except for item 2.d. The following is an outline:

	Previous period	Current period
Mean compliance rate		
2.	40%	69%
Compliance rate in last month of period		
2.	52%	91%
2.a	13%	91%
2.b	75%	91%
2.c	N/A	N/A
2.d	100%	50%

Findings:
NSH acknowledged that the sample (N) did not account for the number of individuals who met the criteria for monitoring.

Other findings:
This monitor reviewed the charts of 12 individuals diagnosed with a variety of cognitive disorders and seven individuals diagnosed with seizure disorders. The reviews found general evidence of some improvement in the following areas:

1. Documentation of foci, objectives and interventions that were aligned with the needs of some individuals diagnosed with seizure and cognitive disorders;
2. Decreased use of regular treatment with anticholinergic and/or benzodiazepine medications for individuals suffering from dementing illnesses;
3. Documentation of the status of some individuals suffering from seizure disorders and dementing illnesses in the present status section of the case formulation;
4. Development of learning-based objectives and interventions for some

		individuals suffering from seizure disorders, including recognizing and responding to warning signs of impending seizure activity (NJ, NMB and PG-1); and 5. Development of learning-based objectives for some individuals diagnosed with cognitive impairments (KDP). However, the review also found a persistent pattern of deficiencies that must be corrected to achieve substantial compliance in this area. The following is an outline of these deficiencies: 1. Individuals diagnosed with cognitive impairments (ETR, EV, FLK-1, GMT-1, JR-1, JWS, KDP, MAG, MAK, MAW, WBM and WLV): a. The WRP did not include a focus statement or objectives/ interventions to address the needs of individuals with diagnoses of Mental Retardation (EV, MAG and WBM), Cognitive Disorder NOS (MAK and WLV) and Borderline Intellectual Functioning (GMT-1 and JR-1). b. The WRP included an intervention that did not relate to the stated objective in an individual diagnosed with Dementia Due to General Medical Condition without Behavioral Disturbance (KDP). c. The present status section of the case formulation did not address the cognitive status of an individual diagnosed with Dementia Due to General Medical Condition without Behavioral Disturbance (KDP). d. The psychiatric progress note did not address the cognitive status of individuals diagnosed with Dementia of The Alzheimer's Type with Late Onset, with Behavioral Disturbance (JWS) and Cognitive Disorder NOS (ETR and MAK). 2. Individuals diagnosed with seizure disorders (ELH, JSC, MAW, NJ, NMB, PG-1 and RDS): a. The WRPs did not specify the morphological diagnosis of the seizure disorder in any of the charts reviewed except one (PG-1). This information is needed to assess the appropriateness of the

		anticonvulsant drugs that were selected for treatment. b. The WRP did not include interventions to assist the individual in achieving the objective of learning about warning signs of seizure activity (NJ). c. The WRP included objectives and interventions regarding the side effects of anticonvulsant treatment. However, the objectives and interventions did not address the side effect of cognitive dysfunction in an individual at risk (JSC). d. In all the charts reviewed, the WRPs failed to address the risks of treatment with older anticonvulsant medications, e.g. phenytoin (ELH, JSC, NJ, PG-1 and RDS) and/or phenobarbital (NMB) and other anticonvulsant drugs, e.g. lorazepam (MAW) including their impact on the individual's behavior, cognitive status and quality of life. Some of these individuals were at increased risk due to history of head trauma (NJ) and/or documented evidence of cognitive dysfunction, including: i) Vascular dementia (PG-1); ii) Amnestic disorder with history of alcohol abuse (JSC); iii) Unspecified cognitive impairment with history of head trauma (RDS); iv) Cognitive Disorder NOS (ELH); and v) Dementia Due to General Medical Condition, with Behavioral Disturbance (MAW). e. In the charts reviewed, the rationale for continued treatment with older anticonvulsant medications for individuals who have been seizure-free for more than two years was not documented in the WRP or the physicians' progress notes (e.g. NJ). **Compliance:** Partial. **Current recommendations**: 1. Continue and strengthen the WRP training curriculum to ensure that:

		a. The case formulation includes appropriate review and analysis of assessments to identify the individual's needs in the psychiatric, medical and psychosocial domains, and b. Foci of hospitalization addresses all identified needs of the individual in the above domains. 2. Stratify sample based on specific diagnoses to ensure adequate sample size for valid calculations. 3. Monitor this requirement using the DMH WRP Clinical Chart Auditing Form based on at least a 20% sample. 4. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). 5. Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.
C.2.d	Therapeutic and rehabilitation service planning is based on a comprehensive case formulation for each individual that emanates from interdisciplinary assessments of the individual consistent with generally accepted professional standards of care. Specifically, the case formulation shall:	**Compliance:** Partial.
C.2.d.i	be derived from analyses of the information gathered from interdisciplinary assessments, including diagnosis and differential diagnosis;	**Current findings on previous recommendations:** **Recommendation 1, July 2008:** Implement training on the Case Formulation Module for all WRPTs and ensure that the training includes clinical case examples. **Findings:** See C.1.a for a review of NSH's WRP trainings.

Recommendations 2 and 3, July 2008:

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

Findings:

NSH used the DMH WRP Clinical Chart Auditing Form (June to November 2008) to assess compliance with this requirement. The average sample was 15% of the quarterly and annual WRPCs held each month. The following table summarizes the data:

3.	*The case formulation is derived from analyses of the information gathered from interdisciplinary assessments, including diagnosis and differential diagnosis.*	74%
3.a	*All six sections of the case formulation (i.e., pertinent history, predisposing, precipitating, perpetuating factors, previous treatment and present status) are aligned with the Integrated Assessment and/or additional discipline-specific assessments, including*	63%
3.b	*All six sections of the case formulation indicate interdisciplinary participation and are not written from the point of view of one discipline.*	75%

Compliance increased significantly from the previous review period. The following is an outline:

	Previous period	Current period
Mean compliance rate		
3.	10%	74%
Compliance rate in last month of period		
3.	34%	88%
3.a	41%	91%
3.b	56%	97%

During the current review period, NSH identified three programs with low compliance rates for this indicator and sub-indicators. WRP trainers provided in vivo mentoring to these programs, which resulted in improvements in compliance rates.

Current recommendations:

1. Ensure that Case Formulation training includes adequate clinical case examples.
2. Monitor this requirement using the DMH WRP Clinical Chart Auditing Form based on at least a 20% sample.
3. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).
4. Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.

C.2.d.ii

include a review of: pertinent history; predisposing, precipitating and perpetuating factors; previous treatment history, and present status;

4.	*The case formulation includes a review of: pertinent history; predisposing, precipitating and perpetuating factors; previous treatment history, and present status.*	12%
4.a	*Clinical outcomes and responses to treatment in*	51%

	the previous three (3) months described in clinical notes are incorporated into the case formulation.	
4.b	*Information recorded in the "interventions and Response" tab in the Present Status for the previous three (3) months (for a quarterly WRP) or for the previous 12 months (for an annual WRP) has been summarized in the Previous Treatment Section of the Case Formulation.*	40%

	Previous period	Current period
Mean compliance rate		
4.	0%	12%
Compliance rate in last month of period		
4.	0%	45%

Comparison of the sub-indicator compliance rates between the last months of the prior and current review periods is not available as they were modified during this review period. The modification was done to improve alignment with the WaRMSS system and to assess the quality of the case formulation rather than simply assessing the presence or absence of information under each of the 6-P headings.

5.	*The case formulation considers biomedical, psychosocial, and psychoeducational factors as clinically appropriate.*	52%

	Previous period	Current period
Mean compliance rate		
5.	5%	52%

C.2.d.iii	consider biomedical, psychosocial, and psychoeducational factors, as clinically appropriate, for each category in § [III.B.4.b] above;	

		Compliance rate in last month of period 5. 20% 99% During this review period, the sub-indicators were incorporated into the overall indicator and will no longer be reported individually.
C.2.d.iv	consider such factors as age, gender, culture, treatment adherence, and medication issues that may affect the outcomes of treatment and rehabilitation interventions;	6.a *All five factors: age, gender, culture, treatment adherence, and medication issues (are included)* 72% 6.b *(The formulation) addresses how they affect treatment and rehabilitation outcomes* 64% Previous period / Current period Mean compliance rate 6.a 25% 72% 6.b 6% 64% Compliance rate in last month of period 6.a 53% 98% 6.b 22% 96%
C.2.d.v	support the diagnosis by diagnostic formulation, differential diagnosis and Diagnostics and Statistical Manual DSM-IV-TR (or the most current edition) checklists; and	7.a *There is a completed DSM IV-TR Checklist that was completed prior to the 7-day WRP, and thereafter* 54% 7.b *There is a completed DSM IV-TR Checklist completed when there is a change of a psychiatric diagnosis.* 52% Previous period / Current period Mean compliance rate 7.a 23% 54% 7.b 8% 52%

		Compliance rate in last month of period 7.a 33% 62% 7.b 25% 77% (Oct) The facility reported data for sub-indicator 7.b thru October 2008. At that time the sub-indicator was revised. Data will be presented on the revised indicator at the next review.
C.2.d.vi	enable the interdisciplinary team to reach sound determinations about each individual's treatment, rehabilitation, enrichment and wellness needs, the type of setting to which the individual should be discharged, and the changes that will be necessary to achieve discharge.	8.a *The present status section addresses the following: Treatment, Rehabilitation and Enrichment* 56% 8.b *The case formulation identifies required changes in individual and systems to optimize treatment, rehabilitation and enrichment outcomes* 58% 8.c *The case formulation documents a pathway to the discharge setting* 67% 8.d *There is evidence of proper analysis of the following information: of identification of foci, objectives treatment, rehabilitation, and enrichment interventions and there is linkage between the case formulation and the foci of hospitalization, life goals and objectives and interventions.* 68% 8.e *There is proper linkage within different sections of the case formulation when a factor in one section is related to a factor in another section* 57% 8.f *There is evidence of proper analysis of the following information: of identification of foci, objectives treatment, rehabilitation, and enrichment interventions and there is linkage between the case formulation and the foci of hospitalization, life goals and objectives and interventions.* 58% 8.g *The case formulation identifies reasonable and* 59%

		attainable goals/objectives (e.g., at the level of each individual's functioning) that build on the individual's strengths and address the individual's identified needs.

	Previous period	Current period
Mean compliance rate		
8.a	16%	56%
8.b	15%	58%
8.c	14%	67%
8.d	15%	68%
8.e	13%	57%
8.f	8%	58%
8.g	19%	59%
Compliance rate in last month of period		
8.a	34%	62%
8.b	29%	86%
8.c	23%	95%
8.d	38%	90%
8.e	34%	90% (Oct)
8.f	25%	90% (Oct)
8.g	22%	95% (Oct)

The facility reported data for sub-indicators 8.e, 8.f and 8.g until October 2008. At that time they were removed from this tool as they were found to be redundant with other audits.

C.2.e	The therapeutic and rehabilitation service plan specifies the individual's focus of hospitalization (goals), assessed needs (objectives), and how the staff will assist the	**Current findings on previous recommendation:** **Recommendation, July 2008:** Same as in C.2.c, C.2.f, C.2.g and C.2.o.

	individual to achieve his or her goals/objectives (interventions);	**Findings:** Same as in C.2.c, C.2.f, C.2.g and C.2.o. **Other findings:** NSH presented compliance data based on the DMH WRP Chart Auditing Form (June to November 2008). The average sample was 23% of the WRPs due each month. The following table summarizes the data:

4.	*The therapeutic and rehabilitation service plan specifies the individual's focus of hospitalization (goals), assessed needs (objectives) and how the staff will assist the individual to achieve his or her goals/objectives (interventions).*	30%
4.a	*There is a focus of hospitalization for each axis I, II, and III diagnosis*	44%
4.b	*There is a focus for each discharge criteria*	35%
4.c	*Each focus has an objective and an intervention*	41%
4.d	*Each intervention includes the name of the staff responsible for implementation, the group name and the group time/day.*	59%
4.e	*Each objective includes a staff intervention in the therapeutic milieu.*	53%

Compliance increased significantly from the previous review period. The following is an outline:

	Previous period	Current period
Mean compliance rate		
4.	1%	30%

Compliance rate in last month of period		
4.	4%	45%
4.a	29%	75%
4.b	35%	83%
4.c	34%	81%
4.d	39%	90%
4.e	57%	76%

Other findings:
A review of records of 18 individuals (AC-3, BMS, BSC, CEG, CHB, DS, FBG, FG, GMT-2, JDT, JH, MBB, MER, MPP, PG-2, RJA, RW and SP) receiving Rehabilitation Therapy Services (including PSR Mall groups and direct treatment) to assess compliance with the requirements of C.2.e found two records (FG and JDT) in substantial compliance, seven records in partial compliance (AC-3, CEG, CHB, FBG, GMT-2, MBB and MER) and nine records (BMS, BSC, DS, JH, MPP, PG-2, RJA, RW and SP) not in compliance. Identified patterns of deficiencies that the facility should focus on in order to improve compliance include the following:

1. Objectives are not consistently functional, behavioral, observable and measurable and integrated into the WRP.
2. Foci, objectives and interventions are not consistently aligned in the WRP.
3. Interventions are not consistently written as indicated by facility requirements and integrated into the WRP.

A review of records of 20 individuals who had IA-RTS assessments and Rehabilitation Therapy focused assessments during the review period individuals (AH, AWL, BPJ, CMD, CMS, DPA, DSY, EB, FM, GM, JTC-2, LTH, MM-2, OH, PEM-2, PWL, RGW, RJH, RLM-1 and SMS) to assess compliance with the requirements of C.2.e found one record (RJH) in substantial compliance, 14 records in partial compliance (AWL, BPJ, CMS,

		DSY, EB, FM, GM, JTC-2, MM-2, OH, PWL, RGW, RLM-1 and SMS), and five records (AH, CMD, DPA, LTH and PEM-2) not in compliance. Identified patterns of deficiencies that the facility should focus on in order to improve compliance include the following: 1. Objectives are not consistently functional, behavioral, observable and measurable and integrated into the WRP. 2. Foci, objectives and interventions are not consistently aligned in the WRP. 3. Interventions are not consistently written as indicated by facility requirements and integrated into the WRP. A review of records of 11 individuals with completed Nutrition Care assessments across sub-types (CC, DBC, HDE, JAO, JR-2, JT, LLH, OJR, SCL, TJ and UBH) to assess compliance with having an adequate focus, objective and intervention integrated into the WRP found two records (JR-2 and OJR) in substantial compliance, four records (HDE, JT, SCL and TJ) in partial compliance and five records (CC, DBC, JAO, LLH and UDH) not in compliance. Identified patterns of deficiencies that the facility should focus on in order to improve compliance include the following: 1. WRP Nutrition objectives are not consistently specific, behavioral, observable and measurable. 2. Nutrition foci, objectives and interventions are not included in the WRP. **Compliance:** Partial. **Current recommendation:** Same as in C.2.c, C.2.f, C.2.g and C.2.o.
C.2.f	Therapeutic and rehabilitation service planning	Please see sub-cells for compliance findings.

	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:	
C.2.f.i	develop and prioritize reasonable and attainable goals/objectives (e.g., at the level of each individual's functioning) that build on the individual's strengths and address the individual's identified needs and, if any identified needs are not addressed, provide a rationale for not addressing the need;	**Current findings on previous recommendations:** **Recommendation 1, July 2008:** Monitor this requirement using the Chart Auditing Form based on at least a 20% sample. **Findings:** NSH used the DMH WRP Chart Auditing Form to assess compliance (June to November) with the requirements in C.2.f.i through C.2.f.v. The average sample was 15% of the WRPCs held each month. The following table summarizes the data:

5.	*The team has developed and prioritized reasonable and attainable goals/objectives (e.g. at the level of each individual's functioning) that build on the individual's strengths and addresses the individual's identified needs and, if any identified needs are not addressed, provide a rationale for not addressing the need.*	35%
5.a	*All objectives for Focus 1, 3, and 5 are linked to the individual's stage of change*	44%
5.b	*The individual's strengths are used in the interventions.*	66%
5.c	*There is documented rationale in the focus area if*	16%

	any focus of hospitalization does not have an objective or an intervention.	

Compliance increased significantly from the previous review period. The following is an outline:

	Previous period	Current period
Mean compliance rate		
5.	14%	35%
Compliance rate in last month of period		
5.	25%	68%
5.a	29%	76%
5.b	65%	88%
5.c	0%	13%

NSH also used the DMH WRP Observation Monitoring Form (June to November 2008) to assess compliance with this requirement. The average sample was 25% of the WRPCs each month. The following table summarizes the data:

7.	*The treatment plan includes the individual's strengths related to each enrichment, treatment, or rehabilitation objective.*	10%
7.a	*Strengths are identified and incorporated into the interventions offered.*	18%
7.b	*The strengths are related to each treatment, rehabilitation or enrichment objective.*	10%

Compliance showed mixed changes from the previous review period. The following is an outline:

	Previous period	Current period
Mean compliance rate		
7.	6%	10%
Compliance rate in last month of period		
7.	9%	5%
7.a	14%	15%
7.b	9%	5%

Recommendation 2, July 2008:
Provide data analysis that evaluates low compliance and delineates areas of relative improvement (during the reporting period and compared to the last period).

Findings:
The facility's data analysis and corrective actions are summarized in C.1.a and C.2.a. Additionally, NSH reported that development of the WaRMSS MAPP 2 module emphasized the inclusion of individuals' strengths on active treatment rosters to assist facilitators in incorporating these strengths into Mall groups.

Recommendation 3, July 2008:
Ensure that senior clinicians provide needed supervision and mentoring to improve compliance.

Findings:
Same as in C.1.a.

Other findings:
This monitor reviewed the charts of six individuals (ANA, EAB, HLA MM-1, RL and TJM). The review found compliance in four charts (ANA, EAB, HLA and RL), partial compliance in one (MM-1) and noncompliance in one

		(TJM). **Compliance:** Partial. **Current recommendations**: 1. Monitor this requirement using the DMH WRP Chart Auditing Form and the DMH WRP Observation Monitoring Form based on at least a 20% sample. 2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period. 3. Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.
C.2.f.ii	ensure that the objectives/ interventions address treatment (e.g., for a disease or disorder), rehabilitation (e.g., skills/supports, motivation and readiness), and enrichment (e.g., quality of life activities);	**Current findings on previous recommendation:** **Recommendation, July 2008:** Same as in C.2.f.i. **Findings:** NSH used the DMH WRP Chart Auditing Form (June to November 2008) to assess compliance with this requirement. The average sample was 23% of the WRPCs held each month. The following table summarizes the data: 6. *The objectives/interventions address treatment (e.g., for a disease or disorder), rehabilitation (e.g., skills/supports, motivation and readiness), and enrichment (e.g., quality of life activities.)* — 83% 6.a *There are specific skills training and support groups identified in the interventions that are linked to specific objectives and are provided in the PSR mall.* — 97%

6.b	*There are specific leisure and recreation groups specified in the interventions that are linked to objectives derived from Focus 10.*	94%

Note: the facility's rate for 6.a was based on incomplete data and did not appear to be consistent with the limited data provided.

Compliance increased significantly from the previous review period. The following is an outline:

	Previous period	Current period
Mean compliance rate		
6.	32%	83%
Compliance rate in last month of period		
6.	56%	95%
6.a	72%	98%
6.b	77%	96%

Other findings:
This monitor found compliance in all six charts reviewed (ANA, EAB, HLA MM-1, RL and TJM).

Compliance:
Partial.

Current recommendations:
1. Monitor this requirement using the DMH WRP Chart Auditing Form based on at least a 20% sample.
2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period.
3. Provide a summary outline of improvements in practice made as a result

		of review by the facility of internal monitoring data.
C.2.f.iii	write the objectives in behavioral, observable, and/or measurable terms;	**Current findings on previous recommendation:** **Recommendation, July 2008:** Same as in C.2.f.i. **Findings:** The facility reported a mean compliance rate of 27%, compared to 10% during the last review. The compliance rate for the last month of this period was 63% compared to 22% during the last review. **Other findings:** This monitor found partial compliance in all six charts reviewed (ANA, EAB, HLA, MM-1, RL and TJM). **Compliance:** Partial. **Current recommendation**: Same as in C.2.f.ii.
C.2.f.iv	include all objectives from the individual's current stage of change or readiness for rehabilitation, to the maintenance stage for each focus of hospitalization, as clinically appropriate;	**Current findings on previous recommendation:** **Recommendation, July 2008:** Same as in C.2.f.i. **Findings:** The facility reported a mean compliance rate of 53%, compared to 16% during the last review. The compliance rate for the last month of this period increased to 89% from 29% during the last review.

		Other findings: This monitor found partial compliance in five charts (ANA, EAB, HLA, MM-1 and RL) and compliance in one (TJM). **Compliance:** Partial. **Current recommendation**: Same as in C.2.f.ii.
C.2.f.v	ensure that there are interventions that relate to each objective, specifying who will do what, within what time frame, to assist the individual to meet his/her needs as specified in the objective;	**Current findings on previous recommendation:** **Recommendation, July 2008:** Same as in C.2.f.i. **Findings:** The facility reported a mean compliance rate of 51%, compared to 18% during the last review. The compliance rate for the last month of this period increased to 81% from 33% during the last review. **Other findings:** This monitor found compliance in four charts (ANA, HLA, RL and TJM) and partial compliance in two (EAB and MM-1). **Compliance:** Partial. **Current recommendation**: Same as in C.2.f.ii.
C.2.f.vi	implement interventions appropriately throughout the individual's day, with a minimum of 20 hours of active treatment	**Current findings on previous recommendation:**

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;

Recommendation, July 2008:
Continue to monitor hours of active treatment (scheduled and attended) and provide data regarding number of individuals, hours scheduled and hours attended as well as analysis and corrective actions to ensure that individuals attend the required hours.

Findings:
The table below showing the facility's census (N) and individuals' scheduled and attended Mall during this review period (June to November 2008) is a summary of the facility's data:

	Number of individuals by category	
	Mean scheduled hours	Mean attended hours
N	1167	1167
Hours:		
0-5	58	601
6-10	76	324
11-15	200	159
16-20	833	83

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

Mall Attendance		
	Previous period	Current period
Mean number of individuals		
0-5 hours	587	601
6-10 hours	298	324
11-15 hours	59	159
16-20+ hours	88	83

Number of individuals in last month of period		
0-5 hours	459	559
6-10 hours	393	341
11-15 hours	217	176
16-20+ hours	93	95

As the tables above show, even though NSH is scheduling an increasing number of individuals for (close to) the required 20 hours of Mall services per week, the number of individuals actually attending 16-20 hours per week is low (seven percent of the facility's population).

According to the Clinical Administrator, she and the Enhancement Plan Coordinator at NSH met with Discipline Chiefs, Seniors, and Program Management staff to improve participation of individuals in their assigned Mall groups, as well as to ensure that Mall groups are held as scheduled. In addition, the Enhancement Plan Coordinator worked with Nursing coordinators to increase the number of Mall groups facilitated by the unit nursing staff.

NSH experienced an increase in the number of individuals triggering the non-adherence to WRP threshold during this review period, with a mean of 252 individuals per week. Correspondingly, NSH increased the number of Enhancing Motivation groups to 144 to motivate individuals to attend their scheduled PSR services.

NSH continues to use Narrative Restructuring Therapy (NRT) as part of a number of interventions to motivate individuals to engage in treatment. However, the number of trained staff is limited thereby reducing the number of individuals receiving NRT to only four (the number receiving NRT during the previous period was 10).

NSH should utilize all available assessments, interventions and supports to motivate individuals to regularly attend their assigned PSR services. Certainly, reducing the hours/numbers of effective interventions/ supports is not the way to do it, as appears to be the case with NRT despite the fact that treatment outcome is favorable for all current participants.

Other findings:
This monitor reviewed eight charts (BT, CG, DF, DL, GB, JC, PW and VH) to assess documentation of active treatment hours listed on the WRP and corresponding MAPP data regarding hours scheduled and attended. The table below showing the individuals' WRP scheduled hours, their MAPP scheduled hours, and their MAPP attended hours is a summary of the data:

Individual	WRP scheduled	MAPP scheduled	MAPP attended
BT	14	5	2
CG	20	21	10
DF	17	20	16
DL	13	17	12
GB	18	20	2
JC	16	21	11
PW	13	17	7
VH	8	3	3

As the table above shows, there is a wide variation in the hours of scheduled activities in both the WRP and MAPP. The hours attended is low. There are also differences between the WRP and MAPP scheduled hours.

This monitor's review of the lesson plan for the Enhancing Motivation group and interview of the facilitator from one of the Enhancing Motivation groups found that identifying and problem-solving reasons for

		an individual's reluctance to attend assigned PSR services is not an integral part of the topics covered in the groups. It is important for facilitators of these groups to assess the causes of the barriers to participation so that individualized support can be offered to assist individuals to attend their assigned groups. **Compliance:** Partial. **Current recommendation**: Continue to monitor hours of active treatment (scheduled and attended) and provide data regarding number of individuals, hours scheduled and hours attended as well as analysis and corrective actions to ensure that individuals attend the required hours.
C.2.f.vii	maximize, consistent with the individual's treatment needs and legal status, opportunities for treatment, programming, schooling, and other activities in the most appropriate integrated, non-institutional settings, as clinically appropriate; and	**Current findings on previous recommendations:** **Recommendations 1 and 2, July 2008:** • Monitor this requirement based on at least a 20% sample. • Provide data analysis that evaluates low compliance and delineates areas of relative improvement (during the reporting period and compared to the last period). **Findings:** Using item 10 from the DMH Chart Auditing Form, NSH assessed its compliance based on review of an average sample of 23% of the WRPs due (in Program IV) for the month (June to November 2008). The table below is a summary of the data. 10. *The WRP maximizes, consistent with the individual's treatment needs and legal status, opportunities for treatment, programming, schooling, and other activities in the most appropriate integrated, non-* — 12%

		institutional settings, as clinically appropriate. Comparative data showed only modest improvement in compliance from 2% in the last review. This monitor reviewed the charts of four individuals who were admitted under civil commitment (CC, DN, LAC and SFL). Two of them (LAC and SFL) had programming opportunities to participate in the most appropriate integrated setting, and the other two did not (CC and DN). According to NSH, WRPTs have difficulty in specifying facilitator, time and location of the non-institutional activities for which the individual is scheduled. To address this barrier, NSH has directed the Mall services staff to complete assessments for off-facility treatment and track the services for these individuals. In addition, the Clinical Administrator has directed that as of February 2009, the Mall Director and the Program IV Director will ensure that WRPTs recommend a minimum of one off-facility Mall group. **Compliance:** Partial. **Current recommendations**: 1. Monitor this requirement based on at least a 20% sample. 2. Provide data analysis that evaluates low compliance and delineates areas of relative improvement (during the reporting period and compared to the last period).
C.2.f.viii	ensure that each therapeutic and rehabilitation service plan integrates and coordinates all services, supports, and treatments provided by or through each State hospital for the individual in a manner	**Current findings on previous recommendation:** **Recommendation, July 2008:** Monitor this requirement using the WRP Mall Alignment Checklist and implement corrective actions to improve compliance.

	specifically responsive to the plan's therapeutic and rehabilitation goals. This requirement includes but is not limited to ensuring that individuals are assigned to mall groups that link directly to the objectives in the individual's WRP and needs.	**Findings:** Using item 1 from the DMH Mall Alignment Monitoring Form, NSH assessed its compliance based on a mean sample of 20 charts (2% of the average monthly population) for each month of this review period (June to November 2008). The following is a summary of the data: 1. *Integrates and coordinates all services, supports, and treatments provided by or through each state hospital for the individual in a manner specifically responsive to the plan's therapeutic and rehabilitation goals. This requirement includes but is not limited to ensuring that individuals are assigned to mall groups that link directly to the objectives in the individual's WRP and needs.* — 42% Comparative data showed modest improvement in compliance from 32% in the prior review period. This monitor reviewed six charts (BT, DL, GB, JC, PW and VH). The interventions, supports and skills identified in two of the WRPs in the charts (GB and JC) evidenced proper alignment between the individual's needs, documentation in the WRP, and the services and support provided. The remaining four (BT, DL, PW and VH) did not evidence full alignment. NSH reported that a change in leadership at the Mall Director's level during this review period slowed down the improvement process. To correct this situation, NSH plans to have the Mall leadership complete Mall alignment evaluation on a monthly basis and present the data with corrective actions to the Mall Services Coordinators and the Clinical Management Team. **Compliance:**

		Partial. **Current recommendation**: Monitor this requirement using the WRP Mall Alignment Checklist and implement corrective actions to improve compliance.
C.2.g	Therapeutic and rehabilitation service plans are revised as appropriate to ensure that planning is based on the individual's progress, or lack thereof, as determined by the scheduled monitoring of identified criteria or target variables, consistent with generally accepted professional standards of care. Specifically, the interdisciplinary team shall:	Please see sub-cells for compliance findings.
C.2.g.i	revise the focus of hospitalization, objectives, as needed, to reflect the individual's changing needs and develop new interventions to facilitate attainment of new objectives when old objectives are achieved or when the individual fails to make progress toward achieving these objectives;	**Current findings on previous recommendations:** **Recommendations 1 and 2, July 2008:** • Monitor this requirement using both clinical chart and process observation auditing based on at least a 20% sample. • Provide data analysis that evaluates low compliance and delineates areas of relative improvement (during the reporting period and compared to the last period). **Findings:** NSH used the DMH WRP Observation Monitoring Form (June to November 2008) to assess compliance with this requirement. The average sample was 25% of the WRPCs held each month. The following table summarizes the data: 8. *The team revised the focus of hospitalization, objectives, as needed, to reflect the individual's changing needs and developed new interventions to* — 11%

	facilitate attainment of new objectives when old objectives are achieved or when the individual fails to make progress toward achieving these objectives.	
8.a	*When an objective has been achieved the team develops a new objective and associated intervention(s) for that focus of hospitalization.*	15%
8.b	*When an individual has not shown progress on an objective for two months the team revises or develops a new objective or a new intervention.*	4%

Compliance showed mixed changes from the previous review period:

	Previous period	Current period
Mean compliance rate		
8.	7%	11%
Compliance rate in last month of period		
8.	12%	10%
8.a	18%	12%
8.b	5%	4%

NSH also used the DMH WRP Clinical Chart Auditing Form (June to October 2008) to assess compliance with this requirement. The average sample was 14% of the quarterly and annual WRPCs held each month. The following table summarizes the data:

9.	*The team revised the focus of hospitalization, objectives, as needed, to reflect the individual's changing needs and developed new interventions to facilitate attainment of new objectives when old objectives are achieved or when the individual fails to make progress toward achieving these objectives.*	22%

9.a	*When an objective has been achieved the team develops a new objective and associated intervention(s) for that focus of hospitalization.*	53%
9.b	*When an individual has not shown progress on an objective for two months the team revises or develops a new objective or a new intervention.*	19%

Compliance showed mixed changes from the previous review period:

	Previous period	Current period
Mean compliance rate		
9.	13%	22%
Compliance rate in last month of period		
9.	37%	19%
9.a	48%	59%
9.b	27%	19%

NSH's analysis and actions plans are the same as those described in C.1.a and C.2.a.

Other findings:
This monitor found compliance in four charts (ANA, EAB, HLA and RL), partial compliance in one (TJM) and noncompliance in one (MM-1).

Additionally, a review of records of 17 individuals receiving direct Occupational, Physical, and Speech Therapy services (ARL-2, BMS, BSC, CEC, DM, DP, DS, JAH, JH, JH-2, JJR, OH, RW, SP, TTR, WAB and WFO) found seven records (BSC, DP, JH, OH, RW, SP and TTR) in compliance and ten records (ARL-2, BMS, CEC, DM, DS, JAH, JH-2, JJR, WAB and WFO) not in compliance.

		Compliance: Partial. **Current recommendations**: 1. Monitor this requirement using the DMH WRP Clinical Chart Auditing Form based on at least a 20% sample. 2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period. 3. Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.
C.2.g.ii	review the focus of hospitalization, needs, objectives, and interventions more frequently if there are changes in the individual's functional status or risk factors (i.e., behavioral, medical, and/or psychiatric risk factors);	**Current findings on previous recommendations:** **Recommendation 1, July 2008:** Implement corrective actions to ensure: a. Review by the WRPTs of the use of seclusion/restraints and the circumstances related to such use; and b. Timely and appropriate modification of the WRPs in response to the review. **Findings:** This monitor reviewed the charts of six individuals who experienced the use of seclusion and/or restraints during this review period (AC-1, DP, ERM, FTP, HMS and MKS). The review focused on the documentation in the present status section of the following: 1. The use of restrictive interventions; 2. The circumstances leading to use; 3. The treatment provided to avert the use of these interventions; 4. Modifications of ongoing treatment to decrease the risk of future occurrences; and 5. Assessment/update of risk factors as a result of these incidents.

The review found noncompliance in four charts (AC-1, DP, ERM and FTP) and partial compliance in two (HMS and MKS).

Recommendations 2 and 3, July 2008:

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

Findings:

NSH used the DMH WRP Observation Monitoring Form (June to November 2008) to assess compliance with this requirement. The average sample was 25% of the WRPCs held each month. The following table summarizes the data:

9.	*The team revised the focus of hospitalization, objectives, as needed, to reflect the individual's changing needs and developed new interventions to facilitate attainment of new objectives when old objectives are achieved or when the individual fails to make progress toward achieving these objectives.*	12%
9.a	*When an objective has been achieved, the team develops a new objective and associated intervention(s) for that focus of hospitalization.*	12%
9.b	*When an individual has not shown progress on an objective for two months, the team revises or develops a new objective or a new intervention.*	29%

Comparative data showed mixed changes in compliance from the prior review period:

	Previous period	Current period
Mean compliance rate		
9.	15%	12%
Compliance rate in last month of period		
9.	12%	13%
9.a	12%	13%
9.b	23%	30%

NSH also used the DMH WRP Chart Auditing Form (June to October 2008) to assess compliance with this requirement. The average sample was 23% of the WRPCs held each month. The facility reported a mean compliance rate of 40% compared to 6% during the last review. The rate for the last month of this period increased to 47% from 23% during the last month of the previous review period.

NSH reported its expectation that the implementation of the new DMH Risk Management Special Order in December 2008 will improve compliance with this indicator. This new procedure contains mechanisms to identify thresholds and triggers, to communicate thresholds and triggers to the WRPTs and track timeliness of WRP revisions.

Recommendation 4, July 2008:
Revise the current monitoring tool to include individuals whose functional status has improved.

Findings:
The facility has not yet addressed this recommendation.

Compliance:
Partial.

		Current recommendations: 1. Develop and implement corrective actions to ensure: a. Review by the WRPTs of the circumstances related to the use of restrictive interventions and b. Timely and appropriate modification of the WRPs in response to the review. 2. Report on the status of implementation of the new risk management procedure regarding identification of individuals at risk and provision of timely and appropriate interventions to reduce the risk. 3. Monitor this requirement using the DMH WRP Observation Monitoring Form and DMH WRP Chart Auditing Form based on at least a 20% sample. 4. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period. 5. Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.
C.2.g.iii	ensure that the review process includes an assessment of progress related to discharge to the most integrated setting appropriate to meet the individuals assessed needs, consistent with his/her legal status; and	**Current findings on previous recommendations:** **Recommendation 1, July 2008:** Implement training of the WRPTs based on the MSH module regarding discharge planning. **Findings:** NSH's training programs, including recent revisions, are described in C.1.a. **Recommendations 2 and 3, July 2008:** • Continue to monitor this requirement using process observation based on at least a 20% sample. • Provide data analysis that evaluates low compliance and delineates areas of relative improvement (during the reporting period and compared to the last period).

Findings:
NSH used the DMH WRP Observation Monitoring Form (June to November 2008) to assess compliance with this requirement. The average sample was 25% the WRPCs held each month. The following table summarizes the data:

10.	*The review process includes an assessment of progress related to discharge to the most integrated setting appropriate to meet the individuals assessed needs, consistent with his/her legal status.*	7%
10.a	*The team reviews all foci that are barriers to discharge.*	30%
10.b	*The team reviews the PSR Mall Facilitator's Monthly Notes for all objectives related to discharge.*	5%

Compliance rates increased only modestly from the previous review period:

	Previous period	Current period
Mean compliance rate		
10.	5%	7%
Compliance rate in last month of period		
10.	3%	5%
10.a	19%	30%
10.b	0%	4%

The facility identified inconsistent documentation and utilization of PSR Mall Notes as a barrier to increased compliance with this requirement. The members of Clinical Management Team intend to track completion and utilization of these notes. Additionally, NSH reported that all clinical social workers will complete discipline-specific training in February 2009.

		This training will emphasize their role in identification and review of foci that are barriers to discharge. **Other findings:** This monitor's review focused on documentation in the present status section of the case formulation of the following functions of the WRPT: 1. The formulation of discharge criteria that weare measurable and sufficiently individualized; and 2. The discussion of the individual's progress towards these criteria. The review found partial compliance in four charts (ANA, HLA, MM-1 and RL) and compliance in two (EAB and TJM). **Compliance:** Partial. **Current recommendations**: 1. Develop and implement corrective actions to ensure that discharge criteria are individualized and that the WRPTs document their discussion of progress towards discharge criteria. 2. Monitor this requirement using DMH WRP Observation Monitoring Form in this section and DMH Discharge Planning and Community Integration in section E.3 based on at least a 20% sample. 3. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period. 4. Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.
C.2.g.iv	base progress reviews and revision recommendations on data collected as specified in the therapeutic and	**Current findings on previous recommendations:**

rehabilitation service plan.

Recommendation 1, July 2008:
Same as in C.2.g.i.

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

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

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

Recommendation 3, July 2008:
Revise the current format of the Mall Facilitator note to ensure that the notes adequately inform the WRPTs of the individual's progress.

Findings:
The template for the Mall Facilitator note was updated in alignment with this recommendation. The facility reported that it would begin using the updated template in June 2009 when the WaRMSS MAPP2 module is fully implemented.

Other findings:
NSH used the DMH WRP Observation Monitoring Form (June to November 2008) to assess compliance with this requirement. The average sample was 25% of the WRPCs held each month. The following table summarizes the data:

11.	*Progress reviews and revision recommendations are based on data collected as specified in the therapeutic and rehabilitation service plan.*	3%
11.a	*The team reviews the PSR Mall Facilitator's Monthly Progress Notes for all current objectives*	4%

	and interventions for this individual.	
11.b	*Revisions to the WRP are based on the data provided by the group facilitator or individual therapist in the PSR Mall Facilitator's Monthly Progress Notes, if applicable.*	3%

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

	Previous period	Current period
Mean compliance rate		
11.	1%	3%
Compliance rate in last month of period		
11.	2%	2%
11.a	2%	3%
11.b	3%	2%

Reviews by this monitor focused on the following functions of the WRPT:

1. The completion and timely filing of the Mall Facilitator progress note template;
2. The implementation of the DMH updated Mall Facilitator Progress Note template to capture sufficient information to guide the revisions of the WRP and
3. The review of the notes and the integration and utilization of this review in the revisions of the WRP.

The review found partial compliance in five charts (ANA, EAB, HLA, MM-1 and RL) and noncompliance in one (TJM).

Compliance:
Partial.

		Current recommendations: 1. Implement the DMH updated template of the Mall Facilitator's Note. 2. Monitor this requirement using DMH WRP Observation Monitoring Form based on at least a 20% sample. 3. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period. 4. Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.
C.2.h	Individuals in need of positive behavior supports in school or other settings receive such supports consistent with generally accepted professional standards of care.	Please see F.2.a through F.2.c (including sub-cells) for PBS-related recommendations.
C.2.i	Adequate active psychosocial rehabilitation is provided, consistent with generally accepted professional standards of care, that:	**Compliance:** Partial.
C.2.i.i	is based on the individual's assessed needs and is directed toward increasing the individual's ability to engage in more independent life functions;	**Current findings on previous recommendations:** **Recommendation 1, July 2008:** Assess the WRP for integration of this element of the assessments into the WRP. **Findings:** NSH provided training to Discipline Seniors and Program Management on the revised Mall Alignment Monitoring and Facilitator Observation Monitoring Tools. NSH also assigned oversight of the NSH MAPP Program to the Mall Director. NSH has assigned three MAPP Operators to support Mall services.

Using item 2 from the DMH WRP Mall Alignment Monitoring Form, NSH assessed its compliance based on an average sample of 2% of census for the month (June to November 2008). The following is a summary of the data:

2.	*Is based on the individual's assessed needs and is directed toward increasing the individual's ability to engage in more independent life functions*	48%

Comparative data showed improvement in compliance from 20% in the prior review period.

This monitor reviewed 17 charts (AC-2, ADS, AVN, CHH, DML, DN, DN-2, FK, GAR, IL, JHM, JWM, RDZ, SPP, SSB, TL and YJL). Information in 11 of the WRPs in the charts (AC-2, AVN, CHH, DML, DN, FK, IL, SPP, SSB, TL and YJL) indicated that active interventions were offered in accordance with the individual's level of functioning, stage of change, and discharge needs, and matched with the individual's PSR Mall services. The remaining six WRPs (ADS, DN-2, GAR, JHM, JWM and RDZ) showed a number of discrepancies between the individual's needs and the services offered. The discrepancies included a lack of match between the services offered and that stated in the intervention sections, absence of foci and associated objectives and interventions for life goals and discharge criteria.

NSH had difficulty updating WRPs when changes were made to treatment schedules, encountered MAPP errors, and experienced performance deficits with new team members. NSH plans to provide focused training and mentoring to improve staff performance, review WRP data on a monthly basis at Clinical Management Team meetings, and rectify MAPP errors.

		Recommendation 2, July 2008: Ensure that there is a match among the WRP, Mall activity schedule, and the group individuals attend. **Findings:** This monitor reviewed 12 charts (AC-2, ADS, AN, CM, DML, DR, FLK-2, ILL, JEB, JH, TL and YL). There was agreement between the recommendations in the individual's WRP and the groups in the Mall activity schedule in two of the WRPs (DML and ILL) in the charts. There was disagreement with one or more of the Mall groups identified in the WRP and the Mall activity schedule in the remaining 10 WRPs (AC-2, ADS, AN, CM, DR, FLK-2, JEB, JH, TL and YL). According to the Compliance Director and the Mall Director, the computer MAPP system was spewing out too many errors, causing the disagreement between the WRP documentation and the MAPP Mall activity schedule. **Other findings**: A review of records of 18 individuals (AC-3, BMS, BSC, CEG, CHB, DS, FBG, FG, GMT-2, JDT, JH, MBB, MER, MPP, PG-2, RJA, RW and SP) receiving Rehabilitation Therapy Services (including PSR Mall groups and direct treatment) to assess compliance with the requirements of C.2.i.i found 17 records (AC-3, BMS, BSC, CEG, CHB, DS, FBG, FG, GMT-2, JDT, JH, MER, MPP, PG-2, RJA, RW and SP) in compliance and one record (MBB) not in compliance. **Current recommendations**: 1. Assess the WRP for integration of this element of the assessments into the WRP. 2. Ensure that there is a match among the WRP, Mall activity schedule, and the group individuals attend.

<table>
<tr>
<td>C.2.i.ii</td>
<td>Has documented objectives, measurable outcomes, and standardized methodology</td>
<td>

Current findings on previous recommendations:

Recommendation 1, July 2008:
Ensure that learning outcomes are developed and are stated in measurable terms.

Findings:
Using item 7 from the DMH WRP Chart Auditing Form, NSH assessed its compliance based on an average sample of 21% of the census for the month (June to November 2008). The following is a summary of the data:

<table>
<tr>
<td>7.</td>
<td>The WRP plan includes behavioral, observable, and/or measurable objectives written in terms of what the individual will do.</td>
<td>40%</td>
</tr>
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Comparative data showed improvement in compliance from 12% in the prior review period.

This monitor reviewed 11 charts (AVN, CHH, DN, DN-2, GAR, ILL, JHM, JWM, RDZ, SPP and SSB). Five of the WRPs in the charts (CHH, DN, JWM, SPP and SSB) stated the learning outcomes in measurable terms and the remaining six (AVN, DN-2, GAR, ILL, JHM and RDZ) did not.

To improve compliance, NSH has arranged for the Mall management team to conduct monthly audits on Mall alignment issues and deliver corrective actions to Mall Services coordinators and the clinical management team. The Clinical Administrator will review the performance and corrective actions taken.

Recommendation 2, July 2008:
Ensure that the DMH PSR Mall Facilitator Monthly Progress Note is implemented and made available to the teams for tracking outcomes related to the WRP.

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		Findings: This monitor reviewed 10 charts (AC-2, ADS, AVN, CWR, DML, FLK-2, ILL, JH, TL and TM). One of them (AVN) did not have any notes. The remaining nine had one or more notes (none of the charts contained all the required notes for all the Mall groups to which the individual had been assigned). Six (AC-2, ADS, CWR, DML, FLK-2 and TL) of the nine had documented evidence in the Present Status section showing the WRPTs had reviewed the notes. There was no evidence of a review of the notes in three of them (ILL, JH and TM). **Current recommendations**: 1. Ensure that learning outcomes are developed and are stated in measurable terms 2. Ensure that the DMH PSR Mall Facilitator Monthly Progress Note is implemented and made available to the teams for tracking outcomes related to the WRP.
C.2.i.iii	Is aligned with the individual's objectives that are identified in the individual's Wellness and Recovery Plan	**Current findings on previous recommendation:** **Recommendation, July 2008:** Ensure that all therapies and rehabilitation services provided in the Malls are aligned with the assessed needs of the individuals. **Findings:** Using item 4 from the DMH WRP Mall Alignment Monitoring Form, NSH assessed its compliance based on an average sample of 2% of the census for the month (June to November 2008). The following is a summary of the data: 4. *Is aligned with the individual's objectives that are identified in the individual's Wellness and Recovery Plan.* — 72%

		Comparative data showed improvement in compliance from 49% in the prior review period. Compliance was 92% in the last month of the current review period. This monitor reviewed eight charts (BT, CG, DF, DL, GB, JC, PW and VH). In three charts (DF, GB and JC), identified therapies and services were aligned with the individual's assessed needs, and the prescribed groups and services matched with the Mall and/or recreational and leisure schedules. The individuals' needs and services offered were misaligned in five charts (BT, CG, DL, PW and VH). In many cases, groups identified in the WRPs were not listed in the Mall schedule, or the groups listed in the Mall schedule were not documented in the WRPs. The Mall Director indicated that there were issues with the MaPP program. NSH plans to continue with mentoring and monitoring to improve compliance to this recommendation. The facility will continue to address this issue during the Monthly Provider Meetings, post compliance data at Clinical Management Team Meetings, increase Mall staff to provide better supervision and audits, and rectify issues related to the MaPP program. **Current recommendation**: Ensure that all therapies and rehabilitation services provided in the Malls are aligned with the assessed needs of the individuals.
C.2.i.iv	utilizes the individual's strengths, preferences, and interests;	**Current findings on previous recommendations:** **Recommendations 1 and 2, July 2008:** • Ensure that the individual's strengths, preferences, and interests are clearly specified in the interventions in the individual's WRP in accordance with the DMH WRP manual. • Ensure that the group facilitators and individual therapists know and use the individual's strengths, preferences and interests when

delivering rehabilitation services.

Findings:
According to the Clinical Administrator, WRP trainers worked with the WRPTs on this recommendation. Discipline Chiefs and Seniors continue to meet with WRPTs to ensure that strengths are included in the intervention sections. Monthly Providers meetings review methods of incorporating individuals' strengths during Mall group sessions. Licensed Nursing staff has been participating in six-hour mandatory training that includes a two-hour session on WRP.

Using item 5 from the DMH WRP Mall Facilitator Checklist, NSH assessed its compliance based on an average sample of 2% of the census for the month (June to November 2008). The following is a summary of the data:

5.	*Provider utilizes the individual's strengths, preferences, and interests.*	72%

Comparative data showed improvement in compliance from 30% in the prior review period. Compliance was 91% in the last month of the current review period.

This monitor reviewed 11 charts (AC-2, AVN, CWR, DML, DR, FLK-2, ILL, JEB, TL, TM and YL). Five of the WRPs in the charts (CWR, DML, DR, FLK-2 and YL) specified the individual's strengths, preferences, and interests in the intervention sections of the individual's WRP. The remaining six (AC-2, AVN, ILL, JEB, TL and TM) either failed to include the individual's strengths, preferences, and/or interests in the interventions or the documented strengths, preferences, and interests were not aligned with the intervention or were of poor quality.

This monitor observed four Mall groups (Substance Abuse Recovery, Reality Orientation, Relaxation Technique, and Life Skills). The facilitator

		in the Substance Abuse group conducted the lesson using the individuals' needs, preferences, and strengths. The facilitators in the Reality Orientation group were not the primary/regular facilitators and were unable to use the individuals' strengths, preferences, and interests. The facilitators in the other two groups were familiar with the individuals and when asked by this monitor were able to state the strengths and interests of a number of individuals in the group. However, the facilitators did not use this information but rather used generic motivational strategies. According to NSH, low compliance was due to poor communication of individuals' strengths to Mall group facilitators, and the Course Outline MAPP 1 Modules have not been implemented. To improve performance, NSH has directed Mall facilitators to use the WaRMSS WRP module to identify strengths of individuals. NSH will also roll out the group rosters with the individuals' strengths. **Current recommendations**: 1. Ensure that the individual's strengths, preferences, and interests are clearly specified in the interventions in the individual's WRP in accordance with the DMH WRP manual. 2. Ensure that the group facilitators and individual therapists know and use the individual's strengths, preferences and interests when delivering rehabilitation services.
C.2.i.v	focuses on the individual's vulnerabilities to mental illness, substance abuse, and readmission due to relapse, where appropriate;	**Current findings on previous recommendations:** **Recommendations 1-3, July 2008:** • Address and correct factors related to low compliance with the requirement to include the individual's vulnerabilities in the case formulation under predisposing, precipitating, and perpetuating factors. • Present monitoring data regarding the recommendation to include in

the present status an update on the current status of these vulnerabilities.

- Complete substance abuse training on all stages of change to all group facilitators.

Findings:
Using item 6 from the DMH WRP Mall Alignment Monitoring Form, NSH assessed its compliance based on an average sample of 2% of the census for the month (June to November 2008). The following is a summary of the data:

6.	*Focuses on the individual's vulnerabilities to mental illness, substance abuse, and readmission due to relapse, when appropriate.*	52%

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

	Previous period	Current period
Mean compliance rate		
6.	36%	52%
Compliance rate in last month of period		
6.	25%	58%

This monitor reviewed 11 charts (AC-2, AVN, CWR, DML, DR, FLK-2, ILL, JEB, TL, TM and YJL). Eight of the WRPs in the charts (AC-2, CWR, DML, DR, FLK-2, TL, TM and YJL) included the individual's vulnerabilities in the case formulation under predisposing, precipitating, and perpetuating factors, and where appropriate updated the current status of these vulnerabilities in the present status section of the WRP. Three of them (AVN, ILL, and JEB) did not fully describe the individual's vulnerabilities or update the current status of the individual's vulnerabilities.

		Other findings: NSH increased the number of WRAP Mall groups, which have curricula designed to include vulnerabilities to mental illness, substance abuse, and relapse. WRAP facilitator training had been conducted four times during this review period. However, according to the Mall Director and the Clinical Administrator, the 40 WRAP Mall group sessions offered during this review period are insufficient for all individuals to participate in the WRAP groups that address their vulnerabilities to mental illness, substance abuse, and relapse. In addition, the current course offerings are for those functioning at an average level, and many individuals are not able to participate in these WRAP groups due to their levels of impairment and/or lack of motivation. Furthermore, not all groups offered for Foci 1, 3, 5, and 7 are staged or offered at the individuals' cognitive levels. As plan of improvement, NSH plans to offer WRAP Mall groups at different levels to enable all individuals to participate. Mall leadership is to submit corrective actions to Mall Services Coordinators and the Clinical Management Team. The Clinical Administrator will review the status of this plan. NSH continues to provide Substance Recovery (SR) training on all stages of change to its providers. Interview of the Mall Director and documentation review found that NSH has 131 Substance Recovery providers (75 psychologists and 56 psychiatrists), and 71 SR curriculum-trained providers (includes psychologists, psychiatrists, social workers, nursing, and rehabilitation therapists). NSH offered 39 SR groups during this review period. However, NSH needs to offer as many as 57 more SR groups to address the needs of all individuals with a Substance Abuse diagnosis. (NSH currently has 684 individuals with at least one Substance Abuse Diagnosis.)

		Current recommendations: 1. Address and correct factors related to low compliance with the requirement to include the individual's vulnerabilities in the case formulation under predisposing, precipitating, and perpetuating factors. 2. Present monitoring data regarding the recommendation to include in the present status an update on the current status of these vulnerabilities. 3. Complete substance abuse training on all stages of change to all group facilitators. 4. Increase the number of WRAP groups offered and provide WRAP groups targeted to different cognitive levels. 5. Increase the number of Substance Recovery groups offered.
C.2.i.vi	is provided in a manner consistent with each individual's cognitive strengths and limitations;	**Current findings on previous recommendations:** **Recommendations 1-3, July 2008:** • Assess all individuals suspected of cognitive disorders, mental retardation and developmental disabilities and other conditions that may adversely impact an individuals' cognitive status. • Ensure that individuals' cognitive functioning is taken into consideration when assigning them to activities. • Ensure that Mall activities are designed to meet differing cognitive strengths and limitations. **Findings:** Using item 7 from the DMH WRP Mall Alignment Monitoring Form, NSH assessed its compliance based on an average sample of 2% of the census for the month (June to November 2008). The following is a summary of the data: 7. *Is provided in a manner consistent with each* 40%

	individual's cognitive strengths and limitations.	

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

	Previous period	Current period
Mean compliance rate		
7.	15%	40%
Compliance rate in last month of period		
7.	20%	71%

This monitor's documentation review (Integrated Assessment: Psychology Section, Mall courses, and the DCAT assessment database) found that all individuals' cognitive levels are screened at admission, and where appropriate a full intellectual assessment is conducted. The DCAT teams also conduct cognitive assessments on individuals with suspected cognitive disorders or changes in functioning. Results of the cognitive screening/assessment are shared with the Mall Director. The Mall Director has created a database using this information. This information is made available to staff involved in the individual's care, especially the WRPTs and Mall services. In addition, the cognitive levels for which the Mall courses were developed are listed in the Mall courses. WRPTs should be able to use this information to align the Mall groups with the individual's cognitive level. However, this monitor's interview of Mall facilitators, comparison of Mall schedules and WRP interventions, and observation of Mall groups found that individuals' cognitive levels are not always matched to their Mall groups. The Mall facilitators interviewed by this monitor interviewed underscored this point. For example, 21 individuals were scheduled to attend the Substance Abuse Recovery Mall group. According to the facilitator of this group, most of the individuals scheduled for the group would not benefit due to their lower cognitive levels. In other cases, even when the group was homogeneous (i.e. the

		individuals were around the same cognitive levels) the instruction and methodology utilized in the group was not at the individuals' level (for example, the Reality Orientation group). As plan of correction, NSH plans to have its WRP trainers and Senior Psychologists provide training and oversight to ensure that psychologists integrate individuals' cognitive information from the Integrated Assessments when planning treatment services. **Recommendation 4, July 2008:** Ensure that the WRPTs use the WRP Treatment Activity Request Form when a group is not available that matches the individual's cognitive strengths and limitations. **Findings:** WRPTs at NSH are using the WRP Treatment Activity Request Form. This review period, the Mall Services had received nine requests for new Mall groups. However, all the nine requests were received in late November and early December and still under review by the Mall Director. According to the Mall Director, incomplete information in the WRPs on the individuals' vulnerabilities and cognitive levels affect the ability of Mall services staff to properly address the needed groups for individuals. Furthermore, Mall groups are not offered by level of support needed by the individuals; most of the Mall curricula are for individuals at the intermediate/average cognitive levels and thus do not meet the needs of the individuals who need additional support. According to the Mall Director, Mall service providers lack the time to adapt curricula for the individuals in their Mall groups. As plan of correction, NSH plans to create a database with information on individuals' vulnerabilities identified in the discipline-specific integrated assessments. This information will be shared with the Mall facilitators.

		The curriculum committee is to identify group sub-types for Foci 1, 3, 5, and 7, and those groups that need staging. The stages are to be listed in the Mall course catalogs for WRPTs to use. NSH plans to develop additional Mall groups to serve the needs of the cognitively challenged individuals. **Current recommendations**: 1. Assess all individuals suspected of cognitive disorders, mental retardation and developmental disabilities and other conditions that may adversely impact an individuals' cognitive status. 2. Ensure that individuals' cognitive functioning is taken into consideration when assigning them to activities. 3. Ensure that Mall activities are designed to meet differing cognitive strengths and limitations.
C.2.i.vii	Provides progress reports for review by the Wellness and Recovery Team as part of the Wellness and Recovery Plan review process;	**Current findings on previous recommendations:** **Recommendations 1 and 2, July 2008:** • Implement the PSR Mall Facilitator Monthly Progress Notes. • Automate this system to make it feasible for the group facilitators and individual therapists to provide progress reports in a timely manner. **Findings:** NSH has implemented the Mall Progress Notes. Mall progress notes are not fully automated and notes are not written for all groups in a timely manner. According to the Mall Director, the Clinical Administrator, and the Chief of Psychology, the discipline chiefs present completed PSR Mall notes to the Clinical Management Team. NSH is continuing work on developing the WaRMSS MAPP-2 module to automate the PSR Mall notes system. The Clinical Administrator has instructed the discipline Seniors to report monthly to Discipline Chiefs on the completion of Mall monthly progress by facilitators. This monitor's review of Mall progress note data

		by discipline for the month of December 2008 found high returns for Psychology, Social Work, and Rehabilitation Therapy services. However, it appears that the data on PSR Mall note completion was aggregated through facilitator self-report. NSH should consider collecting this data through other paths to ensure that the data is reliable. This monitor reviewed Mall monthly progress notes of five individuals (BFL, BJB, CDK, PM and RLM-2). Most of the required notes were present for many of the individuals. However, a majority of the notes were blank, incomplete and/or lacked useful information for the WRPTs to make decisions and/or take actions, including re-distributing By Choice points, and/or modifying the individual's PSR objectives, interventions and/or services. For example, checking that the individual (CDK) was an active participant and also checking that the objectives were not met without any additional explanation is not useful. On the other hand, a useful note was found in RLM-2's December 2008 progress note by RH (the facilitator for the group "Coping Skills/Mindfulness"), who checked the objective "Not Met" box with the reason noted as, "Normally an active participant. Due to medical issues he did not attend much this month." Another of RLM-2's notes had checked the box for objective "Not Met" with the reason cited as, "Therapist was on vacation in December." It is important that the process be continued when a staff is not present. This is one reason to have a co-facilitator. According to the Clinical Administrator, the current manually conducted monthly Mall progress note process is extremely labor-intensive and cumbersome, and it would be somewhat difficult to achieve high compliance until the WaRMSS MAPPs system is up and running. As plan of correction, discipline chiefs will track and monitor staff completion of the Mall progress notes and report the results at the Clinical Management Team meetings. Audits to verify note completion will use information in the medical records. As of January 2009, facilitators

		will be apprised of their Mall progress note status on a regular basis. NSH plans to use an interim program/database to review and give feedback to facilitators until the WaRMSS MAPP-2 module is readied (scheduled to be completed in June 2009). **Other findings**: A review of records of 18 individuals (AC-3, BMS, BSC, CEG, CHB, DS, FBG, FG, GMT-2, JDT, JH, MBB, MER, MPP, PG-2, RJA, RW and SP) receiving Rehabilitation Therapy Services (including PSR Mall groups and direct treatment) to assess compliance with the requirements of C.2.i.vii found eight records (CEG, CHB, FG, JH, MBB, MER, RW and SP) in partial compliance and ten records (AC-3, BMS, BSC, DS, FBG, GMT-2, JDT, MPP, PG-2 and RJA) not in compliance. **Current recommendations**: 1. Fully implement the PSR Mall Facilitator Monthly Progress Notes. 2. Automate this system to make it feasible for the group facilitators and individual therapists to provide progress reports in a timely manner.
C.2.i.viii	is provided five days a week, for a minimum of four hours a day (i.e., two hours in the morning and two hours in the afternoon each weekday), for each individual or two hours a day when the individual is in school, except days falling on state holidays;	**Current findings on previous recommendations:** **Recommendation 1, July 2008:** 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. **Findings:** The Executive Director had issued this directive at the June 2008 General Management Meeting. The staff this monitor spoke with were aware of this directive. However, as the data in subsequent cells indicate, participation by staff in provision of PSR services is still in need of improvement.

According to the Mall Director and NSH's progress report data, the number of staff providing Mall groups services increased during this review period. For example, 118 of 240 administrative and support staff provided at least one hour of active treatment. Thirty-eight of the 45 WRPT psychiatrists, 175 of 380 Nursing and PT staff, 166 of the 429 RNs, and all Psychologists, Social Workers and Rehabilitation Therapists had provided active treatment during this review period.

The table below showing the mean hours of weekly services provided by the various disciplines, separated by Acute (A) and Long Term Care, for the month of November 2008, is a summary of the facility's data. The disciplines expected minimum hours of services per week are given in parenthesis next to the disciplines.

Discipline	Scheduled	Facilitated
Psychiatry ACUTE (4)	1.0	0.2
Psychiatry L-T (8)	1.7	0.8
Psychology ACUTE (5)	4.7	2.2
Psychology L-T (10)	8.5	5.8
Social Work ACUTE (5)	5.5	2.4
Social Work L-T (10)	5.6	3.5
Rehab Therapy ACUTE (7)	7.4	4.3
Rehab Therapy L-T (15)	13.3	8.1
Registered Nursing ACUTE (6)	4.0	1.7
Registered Nursing L-T (12)	2.8	1.8

As the table above shows, none of the disciplines are providing the expected hours of services. This causes tremendous strain for the PSR Mall services system, resulting in group cancellations and substitute staff who are not prepared or familiar with the individuals and the curriculum.

		Recommendation 2, July 2008: Ensure that all requests for new Mall groups and individual therapies are implemented. **Findings:** This monitor's documentation review found that nine requests for new Mall groups had been forwarded to the Mall Director. However, these requests came in November and December 2008. The Mall Director is reviewing and is acting upon these requests. This monitor had indicated in the last review report that there was an urgent need for Pain Management and Sex Offender treatment services at NSH. Interview with Katie Cooper, Enhancement Plan Coordinator, and document review found that NSH now has addressed both these issues and services are being provided to individuals having the need and/or meeting the criteria. **Other findings**: According to the Mall Director and the Clinical Administrator, non-participation by individuals and non-return of treatment rosters by group facilitators were barriers to achieving compliance with the requirements of this cell. As plan of correction, NSH plans to provide training on Motivational Interviewing to all facilitators and complete the Enhancing Motivation training for nursing staff. Mall Services will track Mall service provision by WRPT members and review the data with Discipline Chiefs for corrective action. Senior supervisors are expected to ensure that treatment rosters are returned as expected, and the Mall Coordinators will meet with facilitators to ensure that rosters are accurate and timely. **Other findings**: See C.2.f.vi for data on individuals' scheduled and attended hours of treatment.

		Current recommendation: Ensure that all requests for new Mall groups and individual therapies are implemented.
C.2.i.ix	is provided to individuals in bed-bound status in a manner and for a period that is commensurate with their medical status;	**Current findings on previous recommendation:** **Recommendation, July 2008:** Ensure that bed-bound individuals receive appropriate services following EP guidelines including hours of services. **Findings:** This monitor's interview of the Mall Director and the Clinical Administrator, chart review, and visits to the SNF unit found that NSH has had four individuals (CHH, JHM, RDZ and SSP) designated as bed-bound at various times during this review period. There were no bed-bound individuals during this monitor's visit. The nursing chief in the SNF unit stated that all individuals in the unit were ambulatory or were transported to their activities in a wheelchair. This monitor's documentation review (progress notes and WRPs) found that the four individuals had been receiving PSR services; for example SSP was scheduled for 20 hours of services. Most of the documented groups/activities for these individuals were appropriate given their physical and cognitive status. There was documentation regarding Mall services in the Present Status section of the WRP for SSP, but not for the other three. Objectives and interventions were developed for CHH, RDZ and SSP. To improve compliance, the facility plans to continue monitoring bed-bound individuals to ensure that they receive the maximum possible and appropriate PSR services. The Mall Director plans to review information with the Program Management at the monthly Mall Services Provider meetings.

		Current recommendation: Ensure that bed-bound individuals receive appropriate services per EP requirements including hours of services.
C.2.i.x	routinely takes place as scheduled;	**Current findings on previous recommendations:** **Recommendations 1-3, July 2008:** • Ensure that Mall group activities routinely take place as scheduled. • Inform the WRPT when an individual is not engaging in the assigned treatment. • Implement the plan to assist individuals not going to assigned treatment activities. **Findings:** The table below showing the number of Mall sessions scheduled for the month (N), the number of Mall sessions cancelled for the month (n), and the mean percentage of Mall sessions (%C) cancelled for each month of this review period (June to November 2008) is a summary of the facility's data:

Number of Mall Groups Cancelled							
	Jun	Jul	Aug	Sep	Oct	Nov	Mean
N	1683	1770	1823	1772	1841	1835	1787
n	294	242	255	192	111	199	215
%C	17%	14%	14%	11%	6%	11%	12%

Comparative data showed that the cancellation rate was maintained at 12% from the previous period.

According to the Mall Director, NSH has established a procedure to ensure that Mall groups do not get cancelled due to unscheduled facilitator absences.

		Information on an individual's Mall group participation comes to the WRPTs through the Monthly Mall Progress Notes. However, this process is not satisfactory at present because progress notes are not always written, not written in a timely manner, and when written are often incomplete. The Mall Director conducted training sessions with the nursing staff in Program 3 on using motivational strategies, focusing on ways to identify the reasons for the individual's failure to attend the scheduled groups and to motivate and support them to attend their scheduled groups. NSH did not present data on the number of individuals consistently failing to attend their scheduled groups, and how many of them are attending services/receiving support to motivate them to attend their scheduled groups. NSH utilizes motivational interviewing as one way to encourage individuals to solve problems and attend their PSR services. According to the Mall Director, NSH brought on a Motivational Interviewing expert (Ernest Marshall, LCSW, from Coalinga, CA). A total of 75 staff participated in the eight-hour training, passed a post-test and received Continuing Education Credit. NSH also uses the Enhancing Motivation Mall group with the intention of helping individuals return to their scheduled Mall group services. This monitor reviewed the Enhancing Motivation Mall group curriculum and the lesson plans, and interviewed one of the facilitators for this group. It appears that motivational interviewing and/or problem-solving the individual's reluctance to attend his/her scheduled Mall groups is not a strong part of the group activities. According to NSH, the facility faces difficulty ensuring nursing staff participation as primary group facilitators, due to the need for unit coverage. When the nursing staff is absent, the facility has difficulty

		finding adequately prepared substitutes. To improve compliance, NSH plans to work on getting adequate coverage for Mall groups in the absence of the scheduled facilitators. **Current recommendations**: 1. Ensure that Mall group activities routinely take place as scheduled. 2. Inform the WRPT when an individual is not engaging in the assigned treatment. 3. Implement the plan to assist individuals not going to assigned treatment activities.
C.2.i.xi	includes, in the evenings and weekends, additional activities that enhance the individual's quality of life; and	**Current findings on previous recommendations:** **Recommendations 1 and 2, July 2008:** • 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. • Increase the number of hours of enrichment activities per individual provided in the evenings and on weekends. **Findings:** This monitor's documentation review and interview of the Mall Director and the Supplemental Activity Coordinator found that NSH has implemented the WaRMSS Supplemental Activities Module and expects to use this system to report data on supplemental activities. NSH has increased the hours of supplemental activities offered both on weekdays and weekends. For example, students from Cal State Chico and UC Berkeley provide evening activities on units on Fridays and Saturdays. Other new activities offered include: Monthly Arts in Mental Health week-end special program, Monthly special events offered for the forensic individuals, Quarterly Family Support Group family events for the

<table>
<tr>
<td></td>
<td></td>
<td>individuals and their family members/significant others.

The table below showing the hours supplemental activities offered [i.e. scheduled] (N), the hours of supplemental activities provided (n) for each month of this review period, and the mean percent activities provided (%C) is a summary of the facility's data:

<table>
<tr><th colspan="8">Hours of Supplemental Activities</th></tr>
<tr><th></th><th>June</th><th>July</th><th>Aug</th><th>Sep</th><th>Oct</th><th>Nov</th><th>Mean</th></tr>
<tr><td>N</td><td>1200</td><td>1200</td><td>1200</td><td>1200</td><td>1200</td><td>1200</td><td>1200</td></tr>
<tr><td>n</td><td>587</td><td>394</td><td>256</td><td>250</td><td>239</td><td>244</td><td>328</td></tr>
<tr><td>%C</td><td>49%</td><td>33%</td><td>21%</td><td>21%</td><td>20%</td><td>20%</td><td>27%</td></tr>
</table>

According to the Mall Director, Rehabilitation Therapists are not always available for evening and weekend supplemental activities owing to their increased hours of active treatment provided during Mall hours. The data collection system is not fully implemented.

To improve compliance, the facility will implement the data collection system; continue to increase the number of activities offered and hours of services provided; motivate individuals to attend the activities; and ensure that the activities are conducted regularly.

Current recommendations:
1. 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.
2. Increase the number of hours of enrichment activities per individual provided in the evenings and on weekends.</td>
</tr>
<tr>
<td>C.2.i.xii</td>
<td>is consistently reinforced by staff on the therapeutic milieu, including living units.</td>
<td>Current findings on previous recommendations:</td>
</tr>
</table>

Recommendation 1, July 2008:
Ensure that all WRPs have therapeutic milieu interventions clearly specified in the intervention sections.

Findings:
This monitor reviewed 10 charts (ABN, AC-2, CWR, DML, DR, FLK-2, ILL, JEB, TL and YJL). Two of the WRPs (DR and FLK-2) had developed milieu interventions in the intervention sections of the individual's WRP for each of the active treatment. The remaining eight (ABN, AC-2, CWR, DML, ILL, JEB, TL and YJL) did not have milieu interventions for each of the active treatments in each foci.

Recommendation 2, July 2008:
Ensure that unit staff know what the individuals are learning in the Malls and individual therapies and reinforce their learning in all settings.

Findings:
Using item 12 from the DMH WRP Chart Audit Form, NSH assessed its compliance using a mean sample of 23% of the WRPs due for the month (June to November 2008). The following is a summary of the data:

12.	*Adequate active psychosocial rehabilitation is consistently reinforced by staff on the therapeutic milieu, including living units.*	49%

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

	Previous period	Current period
Mean compliance rate		
12.	29%	49%

Compliance rate in last month of period		
12.	58%	47%

NSH also conducted observations to evaluate compliance with this recommendation, using item 12 from the DMH WRP Therapeutic Milieu Observation Form. Observations were conducted across all units. The following is a summary of the data:

12.	*Staff is observed discussing Mall activities with individuals.*	20%

Comparative data showed a modest increase in mean compliance since the last review as follows:

	Previous period	Current period
Mean compliance rate		
12.	18%	20%
Compliance rate in last month of period		
12.	25%	25%

To improve compliance, NSH plans to implement the DMH nursing task force policies by including a verbal report on the individuals' progress in Foci 1, 3 and 5 during shift lead reports. NSH also plans to shift the Therapeutic Milieu duty from Standards Compliance to the Unit Supervisors.

Current recommendations:

1. Ensure that all WRPs have therapeutic milieu interventions clearly specified in the intervention sections.
2. Ensure that unit staff know what the individuals are learning in the Malls and individual therapies and reinforce their learning in all

<table>
<tr><td></td><td></td><td>settings.</td></tr>
<tr><td>C.2.j</td><td>Adequate, individualized group exercise and recreational options are provided, consistent with generally accepted professional standards of care.</td><td>

Current findings on previous recommendations:

Recommendation 1, July 2008:
Continue to provide training to Mall facilitators to conduct the activities appropriately.

Findings:
According to documentation and information from the Mall Director, all Rehabilitation Therapists participated in the training related to BMI and heat-related issues provided during the Monthly Professional Practice Group meeting on November 5, 2008.

The table below showing the BMI categories, the number of individuals in each BMI category, the number of individuals participating in exercise groups, and the participation rate is a summary of the facility's data:

<table>
<tr><th>BMI Level</th><th>Number of individuals in category</th><th>Number of individuals in category in Exercise Groups</th><th>Participation rate</th></tr>
<tr><td>25 - 30</td><td>490</td><td>439</td><td>90%</td></tr>
<tr><td>31 – 35</td><td>176</td><td>155</td><td>88%</td></tr>
<tr><td>36 - 40</td><td>85</td><td>80</td><td>94%</td></tr>
<tr><td>>40</td><td>41</td><td>39</td><td>95%</td></tr>
</table>

As the table above shows, not all individuals are participating in their exercise groups. NSH should find ways to ensure that all individuals with weight-related issues participate consistently in their exercise programs.

According to NSH, the number of exercise groups it offers is adequate and all individuals assigned to these exercises have the room to participate in the exercise groups. The table below showing the number

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

of exercise groups offered per week, the number of groups needed, and the compliance rate is a summary of the facility's data.

Exercise Groups Offered vs. Needed			
	Jun	Oct	Nov
# groups offered per week	325	330	330
# groups needed @1x per week	139	136	136
%C	100	100	100

Recommendations 2 and 3, July 2008:

- Develop the system to track and review participation of individuals in scheduled group exercise and recreational activities.
- Implement corrective action if participation is low.

Findings:

NSH has elected to track individuals' participation in their enrolled activities through review of the Monthly Mall Progress Notes. However, the Mall progress notes are not written consistently and in a timely manner.

NSH does not have the data on individuals' participation in the various exercise programs needed to take corrective action when participation is low.

To improve compliance, NSH plans to ensure that the Mall Facilitator Monthly Progress Notes are written and presented in a timely manner; and to use the data to take corrective action when participation is low.

Compliance:

Partial.

Current recommendations:

1. Continue to provide training to Mall facilitators to conduct the

		activities appropriately. 2. Develop the system to track and review participation of individuals in scheduled group exercise and recreational activities. 3. Implement corrective action if participation is low.
C.2.k	Individuals who have an assessed need for family therapy services receive such services in their primary language, as feasible, consistent with generally accepted professional standards of care and that these services, and their effectiveness for addressing the indicated problem, are comprehensively documented in each individual's chart.	**Current findings on previous recommendations:** **Recommendation 1, July 2008:** Continue to assess family therapy needs of individuals and/or their families. **Findings:** This monitor's interview of the Chief of Social Work and documentation review found that NSH has developed guidelines for family therapy, including procedures of assessment and services and a DMH tool to monitor family therapy needs for newly admitted and long-term individuals and individuals discharged to their families (MH-C 9064 DMH Family Therapy Auditing Form). The Clinical Administrator had designated two of the SW Seniors to implement the newly approved guidelines and monitoring tools. The Social Work Department also started a family therapy tracking database in order to track the family therapy needs for long-term individuals with a signed release of information. Using item 1 from the DMH Family Therapy Auditing Form, NSH assessed its compliance based on an average sample of 100% of the individuals in the Admission Units in need of family therapy (September to November 2008). The following is a summary of the data: 1. *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* — 94%

	addressing the indicated problem, are comprehensively documented in each individual's chart.	

Using item 2 from the DMH Family Therapy Auditing Form, NSH assessed its compliance based on an average sample of 25% of the individuals in the Long Term Units in need of family therapy (September to November 2008). The following is a summary of the data:

2.	*Efforts to involve the family, and continuing efforts and outcomes of attempts to decrease barriers to family involvement are documented in the Present Status, and Focus 11 contains an objective that prepares the individual for his or her role within their family system.*	36%

Using item 3 from the DMH Family Therapy Auditing Form, NSH assessed its compliance based on an average sample of 100% of the individuals discharged (September to November 2008). The following is a summary of the data:

3.	*There is documentation in the Medical Record that family consultation and counseling was provided, the family was provided the individual's Social Work Recommended Continuing Care Plan, and information was provided to the family on community resources.*	33%

NSH will continue to improve upon the newly developed procedures and practice.

Recommendation 2, July 2008:
Document the education provided and the community referrals made for those who are in need of therapy/services.

		Findings: According to the Chief of Social Work, NSH had three new admissions between August and October 2008 with a need for family therapy. The families of the three individuals received general education regarding the individual's stay at NSH. In addition, the willingness of the families to participate in family therapy and the barriers to their participation were assessed. According to the Chief of Social Work, there were a number of shortcomings to this process. Some Social Work staff did not have all the information to address the family's needs, did not recognize that family education was part of family therapy services, and failed to document the individual's family therapy needs in the Present Status section of the individual's WRP. To improve compliance, Social Work Seniors will work with WRP trainers to revise the guidelines on Social Work staff responsibilities in the WRP process. Seniors will also provide feedback to Social Work staff on following through with the necessary activities for individuals with family therapy service needs. **Compliance:** Partial. **Current recommendations**: 1. Continue to assess family therapy needs of individuals and/or their families. 2. Document the education provided and the community referrals made for those who are in need of therapy/services.
C.2.l	Each individual's therapeutic and rehabilitation service plan identifies general medical diagnoses, the treatments to be employed, the	**Current findings on previous recommendations:**

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.

Recommendations 1 and 2, July 2008:

- Present data regarding WRPs and refusals.
- Continue to monitor this requirement.

Findings:

The DMH Integration of Medical Conditions in WRP audit, based on an average sample of 20% of individuals with at least one diagnosis listed on Axis III that have a WRP due each month (June-November 2008), indicated the following:

1.	*All medical conditions listed in Axis III are included on the Medical Conditions Form.*	76%
2.	*The WRP includes each medical condition listed on the Medical Conditions Form 42.*	69%
3.	*There is an appropriate focus statement for each medical condition or diagnosis.*	53%
4.	*There is an appropriate objective for each medical condition or diagnosis.*	56%
5.	*There are appropriate interventions for each objective.*	50%

NSH's comparison data showed mixed changes in compliance since the last review period:

	Previous period	Current period
Mean compliance rate		
1.	71%	76%
2.	59%	69%
3.	63%	53%
4.	73%	56%
5.	73%	50%

Compliance rate in last month of period		
1.	89%	75%
2.	89%	64%
3.	92%	41%
4.	92%	49%
5.	92%	27%

The Standards Compliance Department (SCD) has taken over data collection for this requirement. NSH indicated that the variability in the compliance data is due to an increase in the reliability of the data. Reliability will be assessed again in January 2009 and auditors not achieving an 85% reliability score will be held accountable.

In October 2008, the WRP Trainers in conjunction with Central Nursing Services (CNS) audited medical conditions for all individuals at NSH. A database was developed with information that included Infection Control, Dental Services and the Incontinence List. The WRP Training staff began reviewing all individuals' WRPs and is providing feedback to the Clinical Oversight Nurse (CON) and the Unit Supervisor for follow-up. The elements of this review includes:

1. Inclusion of all Axis III diagnoses in Focus 6 of the WRP;
2. Interventions and objectives for all Focus 6 conditions;
3. Information on medical conditions entered into WaRMSS module when required for tracking of medical conditions.

In November 2008 the WRP Trainers, in conjunction with CNS, developed and implemented the Nursing Intervention Training. A Nursing Resource binder containing clinical examples and other WRP information was also provided to each unit.

Barriers to compliance include the lack of coordination of services and supervision between CNS, medical ancillary services and the WRPT. In

		addition to actions taken as noted above, the initiation of the Clinical Oversight Nurse (CON) and the Nursing Intervention training should positively affect compliance rates. Also, the implementation by the Medical Management Review Committee (MMRC) of the recently approved DMH Risk Profile will provide focused input for the treatment teams, increase communication among physicians assigned to programs, and provide the structure and focus needed to meet the compliance objectives. A review of the WRPs of 41 individuals (AJS, AMP, ANT, AYT, BCM, BDA, BFL, BJB, CAD, CC, CCC, CDK, CML, CTM, DAP, DJD, DMC, DWH, ELW, GG, GT, IVH, JKC, JRS, JVV, MDJ, MG, NH, OJR, PSK, RCC, REJ, RL, RLM, RVT, SEK, SLC, SPN, TBS, TTS and WT) found that with the exception of the Infection Control-directed WRPs, there has been little improvement in this area from the last review. The problematic areas continue to include inadequate and inappropriate nursing objectives and interventions. Also, there were a number of goals and objectives in the admission and integrated nursing assessments that were inconsistent with the information found in the assessments. The strategies NSH has recently implemented should increase the quality and thus the compliance regarding the WRPs. No data was provided regarding refusals of medical procedures. The facility identified poor communication to and from the WRPT regarding refusals as a factor in need of improvement; the implementation of the change of shift process should provide a format for reporting refusals to the WRPT. The NSH Refusal Workgroup established a system for tracking refusals pending implementation of the WaRMSS Appointment Scheduler Module in March 2009. Information regarding service refusals are being collected by the EP Office and forwarded to the individual's WRPT to be addressed. See F.9.e regarding reviewer findings on dental refusals.

		Compliance: Partial. **Current recommendations**: 1. Provide data from DMH Integration of Medical Conditions regarding refusals. 2. Continue to monitor this requirement.
C.2.m	The children and adolescents it serves receive, consistent with generally accepted professional standards of care:	The requirements of Section C.2.m are not applicable because NSH does not serve children and adolescents.
C.2.m.i	Therapy relating to traumatic family and other traumatic experiences, as clinically indicated; and	
C.2.m.ii	reasonable, clinically appropriate opportunities to involve their families in treatment and treatment decisions.	
C.2.n	Policies and procedures are developed and implemented consistent with generally accepted professional standards of care to ensure appropriate screening for substance abuse, as clinically indicated.	**Current findings on previous recommendation:** **Recommendation, July 2008:** Implement the policy and procedure regarding screening and assessment for substance use disorders. **Findings:** According to Dr. Sutherland, Psychiatrist, and Charlie Oncea, Mall Director, NSH finalized an AD, Comprehensive Substance Recovery Services (July 2008), which contains the policy and procedure. Some aspects of the policy and procedure were implemented prior to its final approval. These included the appointment of a Chief of Substance

		Recovery Services, an increase in substance abuse groups, monitoring and auditing of substance recovery services, alignment of pharmacy services and the establishment of an Interdisciplinary Substance Recovery/Pain Management Consultation Service. However, the facility has yet to fully implement this AD. This monitor also reviewed another AD (557, Comprehensive Substance Recovery Services, January 12, 2009). The AD for Comprehensive Substance Recovery Services was revised to include the Substance Recovery Plan approved at the CRIPA Business Meeting in November 2008. It includes the establishment of a Substance Recovery Advisory Committee composed of NSH experts in the field of SA, addiction, and pain management who will advise SR Mall Services and assist in developing and providing training and competency testing. According to the Mall Director, NSH purchased Addiction Severity Index (ASI) software for use at NSH. The software will be utilized for screening and assessment once training is conducted with the staff. Other assessments include: admission, integrated, and annual discipline assessments and quarterly administration of the URICA by substance recovery treatment group providers at the end of each term. Other assessment tools will be incorporated into the assessment plan as appropriate. According to the Mall Director, delay in purchasing the ASI software and the subsequent delay in training for staff to administer the instrument was a barrier to compliance in the current period. To improve compliance, NSH will implement all components of the Comprehensive Substance Recovery Services plan as outlined in the AD. **Compliance:** Partial.

<table>
<tr><td></td><td></td><td>Current recommendation:
Implement the policy and procedure regarding screening and assessment for substance use disorders.</td></tr>
<tr><td>C.2.o</td><td>Individuals who require treatment for substance abuse are provided appropriate therapeutic and rehabilitation services consistent with generally accepted professional standards of care.</td><td>Current findings on previous recommendations:

Recommendation 1, July 2008:
Finalize and utilize clinical outcomes for individuals and process outcomes for the program.

Findings:
According to the Mall Director, NSH currently is evaluating the outcome process through a number of steps, including the use of PSR Mall Course Facilitator Consults.

NSH presented the following data:

<table>
<tr><td></td><td colspan="2">Urine Drug Screens Administered</td></tr>
<tr><td>Month</td><td>Number of Screens</td><td>Number Testing Positive</td></tr>
<tr><td>June</td><td>168</td><td>9</td></tr>
<tr><td>July</td><td>168</td><td>1</td></tr>
<tr><td>Aug</td><td>178</td><td>1</td></tr>
<tr><td>Sept</td><td>177</td><td>6</td></tr>
<tr><td>Oct</td><td>158</td><td>2</td></tr>
<tr><td>Nov</td><td>126</td><td>3</td></tr>
</table>

NSH is providing a total of 39 Substance Recovery groups this cycle. The number of groups offered is down from 57 during the previous review period. It appears that NSH is handling the number of individuals with substance abuse diagnosis by increasing the number of individuals in the existing Substance Abuse Recovery groups. Twenty-one individuals had been scheduled in the Substance Abuse Recovery group observed by this</td></tr>
</table>

monitor. NSH continues to provide four Substance Recovery groups in Spanish (for monolingual individuals or those who prefer Spanish).

Recommendations 2 and 3, July 2008:

- Ensure monitoring of substance use disorders using the DMH WRP Clinical Chart Audit and the Substance Abuse Audit Forms, based on a sample of at least 20% of individuals diagnosed with these disorders.
- Provide data analysis addressing sub-items of this requirement. The analysis must evaluate areas of low compliance and delineate areas of relative improvement.

Findings:

Using items 1-6 from the DMH Substance Abuse Audit Form, NSH assessed its compliance based on an average sample of 14% of individuals with a diagnosis of substance abuse (June to November 2008). The table below with its indicators and mean compliance is a summary of the data:

1.	*Substance abuse is integrated into the case formulation and discussed in the present status.*	43%
2.	*There is an appropriate Focus statement listed under Focus 5.*	91%
3.	*There is at least one objective related to the individual's stage of change.*	82%
4.	*There are interventions that are appropriately linked to the active objective(s).*	86%
5.	*The active treatment for substance abuse that is specified in the WRP is aligned with the individual's mall schedule.*	80%
6.	*The discharge criteria related to substance abuse are individualized and written in behavioral, observable and/or measurable terms.*	70%

Comparative data showed mixed changes in compliance since the last

review as follows:

	Previous period	Current period
Mean compliance rate		
1.	54%	43%
2.	84%	91%
3.	85%	82%
4.	82%	86%
5.	65%	80%
6.	53%	70%
Compliance rate in last month of period		
1.	35%	49%
2.	90%	90%
3.	93%	78%
4.	88%	87%
5.	49%	87%
6.	62%	68%

This monitor reviewed seven charts (BT, CMG, GAB, GAF, JTC-1, PVW and SVP) and found the following:

1. Substance abuse was integrated into the case formulation and discussed in the present status in three of the WRPs (CMG, GAF and JTC-1). There was no documentation for the remaining four (BT, GAB, PVW and SVP).
2. All seven charts reviewed had an appropriate Focus statement listed under Focus 5.
3. Five (CMG, GAB, GAF, PVW and SVP) of seven WRPs had at least one objective related to the individual's stage of change.
4. Six (CMG, GAB, GAF, JTC-1, PVW and SVP) of the seven had interventions that were appropriately linked to the objectives.

		The active treatment for substance abuse specified in the WRP was aligned with the individual's Mall schedule in four (BT, CMT, GAF and JTC-1) of the six WRPs (BT, CMG, GAB, GAF, JTC-1 and SVP) reviewed. The discharge criteria related to substance abuse in one (JTC-1) of five (CMG, GAF, JTC-1, PVW and SVP) WRPs reviewed were written in behavioral, observable and/or measurable terms. **Compliance:** Partial. **Current recommendations**: 1. Finalize and utilize clinical outcomes for individuals and process outcomes for the program. 2. Ensure monitoring of substance use disorders using the DMH WRP Clinical Chart Audit and the Substance Abuse Audit Forms, based on a sample of at least 20% of individuals diagnosed with these disorders. 3. Provide data analysis addressing sub-items of this requirement. The analysis must evaluate areas of low compliance and delineate areas of relative improvement.
C.2.p	Group facilitators and therapists providing therapeutic and rehabilitation services (in groups or individual therapy) are verifiably competent regarding selection and implementation of appropriate approaches and interventions to address therapeutic and rehabilitation services objectives, are verifiably competent in monitoring individuals' responses to therapy and rehabilitation, and receive regular, competent supervision.	**Current findings on previous recommendations:** **Recommendations 1 and 2, July 2008:** • Continue current practice. • Same as in C.2.g.iv. **Findings:** According to the Mall Director and the newly hired Substance Abuse Recovery Director, NSH has asked disciplines that do not automatically privilege staff with the relevant educational background (for example, Rehabilitation Therapy and Nursing) to provide Substance Abuse

		treatment to privilege them to facilitate the Pre-Contemplation/ Contemplation stage/portion of the Substance Abuse Recovery curriculum, once the staff have received training on the curriculum. The Substance Recovery Advisory Committee is working towards establishing training needs of these staff. Furthermore, the Medical Director has established Substance Recovery groups as a focus for psychiatrists' groups as they prepare their Mall schedules (facilitating four groups per week during the 4:40 pm Mall session). This monitor observed four Mall groups (Substance Abuse/Recovery, Reality Orientation, Relaxation Technique, and Life Skills). One group (Reality Orientation) was facilitated by a "last minute" substitute facilitator. This facilitator was valiant in attempting to do something with the individuals in the group, but had significant difficulty in translating the course content to the very challenged individuals in the group; some of them also needed ASL communication (staff accompanying this monitor stepped in to assist with ASL communication). The facilitators in the other three groups were prepared, had lesson plans, and used language and activities suitable to the topic and functioning levels of the individuals in the group. The Substance Abuse Recovery group was well conducted and the facilitator knew the strengths of the individuals and engaged each one of them with appropriate feedback and verbal praise. Nearly two-thirds of the individuals scheduled did not attend this group. According to the facilitator, many of the individuals would not benefit from attending this group due to their functioning level. This monitor also learned from the individuals that they did not receive any Substance Abuse Recovery instruction the previous week, but instead went walking with a substitute facilitator. NSH should work to bring in the co-therapist and/or trained substitute staff for certain specialty groups like the Substance Abuse Recovery groups. To improve compliance, NSH plans to implement all components of the Comprehensive Substance Recovery Services and increase the number of

		facilitators observed as part of the Mall Facilitator Consultation. **Compliance:** Partial. **Current recommendations**: 1. Continue current practice. 2. Same as in C.2.g.iv.
C.2.q	Group facilitators and therapists providing therapeutic and rehabilitation services in the field of substance abuse should be certified substance abuse counselors.	**Current findings on previous recommendations:** **Recommendations 1-3, July 2008:** • Ensure that all providers complete the NSH substance abuse training and provide data to show that training has occurred. • Clarify and streamline staff competency criteria to ensure their alignment with the current training curriculum. • Provide data showing the competency and quality of services provided by the facilitators trained in the Substance Abuse treatment curriculum. **Findings:** This monitor's documentation review and interview of the Mall Director found that at the time of the tour, NSH cared for 684 individuals with one or more Substance Abuse diagnoses. At a 1:8 staff-to-individual ratio, NSH will need 86 Substance Abuse Recovery groups to serve the needs of all individuals with a Substance Abuse diagnosis. These groups will require a minimum of 86 facilitators trained in Substance Abuse Recovery (not including co-facilitators). As of January 26, 2009, NSH has 71 providers trained in the Substance Abuse Recovery Curriculum (the providers are from Social Work, Rehabilitation Therapy, and Nursing). NSH also has another 131 providers (75 psychologists and 56 psychiatrists, as of January 26, 2009). These data do not align with the provider data identified in the MAPP output (December 11, 2008). NSH should correct

		this discrepancy to ensure reliability of the data. NSH did not present data on the competency and quality of services provided by the facilitators trained in the Substance Abuse treatment curriculum. NSH has just recently (in January 2009) hired staff to be in charge of the Substance Abuse/Recovery section. The new Director for this section is expected to work on streamlining staff competency criteria to ensure alignment with the training curriculum. NSH also had a change in the Mall Director position. Both these staff are planning to work together to increase the compliance with requirements concerning Substance Abuse Recovery. NSH also plans to implement all components of the Comprehensive Substance Recovery Services, complete training of all Substance Abuse Recovery Mall facilitators, and increase the number of facilitators observed as part of the Mall Facilitator Consultation. **Compliance:** Partial. **Current recommendations**: 1. Ensure that all providers complete the NSH substance abuse training and provide data to show that training has occurred. 2. Clarify and streamline staff competency criteria to ensure their alignment with the current training curriculum. 3. Provide data showing the competency and quality of services provided by the facilitators trained in the Substance Abuse treatment curriculum.
C.2.r	Transportation and staffing issues do not preclude individuals from attending appointments.	**Current findings on previous recommendations:** **Recommendation 1, July 2008:** Review reasons for cancellations and assess and correct factors

contributing to such events.

Findings:
The table below showing the number of appointments scheduled for each month of this review period (June to November 2008), the number of appointments cancelled each month, and the reasons for the cancellations is a summary of the facility's data.

Missed Appointments Monitoring – Medical Services			
Month	Appointments		Reasons for Cancellation
	Scheduled	Cancelled	
June	1000	79	2 staffing 5 transportation 72 other
July	1094	116	24 staffing 1 transportation 91 other
Aug	946	86	6 staffing 1 transportation 79 other
Sept	914	68	6 staffing 1 transportation 61 other
Oct	1161	92	10 staffing 1 transportation 81 other
Nov	940	121	8 staffing 3 transportation 110 other

As the table above shows, staffing (July, August, September, October, and November) and transportation (June and November) accounted for 10% and 2% of cancellations respectively. Eighty-eight percent of the

		cancellations (494 cancellations in total) were attributed under the "Other" category. Reasons for the 'other' cancellations were given as the individual being help up at other locations including (for example, the court, hospitalization, etc.), and cancellation of the scheduled appointments by clinics. NSH should work to reduce the number of cancellations. **Recommendation 2, July 2008:** Complete and implement the Medical Scheduler. **Findings:** According to the Compliance Director, the WaRMSS Appointment Scheduler Module was completed in December 2008, but the facility experienced some output problems and is working to fix the problem. **Compliance** Partial. **Current recommendations**: 1. Review reasons for cancellations and assess and correct factors contributing to such events. 2. Complete and implement the Medical Scheduler.
C.2.s	Adequate oversight to treatment, rehabilitation and enrichment groups is provided to ensure that individuals are assigned to groups that are appropriate to their assessed needs, that groups are provided consistently and with appropriate frequency, and that issues particularly relevant for this population, including the use of psychotropic medications and substance abuse, are appropriately addressed, consistent with generally accepted	**Current findings on previous recommendation:** **Recommendation, July 2008:** Develop and implement monitoring systems that address the required elements. **Findings:** According to the Mall Director, NSH has established a monitoring system that involves senior clinicians. The senior clinicians provide mentoring and use the audit data to provide feedback to the providers.

professional standards of care.

Using item 10 from the DMH WRP Clinical Chart Auditing Form, NSH assessed its compliance based on a mean sample of 15% of the Quarterly and Annual WRPs due each month (June to November 2008). The table below is a summary of the facility's data:

10.	*Adequate oversight to treatment, rehabilitation and enrichment groups is provided to ensure that individuals are assigned to groups that are appropriate to their assessed needs, that groups are provided consistently and with appropriate frequency, and that issues particularly relevant for this population, including the use of psychotropic medications and substance abuse are appropriately addressed, consistent with generally accepted professional standards of care.*	60%
10.a	*The individual's cognitive functioning level, needs, and strengths (as documented in the case formulation) are aligned with the group assignments.*	73%
10.b	*For each Axis I, II and III diagnoses, the interventions are related to excesses and deficits associated with each diagnosis.*	74%
10.c	*All interventions are offered at the cognitive functioning level of the individual*	68%

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

	Previous period	Current period
Mean compliance rate		
10.	18%	60%

<table>
<tr>
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<table>
<tr><th colspan="3">Compliance rate in last month of period</th></tr>
<tr><td>10.</td><td>26%</td><td>94%</td></tr>
<tr><td>10.a</td><td>34%</td><td>95%</td></tr>
<tr><td>10.b</td><td>63%</td><td>95%</td></tr>
<tr><td>10.c</td><td>34%</td><td>89%</td></tr>
</table>

This monitor reviewed five charts (BFL, BJB, CDK, JWM and RM). Two of them (BJB and JWM) had proper case formulation, identified the individual's needs and strengths, specified interventions related to the individual's excesses and deficits associated with the diagnosis, and the Mall groups were aligned with the individual's needs. The remaining three (BFL, CDK and RM) had one or more elements missing and/or not aligned with the individual's needs.

To improve compliance, NSH plans to intensify focused discipline/ clinician mentoring and supervision on improving the WRP process and procedures and documentation. The facility will continue with the WRP training program; psychiatry Seniors will mentor team members to improve performance, and when necessary implement measures to promote accountability. Beginning in January 2009, discipline Seniors will incorporate compliance with the EP as part of the staff development plan.

Compliance:
Partial.

Current recommendation:
Develop and implement monitoring systems that address the required elements.
</td>
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<tr>
<td>C.2.t</td>
<td>Treatment, rehabilitation and enrichment services are monitored appropriately against rational, operationally-defined target variables and revised as appropriate in light of significant</td>
<td>**Current findings on previous recommendation:**

Recommendation, July 2008:
Ensure that the newly developed process is fully implemented and</td>
</tr>
</table>

	developments, and the individual's progress, or lack thereof;	addresses all of the elements of this requirement. **Findings:** Using item 11 from the DMH WRP Clinical Chart Auditing Form, NSH assessed its compliance based on a mean sample of 15% of the Quarterly and Annual WRPs due each month (June to November 2008). The table below is a summary of the facility's data:

11.	*Treatment, rehabilitation and enrichment services are monitored appropriately against rational, operationally-defined target variables and revised as appropriate in light of significant development, and the individual's progress, or lack thereof.(C.2.t)*	5%
11.a	*Each objective is observable, measurable and behavioral.*	34%
11.b	*All groups and individual therapies are linked directly to the foci, objective and interventions specified in the individual`s WRP.*	78%
11.c	*There is a DMH PSR Mall Facilitator Monthly Progress Note for each active treatment in the individual`s WRP.*	24%
11.d	*If the individual has not made progress on an objective in 2 months, the objective and/or intervention is revised, or there is documentation of clinically justifiable reasons for continuing with the objective.*	22%
11.e	*If the individual has met the objective, a new objective and related interventions have been developed and implemented.*	71%

Comparative data shows modest improvement in compliance from the previous review period:

	Previous period	Current period
Mean compliance rate		
11.	1%	5%
Compliance rate in last month of period		
11.	0%	2%
11.a	19%	52%
11.b	56%	95%
11.c	10%	13%
11.d	17%	35%
11.e	48%	67%

This monitor reviewed five charts (BFL, CDK, PEM-1, RLM-2 and TR). All five were deficient in one or more of the required elements. Deficiencies included:

- Lack of modification of the interventions based on the individual's progress or lack of progress;
- Absence of Mall progress notes;
- Objectives not observable and/or measurable;
- Lack of alignment between objectives and interventions; and
- The assigned groups were not directly linked to the individual's objectives and interventions.

NSH has identified specific programs that contribute to the low compliance, and plans to target these programs for training, mentoring, and feedback to increase compliance. The facility also plans to provide more timely and specific monitoring and feedback. The Clinical Administrator, in concert with the Discipline Chiefs, will track and monitor the results on a monthly basis, report the results at the monthly clinical Management Team meetings and take corrective action when warranted.

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

Current recommendation:
Ensure that the newly developed process is fully implemented and addresses all of the elements of this requirement.</td></tr>
<tr><td>C.2.u</td><td>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.</td><td>Current findings on previous recommendations:

Recommendations 1 and 2, July 2008:
• Provide information regarding number of groups offered, number of individuals attending WRP education, the type of groups offered that provide this education and criteria used to determine target individuals for each type.
• Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).

Findings:
Documentation review found that NSH was providing a total of 40 WRP education groups in seven formats, serving 342 individuals. NSH has also developed a number of new curricula to enhance involvement individuals in the WRP planning process.

NSH has continued to increase the number of these groups. The following table illustrates a significant increase during this review period:

<table>
<tr><td colspan="5">Number of Introduction to Wellness and Recovery Groups Offered During the Current and Prior Three Mall Terms</td></tr>
<tr><td>Oct–Dec 2007</td><td>Jan-Mar 2008</td><td>Apr-Jun 2008</td><td>Jul-Sep 2008</td><td>Oct-Dec 2008</td></tr>
<tr><td>3</td><td>3</td><td>24</td><td>24</td><td>40</td></tr>
</table></td></tr>
</table>

		NSH plans to continue with the assessment of individuals in need of the WRP education groups and to continue to increase the number of groups until every individual has the opportunity to attend. NSH also plans to develop and implement new curricula until adequate numbers of courses are developed to meet the needs of individuals. NSH plans to schedule all individuals in the Mall Services for the Personal Wellness Groups. **Compliance:** Partial. **Current recommendations**: 1. Provide information regarding number of groups offered, number of individuals attending WRP education, the type of groups offered that provide this education and criteria used to determine target individuals for each type. 2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).
C.2.v	Staff educates individuals about their medications, the expected results, and the potential common and/or serious side effects of medications, and staff regularly asks individuals about common and/or serious side effects they may experience.	**Current findings on previous recommendations:** **Recommendation 1, July 2008:** Provide information regarding number of groups offered by the facility, number of individuals attending these groups and criteria used to determine individuals in need (and the number of these individuals). **Findings:** NSH reported the following information regarding medication education groups: 1. The facility offered 37 medication education groups during the April-June 2008 and July-September 2008 quarters and 35 groups during the October-December 2008 quarter.

		2. In the current quarter, January-March 2009, 299 individuals were enrolled in groups. 3. The facility developed a medication education curriculum specific to individuals with cognitive or learning issues. 4. Psychiatrists will begin facilitating medication education groups. 5. A method for assessing and tracking individuals' needs for medication education groups has yet to be established. **Recommendation 2, July 2008:** Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). **Findings:** NSH intends to develop and implement a database designed to aggregate information related to assessed needs for medication education groups. This should facilitate scheduling of an adequate number of medication education groups based on cognitive level and stage of change. **Compliance:** Partial. **Current recommendations**: 1. Develop and implement a mechanism to identify individuals in need of medication education. 2. Provide data regarding the target population and the number of WRP education groups offered to these individuals. Include number of groups per term, the hours offered and the number of individuals attending and compare to the last review period.
C.2.w	Interdisciplinary teams review, assess, and develop positive clinical strategies to overcome individuals' barriers to participation in	**Current findings on previous recommendations:**

	therapeutic and rehabilitation services.	**Recommendation 1, July 2008:**
		Finalize process to provide key indicator data regarding individuals' non-adherence to interventions in the WRP.
		
		Findings:
		According to the Mall Director, NSH has established the process to collect key indicator data on non-adherence to interventions in the WRP. One week in a month, on the same week as the Mall schedule, Mall data will be forwarded to the MAPP operator for entry into the MAPP system. Mall staff will use the data to identify individuals who meet the non-adherence threshold, and insert in the key indicator report. The key indicator report will be forwarded to all Chairs of all Risk Management Groups, Discipline Chiefs, and members of the Quality Council, and followed through with the WRPT for review and action.
		
		Recommendations 2 and 3, July 2008:
		• Provide information to demonstrate that NSH's current program to motivate individuals addresses barriers towards individuals' participation in their WRPs, including Mall groups.
		• Provide data regarding:
		  o All systematic methods of behavior change including Motivational Interviewing, Narrative Restructuring Therapy and other cognitive behavioral interventions that are provided (with number of providers);
		  o The number of individuals receiving these interventions; and
		  o The number of individuals who trigger non-adherence to WRP in the key indicators.
		
		Findings:
		NSH's data showed that on average 252 individuals per week were non-adherent to their WRPs. [Key indicator data submitted by the facility shows that on average for each month from June to November 2008, an average of 1,091 individuals were non-adherent to more than 20% of

interventions. In theory this would align with data provided to the court monitor in the context of the tour if individuals who are repetitively non-adherent in a month are counted every seven days.] NSH is providing 144 courses designed to enhance individuals' motivation to participate in their PSR services. In addition, NSH has continued to provide Narrative Restructuring Therapy (NRT) to motivate individuals to engage in their treatment and move through the stages of change. Unfortunately, due to staffing shortages NSH has offered this treatment to only four individuals (10 individuals participated in this therapy during the previous review period.

NSH presented the outcome data on NRT for the four individuals, as shown in the tables below:

Individual	Hope Scale Scores	
	Pre-NRT	With NRT
HS	27	31
PS	28	31
RP	18	24
TG	28	28

Individual	Mindfulness Attention Awareness Scale Scores	
	Pre-NRT	With NRT
HS	3.5	5.4
PS	3.0	2.4
RP	2.6	3.9
TG	3.7	5.3

Individual	URICA (Self-Assessment by the Individuals)	
	Pre-NRT	With NRT
HS	9.9	8.1
PS	8.3	10.9
RP	10.3	12.9
TG	10.6	8.0

Given the heterogeneity of causes for non-adherence across persons, NSH should marshal a variety of techniques and methods in the enhancement motivational Mall groups to move the individuals from the enhancement group to the individuals' assigned needs-based groups. Furthermore, NSH should train additional staff on Motivational Interviewing, Mindfulness, and NRT.

At present, NSH does not have the necessary number of trained staff to provide Narrative Restructuring to all individuals assessed to benefit from it. The facility plans to train additional therapists to provide this service.

Compliance:
Partial.

Current recommendations:
1. Implement process to provide key indicator data regarding individuals' non-adherence to interventions in the WRP.
2. Provide information to demonstrate that NSH's current program to motivate individuals addresses barriers towards individuals' participation in their WRPs, including Mall groups.
3. Provide data regarding:
   a. All systematic methods of behavior change including Motivational Interviewing,
   b. Narrative Restructuring Therapy and other cognitive behavioral

		interventions that are provided (with number of providers); The number of individuals receiving these interventions; and c. The number of individuals who trigger non-adherence to WRP in the key indicators.

D. Integrated Assessments		
D	Each State hospital shall ensure that, consistent with generally accepted professional standards of care, each individual shall receive, promptly after admission to each State hospital, an accurate and comprehensive assessment of the conditions responsible for the individual's admission, to the degree possible given the obtainable information at the time of admission. Thereafter, each individual shall receive an accurate and comprehensive reassessment of the reasons for the individual's continued hospitalization whenever there has been a significant change in the individual's status, or a lack of expected improvement resulting from clinically indicated treatment. The individual's interdisciplinary team shall be responsible for investigating the past and present medical, nursing, psychiatric, and psychosocial factors bearing on the individual's condition, and, when necessary, for revising assessments and therapeutic and rehabilitation plans in accordance with new information that comes to light. Each State hospital shall monitor, and promptly address deficiencies in the quality and timeliness of such assessments.	**Summary of Progress on Psychiatric Assessments and Diagnoses:** 1. NSH has filled the senior psychiatrist supervisory positions. 2. NSH began hospital-wide implementation of the DMH revised templates for the Admission Medical and Psychiatric Assessments. 3. NSH has improved the quality of the admission psychiatric assessments. 4. NSH has decreased the overall number of individuals receiving provisional psychiatric diagnoses. 5. NSH has aggregated the data from psychiatric assessment audits and developed individual practitioner profiles that can be utilized for performance improvement. **Summary of Progress on Psychological Assessments:** 1. NSH made strong improvements in most areas in this section. Most notably strong improvements were evidenced in the timeliness of the Integrated Assessment: Psychology Section, the quality of the assessments, and the use of the assessment findings to make recommendations for PSR services. 2. NSH is conducting or requesting additional assessments when there is insufficient information to make a firm diagnosis. **Summary of Progress on Nursing Assessments:** Training regarding the admission and integrated assessments was provided to all admission unit RNs. **Summary of Progress on Rehabilitation Therapy Assessments:** 1. Quality of D.4 admission and focused assessments continues to improve, as indicated by facility data and record review. 2. An improvement is noted in the psychosocial wellness and recovery portion of the focused physical rehabilitation assessments. 3. Data analysis based on requisite audit samples for each area of D.4

		has been initiated. This process should continue to be developed to ensure that the facility provides a thorough and meaningful analysis of all sub-items below 90% compliance, with appropriate plans of correction to improve compliance implemented as needed. This self-assessment should be consistent with the self-assessment specifications found in the introduction of this report. **Summary of Progress on Nutrition Assessments:** Data analysis based on requisite audit samples for each area of D.5 has been initiated. This process should continue to be developed to ensure that the facility provides a thorough and meaningful analysis of all sub-items below 90% compliance, with appropriate plans of correction to improve compliance implemented as needed. This self-assessment should be consistent with the self-assessment specifications found in the introduction of this report. **Summary of Progress on Social History Assessments:** NSH has maintained or improved performance in many areas in this section. Most notably, NSH's Integrated Assessments: Social Work section timeliness and quality has improved. **Summary of Progress on Court Assessments:** NSH has achieved substantial compliance with the EP requirements regarding court reports for individuals admitted under PC 1026 and PC 1370.

1. Psychiatric Assessments and Diagnoses		
	Each State hospital shall provide all of the individuals it serves with routine and emergency psychiatric assessments and reassessments consistent with generally accepted professional standards of care; and,	**Methodology:** <u>Interviewed</u>: 1. Inder Bhanver, MD, Acting Chief Psychiatrist 2. Patricia Tyler, MD, Acting Medical Director <u>Reviewed</u>: 1. The charts of the following 60 individuals: AIR, AJS, AKL, AM, ARC, ARL, BAM, BC, BJB, BMS, BSC, BDA, CAG, CB, DAP, DCB, DJS, DMD, DR, DRR, DRS, DWH, EB, ESP, FO, FDP, FP, GR, GVA, ILL, JAO, JLB, JPJ, LAR, LR, MAG, MAK, ME, MP, MTA, NAJ, NH, NP, PSV, PV, RD, RDS, RES, RG, RLB, RMP, RR, SJF, TJM, TKK, TTS, WJT, WLV, WTA and WV 2. NSH database of all individuals with their diagnoses and medication regimens 3. DMH revised template for the Admission Medical Assessment 4. NSH Psychiatry Department Topic Compliance Rates (June-November 2008) 5. NSH Initial Medical Assessment Monitoring Form 6. NSH Initial Medical Assessment Monitoring summary data (June to November 2008) 7. DMH revised template for the Admission Psychiatric Assessment 8. DMH Admission Psychiatric Assessment Auditing Form 9. DMH Admission Psychiatric Assessment Instructions 10. NSH Admission Psychiatric Assessment summary data (June to November 2008) 11. DMH Integrated Psychiatric Assessment Auditing Form 12. NSH Integrated Psychiatric Assessment Auditing summary data (June to November 2008) 13. NSH Admission Medical Assessment Auditing Form 14. NSH Admission Medical Assessment Auditing summary data (June to November 2008)

		15. DMH Weekly PPN Auditing Form 16. NSH Weekly PPN Auditing summary data (June to November 2008) 17. NSH template for documentation of monthly psychiatric reassessments 18. DMH Monthly Physician Progress Note (PPN) Auditing Form 19. NSH Monthly PPN Auditing summary data (June to November 2008) 20. DMH Physician Inter-Unit Transfer Note Auditing Form 21. NSH Physician Inter-Unit Transfer Note Auditing summary data (June to November 2008)
D.1.a	Each State hospital shall use the diagnostic criteria in the most current Diagnostics and Statistical Manual of Mental Disorders ("DSM") for reaching the most accurate psychiatric diagnoses.	**Current findings on previous recommendations:** **Recommendations 1 and 2, July 2008:** • Monitor this requirement using the DMH Admission Assessment, Integrated Psychiatric Assessment and Monthly Progress Note auditing forms based on at least a 20% sample. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). **Findings:** NSH used the DMH Admission Assessment, Integrated Psychiatric Assessment and Monthly Physician Progress Note auditing forms to assess compliance (June to November 2008). The average samples were 77% of admission assessments, 49% of integrated assessments and 13% of monthly notes on individuals who have been hospitalized for more than 90 days, respectively. The following table summarizes the data:

Admission Assessment		
4.a	*Admission diagnoses Axis I-V are addressed*	
4.b	*DSM-IV diagnosis consistent with history and presentation*	96%

This is consistent with the mean compliance rate of 97% reported during the previous review period.

Integrated Assessment		
2.b	*Statements from the individual are included, if available.*	96%
2.d	*Includes Diagnosis and medications given at previous facility are included*	82%
7.	*Includes diagnostic formulation*	53%
8.	*Includes differential diagnosis*	80%
9.	*Includes current psychiatric diagnoses*	96%

The mean compliance rates for indicators below 90% in this review period increased from the previous review period. The following is an outline of comparative data:

	Previous period	Current period
Mean compliance rate		
2.d	77%	82%
7.	38%	53%
8.	42%	80%
Compliance rate in last month of period		
2.d	77%	90%
7.	48%	47%
8.	39%	88%

Monthly PPN		
3.b.1	*The note includes the 5-axis diagnosis and this is consistent with the current presentation and recent developments*	90%
3.b.2	*If there is a NOS diagnosis or no diagnosis on Axis I, there is documentation that justifies the diagnosis*	28%
3.b.3	*Deferred and rule-out diagnosis are resolved within 60 days of initiation of the diagnosis and there is a clear description of the rationale for the specific resolution*	42%

The mean compliance rates for indicators below 90% in this review period decreased from the previous review period. The following is an outline of comparative data:

	Previous period	Current period
Mean compliance rate		
3.b.2	46%	28%
3.b.3	58%	42%

NSH noted that practitioners were not meeting expectations on items related to differential diagnosis and resolution of rule-outs and deferred diagnoses. The facility further analyzed the data and noted an overall decrease in frequency of each for individuals, specifically those receiving treatment for more than 60 days. A summary of this follows:

Number of individuals with these diagnoses		
Dx	Previous Period	Current Period
Rule Out	57	47

Deferred	101	70
NOS	281	206

Number of individuals with these diagnoses receiving treatment for more than 60 days		
Dx	Previous Period	Current Period
Rule Out	33	30
Deferred	82	56
NOS	243	169

Based on these findings, NSH reported that the facility took the following actions:

1. In October 2008, Senior Psychiatrists began receiving both aggregate and practitioner-specific audit data to facilitate identification of training needs.
2. In January 2009, psychiatrists began receiving their own Audit Driven Corrective Action Plans (ADCAPs.) This report outlines the specific audit items for which a particular psychiatrist's work did not meet expectations. NSH reports that this feedback process has been utilized successfully in other NSH departments.
3. In October 2008, Senior Psychiatrists and Psychologists began receiving a list of individuals (monthly) with R/O, Deferred, NOS and no diagnosis. The senior clinicians reviewed these cases with their supervisees for clinical accuracy. NSH reported a 20-30% decrease in the number of individuals with Deferred and NOS diagnosis following implementation of this process.

Other findings:
DMH has finalized a new template for the admission psychiatric assessment that includes assessment of suicide and violence risk. The new template meets current generally accepted professional standards

		of care. Proper implementation of this template can significantly enhance compliance with EP requirements. NSH implemented the template during this review period. This monitor found that the format was implemented in all charts selected from a random sample of individuals who were admitted during this review period (AJS, AM, ARC, ARL, BDA, DAP, DCB, DWH, FO, FP, ILL, NAJ, PV, SJF, and TJM). This review found that implementation has improved the quality of the assessments compared to the last review. This monitor found fewer deficiencies in the admission psychiatric and integrated psychiatric assessments compared to the last review (see examples in D.1.c.ii, D.1.c.iii and D.1.f). However, the current deficiencies must be corrected to achieve substantial compliance with this requirement. **Compliance:** Partial. **Current recommendations**: 1. Monitor this requirement using the DMH Admission Psychiatric Assessment, DMH Integrated Assessment: Psychiatric Section and Monthly Physician Progress Note auditing forms based on at least a 20% sample. 2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period. 3. Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.
D.1.b	Each State hospital shall ensure that all psychiatrists responsible for performing or reviewing psychiatric assessments:	Please see sub-cells for compliance findings.

D.1.b.i	are certified by the American Board of Psychiatry and Neurology ("ABPN") or have successfully completed at least three years of psychiatry residency training in an Accreditation Counsel for Graduate Medical Education accreditation program, and	**Current findings on previous recommendation:** **Recommendation, July 2008:** Continue current practice. **Findings:** The facility has maintained current practice. All psychiatrists at the facility have successfully completed at least three years of psychiatry residency training in a program approved by the Accreditation Council for Graduate Medical Education. The facility reported that in November, 57% of psychiatrists were board-certified compared to 45% during the previous review. The facility currently has 59 psychiatrists who provide direct clinical services. This is an increase from 54 during the previous review. **Compliance:** Substantial. **Current recommendations**: 1. Continue current practice. 2. Provide the number of allocated and filled FTEs relevant to this indicator.
D.1.b.ii	Are verifiably competent (as defined by privileging at initial appointment and thereafter by reprivileging for continued appointment) in performing psychiatric assessments consistent with each State Hospital's standard diagnostic protocols.	**Current findings on previous recommendation:** **Recommendation, July 2008:** Develop and implement a Quality Profile for staff psychiatrists to include competency in the diagnosis, assessment and reassessment of individuals, and ensure that the reprivileging process incorporates internal monitoring data derived from this process.

		Findings: NSH reported that reprivileging now contains limited data derived from results of psychiatric audits (e.g., target symptoms, documentation of risk factors and rationale for psychopharmacology plan from the monthly Physician's Progress Notes.) **Compliance:** Partial. **Current recommendation**: Specify and describe the indicators and process used in the current reprivileging system.
D.1.c	Each State hospital shall ensure that:	Please see sub-cells for compliance findings.
D.1.c.i	Within 24 hours of an individual's admission to each State hospital, the individual receives an Admission Medical Assessment that includes:	**Current findings on previous recommendations:** **Recommendation 1, July 2008:** Finalize the DMH Initial Medical Examination Auditing Form and Instructions for use across facilities. **Findings:** This recommendation was not addressed during the review period. **Recommendations 2 and 3, July 2008:** • Monitor this requirement using the standardized DMH tool based on at least a 20% sample and ensure that monitoring addresses the quality of the assessments, including the plan of care and follow up regarding incomplete examinations. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).

Findings:
The facility used the NSH Initial Admission Medical Assessment Monitoring Form (June to November 2008) to assess compliance with this requirement. The average sample was 36% of the admissions per month. The following table summarizes the data:

Initial Medical Assessment		
1.	*Completed within 24 hrs.*	95%
5.	*Rectal exams refer to Physician &Surgeon/NP if deferred /refused?*	97%

The mean compliance rates for the requirements in D.1.c.i.1 to D.1.c.i.5 are reported in each corresponding cell below. The sub-indicators and facility's analysis are listed as appropriate.

Other findings:
This monitor reviewed the charts of 10 individuals (AJS, ARC, ARL, BDA, DCB, DWH, FP, NAJ, PV and TJM) who were admitted during this reporting period. The review found the following:

1. The admission medical assessments were completed in a timely manner in all charts.
2. In the chart of one individual who had refused the assessment (AJS), there was evidence of appropriate follow-up by the physician and surgeon in an attempt to complete the examination. However, the WRP did not address the individual's continued refusal of the assessment.
3. Some charts (NAJ and TJM) included medical assessments that were completed using the DMH newly revised template. This template included appropriate prompts to correct the deficiencies outlined in the previous reports.
4. The medical assessments that were completed using the facility's old format included incomplete plans of care in most cases.

		5. The chart of one individual (ARL) included conflicting information regarding neurological status among the neurological consultation, the medical assessment and the WRP. 6. The neurological examination was incomplete in one chart (DCB). 7. There was no documentation that the assessment completed by the nurse practitioner was reviewed by the physician and surgeon in some charts (ARC, DWH, FP, PV and TJM). 8. In one chart (FP), the physical examination did not include an examination of the breast, heart, lungs or blood vessels, with no evidence of appropriate follow-up. **Compliance:** Partial. **Current recommendations**: 1. Finalize and implement the DMH Initial Medical Examination Auditing Form and Instructions for use across facilities. 2. Ensure consistent implementation of the DMH's newly revised template for the admission medical assessment. 3. Ensure that all admission medical assessments that are not completed by the physicians and surgeons are reviewed and cosigned by these physicians. 4. Continue to monitor completeness of the admission medical examination within the specified time frame and follow-up regarding incomplete items on the examination, based on at least a 20% sample. 5. Provide data analysis that evaluates and delineates areas of low compliance and relative improvement (during the reporting period and compared to the last period).
D.1.c.i.1	a review of systems;	97% (compared to 95% during the last review).
D.1.c.i.2	medical history;	97% (compared to 95% during the last review).

D.1.c.i.3	physical examination;	97% (compared to 95% during the last review).
D.1.c.i.4	diagnostic impressions; and	97% (compared to 95% during the last review).
D.1.c.i.5	management of acute medical conditions	97% (compared to 94% during the last review).
D.1.c.ii	within 24 hours of an individual's admission to each State hospital, the individual receives an Admission Psychiatric Assessment that includes:	**Current findings on previous recommendations:** **Recommendation 1, July 2008:** Ensure full implementation of the new DMH template for the admission psychiatric assessment. **Findings:** NSH has implemented the DMH template for admission psychiatric assessments. **Recommendations 2 and 3, July 2008:** • Monitor this requirement using the standardized DMH tool based on at least a 20% sample. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). **Findings:** NSH used the DMH Admission Psychiatric Assessment Auditing Form (June to November 2008) to assess compliance with this requirement. The average sample was 84% of the admissions each month. The mean compliance rate for this requirement was 100%. The mean compliance rates for the requirements in D.1.c.ii.2 through D.1.c .ii.6 are listed for each corresponding cell below. The comparative data are listed, as appropriate.

		Other findings: This monitor reviewed the charts of 15 individuals who were admitted during this reporting period (AJS, AM, ARC, ARL, BDA, DAP, DCB, DWH, FO, FP, ILL, NAJ, PV, SJF and TJM). As mentioned earlier, this monitor found that NSH has implemented the DMH revised template for the admission psychiatric assessments in all cases reviewed, which has resulted in significant improvement in the quality of these assessments. The review found compliance in 10 charts AM, ARL, BDA, DAP, FP, FO, ILL, NAJ, PV, and SJF) and partial compliance in five ARC, AJS, DCB, DWH and TJM). In order to achieve substantial compliance with this requirement, the facility must correct several deficiencies of which the following are examples: 1. The violence risk assessment included inaccurate information regarding the presence of command auditory hallucinations in one individual (TJM). 2. The mental status examination included reference to auditory hallucinations (DWH) and persecutory delusions (AJS) without providing necessary specifics. 3. Most of the assessments included generic references to the status of the individual's insight and judgment. **Compliance:** Partial. **Current recommendations**: 1. Monitor this requirement using the DMH Admission Psychiatric Assessment Auditing Form based on at least a 20% sample. 2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period. 3. Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.

<table>
<tr><td></td><td></td><td></td></tr>
<tr><td>D.1.c.ii.1</td><td>psychiatric history, including a review of presenting symptoms;</td><td>
<table>
<tr><td>2.</td><td>Psychiatric history, including review of presenting symptoms</td><td>81%</td></tr>
<tr><td>2.a</td><td>Identifying data including legal status</td><td>98%</td></tr>
<tr><td>2.b</td><td>Discharge diagnosis and condition</td><td>90%</td></tr>
<tr><td>2.c</td><td>Reason for admission and chief complaint</td><td>96%</td></tr>
<tr><td>2.d</td><td>History of present illness</td><td>96%</td></tr>
<tr><td>2.e</td><td>Psychiatric history</td><td>96%</td></tr>
<tr><td>2.f</td><td>Substance abuse history</td><td>99%</td></tr>
<tr><td>2.g</td><td>Allergies</td><td>99%</td></tr>
<tr><td>2.h</td><td>Current medications</td><td>98%</td></tr>
</table>
The facility reported a mean compliance rate of 81% compared to 70% during the last review. The rate for the last month of this period increased to 78% from 70% during the last review.
</td></tr>
<tr><td>D.1.c.ii.2</td><td>complete mental status examination;</td><td>94% (compared to 89% during the last review).</td></tr>
<tr><td>D.1.c.ii.3</td><td>admission diagnoses;</td><td>94% (compared to 96% during the last review).</td></tr>
<tr><td>D.1.c.ii.4</td><td>completed AIMS;</td><td>98% (compared to 98% during the last review).</td></tr>
<tr><td>D.1.c.ii.5</td><td>laboratory tests ordered;</td><td>96% (compared to 95% during the last review).</td></tr>
<tr><td>D.1.c.ii.6</td><td>consultations ordered; and</td><td>92% (compared to 75% during the last review).</td></tr>
<tr><td>D.1.c.ii.7</td><td>plan of care.</td><td>
<table>
<tr><td>8.</td><td>Plan of care</td><td>76%</td></tr>
<tr><td>8.a</td><td>Regular psychotropic medications with rationale</td><td>87%</td></tr>
<tr><td>8.b</td><td>PRN and/or Stat medications as applicable, with specific behavioral indicators</td><td>69%</td></tr>
</table>
</td></tr>
</table>

		8.c — *Special precautions to address risk factors as indicated* — 88% Comparative data showed increased mean compliance since the last review as follows: Previous period / Current period Mean compliance rate 8. 40% 76% Compliance rate in last month of period 8. 58% 83% 8.a 67% 91% 8.b 63% 79% 8.c 81% 94%
D.1.c.iii	within 7 days (60/72 hrs) of an individual's admission to each State hospital, the individual receives an Integrated Psychiatric Assessment that includes:	**Current findings on previous recommendations:** **Recommendations 1 and 2, July 2008:** • Monitor this requirement using the standardized DMH tool based on at least a 20% sample. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). **Findings:** NSH used the DMH Integrated Assessment Psychiatry Section Auditing Form (June to November 2008) to assess compliance with this requirement. The average sample was 49% of the integrated assessments due each month. The mean compliance rate for this requirement was 95% compared to 68% for the previous review period. The mean compliance rates for the other requirements in D.1.c.iii are

		listed in each corresponding cell below. Comparative data are listed, as appropriate. The facility identified that psychiatrists failed to specifically state when information related to previous treatment was not available. This impacted compliance on several items. NSH's corrective actions are described in D.1.a above. **Other findings:** This monitor reviewed the charts of 15 individuals who were admitted during this reporting period (AJS, AM, ARC, ARL, BDA, DAP, DCB, DWH, FO, FP, ILL, NAJ, PV, SJF and TJM). The review found compliance in five charts (AM, DAP, FO, ILL and SJF) and partial compliance in 10 (AJS, ARC, ARL, BDA, DCB, DWH, FP, NAJ, PV and TJM). Overall, the quality of the assessments has improved somewhat compared to the review period. However, this monitor found several deficiencies that must be corrected to achieve substantial compliance with this requirement. The following are examples: 1. The past psychiatric history did not include important clinical data in several assessments. 2. The integrated assessment did not include any information regarding educational, occupational, sexual or family history in one individual (PV). 3. The mental status examination (affect) in several individuals did not include necessary information regarding current suicidal and/or homicidal ideations/intent/plan (BDA and TJM). 4. One integrated assessment (ARL) did not include a mini mental status examination despite documented reference to cognitive impairment. 5. There was no documentation of a differential diagnosis in an integrated assessment that established a provisional diagnosis of Psychotic Disorder NOS (FP).

		6. In one assessment (PV), the practitioner referred to the individual's strengths/assets with one inappropriate statement- "impaired." 7. The diagnostic formulations were inadequate in several assessments (e.g. ARC). 8. In almost all the charts, the assessment of strengths was limited to a generic list of characteristics of the individuals that could not be utilized in the WRP. 9. Most of the assessments included generic references to the individuals' insight and judgment. 10. In one assessment (DCB), the individual's judgment was described as "poor" but the information in the assessment indicated otherwise. 11. The plans of care often did not include needed information regarding the use of PRN/Stat medications. **Compliance:** Partial. **Current recommendations**: 1. Provide training to WRPT members regarding the proper formulation of individuals' strengths. The training should focus on identifying attributes of the individuals that could be utilized in WRP. 2. Monitor this requirement using the DMH Integrated Assessment: Psychiatric Section auditing form based on at least a 20% sample. 3. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period. 4. Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.

D.1.c.iii.1	psychiatric history, including a review of present and past history;	

2.	*Psychiatric history, including a review of present and past history.*	66%
2.a	*Identifying data including legal status.*	99%
2.b	*Statements from the individual are included, if available.*	96%
2.c	*Chief complaint*	99%
2.d	*Diagnosis and medications given at previous facility are included.*	82%
2.e	*Effectiveness of medications from previous facility is included*	77%
2.f	*Past psychiatric history is documented including a review of pertinent physical exam status.*	84%

Mean compliance increased significantly since the previous review period:

	Previous period	Current period
Mean compliance rate		
2.	38%	66%
Compliance rate in last month of period		
2.	73%	78%
2.d	77%	90%
2.e	91%	87%
2.f	96%	87%

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

3.	*Psychosocial history is documented.*	68%
3.a	*Developmental history*	98%
3.b	*Family history*	98%
3.c	*Educational history*	98%

		3.d	*Religious and cultural influences*	98%
		3.e	*Occupational history*	99%
		3.f	*Marital status*	99%
		3.g	*Sexual history*	97%
		3.h	*Legal history*	71%

Mean compliance increased significantly since the previous review period:

	Previous period	Current period
Mean compliance rate		
3.	30%	68%
Compliance rate in last month of period		
3.	55%	82%
3.h	55%	91%

D.1.c.iii.3	mental status examination;	4.	*Complete mental status examination is documented*	79%
		4.a	*Attitude/cooperation*	98%
		4.ba	*General appearance*	99%
		4.c	*Motor Activity*	99%
		4.d	*Speech*	100%
		4.e	*Mood/affect*	100%
		4.f	*Thought process/content*	98%
		4.g	*Perceptual alterations*	97%
		4.h	*Fund of general knowledge*	94%
		4.i	*Abstraction ability*	93%
		4.j	*Judgment*	99%
		4.k	*Insight*	99%
		4.l	*MMSE*	83%

<table>
<tr><td></td><td></td><td>Mean compliance increased since the previous review period:
<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>4.</td><td>61%</td><td>79%</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>4.</td><td>73%</td><td>95%</td></tr>
<tr><td>4.l</td><td>73%</td><td>95%</td></tr>
</table></td></tr>
<tr><td>D.1.c.iii.4</td><td>strengths;</td><td>91% (compared to 64% during the last review).</td></tr>
<tr><td>D.1.c.iii.5</td><td>psychiatric risk factors;</td><td>
<table>
<tr><td>6.</td><td>Psychiatric risk factors are documented</td><td>47%</td></tr>
<tr><td>6.a</td><td>Risk for suicide</td><td>96%</td></tr>
<tr><td>6.b</td><td>Risk for self-injurious behavior</td><td>90%</td></tr>
<tr><td>6.c</td><td>Risk factors for seclusion (medical and emotional)</td><td>96%</td></tr>
<tr><td>6.d</td><td>Risk factors for restraint (medical and emotional)</td><td>96%</td></tr>
<tr><td>6.e</td><td>Risk for aggression</td><td>95%</td></tr>
<tr><td>6.f</td><td>Risk for fire setting</td><td>88%</td></tr>
<tr><td>6.g</td><td>Risk for elopement</td><td>86%</td></tr>
<tr><td>6.h</td><td>Risk for victimization</td><td>50%</td></tr>
</table>
Mean compliance increased significantly since the previous review period:
<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>6.</td><td>17%</td><td>47%</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>6.</td><td>32%</td><td>78%</td></tr>
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<table>
<tr><td></td><td></td><td>
<table>
<tr><td>6.f</td><td>96%</td><td>91%</td></tr>
<tr><td>6.g</td><td>96%</td><td>91%</td></tr>
<tr><td>6.h</td><td>38%</td><td>81%</td></tr>
</table>
</td></tr>
<tr><td>D.1.c.iii.6</td><td>diagnostic formulation;</td><td>53% (compared to 38% during the last review). The rate for the last month of this review period was 47% compared to 48% during the last month of the previous review period.</td></tr>
<tr><td>D.1.c.iii.7</td><td>differential diagnosis;</td><td>80% (compared to 42% during the last review). The rate for the last month of this review period was 88% compared to 39% during the last month of the previous review period.</td></tr>
<tr><td>D.1.c.iii.8</td><td>current psychiatric diagnoses;</td><td>96% (compared to 75% during the last review period).</td></tr>
<tr><td>D.1.c.iii.9</td><td>psychopharmacology treatment plan; and</td><td>
<table>
<tr><td>10.</td><td>Psychopharmacology treatment plan is documented</td><td>50%</td></tr>
<tr><td>10.a</td><td>Current target symptoms</td><td>86%</td></tr>
<tr><td>10.b</td><td>Specific medications to be used</td><td>94%</td></tr>
<tr><td>10.c</td><td>Dosage titration schedules, if indicated</td><td>93%</td></tr>
<tr><td>10.d</td><td>Adverse reactions to monitor for</td><td>65%</td></tr>
<tr><td>10.e</td><td>Rationale for anticholinergics, benzodiazepines, polypharmacy and new generation antipsychotics in at-risk population, if indicated.</td><td>74%</td></tr>
<tr><td>10.f</td><td>Response to medications since admission, if applicable, including PRN and Stat medications.</td><td>74%</td></tr>
<tr><td>10.g</td><td>Medication consent issues were addressed.</td><td>95%</td></tr>
</table>
Mean compliance increased since the previous review period:
</td></tr>
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<table>
<tr><td></td><td></td><td>
<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>10.</td><td>30%</td><td>50%</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>10.</td><td>60%</td><td>65%</td></tr>
<tr><td>10.a</td><td>85%</td><td>91%</td></tr>
<tr><td>10.d</td><td>74%</td><td>76%</td></tr>
<tr><td>10.e</td><td>71%</td><td>89%</td></tr>
<tr><td>10.f</td><td>67%</td><td>88%</td></tr>
</table>
</td></tr>
<tr><td>D.1.c.iii.10</td><td>management of identified risks.</td><td>84% (compared to 62% during the last review). The rate for the last month of this review period was 94% compared to 86% during the last month of the previous review period.</td></tr>
<tr><td>D.1.d</td><td>Each State hospital shall ensure that:</td><td>Please see sub-cells for compliance findings.</td></tr>
<tr><td>D.1.d.i</td><td>Clinically justifiable diagnoses are provided for each individual, and all diagnoses that cannot be clinically justified for an individual are discontinued no later than the next review;</td><td>Current findings on previous recommendations:

Recommendation 1, July 2008:
Provide documentation of CME training of psychiatry staff in the assessment of cognitive and other neuropsychiatric disorders, including dates and titles of courses and names of instructors and their affiliations.

Findings:
During the review period, NSH offered three CME trainings relevant to cognitive and neuropsychiatric disorders. A summary follows:</td></tr>
</table>

Date	Title	Speaker/Affiliation
7/11/08	Detection of Noncredible Performance in Neuro-psychological Testing	Kyle Boone, PhD, ABPP Professor, Center for Forensic Studies, Alliant University
9/24/08	Delirium	Debra Kahn, MD, Assistant Physician Diplomate Health Sciences Assistant Clinical Professor, UC Davis Department of Psychiatry and Behavioral Sciences
11/19/08	The MATRICS Consensus Cognitive Battery, Part 1: Test Selection, Reliability and Validity	James Eyerman, MD Napa State Hospital

Recommendation 2, July 2008:
Develop and implement corrective actions to address the deficiencies in finalization of diagnoses listed as R/O and/or NOS.

Findings:
NSH reported a decrease in R/O and NOS diagnoses during this review period. See D.1.a for data presentation.

Other findings:
This monitor reviewed the charts of 12 individuals with documented unspecified diagnoses for three or more months during this review period. The review found that the facility has yet to correct the deficiencies in the following areas:

1. Documentation of efforts to finalize the diagnosis, as indicated;

2. Delineation and tracking of cognitive impairments, as indicated;
3. Appropriate match of medications and diagnosis; and/or
4. Alignment of the diagnostic information in the current WRP with the corresponding psychiatric progress notes.

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

Initials	Diagnosis
CAG	Cognitive Disorder NOS
DCB	Dementia NOS
DMD	Dementia NOS
DRR	Mood Disorder, NOS
DWH	Depressive Disorder NOS
ESP	Psychotic Disorder, NOS
LAR	Dementia NOS
MAK	Cognitive Disorder NOS
PSV	Psychotic Disorder, NOS
RDS	Mental Disorder
RES	Mood Disorder, NOS
WLV	Depressive Disorder NOS and Cognitive Disorder NOS

Compliance:
Partial.

Current recommendations:
1. Provide documentation of CME training of psychiatry staff in the assessment of cognitive and other neuropsychiatric disorders, including dates and titles of courses and names of instructors and their affiliations.
2. Develop and implement corrective actions to address the deficiencies in finalization of diagnoses listed as R/O and/or NOS.
3. Same as D.1.a.

D.1.d.ii	The documented justification of the diagnoses is in accord with the criteria contained in the most current DSM (as per DSM-IV-TR Checklist);	**Current findings on previous recommendation:** **Recommendation, July 2008:** Same as in D.1.a and D.1.i. **Findings:** Same as in D.1.a and D.1.i. **Compliance:** Partial. **Current recommendations**: Same as in D.1.a and D.1.i.
D.1.d.iii	Differential diagnoses, "deferred," or "rule-out" diagnoses, and diagnoses listed as "NOS" ("Not Otherwise Specified") are timely addressed (i.e., within 60 days), through clinically appropriate assessments, and resolved in a clinically justifiable manner; and	**Current findings on previous recommendation:** **Recommendation, July 2008:** Same as in D.1.a and D.1.i. **Findings:** Same as in D.1.a and D.1.i. **Compliance:** Partial. **Current recommendations**: Same as in D.1.a and D.1.i.
D.1.d.iv	"no diagnosis" is clinically justified and documented.	**Current findings on previous recommendation:** **Recommendation, July 2008:** Continue current practice.

		Findings: NSH has continued its current practice. During this review, two individuals had "no diagnosis" on Axis I. The facility reported that senior psychiatrists have reviewed these two cases and concluded that "no diagnosis" was clinically justified. **Other findings:** Chart reviews by this monitor found no evidence of "no diagnosis" listed on Axis I. **Compliance:** Substantial. **Current recommendations**: Continue current practice.
D.1.e	Each State hospital shall ensure that psychiatric reassessments are conducted at a frequency that reflects the individual's clinical needs. At a minimum the reassessments are completed weekly for the first 60 days on the admissions units and monthly on other units.	**Current findings on previous recommendations:** **Recommendations 1 and 2, July 2008:** • Monitor this requirement using the DMH Weekly and Monthly PPN Auditing Forms based on at least a 20% sample. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). **Findings:** NSH used the DMH Weekly Physician Progress Note (PPN) Auditing Form (June to November 2008) to assess compliance with this requirement. The average sample was 34% of individuals with a length of admission less than 60 days. The following table summarizes the data: 1. *The reassessments are completed weekly for the first* 61%

	60 days on the admission units:	
1.a	*There is a note present every seven days from the date of admission, with the understanding that the Integrated Assessment: Psychiatry Section can serve as the first weekly note.*	71%
1.b	*The note must contain the subjective complaint, objective findings, assessment and plan of care*	86%

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

	Previous period	Current period
Mean compliance rate		
1.	57%	61%
Compliance rate in last month of period		
1.	76%	42%
1.a	79%	46%
1.b	91%	92%

NSH also used the DMH Psychiatry Monthly PPN Auditing Form (June to November 2008) to assess compliance with this requirement. The average sample was 13% of individuals with a length of admission greater than 90 days. The mean compliance rate for this requirement was 100%.

NSH reported that timeliness of weekly notes was negatively impacted by weekends, holidays, etc. The facility indicated that in December 2008 it revised the requirement to be seven days plus or minus one day to address this barrier.

Other findings:
This monitor reviewed the charts of 10 individuals who were admitted

		during this review period (AJS, ARC, ARL, BDA, DCB, DWH, FP, NAJ, PV and TJM). Regarding the frequency of weekly notes, the review found compliance in five charts (AJS, ARC, ARL, FP and TJM), partial compliance in four (BDA, DWH, NAJ and PV) and noncompliance in one (DCB). The monthly notes were completed in a timely manner in all charts following the first 60 days of hospitalization, as applicable. **Compliance:** Partial. **Current recommendations**: 1. Monitor this requirement using the DMH Weekly Physician Progress Note and DMH Psychiatry Monthly PPN Auditing Forms based on at least a 20% sample. 2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period. 3. Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.
D.1.f	Each State hospital shall ensure that psychiatric reassessments are documented in progress notes that address the following:	**Current findings on previous recommendations:** **Recommendation 1, July 2008:** Finalize and implement a format for psychiatric reassessments that ensures correction of the deficiencies outlined in this monitor's report and in the previous report. **Findings:** NSH has developed an adequate template for the documentation of psychiatric reassessments. However, the content of documentation showed deficiencies that must be corrected to achieve substantial compliance (see other findings).

		Recommendations 2 and 3, July 2008: • Monitor this requirement based on a review of at least 20% sample. • Provide data analysis that evaluates low compliance and delineates areas of relative improvement (during the reporting period and compared to the last period). **Findings:** NSH used the DMH Psychiatry Monthly PPN Auditing Form (June to November 2008) to assess compliance with this requirement. The average sample was 13% of the individuals with a length of admission greater than 90 days. The mean compliance rates for the requirements in D.1.f.i to D.1.f.vii are entered for each corresponding cell below. Comparative data are listed, as appropriate. The facility reported that during the previous review period approximately 25% of practitioners did not write monthly notes consistently. NSH reported that at the time of the current review, this had decreased to 5% of practitioners. All practitioners and their supervisors have started to receive ADCAP results to facilitate targeted mentoring and training. The facility's plan of correction is delineated in D.1.a. **Other findings:** This monitor reviewed the charts of 28 individuals (AIR, AKL, BC, BSC, DJS, DR, DRR, EB, ESP, GR, GVA, JAO, JPJ, LR, MAG, ME, MP, NAJ, NP, RES, RG, RLB, RMP, RR, TKK, WJT, WTA and WV) to assess the quality of documentation in the monthly notes. The reviews found improved consistency in the implementation of the facility's template for the monthly notes, but only minor improvement in the content of these notes compared to the last review. The following are examples of the main areas of deficiency: 1. The documentation of interval events ignored some important

		developments during the interval. 2. The documentation of current status, relevant laboratory findings and risk factors did not include significant relevant changes in laboratory findings and associated risks for the individual nor adequately address these changes. 3. The documentation of risks and benefits of drug treatments was mostly a generic rehash of the theoretical side effects of medications while ignoring some actual and significant occurrences of side effects in some individuals. 4. The documentation of behavioral interventions was typically generic and reflected incomplete understanding of behavioral guidelines and PBS plans that were provided to some individuals. This monitor also reviewed the charts of six individuals who experienced the use of seclusion and/or restraint during this review period (BJB, BMS, JLB, MTA, NH and TTS). This review focused on the use of PRN/Stat medications as documented in the orders and progress notes. This review is also relevant to the requirements in D.1.f.vi and F.1.b. The review found a persistent pattern of deficiencies in the following areas: 1. Prescription of PRN medications for specified behavioral indications; 2. Documentation in the progress notes of the appropriateness and efficacy of the PRN regimen and of timely adjustments of regular treatment following the repeated use of PRN medications; 3. Development and implementation of adequate behavioral guidelines for individuals who were refractory to current medication trials; and 4. Documentation of a face-to-face assessment by the psychiatrists within 24 hours of the administration of Stat medications to address the circumstances of use and diagnostic and/or treatment implications.

		Compliance: Partial. **Current recommendations**: 1. Streamline and simplify the current template for the documentation of psychiatric reassessments to ensure adequate focus on relevant developments in individuals' status. 2. Monitor this requirement using the DMH Psychiatry Monthly PPN Auditing Form based on at least a 20% sample. 3. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period. 4. Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.
D.1.f.i	significant developments in the individual's clinical status and of appropriate psychiatric follow up;	

2.	*Progress notes address changes /developments in the individual's clinical status with appropriate psychiatric follow-up including identified target symptoms*	60%
2.a	*Subjective complaints are documented.*	95%
2.b	*Identified target symptoms are documented*	94%
2.c	*Participation in treatment is documented.*	86%
2.d	*Progress towards objectives in the WRP.*	84%
2.e	*The mental status exam is documented*	94%
2.f	*The individual's legal status and any change in legal status, if applicable.*	80%
2.g	*Current status of medical problems and treatment are documented*	84%
2.h.1	*The lab/diagnostic tests and consults for relevant medical conditions are documented and follow-up provided as indicated*	87%
2.h.2	*Current psychotropic medication dosage/laboratory*	84%

	monitoring/diagnostic testing and consultation protocols are followed as indicated (as per DMH Psychotropic Guidelines)	

Mean compliance improved modestly since the previous review period:

	Previous period	Current period
Mean compliance rate		
2.	54%	60%
Compliance rate in last month of period		
2.	55%	59%
2.c	84%	94%
2.d	81%	94%
2.f	85%	80%
2.g	79%	88%
2.h.1	87%	89%
2.h.2	86%	83%

D.1.f.ii

Timely and justifiable updates of diagnosis and treatment, as clinically appropriate;

3.	*Timely and justifiable updates of diagnoses / treatment as clinically appropriate.*	43%
3.a	*The MMSE is completed and documented in the progress note.*	45%
3.b	*The current diagnosis includes resolution of NOS, deferred, and rule out diagnoses, if applicable.*	81%

The mean compliance rate for the indicator was consistent with the rate at the previous review. However, an increase in mean compliance rate from the last month of the previous review period to the last month of the current review period was reported for the sub-indicators. The following is an outline of comparative data:

		Previous period	Current period
		Mean compliance rate	
		3.	44%	43%
		Compliance rate in last month of period	
		3.	44%	58%
		3.a	39%	59%
		3.b	77%	91%

D.1.f.iii

Analyses of risks and benefits of chosen treatment interventions;

4.	*Analyses of risks and benefits of chosen treatment interventions*	64%
4.a	*The risks for the current psychopharmacology plan including anticholinergics, benzodiazepines, and polypharmacy are documented.*	67%
4.b	*The benefits for the current psychopharmacology plan including anticholinergics, benzodiazepines, and polypharmacy are documented.*	76%
4.c	*Rationale for the current psychopharmacology plan including anticholinergics, benzodiazepines, and polypharmacy are documented*	75%

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

	Previous period	Current period
Mean compliance rate		
4.	57%	64%
Compliance rate in last month of period		
4.	54%	67%
4.a	56%	70%

		4.b	77%	81%
		4.c	68%	78%
D.1.f.iv	Assessment of, and attention to, high-risk behaviors (e.g., assaults, self-harm, falls) including appropriate and timely monitoring of individuals and interventions to reduce risks;	5.	*Assessment of, and attention to, high-risk behaviors (assaults, self-harm, falls) including appropriate and timely monitoring of individuals and interventions to reduce risks*	70%
		5.a	*There is a description of the current risks specific to this individual and the precautions instituted to minimize those risk.*	79%
		5.b	*The monthly note identifies specific risk behaviors including triggers during the interval period.*	73%
		5.c	*If applicable, treatment is modified to minimize risk.*	79%

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

	Previous period	Current period
Mean compliance rate		
5.	66%	70%
Compliance rate in last month of period		
5.	68%	74%
5.a	73%	84%
5.b	74%	78%
5.c	73%	83%

D.1.f.v	Responses to and side effects of prescribed medications, with particular attention to risks associated with the use of benzodiazepines,	6.	*Responses to and side effects of prescribed medications, with particular attention to risks*	54%

	anticholinergic medications, polypharmacy (use of multiple drugs to address the same condition), and conventional and atypical antipsychotic medications;		*associated with the use of benzodiazepines, anticholinergic medications, polypharmacy (use of multiple drugs to address the same condition), and conventional and atypical antipsychotic medications*	
		6.a	*Rationale for current psychopharmacology plan including analysis of risks and benefits.*	66%
		6.b	*There is a description of any side effects caused by medications, including sedation and cognitive impairment.*	78%
		6.c	*The AIMS was done annually for all individuals and quarterly if there is a positive AIMS or a current diagnosis or history of Tardive Dyskinesia.*	80%
		6.d	*Response to pharmacologic treatment is documented. There is a description of the response to the psychopharmacologic regimen in terms of symptom reduction or other measurable objectives*	83%

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

	Previous period	Current period
Mean compliance rate		
6.	45%	54%
Compliance rate in last month of period		
6.	43%	54%
6.a	57%	66%
6.b	70%	83%
6.c	66%	88%
6.d	84%	84%

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

7.	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	59%
7.a	*Describes the rationale/specific indications for all PRN orders.*	73%
7.b	*Reviews the PRNs and Stats during the interval period.*	65%
7.c	*Discusses use of PRN/Stat as indicated to reduce the risk of restrictive interventions.*	54%
7.d	*Describes modification of regularly scheduled medication regimen based on the use of PRN/Stat medications.*	48%

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

	Previous period	Current period
Mean compliance rate		
7.	21%	59%
Compliance rate in last month of period		
7.	32%	71%
7.a	61%	85%
7.b	57%	79%
7.c	41%	66%
7.d	39%	63%

D.1.f.vii	Verification in a clinically justifiable manner, that psychiatric and behavioral treatments are properly integrated. The psychiatrist shall	

8.	*Verification in a clinically justifiable manner, that psychiatric and behavioral treatments are properly*	74%

	review the positive behavior support plan prior to implementation to ensure consistency with psychiatric formulation, document evidence of regular exchange of data or information with psychologists regarding differentiation of learned behaviors and behaviors targeted for psychopharmacological treatments, and document evidence of integration of treatments.		*integrated.*	
		8.a	*There is a description in the note of the response to non-pharmacologic treatment.*	84%
		8.b	*If applicable, there is documentation to support that the psychiatrist reviewed the PBS plan prior to implementation to ensure consistency with psychiatric formulation.*	55%
		8.c	*There is documentation to support evidence of regular exchange of data or information with psychologists regarding differentiation of learned behaviors and behaviors targeted for psychopharmacologic treatments, and document evidence of integration of treatments.*	43%
		8.d	*There is modification, as clinically appropriate, of diagnosis and/or pharmacological treatment based on above reviews/assessments.*	74%

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

	Previous period	Current period
Mean compliance rate		
8.	68%	74%
Compliance rate in last month of period		
8.	63%	72%
8.a	72%	86%
8.b	67%	59%
8.c	44%	46%
8.d	87%	67%

The sample for this indicator and sub-indicators was not based on the

		number of individuals (N) who met the specific criteria relevant to these items. This resulted in small samples (i.e., n = one to four individuals) for several monthly cells.
D.1.g	When individuals are transferred between treatment teams, a psychiatric transfer note shall be completed addressing: review of medical and psychiatric course of hospitalization, including medication trials; current target symptoms; psychiatric risk assessment; current barriers to discharge; and anticipated benefits of transfer.	**Current findings on previous recommendations:** **Recommendations 1 and 2, July 2008:** • Monitor this requirement using the DMH Inter Unit Transfer Note Auditing Form based on at least a 20% sample. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). **Findings:** NSH used the DMH Physician Inter-Unit Transfer Note Auditing Form (June to November 2008) to assess compliance with this requirement. The average sample was 67% of all individuals transferred between WRPTs each month. The following table summarizes the data:

1.	*Psychiatric course of hospitalization,*	57%
2.	*Medical course of hospitalization,*	69%
3.	*Current target symptoms,*	78%
4.	*Psychiatric risk assessment,*	56%
5.	*Current barriers to discharge,*	62%
6.	*Anticipated benefits of transfer.*	67%

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

	Previous period	Current period
Mean compliance rate		
1.	63%	57%

2.	60%	69%
3.	68%	78%
4.	56%	56%
5.	45%	62%
6.	50%	67%
Compliance rate in last month of period		
1.	79%	68%
2.	59%	72%
3.	72%	100%
4.	62%	64%
5.	69%	87%
6.	72%	95%

The facility's plan of correction is delineated in D.1.a.

Recommendation 3, July 2008:
Implement template for Psychiatry Transfer Note.

Findings:
NSH reported that the Psychiatry Transfer Note template was implemented in January 2009.

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

Initials	Date of transfer
BAM	07/27/08
CB	07/02/08
DAP	10/29/08
DRS	09/11/08
FDP	07/31/08

		RD | 09/24/08 The review found compliance in three charts (CB, DAP and RD), partial compliance in two (BAM and DRS) and noncompliance in one (FDP). The review found the following deficiencies: 1. One individual was transferred while displaying management problems without evidence that a behavioral plan had been developed and implemented to address maladaptive behavior (BAM). 2. The course of hospitalization (psychiatric and medical), psychiatric risk assessment and discharge barriers were incomplete and inadequate to ensure continuity of care at the receiving unit (BAM and FDP). **Compliance:** Partial. **Current recommendations**: 1. Monitor this requirement using the DMH Physician Inter-Unit Transfer Note Auditing Form based on at least a 20% sample. 2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period. 3. Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data

2. Psychological Assessments		
		Methodology: Interviewed: 1. Carmen Caruso, Clinical Administrator 2. Cindy Black, Director of Standards Compliance 3. Jim Jones, PhD, Chief of Psychology 4. Kathleen Patterson, PhD, Senior Supervising Psychologist 5. Katie Cooper, PsyD, Enhancement Plan Coordinator Reviewed: 1. Charts of the following 45 individuals: AA, ABN, AC, AM, ARL, AS, CDH, CH, CW, CWR, DD, DH, DML, DR, DSY, FLK, GR, HC, ILL, JC, JDR, JEB, JR, JS, JU, KH, KT, MH, NH, NN, OAP, OTP, PSK, RH, RW, SN, TH, TCT, TL, TM, TN, TO, TR, VC AND YJL 2. Structural and Functional Assessments 3. Psychology Focused Assessments 4. Integrated Assessments: Psychology Section 5. List of individuals with high triggers 6. List of individuals evaluated in their primary/preferred languages 7. List of individuals needing cognitive and academic assessments within 30 days of admission 8. List of individuals needing PBS plans 9. List of individuals referred for neuropsychological assessments 10. List of individuals whose neuropsychological assessments were completed 11. List of individuals under 23 years of age 12. List of individuals whose primary/preferred language is other than English 13. List of individuals with diagnostic uncertainties 14. List of psychologists undertaking psychological evaluations 15. Positive Behavioral Support Plans

		Observed: 1. Life Skills Mall Group 2. PSSC/ETRC meeting 3. Reality Orientation Mall Group 4. Relaxation Technique Mall Group 5. Shift Lead Meeting 6. Substance Abuse/Recovery Mall Group 7. WRPC for JF (unit T-4, Program 5) 8. WRPC for RJ (unit T-8, Program 1)
D.2.a	Each State hospital shall develop and implement standard psychological assessment protocols, consistent with generally accepted professional standards of care. These protocols shall address, at a minimum, diagnostic neuropsychological assessments, cognitive assessments, and I.Q./achievement assessments, to guide psychoeducational (e.g., instruction regarding the illness or disorder, and the purpose or objectives of treatments for the same, including medications), educational, rehabilitation, and habilitation interventions, and behavioral assessments (including functional assessment of behavior in schools and other settings), and personality assessments, to inform positive behavior support plans and psychiatric diagnoses.	**Current findings on previous recommendation:** **Recommendation, July 2008:** Continue current practice. **Findings:** NSH has put in place the necessary standard assessment protocols. The protocols have received DMH approval. **Compliance:** Substantial. **Current recommendation:** Continue current practice.
D.2.b	Each State hospital shall require the completion of cognitive and academic assessments within 30 days of admission of all school-age and other individuals, as required by law, unless comparable testing has been performed within one year of admission and is available to the interdisciplinary team.	**Current findings on previous recommendation:** **Recommendation, July 2008:** Continue current practice.

Findings:
NSH used the DMH Psychology Assessment Monitoring Form to assess compliance (June to November 2009) based on a 100% sample of the individuals under 22 years of age meeting criteria for the assessment. The following is a summary of the data:

1.	*Each State hospital shall require the completion of cognitive and academic assessments within 30 days of admission of all school-age and other individuals, as required by law, unless comparable testing has been performed within one year of admission and is available to the interdisciplinary team.*	100%
1.a	*Both intellectual and academic assessments were completed within 30 days of admission. The assessments provide sufficient data to inform the WRPT of the individual's cognitive and academic level for the purpose of educational services; or*	100%
1.b	*Copies of prior cognitive and academic assessments completed within 12 months of admission are available in the chart. The assessments provide sufficient data to inform the WRPT regarding the individual's cognitive and academic level for the purpose of educational services.*	100%

Discussion with the Chief of Psychology and the Senior Psychologist found that NSH has established a system of tracking individuals under 23 years of age for the provision of cognitive and academic assessments. The Senior Psychologist receives and reviews the daily census and identifies individuals meeting criteria for testing. Once individuals are identified, the Senior Psychologist alerts the unit psychologist and prepares the staff to conduct the necessary assessments. With this system in place, NSH should be able to continue to ensure consistent compliance with this requirement.

		This monitor reviewed six charts of individuals below 23 years of age admitted at NSH in the last six months (JR, JS, NH, NN, RW and TN). All six individuals had the required cognitive and academic testing completed within the 30-day period. NSH continued to pursue testing until completion with individuals refusing to participate in the assessments. **Compliance:** Substantial. **Current recommendation**: Continue current practice.
D.2.c	Each State hospital shall ensure that all clinicians responsible for performing or reviewing psychological assessments and evaluations are verifiably competent in the methodology required to conduct the assessment.	**Current findings on previous recommendation:** **Recommendation, July 2008:** Continue current practice. **Findings:** The table below showing the number of psychologists responsible for conducting psychological assessments, the number meeting credentialing, the number observed conducting psychological assessments, and the number considered competent is a summary of the data.

1.a	*Number of psychologists who are responsible for performing or reviewing psychological assessments and evaluations*	78
1.b	*Number of psychologists who meet the hospital's credentialing and privileging requirements*	78
2.a	*Number of psychologists observed while undertaking psychological assessments*	78

		2.b — *Number observed to be verifiably competent in assessment procedures* — 78 This monitor's findings based on review of documentation for psychologists hired in the last six months are in agreement with the facility's data. NSH's determination of a psychologist's competency starts with the credentialing committee's review of the individuals' education and experience and approval of the psychologist's hiring. Senior psychologists then observe the psychologist conducting psychological assessments. In addition, psychologists conducting psychological assessments undergo peer review once every six months, as part of NSH's requirement. **Compliance:** Substantial. **Current recommendation**: Continue current practice.
D.2.d	Each State hospital shall ensure that all psychological assessments, consistent with generally accepted professional standards of care, shall:	**Compliance:** Substantial.
D.2.d.i	expressly state the clinical question(s) for the assessment;	**Current findings on previous recommendation:** **Recommendation, July 2008:** Continue current practice. **Findings:** Using item 3 from the DMH Psychology Assessment Monitoring Form,

<table>
<tr>
<td></td>
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<td>NSH assessed its compliance based on an average sample of 52% of the Focused Psychological Assessments completed for the month (June to November 2008). The table below is a summary of the data:

<table>
<tr><td>3.</td><td>Expressly state the clinical question(s) for the assessment.</td><td>100%</td></tr>
</table>

Comparative data showed maintenance of compliance at 100% from the previous review period.

All five charts reviewed by this monitor (CH, DD, DH, JDR and KH) had their clinical questions expressly and clearly stated for the assessment.

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

Recommendation, July 2008:
Continue current practice.

Findings:
Using item 4 from the DMH Psychology Assessment Monitoring Form, NSH assessed its compliance based on an average sample of 58% of the Focused Psychological Assessments completed for the month (June to November 2008). The table below is a summary of the data:

<table>
<tr><td>4.</td><td>Include findings specifically addressing the clinical question(s), but not limited to diagnoses and treatment recommendations.</td><td>100%</td></tr>
</table>

Comparative data showed maintenance of compliance at 100% from the previous review period.</td>
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<table>
<tr><td></td><td></td><td>All five Focused Psychological Assessments reviewed by this monitor (CH, DD, DH, JDR and KH) had addressed the clinical questions, and included sufficient information that informed the psychiatric diagnosis, identified the individual's treatment needs, and suggested intervention priorities for consideration by the individual's WRPT.

Current recommendation:
Continue current practice.</td></tr>
<tr><td>D.2.d.iii</td><td>Specify whether the individual would benefit from individual therapy or group therapy in addition to attendance at mall groups;</td><td>Current findings on previous recommendation:

Recommendation, July 2008:
Continue current practice.

Findings:
Using item 5 from the DMH Psychology Assessment Monitoring Form, NSH assessed its compliance based on an average sample of 58% of the Focused Psychological Assessments completed for the month (June to November 2008). The table below is a summary of the data:

<table>
<tr><td>5.</td><td>Specify whether the individual would benefit from individual therapy or group therapy in addition to attendance at mall groups.</td><td>100%</td></tr>
</table>

Comparative data showed maintenance of high compliance from 94% in the prior review period.

All five focused psychological assessments reviewed by this monitor (CH, DD, DH, JDR and KH) used the findings to make appropriate recommendations that would benefit the individual related to participation in group and/or individual therapy, and the recommendations were aligned with the findings.</td></tr>
</table>

<table>
<tr><td></td><td></td><td>Current recommendation:
Continue current practice.</td></tr>
<tr><td>D.2.d.iv</td><td>be based on current, accurate, and complete data;</td><td>Current findings on previous recommendation:

Recommendation, July 2008:
Continue current practice.

Findings:
Using item 6 from the DMH Psychology Assessment Monitoring Form, NSH assessed its compliance based on an average sample of 58% of the Focused Psychological Assessments completed for the month (June to November 2008). The table below is a summary of the data:

<table><tr><td>6.</td><td>Be based on current, accurate, and complete data.</td><td>100%</td></tr></table>
Comparative data showed maintenance of high compliance from 96% in the prior review period.

This monitor reviewed five focused psychological assessments (CH, DD, DH, JDR and KH). All five assessments were accurate, current, and complete. The assessments included the required identifying information, the necessary and available sources of information, and the information gathered from direct observation of the individual during the course of the assessment.

Current recommendation:
Continue current practice.</td></tr>
<tr><td>D.2.d.v</td><td>determine whether behavioral supports or interventions (e.g., behavior guidelines or mini behavior plans) are warranted or whether a</td><td>Current findings on previous recommendation:</td></tr>
</table>

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<td>full positive behavior support plan is required;</td>
<td>
Recommendation, July 2008:
Continue to provide training and supervision to all psychologists to ensure that all psychological assessments of individuals with maladaptive behavior meet this requirement.

Findings:
Using item 7 from the DMH Psychology Assessment Monitoring Form, NSH assessed its compliance based on an average sample of 58% of the Focused Psychological Assessments completed for the month (June to November 2008). The table below is a summary of the data:

<table>
<tr><td>7.</td><td>Determine whether behavioral supports or interventions (e.g., Behavior Guidelines) are warranted or whether a full Positive Behavior Support plan is required</td><td>100%</td></tr>
</table>

Comparative data showed improvement in compliance from 75% in the previous review period.

This monitor reviewed five psychological assessments (CH, DD, DH, JDR and KH). All five assessments had used the findings from the assessments to determine whether behavior supports or interventions were required. The recommendations were aligned with the findings.

Current recommendation:
Continue to provide training and supervision to all psychologists to ensure that all psychological assessments of individuals with maladaptive behavior meet this requirement.
</td>
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<tr>
<td>D.2.d.vi</td>
<td>include the implications of the findings for interventions;</td>
<td>
Current findings on previous recommendation:

Recommendation, July 2008:
Continue current practice.
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Findings:
Using item 8 from the DMH Psychology Assessment Monitoring Form, NSH assessed its compliance based on an average sample of 58% of the Focused Psychological Assessments completed for the month (June to November 2008). The table below is a summary of the data:

<table>
<tr><td>8.</td><td>Include the implications of the findings for interventions</td><td>100%</td></tr>
</table>

Comparative data showed maintenance of compliance at 100% from the previous review period.

This monitor reviewed five focused psychological assessments (CH, DD, DH, JDR and KH). All five assessments included the implications of the findings for the individuals' interventions.

Current recommendation:
Continue current practice.

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<tr>
<td>D.2.d.vii</td>
<td>identify any unresolved issues encompassed by the assessment and, where appropriate, specify further observations, records review, interviews, or re-evaluations that should be performed or considered to resolve such issues; and</td>
<td>

Current findings on previous recommendation:

Recommendation, July 2008:
Ensure that all focused psychological assessments specify whether there is a need for further observations, record review, interviews, or re-evaluations.

Findings:
Using item 9 from the DMH Psychology Assessment Monitoring Form, NSH assessed its compliance based on an average sample of 58% of the Focused Psychological Assessments completed for the month (June to November 2008). The table below is a summary of the data:

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		9. *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.* — 100% Comparative data showed that compliance improved from 82% in the previous review period. This monitor reviewed five focused psychological assessments (CH, DD, DH, JDR and KH). All five assessments specified if further observations, record reviews, interviews, or re-evaluations were warranted. For example, KH was referred for a neurology assessment and CH was recommended for testing to rule out dementia. **Current recommendation**: Ensure that all focused psychological assessments specify whether there is a need for further observations, record review, interviews, or re-evaluations.
D.2.d.viii	Use assessment tools and techniques appropriate for the individuals assessed and in accordance with the American Psychological Association Ethical Standards and Guidelines for testing.	**Current findings on previous recommendation:** **Recommendation, July 2008:** Continue current practice. **Findings:** Using item 10 from the DMH Psychology Assessment Monitoring Form, NSH assessed its compliance based on an average sample of 58% of the Focused Psychological Assessments completed for the month (June to November 2008). The table below is a summary of the data: 10. *Use assessment tools and techniques appropriate for the individuals assessed and in accordance with the* — 100%

		American Psychological Association Ethical Standards and Guidelines for testing. Comparative data showed maintenance of compliance at 100% from the previous review period. This monitor reviewed five focused psychological assessments (CH, DD, DH, JDR and KH). All five assessments used tools approved by and included in the Clinical Indicator List. A clear statement of confidentiality was included in the written reports. The assessments were complete and accurate. **Current recommendation**: Continue current practice.
D.2.e	Each State hospital shall ensure that all psychological assessments of all individuals residing at each State hospital who were admitted there before the Effective Date hereof shall be reviewed by qualified clinicians with demonstrated current competency in psychological testing and, as indicated, revised to meet the criteria in § [IV.B.1 and IV.B.2], above.	**Current findings on previous recommendation:** **Recommendation, July 2008:** Continue current practice. **Findings:** NSH has 670 individuals who were admitted prior to the Effective Date (June 2006). NSH has completed reviewing and where indicated re-assessed all the psychological assessments of all 670 individuals. **Compliance:** Substantial.
D.2.f	Each State hospital shall ensure that all appropriate psychological assessments shall be provided in a timely manner whenever clinically indicated, consistent with generally accepted professional standards of care, including whenever	**Compliance:** Substantial.

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

Current findings on previous recommendation:

Recommendation, July 2008:
Ensure that integrated psychological assessments are conducted in a timely manner as required.

Findings:
Using item 12 from the DMH Psychology Assessment Monitoring Form, NSH assessed its compliance based on an average sample of 74% of the Integrated Assessments: Psychology Section due each month of this review period (June to November 2008). The table below is a summary of the data:

<table>
<tr><td>12.</td><td>Before an individual's therapeutic and rehabilitation service plan is developed, a psychological assessment of the individual shall be performed.</td><td>99%</td></tr>
</table>

Comparative data showed maintenance of high compliance from 100% in the prior review period.

All 14 integrated psychological assessments reviewed by this monitor (AM, DSY, JC, JR, JS, NH, NN, OAP, PSK, RH, RW, SN, TM and TN) were conducted in a timely manner and the assessments were comprehensive, with the findings used to inform the WRPTs of the individual's service needs.

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

Recommendations 1 and 2, July 2008:
• Continue to provide training to ensure that integrated psychology assessments address the nature of the individual's impairments to inform the psychiatric diagnosis.
• Use the DSM-IV-TR Checklist to inform psychiatric diagnoses.

Findings:
Using item 13 from the DMH Psychology Assessment Monitoring Form, NSH assessed its compliance based on an average sample of 74% of the Integrated Assessments: Psychology Section due each month of this review period (June to November 2008). The table below is a summary of the data:

<table>
<tr><td>13.</td><td>Address the nature of the individual's impairments to inform the psychiatric diagnosis;</td><td>100%</td></tr>
</table>

Comparative data showed improvement in compliance from 78% in the previous review period.

All 13 Integrated Assessments: Psychology Section reviewed by this monitor (AM, DSY, JC, JR, JS, NH, NN, OAP, PSK, RH, RW, SN and TM) addressed the nature of the individual's signs and symptoms of the psychiatric diagnosis, and the nature of the psychological excesses and deficits. Twelve of the same 13 assessments had the DSM-IV-TR Checklist completed (AM, DSY, JC, JS, NH, NN, OAP, PSK, RH, RW, SN and TM).
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</table>

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

Recommendation, July 2008:
Ensure accurate evaluation of psychological functioning that informs the WRPT of the individual's rehabilitation service needs.

Findings:
Using item 14 from the DMH Psychology Assessment Monitoring Form, NSH assessed its compliance based on an average sample of 74% of the Integrated Assessments: Psychology Section due each month of this review period (June to November 2008). The table below with its indicator and mean compliance is a summary of the data:

<table>
<tr><td>14.</td><td>Provide an accurate evaluation of the individual's psychological functioning to inform the therapeutic and rehabilitation service planning process;</td><td>99%</td></tr>
</table>

Comparative data showed improvement in compliance from 83% in the previous review period.

All 12 Integrated Assessments: Psychology Section reviewed by this monitor (AM, DSY, JC, JS, NH, NN, OAP, PSK, RH, RW, SN and TM) documented the individual's psychological functioning and used the findings to recommend interventions needed for the individual's rehabilitation.

Current recommendation:
Ensure accurate evaluation of psychological functioning that informs</td></tr>
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		the WRPT of the individual's rehabilitation service needs.
D.2.f.ii	if behavioral interventions are indicated, a structural and functional assessment shall be performed, consistent with generally accepted professional standards of care, by a professional having demonstrated competency in positive behavior supports; and	**Current findings on previous recommendation:** **Recommendation, July 2008:** Ensure that appropriate structural and functional assessments are undertaken by a qualified psychologist when an individual has learned maladaptive behavior. **Findings:** Using item 5 from the DMH Psychology Services Monitoring Form, NSH assessed its compliance based on an average sample of 100% of the PBS assessments completed during each month of the review period (June to November 2008). The table below with its indicator and sub-indicators and corresponding mean compliance is a summary of the data:

5.	*PBS assessments include structural and functional assessments, and as necessary, functional analysis*	100%
5.a	*Pertinent records were reviewed (e.g., individual's chart/record, meeting notes, anecdotal records, evaluations, previous interventions),*	100%
5.b	*Structural assessments (e.g., ecological, sleep, medication effects, mall attendance) were conducted, as needed, to determine broader variables affecting the individual's behavior,*	100%
5.c	*Functional assessment interviews were conducted with people (e.g., individual, parents and family members, therapists and care staff, teachers) who often interact with the individual within different settings and activities, as needed.*	100%
5.d	*Direct observations were conducted across relevant circumstances (e.g., multiple settings, over time) and by more than one observer, as*	100%

		appropriate,	
		5.e	*Other assessment tools (e.g., rating scales, checklists) were used to produce objective information regarding events preceding and following the behavior of concern, as well as ecological and motivational variables that may be affecting the individual's behavior, as needed, and*	100%
		5.f	*If necessary, suspected maintaining variables were manipulated to assess the motivation(s) for the individual's behavior.*	N/A

Comparative data showed that compliance for item 5 increased from 75% in the previous review period.

All eight PBS plans (AS, CDH, DH, GR, JU, KT, TR and VC) reviewed by this monitor were developed using data from derived from structural and functional assessments. The assessments met acceptable methodological, structural, and procedural aspects of these assessments. However, as indicated in F.2.a, a few of the assessments can further improve in the areas of incorporating data collection and analysis of the individual's replacement behaviors. The ultimate goal of PBS is not merely to suppress/eliminate challenging behaviors, but more to supplant them with replacement behaviors that make the challenging behaviors unnecessary.

Current recommendation:
Ensure that appropriate structural and functional assessments are undertaken by a qualified psychologist when an individual has learned maladaptive behavior.

D.2.f.iii	additional psychological assessments shall be performed, as appropriate, where clinical information is otherwise insufficient, and to	**Current findings on previous recommendation:**

	address unresolved clinical or diagnostic questions, including differential diagnosis, "rule-out," "deferred," "no-diagnosis" and "NOS" diagnoses.	**Recommendation, July 2008:** Ensure that additional psychological assessments are performed, as appropriate, where clinical information is otherwise insufficient, and address unresolved clinical or diagnostic questions. **Findings:** Using items 17-20 from the DMH Psychology Assessment Monitoring Form, NSH assessed its compliance to determine if additional psychological assessments were performed when there was insufficient clinical information or unresolved clinical or diagnostic questions on psychological assessments conducted during this review period (June to November 2008), based on an average sample of 100% of the integrated assessments with the various diagnostic categories. The table below showing the item numbers and their diagnostic categories with their corresponding mean compliance is a summary of the data. Comparative data showed improvement in compliance for all four categories since the last review. This monitor reviewed eight charts (AM, DSY, JC, JS, OTP, RW, TM and TN) containing psychological assessments with one or more unresolved clinical and/or diagnostic questions. Additional psychological assessments were conducted on six of the assessments (AM, DSY, JC, OTP, TM and TN). Additional assessments were not conducted or the requested assessments were not completed for two of the assessments (JS and RW).

		Sample	Mean Compliance
17.	*Rule-Out*	100%	100%
18.	*Deferred*	100%	100%
19.	*No Diagnosis*	100%	100%
20.	*NOS- Diagnosis*	100%	100%

		Current recommendation: Ensure that additional psychological assessments are performed, as appropriate, where clinical information is otherwise insufficient, and address unresolved clinical or diagnostic questions.
D.2.g	For individuals whose primary language is not English, each State hospital shall endeavor to assess them in their own language; if this is not possible, each State hospital will develop and implement a plan to meet the individuals' assessment needs, including, but not limited to the use of interpreters in the individual's primary language and dialect, if feasible.	**Current findings on previous recommendation:** **Recommendation, July 2008:** Monitor the use of the procedure for those individuals whose preferred language is not English. **Findings:** Using item 21 from the DMH Psychology Assessment Monitoring Form, NSH assessed its compliance by auditing the process used to evaluated the five individuals admitted to the facility during this review period (June to November 2008), whose primary and/or preferred language is not English. The table below with its indicators and sub-indicators is a summary of the data:

21.a	*Number of individuals who needed assessment during the evaluation period whose primary language was not English*	5
21.b	*Of those in 21.a, number of individuals who were assessed in their primary language*	5
22.a	*Of those in 21.a, number of individuals who could not be assessed*	0
22.b	*Of those in 22.a, number of individuals who had plans developed to meet their assessment needs*	N/A
23.	*Of those in 22.b, number of individuals whose plans for assessment were implemented*	N/A

		This monitor reviewed eight charts (AA, ARL, CW, JC, MH, TCT, TN and TO) of individuals whose primary/preferred language is not English. All eight assessments were conducted in a timely manner in the individual's preferred/primary language. The monitor's sample of eight is greater than NSH's sample of five because some of the individuals reviewed by this monitor were admitted prior to this monitoring period (for example, TCT was admitted in July 31, 2007 but was re-evaluated because of changes to his functioning (unstable at admission, brain tumor in 2008). TCT's primary and preferred language is Cantonese, and NSH used a Cantonese-speaking interpreter to complete the assessment in January 2009. **Compliance:** Substantial. **Current recommendation**: Monitor the use of the procedure for those individuals whose preferred language is not English.

3. Nursing Assessments		
		Methodology: Interviewed: 1. Artheria C. Morrell, RN, Nursing Coordinator, Program IV 2. Carmen Caruso, Clinical Administrator 3. Catherine Mangapot, RN 4. Charlene Paulson, RN, BSN, Assistant Coordinator of Nursing Services 5. David Schmite, RN, Acting Program Assistant, Program IV 6. [redacted] RN, MBA, EdD, Executive Director 7. Elizabeth Clark, Program Director, Program IV 8. George Watanabe, Training Officer III 9. Jean S. Unajan, RN 10. June Grover, RN, BSN, Nursing Coordinator, Program V 11. Lily Franco, RN, Health Services Supervisor 12. Linda Goodwin, Acting Nurse Administrator 13. Michael D. Stolp, Program Director, Program V 14. Michelle Patterson, Health Services Supervisor 15. Natalie Allen, RN, Psychiatric Nursing Education Director 16. Pat Young, Headquarters 17. Simy Suresh Antony, RN 18. Socorro Soberano-Bausanta, RN 19. Steve Weule, RN Supervisor 20. T.C. Hulsey, Interim Program Director, Program II 21. Valerie Perkins, PT, Nursing Coordinator, Program II Reviewed: 1. NSH's progress report and data 2. Nursing Assessment RN Competency Evaluation Form for Admission and Integrated Assessments 3. Training rosters for Nursing Admission and Integrated Assessments 4. Medical records of the following 41 individuals: AJS, AMP, ANT,

		AYT, BCM, BDA, BFL, BJB, CAD, CC, CCC, CDK, CML, CTM, DAP, DJD, DMC, DWH, ELW, GG, GT, IVH, JKC, JRS, JVV, MDJ, MG, NH, OJR, PSK, RCC, REJ, RL, RLM, RVT, SEK, SLC, SPN, TBS, TTS and WT Observed: 1. WRPC for BB, Program II, Unit Q11 2. WRPC for TEF, Program III, Unit T2
D.3.a	Each State hospital shall develop standard nursing assessment protocols, consistent with generally accepted professional standards of care. These protocols shall address, at a minimum:	**Compliance:** Partial.
D.3.a.i	a description of presenting conditions;	**Current findings on previous recommendations:** **Recommendation 1, July 2008:** Complete training for all nurses regarding Admission/Integrated Assessment by the next review period. **Findings:** At NSH, all admission and integrated assessments are completed on the admission units (A9, T2, T3, T4, and Q7). In September 2008, NSH's training rosters verified that training regarding the admission and integrated assessments was provided to all the admission unit RNs; a total of 69 registered nurses, addressing this recommendation. The DMH Nursing Admission Assessment Monitoring Audit, based on a 99% mean sample of admissions for the month (June-November 2008), indicated the following (items for D.3.a.ii-a.ix are found in the corresponding cells below): 1. *A description of presenting conditions* 53%

1.a	*Each section of the Psychiatric and Psychological section of the Nursing Assessment is complete.*	71%
1.b	*Each box checked is elaborated on in the narrative description in the summary of presenting observations.*	62%
1.c	*The narrative description of the individual is described in recovery language and when possible from the individual's perspective.*	72%

NSH's comparison data showed improvements in compliance for all items:

	Previous period	Current period
Mean compliance rate		
1.	21%	53%
Compliance rate in last month of period		
1.	29%	100%
1.a	68%	100%
1.b	38%	100%
1.c	42%	N/A

Scores of "N/A" represent the use of a revised monitoring tool.

The DMH Nursing Integrated Admission Assessment Monitoring Audit, based on a 97% mean sample of admissions for the month (June-November 2008), indicated the following (items for D.3.a.ii-a.ix are found in the corresponding cells below):

1.	*A description of presenting conditions*	56%
1.a	*Each section of the Psychiatric and Psychological section of the Nursing Assessment is complete.*	65%

1.c	*The narrative description of the individual is described in recovery language and when possible from the individual's perspective.*	57%

NSH's comparison data showed improvements in compliance for all items:

	Previous period	Current period
Mean compliance rate		
1.	35%	56%
Compliance rate in last month of period		
1.	35%	100%
1.a	74%	100%
1.c	37%	N/A

NSH noted that the barrier to compliance was that some of the assessments were incomplete. NSH's plan of correction is described below under Findings for Recommendation 2.

Recommendation 2, July 2008:
Implement monitoring and mentoring strategies for nursing assessments.

Findings:
In September 2008, Central Nursing Services developed and implemented a tracking system and mentoring strategy whereby reviewers provide feedback of the findings and 1:1 mentoring is provided to RNs regarding nursing assessments. In addition, the position of a Clinical Oversight Nurse (CON) was developed and implemented for each unit to assist in the mentoring process.

		Recommendation 3, July 2008: Include comparison data and analysis of barriers in progress report. **Findings:** NSH's current Nursing Assessment progress report (D.3) included comparison and barriers as recommended. **Recommendation 4, July 2008:** Continue to monitor this requirement. **Findings:** A review of the admission assessments for 41 individuals (AJS, AMP, ANT, AYT, BCM, BDA, BFL, BJB, CAD, CC, CCC, CDK, CML, CTM, DAP, DJD, DMC, DWH, ELW, GG, GT, IVH, JKC, JRS, JVV, MDJ, MG, NH, OJR, PSK, RCC, REJ, RL, RLM, RVT, SEK, SLC, SPN, TBS, TTS and WT) found that a number of assessments contained very brief and generic Summaries of Presenting Conditions when the information in the assessment indicated that there were a number of issues that should have been addressed. Also, this section was left blank on some of the admission assessments reviewed. Only a few of the assessments reviewed contained good descriptive narratives of the presenting conditions. Also, there were a number of inconsistencies and discrepancies noted within the assessment information without a comment or explanation provided by the nurse completing the assessment. In addition, a number of goals did not accurately reflect the information found in the assessments. Some of the assessments had incomplete information regarding medications. Many of the assessments noted that the individual did not know why they were taking certain medications; however, the question regarding the assessment of the individual's understanding of the medications was frequently not answered appropriately. All of the assessments reviewed included vital signs, pain assessments and allergies. Although it was documented on the assessments that the physicians were notified when

		vital signs were documented as being out of normal range, there was no indication from the assessments that they were retaken. Although NSH's audit findings indicated an increase in compliance regarding the RN Admission Assessments driven by the training that was provided and the mentoring program that has been implemented, much of the information contained in the assessments reviewed did not reflect the clinical relevance of the questions. From discussion with Nursing, the training and mentoring has been focused on completing the assessment form and building RN skills regarding admission assessments. However, there is a lack of understanding regarding what types of clinical information should be addressed regarding the Admission and Integrated Assessments. Conducting a Nursing Assessment is more than simply a question-and-answer session between the RN and the individual. During the discussion, Nursing also reported that most psychiatrists and psychologists do not usually read the nursing admission/integrated assessments so there is no feedback regarding the information gathered. A better understanding of the clinical relevance of the questions contained in the admission and integrated assessments is needed for nursing to complete quality assessments. A review of the integrated assessments for 41 individuals (AJS, AMP, ANT, AYT, BCM, BDA, BFL, BJB, CAD, CC, CCC, CDK, CML, CTM, DAP, DJD, DMC, DWH, ELW, GG, GT, IVH, JKC, JRS, JVV, MDJ, MG, NH, OJR, PSK, RCC, REJ, RL, RLM, RVT, SEK, SLC, SPN, TBS, TTS and WT) found the same problematic issues that were described above regarding the initial nursing admission assessments. Again, there were a few integrated assessments that provided a good narrative description of the individual. However, most did not. All of the integrated assessments reviewed did include vital signs and allergies.

		Current recommendations: 1. Provide training, using interdisciplinary staff such as Psychiatry and Psychology, to Admission RNs, Clinical Oversight Nurses and nursing mentors that focuses on the clinical relevance of questions contained in the admission and integrated nursing assessments. 2. Continue to monitor this requirement.
D.3.a.ii	current prescribed medications;	<u>Admission Assessments</u> 2. *Current prescribed medications;* 79% 2.a *On the Admission Nursing Assessment all currently prescribed medications are documented to include the last time taken, dose, side effects if any, the individuals understanding of the medication and reasons for treatment. OR* 80% 2.c *In the additional comments section there is documentation that medication records are not available and the individual is unable to provide any information about past medication history.* 65% NSH's data analysis indicated improved compliance since the last review: Mean compliance rate 2. Previous period: 56%; Current period: 79% Compliance rate in last month of period 2. Previous period: 64%; Current period: 94% 2.a Previous period: 64%; Current period: 94% 2.c Previous period: 64%; Current period: N/A See D.3.a.i for barriers to compliance and plan of correction.

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<u>Integrated Assessments</u>
<table>
<tr><td>2.</td><td>Current prescribed medications;</td><td>91%</td></tr>
<tr><td>2.b</td><td>On the Integrated Nursing Assessment all sections of the medication management section are completed.</td><td>92%</td></tr>
<tr><td>2.c</td><td>Include when possible, the individual's perception of medication regimen or side effects to watch for.</td><td>92%</td></tr>
</table>
NSH's data analysis indicated improved compliance since the last review:
<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>2.</td><td>88%</td><td>91%</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>2.</td><td>90%</td><td>97%</td></tr>
<tr><td>2.b</td><td>98%</td><td>97%</td></tr>
<tr><td>2.c</td><td>90%</td><td>N/A</td></tr>
</table>
See D.3.a.i for NSH's barriers and plan of correction.
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<tr>
<td>D.3.a.iii</td>
<td>vital signs;</td>
<td>
<u>Admission Assessments</u>
<table>
<tr><td>3.</td><td>Vital signs</td><td>99%</td></tr>
</table>
<u>Integrated Assessments</u>
<table>
<tr><td>3.</td><td>Vital signs</td><td>91%</td></tr>
</table>
NSH's data analysis demonstrated consistent compliance for this item
</td>
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<table>
<tr><td></td><td></td><td>on the admission assessments and some slight variability for the integrated assessments.</td></tr>
<tr><td>D.3.a.iv</td><td>allergies;</td><td>
<u>Admission Assessments</u>
<table>
<tr><td>4.</td><td>Allergies</td><td>95%</td></tr>
</table>
<u>Integrated Assessments</u>
<table>
<tr><td>4.</td><td>Allergies</td><td>92%</td></tr>
</table>
NSH's data analysis indicated an increase in compliance for both the admission and integrated assessments for this item.
</td></tr>
<tr><td>D.3.a.v</td><td>pain;</td><td>
<u>Admission Assessments</u>
<table>
<tr><td>5.</td><td>Pain</td><td>75%</td></tr>
</table>
<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>5.</td><td>71%</td><td>75%</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>5.</td><td>75%</td><td>97%</td></tr>
</table>
<u>Integrated Assessments</u>
<table>
<tr><td>5.</td><td>Pain</td><td>66%</td></tr>
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	Previous period	Current period
Mean compliance rate		
5.	48%	66%
Compliance rate in last month of period		
5.	30%	97%

NSH's data shows an increase in compliance for this item for both the admission and integrated assessments. See D.3.a.i for barriers and plan of correction.

D.3.a.vi — use of assistive devices;

<u>Admission Assessments</u>

6.	*Use of assistive devices*	75%
6.a	*On Admission Nursing Assessment each section under vision, sleep, hearing, eating, teeth, and speech are completed*	75%
6.b	*On Admission Nursing Assessment, additional assistive devices are completed*	80%

	Previous period	Current period
Mean compliance rate		
6.	53%	75%
Compliance rate in last month of period		
6.	54%	100%
6.a	54%	100%
6.b	75%	N/A

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<u>Integrated Assessments</u>

<table>
<tr><td>6.</td><td>Use of assistive devices</td><td>83%</td></tr>
<tr><td>6.a</td><td>On the Integrated Nursing Assessment the Assistive Devices section is completed OR</td><td>68%</td></tr>
<tr><td>6.b</td><td>The "no problems noted" box is checked. If applicable, the Assistive devices section is completed</td><td>93%</td></tr>
</table>

<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>6.</td><td>79%</td><td>83%</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>6.</td><td>84%</td><td>95%</td></tr>
<tr><td>6.a</td><td>36%</td><td>95%</td></tr>
<tr><td>6.b</td><td>92%</td><td>N/A</td></tr>
</table>

The facility's data demonstrated an increase in compliance for both the admission and integrated assessments for this item. The barrier to compliance reported by NSH was the wording of item 6.a on the Integrated Assessment ("OR") and the inability of the software to calculate two options for this item. This issue has been corrected in the newly approved revised tool.
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<tr>
<td>D.3.a.vii</td>
<td>activities of daily living;</td>
<td>
<u>Admission Assessments</u>

<table>
<tr><td>7.</td><td>Activities of daily living</td><td>97%</td></tr>
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<u>Integrated Assessments</u>

<table>
<tr><td>7.</td><td>Activities of daily living</td><td>95%</td></tr>
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<table>
<tr><td></td><td></td><td>NSH's data demonstrated an increase in compliance for this item in both admission and integrated assessments, from 91% and 84% respectively in the prior review period.</td></tr>
<tr><td>D.3.a.viii</td><td>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</td><td>
<u>Admission Assessments</u>
<table>
<tr><td>8.</td><td>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.</td><td></td></tr>
<tr><td>8.a</td><td>The None Known box is checked</td><td>98%</td></tr>
<tr><td>8.b</td><td>The alerts section is completed</td><td>95%</td></tr>
</table>
NSH's comparison data:
<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>8.a</td><td>83%</td><td>98%</td></tr>
<tr><td>8.b</td><td>84%</td><td>95%</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>8.a</td><td>71%</td><td>N/A</td></tr>
<tr><td>8.b</td><td>79%</td><td>100%</td></tr>
</table>
<u>Integrated Assessments</u>
<table>
<tr><td>8.</td><td>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.</td><td></td></tr>
<tr><td>8.a</td><td>The None Known box is checked</td><td>97%</td></tr>
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		8.b *The alerts section is completed* 90% NSH's comparison data: Previous period / Current period Mean compliance rate 8.a 82% 97% 8.b 70% 90% Compliance rate in last month of period 8.a 87% N/A 8.b 60% 100% The facility's data shows an increase in compliance with this item for the admission and integrated assessments. Comparative data tables have been included to illustrate the increase in compliance for both items 8.a and 8.b.
D.3.a.ix	conditions needing immediate nursing interventions.	<u>Admission Assessments</u> 9. *Conditions needing immediate nursing interventions* 68% Previous period / Current period Mean compliance rate 9. 36% 68% Compliance rate in last month of period 9. 39% 100% <u>Integrated Assessments</u> 9. *Conditions needing immediate nursing interventions* 69%

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<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>9.</td><td>37%</td><td>69%</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>9.</td><td>38%</td><td>97%</td></tr>
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The facility's data demonstrated an increase in compliance with this item for both the admission and integrated assessments. See D.3.a.i for barriers and plan of correction.
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<tr>
<td>D.3.b</td>
<td>Nursing may use a systems model (e.g., Johnson Behavioral System Model) for the nursing evaluation.</td>
<td>
Current findings on previous recommendations:

Recommendation 1, July 2008:
Complete training for all nurses regarding Admission/Integrated Assessment based on the Wellness and Recovery Model by next review period.

Findings:
See D.3.a.i.

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

Findings:
All Nursing Services admissions assessments and policies and procedures demonstrate that NSH is consistently using the Wellness and Recovery Model.

Compliance:
Substantial.
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		Current recommendation: Continue consistent use of the Wellness and Recovery Model for Nursing Services Department.
D.3.c	Each State hospital shall ensure that all nurses responsible for performing or reviewing nursing assessments are verifiably competent in performing the assessments for which they are responsible. All nurses who are employed at Metropolitan State Hospital shall have graduated from an approved nursing program, shall have passed the NCLEX-RN and shall have a license to practice in the state of California.	**Current findings on previous recommendations:** **Recommendation 1, July 2008:** Complete training for all nurses regarding Admission/Integrated Assessment by the next review period. **Findings:** See D.3.a.i. **Recommendation 2, July 2008:** Continue to monitor this requirement. **Findings:** NSH's training rosters verified that from June-November 2008, 100% (41) of newly hired RNs had completed and passed the Admission and Integrated Nursing Assessment competency training. **Other findings:** Although NSH's training data demonstrated that 100% of admission RNs and newly hired RNs have received the training regarding Admission/Integrated Assessments, the findings from this reviewer in D.3.a.i indicated a lack of competency, especially in the area of the clinical relevance of the assessments. While compliance rates have increased in several areas regarding the completeness of the assessments, the lack of quality of the assessments does not support competency in this area thus far. **Compliance:** Partial.

		Current recommendations: 1. See D.3.a.i. 2. Review and revise training material regarding Nursing Admission/ Integrated Assessments to ensure that the clinical relevance of the questions is included.
D.3.d	Each State hospital shall ensure that nursing assessments are undertaken on a timely basis, and in particular, that:	Please see sub-cells for compliance findings.
D.3.d.i	Initial nursing assessments are completed within 24 hours of the individual's admission;	**Current findings on previous recommendations:** **Recommendation 1, July 2008:** Ensure that Admission Assessments are adequately completed. **Findings:** See D.3.a.i. **Recommendation 2, July 2008:** Continue to monitor this requirement. **Findings:** NSH's data, from the DMH Nursing Admission Assessment Monitoring Tool based on a 99% average sample of admissions for the month (June-November 2008), indicated 92% compliance with this requirement, compared to 95% compliance in the previous review period. A review of nursing admission assessments for 41 individuals (AJS, AMP, ANT, AYT, BCM, BDA, BFL, BJB, CAD, CC, CCC, CDK, CML, CTM, DAP, DJD, DMC, DWH, ELW, GG, GT, IVH, JKC, JRS, JVV, MDJ, MG, NH, OJR, PSK, RCC, REJ, RL, RLM, RVT, SEK, SLC, SPN, TBS, TTS and WT) found that 30 were timely completed, two were incomplete, four

		were not signed and dated and five did not have the "Sections Completed" area filled out to accurately determine timeliness. These findings do not support NSH's audit findings. **Compliance:** Partial. **Current recommendations**: 1. Ensure that assessments are completed to adequately determine timeliness. 2. Continue to monitor this requirement.
D.3.d.ii	Further nursing assessments are completed and integrated into the individual's therapeutic and rehabilitation service plan within seven days of admission; and	**Current findings on previous recommendations:** **Recommendation 1, July 2008:** Implement training, mentoring, and tracking system to increased compliance with this requirement. **Findings:** See D.3.a.i. **Recommendation 2, July 2008:** Continue to monitor this requirement. **Findings:** NSH used the DMH Nursing Integrated Assessment Monitoring Tool, based on a 97% average sample of integrated assessments for the month (June-November 2008), and reported the following: 13. *Further Nursing Assessments* 31% 13.a *Further nursing assessments are completed and integrated into the individual's therapeutic and rehabilitation service plan within 7 days of* 39%

	admission.	
13.b	*The Integrated Nursing Assessment is completed between (3) to (5) days of admission.*	71%

NSH's data demonstrated variability in compliance rates:

	Previous period	Current period
Mean compliance rate		
13.	40%	31%
13.a	52%	39%
13.b	69%	71%
Compliance rate in last month of period		
13.	28%	62%
13.a	41%	72%
13.b	60%	80%

See D.3.a.i for NSH's barriers and plan of correction.

A review of integrated assessments for 41 individuals (AJS, AMP, ANT, AYT, BCM, BDA, BFL, BJB, CAD, CC, CCC, CDK, CML, CTM, DAP, DJD, DMC, DWH, ELW, GG, GT, IVH, JKC, JRS, JVV, MDJ, MG, NH, OJR, PSK, RCC, REJ, RL, RLM, RVT, SEK, SLC, SPN, TBS, TTS and WT) found that 27 were completed timely, two lacked signatures and date to determine timeliness and 12 were not timely completed.

Compliance:
Partial.

Current recommendations:
See D.3.d.i.

D.3.d.iii	Nursing assessments are reviewed every 14 days during the first 60 days of admission and every 30 days thereafter and updated as appropriate. The third monthly review shall be a quarterly review and the 12th monthly review shall be the annual review.	**Current findings on previous recommendations:** **Recommendation 1, July 2008:** Implement the procedure that seeks to ensure that staff familiar with specific individuals attend those individuals' WRPCs. **Findings:** NSH's progress report indicated that 75% of WRPCs were attended by the core RN or acceptable substitute and 14% of WRPCs were attended by the core Psychiatric Technician or acceptable substitute. However, no additional information was provided regarding this recommendation. **Recommendation 2, July 2008:** Present complete data addressing this requirement. **Findings:** See below. **Recommendation 3, July 2008:** Continue to monitor this requirement. **Findings:** The data from the DMH WRP Observation Monitoring Form could not be interpreted since it included all team members and did not separate RNs and PTs in the data. NSH indicated that the data will be separated for the next review. In observations of two WRPCs (Program II, Unit Q11 and Program III, Unit T2), this reviewer found that little information was provided by the RN and PT for the WRPC on unit T2. The RN and PT for the WRPC on Unit Q11 provided much more individual-specific information regarding their assessments.

		Compliance: Partial. **Current recommendations**: 1. Provide data for RNs and PTs regarding this requirement. 2. Continue to monitor this requirement.

4. Rehabilitation Therapy Assessments		
		Methodology: Interviewed: 1. Beverly Lynn, Acting Senior Rehabilitation Therapist 2. Camille Gentry, Acting Senior Rehabilitation Therapist 3. Phyllis Moore, Acting Senior Rehabilitation Therapist 4. Reggie Ott, Chief of Rehabilitation Services 5. Robert Newman, Acting Senior Rehabilitation Therapist Reviewed: 1. DMH Rehabilitation Therapy Service Manual 2. DMH Rehabilitation Therapy IA-RTS audit data for June-November 2008 3. Focused assessment audit data for June-November 2008 for Speech Therapy, Vocational Rehabilitation, Occupational Therapy, CIPRTA, and Physical Therapy 4. Vocational Rehabilitation Screening Tool 5. List of individuals who had IA-RTS assessments from June-November 2008 6. Records of the following 14 individuals who had IA-RTS assessments from June-November 2008: CWW, DSY, EB, GG, GM, JTC, KDS, MM, PV, PWL, REG, RJH, TB and TJM 7. List of individuals with Vocational Rehabilitation assessment in June-November 2008 8. Records for the following five individuals who had Vocational Rehabilitation Assessments from June-November 2008: AH, AVC, DPA, LTH and RSS 9. List of individuals with Physical Therapy assessment in June-November 2008 10. Records for the following seven individuals with Physical Therapy assessment in June-November 2008: BPJ, GM, JJ, NA, SMS, TBS and TCT

		11. List of individuals with Speech Therapy assessment in June-November 2008 12. Records for the following six individuals with Speech Therapy assessment in June-November 2008: BMN, FK, FM, JR, PEM and RGW 13. List of individuals with Occupational Therapy assessment in June-November 2008 14. Records for the following six individuals with Occupational Therapy assessment in June-November 2008: CHH, CMD, KLW, OH, RLM and SSP 15. List of individuals with Comprehensive Integrated Physical Rehabilitation Therapy assessment in June-November 2008 16. Records for the following four individuals with Comprehensive Integrated Physical Rehabilitation Therapy assessment in June-November 2008: AWL, CMS, JM and OH 17. List of individuals who had type D.4.d assessments from June-November 2008 18. Records of the following 12 individuals who had type D.4.d assessments from June-November 2008: AKL, GBM, GDP, KSM, KT, LJK, MIS, MLC, MM, MRS, RJK and TWH 19. Rehabilitation Therapy training binder
D.4.a	Each State hospital shall develop standard rehabilitation therapy assessment protocols, consistent with generally accepted professional standards of care, for satisfying the necessary components of a comprehensive rehabilitation therapy assessment.	**Current findings on previous recommendations:** **Recommendation 1, July 2008:** Implement the Department of Mental Health Rehabilitation Therapy Service Manual draft and revise as needed based on changes, new protocols and procedures, and system development; ensure that all discipline specific service procedures and manuals continue to be consistent with Rehabilitation Therapy practice in relation to Wellness and Recovery model and Enhancement Plan requirements.

		Findings: The DMH Rehabilitation Therapy Services Manual was approved and implemented in January 2009 and will be updated as procedures and processes change according to performance improvement and accepted standards of practice. **Recommendation 2, July 2008:** Develop and implement a plan to ensure that individuals (both new admissions and individuals residing at NSH) who would benefit from a Comprehensive Physical Rehabilitation Therapy assessment, POST focused assessment, and/or Vocational Rehabilitation assessment are referred for this service by the WRPT. **Findings:** This recommendation has not been addressed. Based on interview and record review, it does not appear that individuals who require a Comprehensive Integrated Physical Rehabilitation Therapy assessment are receiving this service consistently and in a timely manner. It is recommended that a POST referral form be developed and implemented in order to assist the WRPTs in making referrals for the most clinically appropriate POST focused assessment that would best serve each individual's needs. **Recommendation 3, July 2008:** Revise and implement Vocational Rehabilitation screening tool to ensure a more comprehensive tool for Vocational Rehabilitation referrals. **Findings:** The MH-C 9088 DMH Vocational Rehabilitation Screening Tool and Instructions have been finalized and will be implemented in February 2009.

		Other findings: It was noted upon review of Vocational Rehabilitation assessments and audit data that no standardized assessments have been used to contribute to objective assessment findings. The facility currently has access to the CASAS assessment and plans to explore other standardized Vocational Rehabilitation assessment tools (e.g., VALPAR, Careerscope) to supplement objective findings. **Compliance:** Partial. **Current recommendations**: 1. Use standardized assessments (e.g., Careerscope) to supplement the findings of the Vocational Rehabilitation focused assessments as clinically indicated. 2. Develop and implement a POST referral form to ensure that individuals who require these assessments are referred for appropriate services in a timely manner.
D.4.b	Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:	**Current findings on previous recommendation:** **Recommendation, July 2008:** Ensure that each individual served has a rehabilitation assessment that is timely and consistent with generally accepted professional standards of care. **Findings:** Using the DMH Integrated Assessment-Rehabilitation Therapy Section Monitoring Tool, NSH assessed its compliance with timeliness based on an average sample of 99% of Integrated Rehabilitation Therapy assessments due each month for the review period of June-November 2008 (total of 264 out of 267). The following table outlines the indicators with corresponding mean compliance rates for June-

November 2008:

1.	*Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:*	
1.a	*The assessment was completed within 30 calendar days of the individual's admission, and*	75%
1.b	*Filed in the medical record.*	100%

Comparative data showed no significant change in compliance since the last review as follows:

	Previous period	Current period
Mean compliance rate		
1.	76%	75%
Compliance rate in last month of period		
1.		
1.a	83%	80%
1.b	100%	100%

The facility attributed less than substantial compliance with timeliness to Admission unit staff turnover and to admissions on Thursdays and Fridays, which make it difficult to complete assessments within five calendar days. The facility plans to improve compliance by discussing timeliness barriers with admissions Rehabilitation Therapists on a monthly basis.

Using the DMH Vocational Rehabilitation Focused Assessment Monitoring Tool, NSH assessed its compliance with timeliness based on an average sample of 100% of Vocational Rehabilitation assessments due each month for the review period of June-November 2008 (total

of 43). The following table outlines the indicators with corresponding mean compliance rates for June-November 2008:

1.	*Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:*	
1.a	*The assessment was completed within 30 calendar days of the individual's admission, and*	65%
1.b	*Filed in the medical record.*	100%

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

	Previous period	Current period
Mean compliance rate		
1.	44%	65%
Compliance rate in last month of period		
1.		
1.a	67%	92%
1.b	100%	100%

The facility plans to continue to provide mentoring to staff on a monthly basis in order to improve compliance.

Using the DMH Speech Therapy Focused Assessment Monitoring Tool, NSH assessed its compliance with timeliness based on an average sample of 100% of Speech Therapy assessments due each month for the review period of June-November 2008 (total of 46). The following table outlines the indicators with corresponding mean compliance rates for June-November 2008:

1.	*Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:*	
1.a	*The assessment was completed within 14 calendar days of the individual's admission, and*	83%
1.b	*Filed in the medical record.*	83%

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

	Previous period	Current period
Mean compliance rate		
1.	0%	83%
Compliance rate in last month of period		
1.		
1.a	0%	100%
1.b	100%	100%

The facility plans to continue to provide mentoring to staff on a monthly basis in order to improve compliance.

Using the DMH Physical Therapy Focused Assessment Monitoring Tool, NSH assessed its compliance with timeliness based on an average sample of 100% of Physical Therapy assessments due each month for the review period of June-November 2008 (total of 88). The following table outlines the indicators with corresponding mean compliance rates for June-November 2008:

1.	*Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional*	

	standards of care:	
1.a	*The assessment was completed within 14 calendar days of the individual's admission, and*	82%
1.b	*Filed in the medical record.*	100%

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

	Previous period	Current period
Mean compliance rate		
1.	58%	82%
Compliance rate in last month of period		
1.		
1.a	n/a	87%
1.b	n/a	100%

Using the DMH Occupational Therapy Focused Assessment Monitoring Tool, NSH assessed its compliance with timeliness based on an average sample of 100% of Occupational Therapy assessments due each month for the review period of June-November 2008 (total of 17). The following table outlines the indicators with corresponding mean compliance rates for June-November 2008:

1.	*Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:*	
1.a	*The assessment was completed within 14 calendar days of the individual's admission, and*	88%
1.b	*Filed in the medical record.*	100%

No comparable data were available from the last review period.

Using the DMH Comprehensive Physical Rehabilitation Therapy Focused Assessment Monitoring Tool, NSH assessed its compliance with timeliness based on an average sample of 100% of Comprehensive Physical Rehabilitation Therapy assessments due each month for the review period of June-November 2008 (total of 14). The following table outlines the indicator with corresponding mean compliance rates for June-November 2008:

1.	*Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:*	93%

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

	Previous period	Current period
Mean compliance rate		
1.	25%	93%

Other findings:
A review of the records of 14 individuals (CWW, DSY, EB, GG, GM, JTC, KDS, MM, PV, PWL, REG, RJH, TB and TJM) to assess compliance with timeliness of IA-RTS assessments found thirteen records in compliance and one record (JTC) not in compliance.

A review of the records of four individuals (AVC, DPA, LTH and RSS) to assess compliance with timeliness of Vocational Rehabilitation assessments found three records (AVC, DPA and RSS) in compliance and one record (LTH) not in compliance.

		A review of the records of seven individuals (BPJ, GM, JJ, NA, SMS, TBS and TCT) to assess compliance with timeliness of Physical Therapy assessments found six records (BPJ, GM, JJ, NA, TBS and TCT) in compliance and one record (SMS) not in compliance. A review of the records of six individuals (BMN, FK, FM, JR, PEM and RGW) to assess compliance with timeliness of Speech Therapy assessments found five records in compliance and one record (RGW) not in compliance. A review of the records of five individuals (CHH, CMD, KLW, RLM and SSP) to assess compliance with timeliness of Occupational Therapy assessments found four records (CHH, KLW, RLM and SSP) in compliance and one record (CMD) not in compliance. A review of the records of four individuals (AWL, CMS, JM and OH) to assess compliance with timeliness of Comprehensive Integrated Physical Rehabilitation Therapy focused assessments found three records (AWL, CMS and JM) in compliance and one record (OH) not in compliance. **Compliance:** Partial. **Recommendation:** Ensure that each individual served receives Integrated Rehabilitation Therapy assessments (upon admission) and focused Rehabilitation Therapy assessments (as clinically indicated) that are completed in accordance with facility standards for timeliness.
D.4.b.i	Is accurate and comprehensive as to the individual's functional abilities;	**Current findings on previous recommendation:**

		Recommendation 1, July 2008: Ensure that all Rehabilitation Services admission and focused assessments are accurate and comprehensive as to the individual's functional abilities. **Findings:** Using the DMH Integrated Assessment Rehabilitation Therapy Section Monitoring Tool, NSH assessed its compliance with D.4.b.i based on an average sample of 99% of Integrated Rehabilitation Therapy assessments due each month for the review period of June-November 2008 (total of 264 out of 267). The compliance rate was 98%, compared to 79% in the previous review period. Using the DMH Vocational Rehabilitation Focused Assessment Monitoring Tool, NSH assessed its compliance with D.4.b.i based on an average sample of 100% of Vocational Rehabilitation assessments due each month for the review period of June-November 2008 (total of 43). The compliance rate was 93%, compared to 100% in the previous review period. Using the DMH Occupational Therapy Focused Assessment Monitoring Tool, NSH assessed its compliance with D.4.b.i based on an average sample of 100% of Occupational Therapy assessments due each month for the review period of June-November 2008 (total of 17). The compliance rate was 94%; no comparative data were available from the previous review period. Using the DMH Physical Therapy Focused Assessment Monitoring Tool, NSH assessed its compliance with D.4.b.i based on an average sample of 100% of Physical Therapy assessments due each month for the review period of June-November 2008 (total of 88). The following table outlines the indicators with corresponding mean compliance rates for June-November 2008:

2.	*Is accurate and comprehensive as to the individuals functional abilities;*	87%
2.a	*Identifying information is fully documented*	100%
2.b	*Diagnosis*	99%
2.c	*Functional PT diagnosis*	99%
2.d	*Onset date*	100%
2.e	*Age*	100%
2.f	*Chief complaint/mechanism of injury*	99%
2.g	*Past Medical History*	100%
2.h	*Prior level of function*	92%
2.i	*Special precautions*	97%
2.j	*Orientation*	97%

Comparative data showed a substantial increase in mean compliance from the previous review period:

	Previous period	Current period
Mean compliance rate		
2.	25%	87%

No comparable data was available from the last month of the previous review period.

Using the DMH Speech Therapy Focused Assessment Monitoring Tool, NSH assessed its compliance with D.4.b.i based on an average sample of 100% of Speech Therapy assessments due each month for the review period of June-November 2008 (total of46). The compliance rate was 98%, compared to 100% in the previous review period.

Using the DMH Comprehensive Integrated Physical Rehabilitation

		Therapy Focused Assessment Monitoring Tool, NSH assessed its compliance with D.4.b.i based on an average sample of 100% of Comprehensive Physical Rehabilitation Therapy assessments due each month for the review period of June-November 2008 (total of 14). The compliance rate was 93%, compared to 75% in the previous review period. **Other findings:** A review of the records of 14 individuals (CWW, DSY, EB, GG, GM, JTC, KDS, MM, PV, PWL, REG, RJH, TB and TJM) to assess compliance with D.4.b.i for D.4 IA-RTS assessments found all records in substantial compliance. A review of the records of five individuals (AH, AVC, DPA, LTH and RSS) to assess compliance with D.4.b.i in type D.4 Vocational Rehabilitation focused assessments found all records in substantial compliance. A review of the records of five individuals (BMN, FK, FM, JR and PEM) to assess compliance with D.4.b.i in type D.4 Speech Therapy focused assessments found all records in substantial compliance. A review of the records of six individuals (CHH, CMD, KLW, OH, RLM and SSP) to assess compliance with D.4.b.i in type D.4 Occupational Therapy focused assessments found all records in substantial compliance. A review of the records of seven individuals (BPJ, GM, JJ, NA, SMS, TBS and TCT) to assess compliance with D.4.b.i in type D.4 Physical Therapy focused assessments found six records (GM, JJ, NA, SMS, TBS and TCT) in substantial compliance, and one record (BPJ) in partial compliance.

		A review of the records of three individuals (AWL, CMS and JM) to assess compliance with D.4.b.i in type D.4 Comprehensive Integrated Physical Rehabilitation Therapy focused assessments found two records (AWL and JM) in substantial compliance and one record (CMS) not in compliance. **Compliance:** Partial. **Current recommendations**: 1. Ensure that all Rehabilitation Services admission and focused assessments are accurate and comprehensive as to the individual's functional abilities. 2. Implement plans of correction based on review of audit data to improve compliance with D.4.b.i criteria.
D.4.b.ii	Identifies the individual's current functional status and the skills and supports needed to facilitate transfer to the next level of care; and	**Current findings on previous recommendation:** **Recommendation, July 2008:** Ensure that all Rehabilitation Services admission and focused assessments identify the individual's current functional status and the skills and supports needed to facilitate transfer to the next level of care. **Findings:** Using the DMH Integrated Assessment Rehabilitation Therapy Section Monitoring Tool, NSH assessed its compliance with D.4.b.ii based on an average sample of 99% of Integrated Rehabilitation Therapy assessments due each month for the review period of June-November 2008 (total of 264 out of 267). The following table outlines the indicators with corresponding mean compliance rates for June-November 2008:

3.	*Identifies the individual's current functional status, and*	99%
4.	*The skills and supports needed to facilitate transfer to the next level of care; and*	93%

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

	Previous period	Current period
Mean compliance rate		
3.	85%	99%
4.	80%	93%

Using the DMH Vocational Rehabilitation Focused Assessment Monitoring Tool, NSH assessed its compliance with D.4.b.ii based on an average sample of 100% of Vocational Rehabilitation assessments due each month for the review period of June-November 2008 (total of 43). The following table outlines the indicators with corresponding mean compliance rates for June-November 2008:

3.	*Identifies the individual's current functional status, and*	100%
4.	*The skills and supports needed to facilitate transfer to the next level of care*	84%

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

	Previous period	Current period
Mean compliance rate		
3.	78%	100%
4.	78%	84%
Compliance rate in last month of period		
3.	67%	100%
4.	83%	100%

The facility attributed low compliance with item 4 to new staff completing referrals. The facility plans to improve compliance with monthly monitoring and mentoring.

Using the DMH Occupational Therapy Focused Assessment Monitoring Tool, NSH assessed its compliance with D.4.b.ii based on an average sample of 100% of Occupational Therapy assessments due each month for the review period of June-November 2008 (total of 17). The following table outlines the indicators with corresponding mean compliance rates for June-November 2008:

3.	*Identifies the individual's current functional status, and*	100%
4.	*The skills and supports needed to facilitate transfer to the next level of care*	94%

No comparable data were available from the previous review period regarding mean compliance with Occupational Therapy focused assessments.

Using the DMH Physical Therapy Focused Assessment Monitoring Tool, NSH assessed its compliance with D.4.b.ii based on an average sample of 99% of Physical Therapy assessments due each month for the review

period of June-November 2008 (total of 99 out of 100). The following table outlines the indicators with corresponding mean compliance rates for June-November 2008:

3.	*Identifies the individual's current functional status, and*	97%
4.	*The skills and supports needed to facilitate transfer to the next level of care*	93%

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

	Previous period	Current period
Mean compliance rate		
3.	67%	97%
4.	25%	93%

Using the DMH Speech Therapy Focused Assessment Monitoring Tool, NSH assessed its compliance with D.4.b.ii based on an average sample of 100% of Speech Therapy assessments due each month for the review period of June-November 2008 (total of 46). The following table outlines the indicators with corresponding mean compliance rates for June-November 2008:

3.	*Identifies the individual's current functional status, and*	100%
4.	*The skills and supports needed to facilitate transfer to the next level of care*	85%

The facility attributed less than substantial compliance with item 4 to items 3 and 4 being combined on the assessment form, which resulted in omission of some of the required information.

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

	Previous period	Current period
Mean compliance rate		
3.	40%	100%
4.	80%	85%
Compliance rate in last month of period		
3.	50%	100%
4.	50%	50%

Using the DMH Comprehensive Integrated Physical Rehabilitation Therapy Focused Assessment Monitoring Tool, NSH assessed its compliance with D.4.b.ii based on an average sample of 100% of Comprehensive Physical Rehabilitation Therapy assessments due each month for the review period of June-November 2008 (total of 14). The following table outlines the indicators with corresponding mean compliance rates for June-November 2008:

3.	*Identifies the individual's current functional status, and*	86%
4.	*The skills and supports needed to facilitate transfer to the next level of care*	93%

The facility attributed less than substantial compliance with item 3 to clinicians focusing on each individual's deficits rather than on functional status. The facility plans to improve compliance with this item by providing mentoring and monitoring.

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

	Previous period	Current period
Mean compliance rate		
3.	25%	86%
4.	17%	93%
Compliance rate in last month of period		
3.	17%	100%
4.	100%	100%

Other findings:
A review of the records of 14 individuals (CWW, DSY, EB, GG, GM, JTC, KDS, MM, PV, PWL, REG, RJH, TB and TJM) to assess compliance with D.4.b.ii in D.4 IA-RTS assessments found all records in substantial compliance.

A review of the records of five individuals (AH, AVC, DPA, LTH and RSS) to assess compliance with D.4.b.ii in type D.4 Vocational Rehabilitation focused assessments found three records in substantial compliance (AH, DPA and RSS) and two records in partial compliance (AVC and LTH).

A review of the records of six individuals (CHH, CMD, KLW, OH, RLM and SSP) to assess compliance with D.4.b.ii in type D.4 Occupational Therapy focused assessments found five records in substantial compliance (CHH, CMD, KLW, OH and RLM) and one record in partial compliance (SSP).

A review of the records of seven individuals (BPJ, GM, JJ, NA, SMS, TBS and TCT) to assess compliance with D.4.b.ii in type D.4 Physical Therapy focused assessments found six records in substantial compliance (BPJ, GM, NA, SMS, TBS and TCT) and one record (JJ) in partial compliance.

		A review of the records of five individuals (BMN, FK, FM, JR and PEM) to assess compliance with D.4.b.ii in type D.4 Speech Therapy focused assessments found four records in substantial compliance (BMN, FK, JR and PEM) and one record not in compliance (FM). A review of the records of three individuals (AWL, CMS and JM) to assess compliance with D.4.b.ii in type D.4 Comprehensive Integrated Physical Rehabilitation Therapy focused assessments found one record (JM) in substantial compliance, one record (AWL) in partial compliance, and one record (CMS) not in compliance. **Compliance:** Partial. **Current recommendations**: 1. Ensure that all Rehabilitation Services admission and focused assessments identify the individual's current functional status and the skills and supports needed to facilitate transfer to the next level of care. 2. Implement plans of correction based on review of audit data to improve compliance with D.4.b.ii criteria.
D.4.b.iii	Identifies the individual's life goals, strengths, and motivation for engaging in wellness activities.	**Current findings on previous recommendation:** **Recommendation, July 2008:** Ensure that all Rehabilitation Services admission and focused assessments identify the individual's life goals, strengths, and motivation for engaging in wellness activities. **Findings:** Using the DMH Integrated Assessment Rehabilitation Therapy Section Monitoring Tool, NSH assessed its compliance with D.4.b.iii based on an

average sample of 99% of Integrated Rehabilitation Therapy assessments due each month for the review period of June-November 2008 (total of 264 out of 267). The following table outlines the indicators with corresponding mean compliance rates for June-November 2008:

5.	*Identifies the individual's life goals,*	99%
6.	*Strengths, and*	99%
7.	*Motivation for engaging in wellness activities.*	86%
7.a	*Individual's motivation for engaging in wellness activities are identified with individual's response to the following [required] questions*	90%
7.b	*The individual's current level of motivation has been identified by considering the individual's stage of change, and;*	87%
7.c	*Motivation may include both direct quotes from the individual as well as the therapist's assessment of the individual's motivation*	95%

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

	Previous period	Current period
Mean compliance rate		
5.	99%	99%
6.	84%	99%
7.	55%	86%
Compliance rate in last month of period		
7.	67%	100%

Using the DMH Vocational Rehabilitation Focused Assessment Tool,

NSH assessed its compliance with D.4.b.iii based on an average sample of 100% of Vocational Rehabilitation assessments due each month for the review period of June-November 2008 (total of 43). The following table outlines the indicators with corresponding mean compliance rates for June-November 2008:

5.	*Identifies the individual's life goals,*	100%
6.	*Strengths, and*	98%
7.	*Motivation for engaging in wellness activities.*	44%
7.a	*Individual's motivation for engaging in wellness activities are identified with individual's response to the following [required] questions*	63%
7.b	*The individual's current level of motivation has been identified by considering the individual's stage of change, and;*	49%
7.c	*Motivation may include both direct quotes from the individual as well as the therapist's assessment of the individual's motivation*	79%

The facility's plan of correction to improve compliance is to provide training and mentoring to staff on specific audit results.

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

	Previous period	Current period
Mean compliance rate		
5.	100%	100%
6.	56%	98%
7.	0%	44%
Compliance rate in last month of period		

7.	0%	75%

The facility reported that compliance with item 7 showed an upward trend during the last three months of the review period; the facility attributed this to the current mentoring process.

Using the DMH Occupational Therapy Focused Assessment Tool, NSH assessed its compliance with D.4.b.iii based on an average sample of 100% of Occupational Therapy assessments due each month for the review period of June-November 2008 (total of 17). The following table outlines the indicators with corresponding mean compliance rates for June-November 2008:

5.	*Identifies the individual's life goals,*	100%
6.	*Strengths, and*	100%
7.	*Motivation for engaging in wellness activities.*	35%
7.a	*Individual's motivation for engaging in wellness activities are identified with individual's response to the following [required] questions*	65%
7.b	*The individual's current level of motivation has been identified by considering the individual's stage of change, and;*	47%
7.c	*Motivation may include both direct quotes from the individual as well as the therapist's assessment of the individual's motivation*	94%

No comparable data were available from the previous review period regarding compliance with Occupational Therapy focused assessments, as none were completed in the previous review period.

Using the DMH Physical Therapy Focused Assessment Tool, NSH assessed its compliance with D.4.b.iii based on an average sample of 100% of Physical Therapy assessments due each month for the review

period of June-November 2008 (total of 88). The following table outlines the indicators with corresponding mean compliance rates for June-November 2008:

5.	*Identifies the individual's life goals,*	98%
6.	*Strengths, and*	98%
7.	*Motivation for engaging in wellness activities.*	75%
7.a	*Individual's motivation for engaging in wellness activities are identified with individual's response to the following [required] questions*	76%
7.b	*The individual's current level of motivation has been identified by considering the individual's stage of change, and;*	82%
7.c	*Motivation may include both direct quotes from the individual as well as the therapist's assessment of the individual's motivation*	94%

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

	Previous period	Current period
Mean compliance rate		
5.	73%	98%
6.	82%	98%
7.	0%	75%
Compliance rate in last month of period		
7.	N/A	82%

The facility reported that compliance with item 7 showed an upward trend during the last three months of the review period; the facility attributed this to the current mentoring process.

Using the DMH Speech Therapy Focused Assessment Tool, NSH assessed its compliance with D.4.b.iii based on an average sample of 100% of Speech Therapy assessments due each month for the review period of June-November 2008 (total of 46). The following table outlines the indicators with corresponding mean compliance rates for June-November 2008:

5.	*Identifies the individual's life goals,*	100%
6.	*Strengths, and*	100%
7.	*Motivation for engaging in wellness activities.*	44%
7.a	*Individual's motivation for engaging in wellness activities are identified with individual's response to the following [required] questions*	57%
7.b	*The individual's current level of motivation has been identified by considering the individual's stage of change, and;*	63%
7.c	*Motivation may include both direct quotes from the individual as well as the therapist's assessment of the individual's motivation*	74%

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

	Previous period	Current period
Mean compliance rate		
5.	80%	100%
6.	20%	100%
7.	0%	44%
Compliance rate in last month of period		
7.	0%	50%

The facility reported that compliance with item 7 showed an upward trend during the last three months of the review period; the facility attributed this to the current mentoring process.

Using the DMH Comprehensive Integrated Physical Rehabilitation Therapy Focused Assessment Tool, NSH assessed its compliance with D.4.b.iii based on an average sample of 100% of Comprehensive Physical Rehabilitation Therapy assessments due each month for the review period of June-November 2008 (total of 14). The following table outlines the indicators with corresponding mean compliance rates for June-November 2008:

5.	*Identifies the individual's life goals,*	100%
6.	*Strengths, and*	100%
7.	*Motivation for engaging in wellness activities.*	50%
7.a	*Individual's motivation for engaging in wellness activities are identified with individual's response to the following [required] questions*	71%
7.b	*The individual's current level of motivation has been identified by considering the individual's stage of change, and;*	50%
7.c	*Motivation may include both direct quotes from the individual as well as the therapist's assessment of the individual's motivation*	64%

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

	Previous period	Current period
Mean compliance rate		
5.	100%	100%

6.	88%	100%
7.	63%	50%
Compliance rate in last month of period		
7.	67%	0%

Analysis of barriers to compliance with item 7 and/or plan of correction to improve compliance were not provided.

Other findings:
A review of the records of 14 individuals (CWW, DSY, EB, GG, GM, JTC, KDS, MM, PV, PWL, REG, RJH, TB and TJM) to assess compliance with D.4.b.iii in D.4 IA-RTS assessments found all records in substantial compliance.

A review of the records of five individuals (AH, AVC, DPA, LTH and RSS) to assess compliance with D.4.b.iii in type D.4 Vocational Rehabilitation focused assessments found one record in substantial compliance (AH and DPA) and three records in partial compliance (AVC, LTH and RSS). An identified pattern of deficiency that the facility should focus on in order to improve compliance is that assessments do not consistently provide thorough analysis of individual motivation for engaging in wellness activities.

A review of the records of six individuals (CHH, CMD, KLW, OH, RLM and SSP) to assess compliance with D.4.b.iii in type D.4 Occupational Therapy focused assessments found four records in substantial compliance (CHH, OH, RLM and SSP) and two records in partial compliance (CMD and KLW).

A review of the records of seven individuals (BPJ, GM, JJ, NA, SMS, TBS and TCT) to assess compliance with D.4.b.iii in type D.4 Physical Therapy focused assessments found five records in substantial compliance (BPJ, GM, NA, SMS and TBS) and two records in partial

		compliance (JJ and TCT). A review of the records of five individuals (BMN, FK, FM, JR and PEM) to assess compliance with D.4.b.iii in type D.4 Speech Therapy focused assessments found four records in substantial compliance (BMN, FK, JR and PEM) and one record in partial compliance (FM). A review of the records of three individuals (AWL, CMS and JM) to assess compliance with D.4.b.iii in type D.4 Comprehensive Integrated Physical Rehabilitation Therapy focused assessments found two records (CMS and JM) in substantial compliance and one record (AWL) in partial compliance. **Compliance:** Partial. **Current recommendations**: 1. Ensure that all Rehabilitation Services admission and focused assessments identify the individual's life goals, strengths, and motivation for engaging in wellness activities. 2. Implement plans of correction based on review of audit data to improve compliance with D.4.b.iii criteria.
D.4.c	Each State hospital shall ensure that all clinicians responsible for performing or reviewing rehabilitation therapy assessments are verifiably competent in performing the assessments for which they are responsible	**Current findings on previous recommendation:** **Recommendation, July 2008:** Continue current practice. **Findings:** According to facility report, three out of three new staff Rehabilitation Therapists received training to competency on the training materials for the Integrated Assessment-Rehabilitation Therapy Section during the review period. Raw data from training

		rosters and training post-tests were not available for review. The facility reported that four out of four new Rehabilitation Therapy POST team therapists have been trained to competency on the assessments for which they are responsible; raw data from training rosters and training post-tests were requested but not available for review. **Compliance:** Partial; upgrade to Substantial to be based on availability of confirming documentation. **Current recommendation**: Ensure that all clinicians responsible for performing or reviewing rehabilitation therapy assessments are verifiably competent in performing the assessments for which they are responsible.
D.4.d	Each State hospital shall ensure that all rehabilitation therapy assessments of all individuals who were admitted to each State hospital before the Effective Date hereof shall be reviewed by qualified clinicians and, as indicated, revised to meet the criteria in § [IV.D.2], above.	**Current findings on previous recommendation:** **Recommendation, July 2008:** Ensure that all individuals admitted to NSH prior to June 1, 2006 receive an Integrated Assessment-Rehabilitation Therapy Section Assessment within the next twelve months. **Findings:** According to facility report, 251 out of 611 type D.4.d assessments were completed during the June-November 2008 review period. **Other findings:** A review of the records of twelve individuals who were reported to have received type D.4.d IA-RTS assessments (AKL, GBM, GDP, KSM, KT, LJK, MIS, MLC, MM, MRS, RJK and TWH) found that all records had evidence of completed assessments. Eight records (AKL, GBM, GDP, KSM, KT, LJK, MLC and RJK) were in found to be substantial

		compliance with D.4.d and four records (MIS, MM, MRS and TWH) were in partial compliance with D.4.d with regard to assessment quality. **Compliance:** Partial. **Current recommendation**: Ensure that all individuals admitted to NSH prior to June 1, 2006 who have not yet received an IA-RTS have received an Integrated Assessment-Rehabilitation Therapy Section Assessment within the next six months.

5. Nutrition Assessments		
D.5	Each State hospital shall provide nutrition assessments, reassessments, and interventions consistent with generally accepted professional standards of care. A comprehensive nutrition assessment will include the following:	**Methodology:** Interviewed: 1. Craig Saewong, Registered Dietitian 2. Dana M. Scruggs, Registered Dietitian 3. Emiko Taki, Registered Dietitian 4. Heidi Vogelsang, Registered Dietitian 5. Joan Merrill, Registered Dietitian 6. Kumiko Kato, Registered Dietitian 7. Lynn Wurzel, Registered Dietitian 8. Noriko Takenawa, Registered Dietician 9. Robin Carboni, Registered Dietitian 10. Veronica Oteyza, Registered Dietitian 11. Wen Pao, Registered Dietitian Reviewed: 1. Nutrition Care Monitoring audit data for June-November 2008 for each assessment type 2. Lists of individuals with Nutrition Care Assessments due from June-November 2008 for each assessment type 3. Records for the following five individuals with type D.5.a assessments from June-November 2008: BT, DS, GRF, JR and RM 4. Records for the following two individuals with type D.5.b assessments from June-November 2008: NKB and UDH 5. Records for the following individual with type D.5.c assessment from June-November 2008: DBC 6. Records for the following six individuals with type D.5.d assessments from June-November 2008: HDE, JT, LLH, RAC, RKH and TBS 7. Records for the following eight individuals with type D.5.e assessments from June-November 2008: AAK, ACG, ANA, DSY, JJJ, NH, SCL and WET

		8. Records for the following six individuals with type D.5.f assessments from June-November 2008: GG, OJR, RC, SR, TOM and TTS 9. Records for the following nine individuals with type D.5.g assessments from June-November 2008: AJM, CC, GA, IH, JEH, MJM, PGW, RJ and TJ 10. Records for the following eleven individuals with type D.5.i assessments from June-November 2008: CW, DHP, HV, JAC, JAO, JS, MBD, MH, MHJ, MRS and SPS 11. Records for the following six individuals with type D.5.j.i assessments from June-November 2008: HP, RF, RLH, RLJ, RLM and VM 12. Records for the following 15 individuals with type D.5.j.ii assessments from June-November 2008: AEP, AZ, CD, DS, GDM, ITS, JY, KAL, MWS, PC, RM, TCG, VM, WGS and WKN
D.5.a	For new admissions with high risk referral (e.g., type I diabetes mellitus, enteral/parenteral feeding, dysphagia/recent choking episode), or upon request by physician, a comprehensive Admission Nutrition Assessment will be completed within 24 hours of notification to the dietitian.	**Current findings on previous recommendation:** **Recommendation, July 2008:** Continue current efforts to achieve compliance. **Findings:** Using the DMH Nutrition Care Monitoring Tool, NSH assessed its compliance based on an average sample of 100% of Nutrition Type D.5.a Assessments due each month for the review period of June-November 2008 (total of 11). The following table outlines the indicators with corresponding mean compliance rates for June-November 2008: 1. *Assessment is completed on time per policy* 100% 2. *All required subjective concerns are addressed* 100% 3. *All pertinent objective nutrition information is accurately addressed* 100% 4. *Estimated daily needs for nutrients specified are* 100%

	appropriate	
5.	*Assessment utilizes findings from subjective and objective data*	100%
6.	*Nutrition diagnosis is correctly formulated, prioritized and validated*	90%
7.	*Nutrition education is documented*	100%
8.	*Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified*	100%
9.	*Progress is monitored, measured, and evaluated*	N/A
10.	*Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable*	91%
11.	*Recommendations are appropriate and complete*	100%
12.	*NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment*	100%
13.	*Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present*	80%
14.	*Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support*	N/A
15.	*Assessment utilizes approved abbreviations*	100%
16.	*Assessment is concise*	100%
17.	*Assessment is legible*	100%
18.	*Each page of the assessment is signed*	100%

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

	Previous period	Current period
Mean compliance rate		
1.	50%	100%
2.	100%	100%

3.	100%	100%
4.	100%	100%
5.	100%	100%
6.	83%	90%
7.	75%	100%
8.	50%	100%
9.	N/A	N/A
10.	100%	91%
11.	100%	100%
12.	83%	100%
13.	67%	80%
14.	N/A	N/A
15.	100%	100%
16.	100%	100%
17.	100%	100%
18.	100%	100%
Compliance rate in last month of period		
13.	100%	N/A

Other findings:
A review of the records of five individuals (BT, DS, GRF, JR and RM) to assess compliance with Nutrition type D.5.a assessment criteria found three records (DS, JR and RM) in substantial compliance and two records (BT and GRF) in partial compliance.

Compliance:
Partial.

Current recommendation:
Continue current efforts to achieve compliance.

D.5.b	For new admissions directly into the medical-surgical unit, a comprehensive Admission Nutrition Assessment will be completed within 3 days of admission.	**Current findings on previous recommendation:** **Recommendation, July 2008:** Continue current efforts to achieve compliance. **Findings:** Using the DMH Nutrition Care Monitoring Tool, NSH assessed its compliance based on an average sample of 100% of Nutrition Type D.5.b Assessments due each month for the review period of June-November 2008 (total of 3). The following table outlines the indicators with corresponding mean compliance rates for June-November 2008:

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

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

Comparative data showed maintenance in compliance in all items except 11, which showed a decrease in compliance, since the last review as follows:

	Previous period	Current period
Mean compliance rate		
1.	100%	100%
2.	100%	100%
3.	100%	100%
4.	100%	100%
5.	100%	100%
6.	100%	100%
7.	100%	100%
8.	100%	100%
9.	100%	N/A
10.	100%	100%
11.	100%	67%
12.	100%	100%
13.	100%	N/A
14.	100%	N/A
15.	100%	100%
16.	100%	100%
17.	100%	100%

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<table>
<tr><td>18.</td><td>100%</td><td>100%</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>13.</td><td>N/A</td><td>0%</td></tr>
</table>

Analysis of possible barriers to compliance with #13 and/or plan of correction to improve compliance were not provided.

Other findings:
A review of the records of two individuals (NKB and UDH) to assess compliance with Nutrition type D.5.b assessment criteria found both records in partial compliance.

Compliance:
Partial.

Current recommendation:
Continue current efforts to achieve compliance.
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<tr>
<td>D.5.c</td>
<td>For new admissions directly into the skilled nursing facility unit, a comprehensive Admission Nutrition Assessment will be completed within 7 days of admission.</td>
<td>
Current findings on previous recommendation:

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

Findings:
Using the DMH Nutrition Care Monitoring Tool, NSH assessed its compliance based on an average sample of 100% of Nutrition Type D.5.c Assessments due each month for the review period of June-November 2008 (total of 1). The following table outlines the indicators with corresponding mean compliance rates for June-November 2008:

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

Limited data was available for comparison regarding Nutrition assessment type c., as only one assessment was due and completed this review period. Comparative data showed maintenance in compliance since the last review as follows:

	Previous period	Current period
Mean compliance rate		
1.	100%	100%
2.	100%	100%
3.	100%	100%
4.	100%	100%
5.	100%	N/A
6.	100%	N/A
7.	100%	N/A
8.	N/A	N/A
9.	100%	N/A
10.	100%	100%
11.	100%	100%
12.	100%	100%
13.	N/A	N/A
14.	N/A	N/A
15.	100%	100%
16.	100%	100%
17.	100%	100%
18.	100%	100%

Other findings:
A review of the record of one individual (DBC) to assess compliance with Nutrition type D.5.c assessment criteria found the record in substantial compliance.

Compliance:
Unable to determine due to small sample size.

<table>
<tr><td></td><td></td><td>Current recommendation:
Continue current efforts to achieve compliance.</td></tr>
<tr><td>D.5.d</td><td>For new admissions with identified nutritional triggers from Nursing Admission Assessment or physician's consult (e.g., for severe food allergies, tube feeding, extensive dental problems or dental surgery, NPO/clear liquid diet for more than three days, uncontrolled diarrhea/vomiting more than 24hrs, and MAOI, as clinically indicated), a comprehensive Admission Nutrition Assessment will be completed within 7 days of admission.</td><td>Current findings on previous recommendation:

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

Findings:
Using the DMH Nutrition Care Monitoring Tool, NSH assessed its compliance based on an average sample of 100% of Nutrition Type D.5.d Assessments due each month for the review period of June-November 2008 (total of 19). The following table outlines the indicators with corresponding mean compliance rates for June-November 2008:
<table>
<tr><td>1.</td><td>Assessment is completed on time per policy</td><td>95%</td></tr>
<tr><td>2.</td><td>All required subjective concerns are addressed</td><td>100%</td></tr>
<tr><td>3.</td><td>All pertinent objective nutrition information is accurately addressed</td><td>100%</td></tr>
<tr><td>4.</td><td>Estimated daily needs for nutrients specified are appropriate</td><td>100%</td></tr>
<tr><td>5.</td><td>Assessment utilizes findings from subjective and objective data</td><td>95%</td></tr>
<tr><td>6.</td><td>Nutrition diagnosis is correctly formulated, prioritized and validated</td><td>100%</td></tr>
<tr><td>7.</td><td>Nutrition education is documented</td><td>100%</td></tr>
<tr><td>8.</td><td>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</td><td>94%</td></tr>
<tr><td>9.</td><td>Progress is monitored, measured, and evaluated</td><td>N/A</td></tr>
<tr><td>10.</td><td>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</td><td>84%</td></tr>
<tr><td>11.</td><td>Recommendations are appropriate and complete</td><td>89%</td></tr>
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12.	*NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment*	95%
13.	*Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present*	100%
14.	*Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support*	100%
15.	*Assessment utilizes approved abbreviations*	100%
16.	*Assessment is concise*	100%
17.	*Assessment is legible*	100%
18.	*Each page of the assessment is signed*	100%

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

	Previous period	Current period
Mean compliance rate		
1.	80%	95%
2.	100%	100%
3.	97%	100%
4.	97%	100%
5.	97%	95%
6.	91%	100%
7.	100%	100%
8.	100%	94%
9.	N/A	N/A
10.	94%	84%
11.	69%	89%
12.	91%	95%
13.	67%	100%
14.	N/A	100%
15.	97%	100%

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<tr><td>16.</td><td>100%</td><td>100%</td></tr>
<tr><td>17.</td><td>100%</td><td>100%</td></tr>
<tr><td>18.</td><td>100%</td><td>100%</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>10.</td><td>100%</td><td>100%</td></tr>
<tr><td>11.</td><td>88%</td><td>100%</td></tr>
</table>

Analysis of possible barriers to compliance with items 10 and 11 and/or plans of correction to improve compliance were not provided.

Other findings:
A review of the records of six individuals (HDE, JT, LLH, RAC, RKH and TBS) to assess compliance with Nutrition type D.5.d assessment criteria found four records (HDE, LLH, RKH and TBS) in substantial compliance and two records (JT and RAC) in partial compliance.

Compliance:
Partial.

Current recommendation:
Continue current efforts to achieve compliance.
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<tr>
<td>D.5.e</td>
<td>For new admissions with therapeutic diet orders for medical reasons, a comprehensive Admission Nutrition Assessment will be completed within 7 days of admission.</td>
<td>
Current findings on previous recommendation:

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

Findings:
Using the DMH Nutrition Care Monitoring Tool, NSH assessed its compliance based on an average sample of 100% of Nutrition Type D.5.e Assessments due each month for the review period of June-November 2008 (total of 49). The following table outlines the indicators with corresponding mean compliance rates for June-November 2008:
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1.	*Assessment is completed on time per policy*	100%
2.	*All required subjective concerns are addressed*	100%
3.	*All pertinent objective nutrition information is accurately addressed*	100%
4.	*Estimated daily needs for nutrients specified are appropriate*	100%
5.	*Assessment utilizes findings from subjective and objective data*	98%
6.	*Nutrition diagnosis is correctly formulated, prioritized and validated*	98%
7.	*Nutrition education is documented*	93%
8.	*Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified*	100%
9.	*Progress is monitored, measured, and evaluated*	N/A
10.	*Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable*	96%
11.	*Recommendations are appropriate and complete*	85%
12.	*NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment*	98%
13.	*Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present*	100%
14.	*Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support*	N/A
15.	*Assessment utilizes approved abbreviations*	100%
16.	*Assessment is concise*	100%
17.	*Assessment is legible*	100%
18.	*Each page of the assessment is signed*	100%

Comparative data showed improvement or maintenance of compliance in all items except item 11, which showed a decrease in compliance:

	Previous period	Current period
Mean compliance rate		
1.	91%	100%
2.	100%	100%
3.	91%	100%
4.	100%	100%
5.	82%	98%
6.	90%	98%
7.	89%	93%
8.	78%	100%
9.	N/A	N/A
10.	90%	96%
11.	91%	85%
12.	91%	98%
13.	100%	100%
14.	N/A	N/A
15.	82%	100%
16.	100%	100%
17.	100%	100%
18.	100%	100%
Compliance rate in last month of period		
11.	100%	100%

Analysis of possible barriers to compliance with item 11 and/or plan of correction to improve compliance were not provided.

Other findings:
A review of the records of eight individuals (AAK, ACG, ANA, DSY, JJJ, NH, SCL and WET) to assess compliance with Nutrition type D.5.e assessment criteria found five records (AAK, ACG, ANA, JJJ and

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<td>WET) in substantial compliance and three records (DSY, NH and SCL) in partial compliance.

Compliance:
Partial.

Current recommendation:
Continue current efforts to achieve compliance.</td>
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<tr>
<td>D.5.f</td>
<td>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.</td>
<td>Current findings on previous recommendation:

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

Findings:
Using the DMH Nutrition Care Monitoring Tool, NSH assessed its compliance based on an average sample of 100% of Nutrition Type D.5.f Assessments due each month for the review period of June-November 2008 (total of 24). The following table outlines the indicators with corresponding mean compliance rates for June-November 2008:
<table>
<tr><td>1.</td><td>Assessment is completed on time per policy</td><td>96%</td></tr>
<tr><td>2.</td><td>All required subjective concerns are addressed</td><td>100%</td></tr>
<tr><td>3.</td><td>All pertinent objective nutrition information is accurately addressed</td><td>100%</td></tr>
<tr><td>4.</td><td>Estimated daily needs for nutrients specified are appropriate</td><td>100%</td></tr>
<tr><td>5.</td><td>Assessment utilizes findings from subjective and objective data</td><td>100%</td></tr>
<tr><td>6.</td><td>Nutrition diagnosis is correctly formulated, prioritized and validated</td><td>92%</td></tr>
<tr><td>7.</td><td>Nutrition education is documented</td><td>100%</td></tr>
<tr><td>8.</td><td>Response to MNT is specific to the intervention</td><td>100%</td></tr>
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	provided, adherence potential indicated, and barriers identified	
9.	*Progress is monitored, measured, and evaluated*	N/A
10.	*Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable*	92%
11.	*Recommendations are appropriate and complete*	91%
12.	*NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment*	96%
13.	*Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present*	100%
14.	*Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support*	100%
15.	*Assessment utilizes approved abbreviations*	100%
16.	*Assessment is concise*	100%
17.	*Assessment is legible*	100%
18.	*Each page of the assessment is signed*	100%

Comparative data showed maintenance or improvement of compliance in all items since the last review as follows:

	Previous period	Current period
Mean compliance rate		
1.	94%	96%
2.	96%	100%
3.	97%	100%
4.	99%	100%
5.	96%	100%
6.	89%	92%
7.	98%	100%
8.	96%	100%
9.	N/A	N/A

		10. 92% 92% 11. 79% 91% 12. 93% 96% 13. 100% 100% 14. 100% 100% 15. 90% 100% 16. 100% 100% 17. 100% 100% 18. 92% 100% **Other findings:** A review of the records of six individuals (GG, OJR, RC, SR, TOM and TTS) to assess compliance with Nutrition type D.5.f assessment criteria found three records (SR, TOM and TTS) in substantial compliance, two records (GG and OJR) in partial compliance, and one record (RC) not in compliance. An identified trend that the facility should focus on in order to improve compliance is that nutrition goals are not consistently specific, behavioral, observable and measureable. **Compliance:** Partial. **Current recommendation:** Continue current efforts to achieve compliance.
D.5.g	For all other individuals, a comprehensive Admission Nutrition Assessment will be completed within 30 days of admission.	**Current findings on previous recommendation:** **Recommendation, July 2008:** Continue current efforts to achieve compliance. **Findings:** Using the DMH Nutrition Care Monitoring Tool, NSH assessed its compliance based on an average sample of 100% of Nutrition Type D.5.g

Assessments due each month for the review period of June-November 2008 (total of 152). The following table outlines the indicators with corresponding mean compliance rates for June-November 2008:

1.	*Assessment is completed on time per policy*	95%
2.	*All required subjective concerns are addressed*	98%
3.	*All pertinent objective nutrition information is accurately addressed*	100%
4.	*Estimated daily needs for nutrients specified are appropriate*	100%
5.	*Assessment utilizes findings from subjective and objective data*	98%
6.	*Nutrition diagnosis is correctly formulated, prioritized and validated*	95%
7.	*Nutrition education is documented*	94%
8.	*Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified*	94%
9.	*Progress is monitored, measured, and evaluated*	N/A
10.	*Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable*	97%
11.	*Recommendations are appropriate and complete*	86%
12.	*NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment*	96%
13.	*Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present*	100%
14.	*Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support*	100%
15.	*Assessment utilizes approved abbreviations*	99%
16.	*Assessment is concise*	99%
17.	*Assessment is legible*	100%
18.	*Each page of the assessment is signed*	100%

Comparative data showed maintenance in compliance in all items since the last review as follows:

	Previous period	Current period
Mean compliance rate		
1.	94%	95%
2.	96%	98%
3.	97%	100%
4.	99%	100%
5.	96%	98%
6.	89%	95%
7.	98%	94%
8.	96%	94%
9.	n/a	n/a
10.	92%	97%
11.	79%	86%
12.	93%	96%
13.	100%	100%
14.	100%	100%
15.	90%	99%
16.	100%	99%
17.	100%	100%
18.	92%	100%
Compliance rate in last month of period		
11.	80%	96%

Analysis of possible barriers to compliance with item 11 and/or plan of correction to improve compliance were not provided.

		Other findings: A review of the records of nine individuals (AJM, CC, GA, IH, JEH, MJM, PGW, RJ and TJ) to assess compliance with Nutrition type D.5.g assessment criteria found eight records (AJM, CC, GA, IH, JEH, MJM, PGW and TJ) in substantial compliance and one record (RJ) in partial compliance. **Compliance:** Substantial. **Current recommendation**: Continue current practice.
D.5.h	Acuity level of an individual at nutritional risk will be determined by Nutritional Status Type ("NST") which defines minimum services provided by a registered dietitian.	**Current findings on previous recommendation:** **Recommendation, July 2008:** Continue current practice. **Findings:** Using the DMH Nutrition Care Monitoring Tool, NSH assessed its compliance based on an average sample of 22% of all Nutrition Type D.5 Assessments due each month for the review period of June-November 2008 (447 out of 2015) to assess compliance with D.5.h. The facility found that 96% (weighted mean) of Nutrition admission assessments audited had evidence of a correctly assigned NST level. **Other findings:** A review of records of 66 individuals (AAK, ACG, AEP, AJM, ANA, AZ, BT, CC, CD, DBC, DHP, DS, DS, DSY, GA, GDM, GG, GRF, HDE, HP, HV, IH, ITS, JAC, JAO, JEH, JJJ, JR, JT, KAL, LLH, MBD, MH, MHJ, MJM, MRS, MWS, NH, NKB, OJR, PC, PGW, RAC, RC, RF, RJ, RKH, RLJ, RLM, RLN, RM, RM, SCL, SPS, SR, TBS, TCG, TJ, TOM, TTS, UDH, VM, VM, WET, WGS and WKN) to assess compliance with D.5.h.

<table>
<tr><td></td><td></td><td>found 63 records in compliance and three records (PC, RC and RJ) not in compliance.

Compliance:
Substantial.

Current recommendation:
Continue current practice.</td></tr>
<tr><td>D.5.i</td><td>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.</td><td>Current findings on previous recommendation:

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

Findings:
Using the DMH Nutrition Care Monitoring Tool, NSH assessed its compliance based on an average sample of 9% of Nutrition Type D.5.i Assessments due each month for the review period of June-November 2008 (99 out of 1109). The following table outlines the indicators with corresponding mean compliance rates for June-November 2008:
<table>
<tr><td>1.</td><td>Assessment is completed on time per policy</td><td>66%</td></tr>
<tr><td>2.</td><td>All required subjective concerns are addressed</td><td>100%</td></tr>
<tr><td>3.</td><td>All pertinent objective nutrition information is accurately addressed</td><td>100%</td></tr>
<tr><td>4.</td><td>Estimated daily needs for nutrients specified are appropriate</td><td>100%</td></tr>
<tr><td>5.</td><td>Assessment utilizes findings from subjective and objective data</td><td>89%</td></tr>
<tr><td>6.</td><td>Nutrition diagnosis is correctly formulated, prioritized and validated</td><td>100%</td></tr>
<tr><td>7.</td><td>Nutrition education is documented</td><td>91%</td></tr>
<tr><td>8.</td><td>Response to MNT is specific to the intervention</td><td>98%</td></tr>
</table></td></tr>
</table>

	provided, adherence potential indicated, and barriers identified	
9.	*Progress is monitored, measured, and evaluated*	95%
10.	*Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable*	93%
11.	*Recommendations are appropriate and complete*	98%
12.	*NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment*	95%
13.	*Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present*	100%
14.	*Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support*	100%
15.	*Assessment utilizes approved abbreviations*	97%
16.	*Assessment is concise*	100%
17.	*Assessment is legible*	100%
18.	*Each page of the assessment is signed*	100%

Comparative data showed maintenance or improvement in compliance for all items except 1 and 5, which showed decreases in compliance:

	Previous period	Current period
Mean compliance rate		
1.	83%	66%
2.	98%	100%
3.	96%	100%
4.	78%	100%
5.	100%	89%
6.	96%	100%
7.	82%	91%
8.	100%	98%
9.	98%	95%

10.	100%	93%
11.	100%	98%
12.	100%	95%
13.	100%	100%
14.	75%	100%
15.	98%	97%
16.	100%	100%
17.	100%	100%
18.	100%	100%
Compliance rate in last month of period		
1.	77%	71%
5.	100%	93%

The facility attributed low compliance with item 1 (timeliness) to decreased staffing and large caseloads. The facility has since hired additional Clinical Dietitians to assist with caseload distribution, and expects to see improvement in compliance during the next review period.

Other findings:
A review of the records of eleven individuals (CW, DHP, HV, JAC, JAO, JS, MBD, MH, MHJ, MRS and SPS)to assess compliance with Nutrition type D.5.i assessment criteria found six records (DHP, JAC, MBD, MHJ, MRS and SPS) in substantial compliance, three records (HV, JAO and MH) in partial compliance, and two records (CW and JS) not in compliance. Identified areas of deficiency that the facility should focus on in order to improve compliance with Nutrition type D5d assessments include:

1. Nutrition diagnoses are not consistently correctly formulated, prioritized and validated.
2. Nutrition goals are not consistently specific, behavioral, measurable and aligned with diagnosis.

<table>
<tr><td></td><td></td><td>3. Assessments are not consistently completed, completed on time, and/or filed in the medical record.

Compliance:
Partial.

Current recommendation:
Continue current efforts to achieve compliance.</td></tr>
<tr><td>D.5.j.i</td><td>Individuals will be reassessed when there is a significant change in condition.</td><td>Current findings on previous recommendations:

Recommendation 1, July 2008:
Continue current efforts to achieve compliance.

Findings:
Using the DMH Nutrition Care Monitoring Tool, NSH assessed its compliance based on an average sample of 25% of Nutrition Type D.5.j.i Assessments due each month for the review period of June-November 2008 (28 out of 112). The following table outlines the indicators with corresponding mean compliance rates for June-November 2008:
<table>
<tr><td>1.</td><td>Assessment is completed on time per policy</td><td>100%</td></tr>
<tr><td>2.</td><td>All required subjective concerns are addressed</td><td>100%</td></tr>
<tr><td>3.</td><td>All pertinent objective nutrition information is accurately addressed</td><td>100%</td></tr>
<tr><td>4.</td><td>Estimated daily needs for nutrients specified are appropriate</td><td>100%</td></tr>
<tr><td>5.</td><td>Assessment utilizes findings from subjective and objective data</td><td>96%</td></tr>
<tr><td>6.</td><td>Nutrition diagnosis is correctly formulated, prioritized and validated</td><td>100%</td></tr>
<tr><td>7.</td><td>Nutrition education is documented</td><td>80%</td></tr>
<tr><td>8.</td><td>Response to MNT is specific to the intervention</td><td>100%</td></tr>
</table></td></tr>
</table>

	provided, adherence potential indicated, and barriers identified	
9.	*Progress is monitored, measured, and evaluated*	92%
10.	*Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable*	92%
11.	*Recommendations are appropriate and complete*	100%
12.	*NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment*	100%
13.	*Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present*	89%
14.	*Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support*	n/a
15.	*Assessment utilizes approved abbreviations*	100%
16.	*Assessment is concise*	100%
17.	*Assessment is legible*	100%
18.	*Each page of the assessment is signed*	100%

Comparative data showed maintenance in compliance in all items except 7 and 13:

	Previous period	Current period
Mean compliance rate		
1.	90%	100%
2.	95%	100%
3.	100%	100%
4.	88%	100%
5.	100%	96%
6.	100%	100%
7.	91%	80%
8.	92%	100%
9.	100%	92%

10.	92%	92%
11.	100%	100%
12.	100%	100%
13.	100%	89%
14.	100%	n/a
15.	100%	100%
16.	100%	100%
17.	100%	100%
18.	100%	100%
Compliance rate in last month of period		
7.	80%	100%
13.	100%	100%

Analysis of possible barriers to compliance with items 7 and 13 and/or plans of correction to improve compliance were not provided.

Recommendation 2, July 2008:
Develop and implement a system to record the number of referrals received and due each month.

Findings:
A system has been developed and implemented to record the number of Nutrition referrals received each month. In addition, in an attempt to clarify what constitutes a referral, two criteria for determining significant change (the criteria for "monthly weight change", and "food-drug interaction") have been eliminated as these issues are addressed without the need for a medical/nursing referral.

Other findings:
A review of the records of six individuals (HP, RF, RLH, RLJ, RLM and VM)to assess compliance with Nutrition type D.5.j.i assessment criteria found four records (RF, RLJ, RLM and VM) in substantial compliance and two records (HP and RLH) in partial compliance. Identified areas

		of deficiency that the facility should focus on in order to improve compliance with Nutrition type D.5.j.i assessments include: 1. Nutrition diagnoses are not consistently correctly formulated, prioritized and validated. 2. Nutrition objectives are not consistently specific, behavioral, observable and measurable. **Compliance:** Partial. **Current recommendation**: Continue current efforts to achieve compliance.
D.5.j.ii	Every individual will be assessed annually.	**Current findings on previous recommendation:** **Recommendation, July 2008:** Continue current efforts to achieve compliance. **Findings:** Using the DMH Nutrition Care Monitoring Tool, NSH assessed its compliance based on an average sample of 13% of Nutrition Type D.5.j.ii Assessments due each month for the review period of June-November 2008 (61 out of 476). The following table outlines the indicators with corresponding mean compliance rates for June-November 2008: 1. *Assessment is completed on time per policy* 97% 2. *All required subjective concerns are addressed* 98% 3. *All pertinent objective nutrition information is accurately addressed* 98% 4. *Estimated daily needs for nutrients specified are appropriate* 95% 5. *Assessment utilizes findings from subjective and* 95%

	objective data	
6.	*Nutrition diagnosis is correctly formulated, prioritized and validated*	100%
7.	*Nutrition education is documented*	100%
8.	*Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified*	98%
9.	*Progress is monitored, measured, and evaluated*	80%
10.	*Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable*	98%
11.	*Recommendations are appropriate and complete*	93%
12.	*NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment*	93%
13.	*Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present*	83%
14.	*Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support*	100%
15.	*Assessment utilizes approved abbreviations*	95%
16.	*Assessment is concise*	100%
17.	*Assessment is legible*	98%
18.	*Each page of the assessment is signed*	100%

Comparative data showed maintenance in compliance in all items except item 9:

	Previous period	Current period
Mean compliance rate		
1.	93%	97%
2.	98%	98%
3.	100%	98%
4.	93%	95%

5.	98%	95%
6.	92%	100%
7.	97%	100%
8.	97%	98%
9.	92%	80%
10.	95%	98%
11.	92%	93%
12.	90%	93%
13.	80%	83%
14.	0%	100%
15.	98%	95%
16.	100%	100%
17.	98%	98%
18.	100%	100%
Compliance rate in last month of period		
9.	80%	80%

Analysis of possible barriers to compliance with item 9 and/or plan of correction to improve compliance were not provided.

Other findings:
A review of the records of fifteen individuals (AEP, AZ, CD, DS, GDM, ITS, JY, KAL, MWS, PC, RM, TCG, VM, WGS and WKN) to assess compliance with Nutrition type D.5.j.ii assessment criteria found nine records (AEP, AZ, DS, GDM, KAL, MWS, RM, TCG and WGS) in substantial compliance, five records (CD, ITS, PC, VM and WKN) in partial compliance, and one record (JY) not in compliance. Identified areas of deficiency that the facility should focus on in order to improve compliance with Nutrition type D.5.j.ii assessments include:

1. Nutrition diagnoses are not consistently correctly formulated, prioritized and validated.

		2. Nutrition objectives are not consistently specific, behavioral, observable and measurable. 3. Nutrition recommendations are not consistently specific, complete, and aligned with diagnosis and objectives. **Compliance:** Partial. **Current recommendation**: Continue current efforts to achieve compliance.

6. Social History Assessments		
	Each State hospital shall ensure that each individual has a social history evaluation that, consistent with generally accepted professional standards of care:	**Methodology:** Interviewed: 1. Carmen Caruso, Clinical Administrator 2. Cindy Black, Director, Standards and Compliance 3. Donna M. Robeson, LCSW, Director of Social Work 4. [redacted], RN, MBA, EdD, Executive Director 5. John Wyman, LCSW, Senior Social Worker 6. Katie Cooper, PsyD, Enhancement Plan Coordinator 7. Michael Comini, LCSW, Section Leader Performance Enhancement 8. Monique Jansma, LCSW, Acting Senior Supervisor, Program V 9. Rebecca Baumer, LCSW, Acting Senior Supervisor, Program IV Reviewed: 1. The charts of the following 15 individuals : BFL, BJB, CDK, DAP, DH, DT, GF, JAH, JH, KT, MH, NN, PEM, RLM and SYV 2. List of individuals assessed to need family therapy 3. Social History Monitoring Form 4. Training and Development Roster Observed: 1. Life Skills Mall Group 2. PSSC/ETRC meeting 3. Reality Orientation Mall Group 4. Relaxation Technique Mall Group 5. Shift Lead Meeting 6. Substance Abuse/Recovery Mall Group 7. WRPC for JF (unit T-4, Program 5) 8. WRPC for RJ (unit T-8, Program 1)
D.6.a	Is, to the extent reasonably possible, accurate, current and comprehensive;	**Current findings on previous recommendations:**

Recommendation 1, July 2008:
Ensure that the Integrated Assessments Social Work section is timely, accurate, current and comprehensive.

Findings:
According to the Chief of Social Work, Social Work staff assigned to admission teams underwent individual mentoring and in-service training to conduct all assessments in a timely, comprehensive and accurate manner. Furthermore, weekly meetings were conducted with WRPT Social Work staff to improve the documentation of the assessment information in individuals' WRPs.

Using items 1-3 from the DMH Social History Integrated Assessments, NSH assessed its compliance based on an average sample of 89% of the Integrated Assessments due for the month (June to November 2008). The table below is a summary of the data:

1.	*Is to the extent reasonably possible, accurate,*	
1.a	*Identifying information is complete and accurate;*	99%
1.b	*Sources of information include the individual, collateral information sources and specific documents reviewed, or an explanation for not using these sources. Dates of contacts are listed as appropriate. Dates of source documents are listed; and*	94%
1.c	*The information in the assessment is factually correct and internally consistent.*	100%
2.	*Current, and*	92%
2.a	*Assessment includes information from current interview, collateral sources, and source documents, or there is sufficient documentation in the assessment to indicate why these sources of information were not utilized, and*	96%

2.b	*Includes behavioral observations since the time of admission.*	95%
3.	*Comprehensive: all sections are completed with at least the minimum information required in the instructions as applicable or indicates why information is not available.*	96%

Comparative data showed improvement in compliance across indicators since the last review.

This monitor reviewed eight Integrated Assessments (DAP, DH, GF, JH, KT, MH, NN and SYV). Seven (DAP, DH, GF, JH, KT, MH, and NN) of the assessments were timely, complete, and accurate. One of them (SYV) was not timely even though it was complete and accurate.

Recommendation 2, July 2008:
Ensure that the 30-day Social History Assessments are timely, accurate, current and comprehensive.

Findings:
Using item 1-3 from the DMH Social History 30-Day Psychosocial Assessment Monitoring Form, NSH assessed its compliance based on an average sample of 93% of the 30-Day Psychosocial Assessments due for the month (June to November 2008). The table below with its indicators and sub-indicators and corresponding mean compliance is a summary of the data:

1.	*Is, to the extent reasonably possible, accurate,*	
1.a	*Identifying information is complete and accurate;*	98%
1.b	*Sources of information include the individual, collateral information sources and specific documents reviewed, or an explanation for not using these sources. Dates of contacts are listed*	91%

	as appropriate. Dates of source documents are listed; and	
1.c	*The information in the assessment is factually correct and internally consistent.*	99%
2.	*Current, and*	94%
2.a	*Assessment includes information from current interview, collateral sources, and source documents, or there is sufficient documentation in the assessment to indicate why these sources of information were not utilized;*	99%
2.b	*Includes behavioral observations since the time of admission; and*	97%
2.c	*Provides adequate information regarding the individual's current psychosocial functioning.*	97%
3.	*Comprehensive.*	90%
3.a	*All sections are completed with at least the minimum information required in the instructions as applicable or indicate why information is not available.*	90%

Comparative data showed improvement in compliance across indicators since the last review.

This monitor reviewed nine Psychosocial Assessments (DAP, DH, GF, JAH, JH, KT, MH, NN and SYV). Four of the assessments (DAP, GF, JH and SYV) were accurate, current, and comprehensive, meeting all the required elements of this recommendation. The remaining five (DH, JAH, KT, MH and NN) were untimely, inaccurate, and/or incomplete.

As a plan of correction, Senior Social Work staff will conduct bi-monthly meetings with WRPT members to review five-day integrated assessments, and 30-day Psychosocial Assessments. NSH will also conduct performance review with underperforming staff.

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

Current recommendations:
1. Ensure that the Integrated Assessments Social Work section is timely, accurate, current and comprehensive.
2. Ensure that the 30-day Social History Assessments are timely, accurate, current and comprehensive.</td></tr>
<tr><td>D.6.b</td><td>Expressly identifies factual inconsistencies among sources, resolves or attempts to resolve inconsistencies, and explains the rationale for the resolution offered;</td><td>Current findings on previous recommendation:

Recommendation, July 2008:
Ensure that social workers identify and address the inconsistencies in current assessments.

Findings:
Using items 4-6 from the DMH Social History 30-Day Psychosocial Assessment Monitoring Form, NSH assessed its compliance based on an average sample of 93% of the 30-Day Psychosocial Assessments due each month of this review period (June to November 2008). The table below is a summary of the data:

<table>
<tr><td>4.</td><td>Expressly identifies factual inconsistencies among sources.</td><td>94%</td></tr>
<tr><td>5.</td><td>Resolves or attempts to resolve inconsistencies.</td><td>95%</td></tr>
<tr><td>6.</td><td>Explains the rationale for the resolution offered.</td><td>94%</td></tr>
</table>

Comparative data showed that compliance for items 4, 5 and 6 increased from 51%, 58% and 61% respectively in the prior review period.

This monitor reviewed nine charts (DAP, DH, GF, JAH, JH, KT, MH, NN</td></tr>
</table>

<table>
<tr><td></td><td></td><td>and SYV). Inconsistencies were addressed and resolutions offered when there were inconsistencies in eight (DAP, DH, GF, JH, KT, MH, NN and SYV) of the 30-day Social History assessments in the charts. The inconsistencies were not addressed in one of the assessments (JAH).

Compliance:
Substantial.

Current recommendation:
Ensure that social workers identify and address the inconsistencies in current assessments.</td></tr>
<tr><td>D.6.c</td><td>Is included in the 7-day integrated assessment and fully documented by the 30th day of an individual's admission; and</td><td>Current findings on previous recommendation:

Recommendation, July 2008:
Ensure all SW integrated assessments are completed and available to the WRPT before the seven-day WRPC.

Findings:
Using item 7 from the DMH Social History Assessment: Integrated Assessment Monitoring Form, NSH assessed its compliance based on an average sample of 89% of the Integrated Assessments due each month of this review period (June to November 2008). The table below is a summary of the data:

<table>
<tr><td>7.</td><td>Is included in the 7-day integrated assessment.</td><td>90%</td></tr>
<tr><td>7.a</td><td>The assessment was completed within 5 calendar days of the individual's admission, and</td><td>90%</td></tr>
<tr><td>7.b</td><td>Filed in the medical record.</td><td>100%</td></tr>
</table>

Comparative data showed compliance for item 7 improved from 82% in the prior review period.</td></tr>
</table>

Thirteen (BFL, BJB, CDK, DAP, DH, GF, JAH, JH, KT, MH, NN, PEM and RLM) of the fourteen Integrated Assessments (BFL, BJB, CDK, DAP, DH, GF, JAH, JH, KT, MH, NN, PEM, RLM and SVY) reviewed by this monitor were completed in a timely manner.

Using item 8 from the DMH Social History Assessment Monitoring Form, NSH also assessed its compliance based on an average sample of 93% of the 30-Day Psychosocial Assessments due for the month (June to November 2008). The table below is a summary of the data:

8.	*Fully documented by the 30th day of the individual's admission.*	57%
8.a	*Competed no earlier than the first work day after the 7-day WRPC and no later than the 30th calendar day after admission*	57%
8.b	*Filed in the medical record.*	99%

Comparative data showed a slight decline in compliance since the last review as follows:

	Previous period	Current period
Mean compliance rate		
8.	63%	57%
Compliance rate in last month of period		
8.	77%	73%
8.a	77%	73%
8.b	100%	100%

This monitor reviewed ten 30-Day Psychosocial Assessments (DAP, DH, DT, GF, JAH, JH, KT, MH, NN and SYV). Six of the Psychosocial Assessments were completed in a timely manner (DAP, DT, GF, JAH,

		JH and SYV), and the remaining four (DH, KT, MH and NN) were untimely. According to the Chief of Social Work, the revised monitoring procedures used at NSH delayed the timely completion of the Social History Assessments. Additionally, underperformance by a small number of staff resulted in the low compliance with this requirement. As a plan of correction, NSH will monitor the underperforming staff and work with them to bring up the timeliness of the assessments. NSH will insist on a 48-hour turnaround of the assessments, and the Senior Social Work staff will mentor, monitor, and supervise these requirements. **Compliance:** Partial. **Current recommendations**: 1. Ensure all SW integrated assessments are completed and available to the WRPT before the seven-day WRPC. 2. Ensure full documentation by the 30th day of admission.
D.6.d	Reliably informs the individual's interdisciplinary team about the individual's relevant social factors and educational status.	**Current findings on previous recommendation:** **Recommendation, July 2008:** Ensure that social histories reliably inform the individual's WRPT about the individual's relevant social factors and educational status. **Findings:** Using item 10 from the DMH Social History Assessment Monitoring Form: Integrated Assessment, NSH assessed its compliance based on an average sample of 89% of the Integrated Assessments due each month of this review period (June to November 2008). The table below

is a summary of the data:

10.	*Educational status*	97%
10.a	*Education includes educational level(s) completed by the individual and subject of any degrees or focus of any vocational training, or*	99%
10.b	*"Unknown" is checked.*	77%

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

	Previous period	Current period
Mean compliance rate		
10.	78%	97%
10.a	85%	99%
10.b	50%	77%
Compliance rate in last month of period		
10.	79%	100%
10.a	80%	100%
10.b	71%	100%

All six Integrated Assessments (CDK, DAP, DH, GF, NN and RLM) reviewed by this monitor included the necessary information to meet the requirements of this cell.

Using item 10 from the DMH Social History Assessment Monitoring Form: 30-Day Psychosocial Assessments, NSH assessed its compliance based on an average sample of 92% of the 30-Day Psychosocial Assessments due each month of this review period (June to November 2008). The table below is a summary of the data:

10.	*Educational status*	82%
10.a	*Education includes recommendations for learning accommodations and testing, or states if none are needed, and*	87%
10.b	*Discusses the impact of the individual's education on his/her Wellness and Recovery.*	84%

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

	Previous period	Current period
Mean compliance rate		
10.	6%	82%
10.a	19%	87%
10.b	10%	84%
Compliance rate in last month of period		
10.	9%	92%
10.a	27%	92%
10.b	18%	92%

This monitor reviewed ten 30-Day Psychosocial Assessments (DAP, DH, DT, GF, JAH, JH, KT, MH, NN and SYV). Eight (DAP, DH, DT, JH, KT, MH, NN and SYV) contained information on the individual's educational and social status. The remaining two (GF and JAH) did not contain sufficient information regarding the individual's educational and/or social status.

As its plan of correction, NSH will implement the newly modified tool for subsequent audits. The Integrated Social History Assessment will be discussed at the bi-monthly meetings of the Senior Social Work staff. NSH will conduct reviews with underperforming staff.

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

7. Court Assessments		
		Methodology: Interviewed: Katherine Warburton, DO, Chair, FRP Reviewed: 1. Charts of six individuals (BS, DRM, GR, MB, RS and TM) who were admitted under PC 1026 2. Charts of six individuals (JSW, KRT, PG, RLM, SLC and WGS) who were admitted under PC 1370 3. Sample of feedback provided by Chair of the Forensic Review Panel (FRP) to WRPTs via court reports tracking records 4. Sample of email feedback notices by the FRP to the WRPTs 5. DMH PC 1026 Report Auditing Form 6. DMH PC 1026 Report Auditing Form Instructions 7. NSH PC 1026 Report Auditing summary data (June to November 2008) 8. DMH PC 1370 Report Auditing Form 9. DMH PC 1370 Report Auditing Form Instructions 10. NSH PC 1370 Report Auditing summary data (June to November 2008) 11. Forensic Review Panel (FRP) meeting minutes (June to November 2008)
D.7.a	Each State hospital shall develop and implement policies and procedures to ensure an interdisciplinary approach to the development of court submissions for individuals adjudicated "not guilty by reason of insanity" ("NGI") pursuant to Penal Code Section 1026, based on accurate information, and individualized risk assessments. The forensic reports should include the following,	**Compliance:** Substantial.

	as clinically indicated:	
D.7.a.i	clinical progress and achievement of stabilization of signs and symptoms of mental illness that were the cause, or contributing factor in the commission of the crime (i.e., instant offense);	**Current findings on previous recommendations:** **Recommendation 1, July 2008:** Continue training of the WRPTs regarding implementation of all requirements related to PC 1026 reports. **Findings:** NSH has provided the following training activities and corrective actions during this review period: 1. The FRP has continued to utilize a tracking form and the monitoring tools, with comments, to provide feedback to WRPTs on 100% of the court reports throughout the monitoring period. 2. The Chair of the FRP has provided personal contact via telephone or email to provide positive feedback in the case of well-written reports and to provide constructive feedback when needed. 3. The FRP has provided written corrective edits in non-compliant reports to assist report writers in correcting remaining areas of low compliance. 4. A weekly "Court Report Writing Seminar" has been held for two hours a week to review details of the report writing process with WRPT members. Attendance has been mostly voluntary; however in some cases the supervising senior clinicians have mandated the attendance of WRPT members who required additional training in court report writing. All new psychiatrists have continued to receive this training as well. 5. A "Court Report of the Week" award has been announced each week in the hospital bulletin. **Recommendation 2, July 2008:** Ensure that 1026 reports are written in a consistent format.

		Findings: NSH has made efforts to improve format consistency using the DMH template for 1026 reports. Reviews by this monitor found improved report content (see Other Findings in this section), but the format still lacks consistency regarding the location of information relevant to each section of the report. **Recommendations 3 and 4, July 2008:** • Monitor this requirement using the DMH PC 1026 Auditing Form based on a 100% sample. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). **Findings:** NSH used the DMH PC 1026 Court Report Auditing Form to assess compliance (June to November 2008). The average sample was 100% of PC 1026 reports. The facility reported a mean compliance rate of 98% with this requirement, compared to 89% during the last review. The mean compliance rate and comparative data for the requirements of D.7.a.ii to D.7.a.ix are provided in each corresponding cell below. **Other findings:** This monitor reviewed the court reports of six individuals (BS, DRM, GR, MB, RS and TM) who were admitted during this review period under PC 1026. The review found compliance in all six reports regarding this requirement. **Current recommendations**: 1. Continue training of the WRPTs regarding implementation of all

		requirements related to PC 1026 reports. 2. Improve format consistency of PC 1026 reports. 3. Monitor this requirement using the DMH PC 1026 Auditing Form, based on a 100% sample. 4. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).
D.7.a.ii	acts of both verbal and physical aggression and property destruction during the past year of hospitalization and, if relevant, past acts of aggression and dangerous criminal behavior;	NSH reported a mean compliance rate of 99%, compared to 87% during the last review. Chart reviews by this monitor found compliance in five charts (BS, DRM, GR, MB and RS) and partial compliance in one (TM).
D.7.a.iii	understanding of potential for danger and precursors of dangerous/criminal behavior, including instant offense;	NSH reported a mean compliance rate of 97%, compared to 85% during the last review. Reviews by this monitor found partial compliance in all charts. While all reports included an adequate review of the psychiatric symptoms that antedated and/or triggered the instant offense, the facility stills needs to make progress in addressing the psychosocial precursors of dangerous behavior in general.
D.7.a.iv	acceptance of mental illness and understanding of the need for treatment, both psychosocial and biological, and the need to adhere to treatment;	NSH reported the following mean compliance rates: 14. *Individual's acceptance of mental illness* 99% 15. *Individual's understanding of the need for treatment* 98% 16. *Individual's adherence to treatment* 99% Comparative data showed improved compliance since the last review as follows:

<table>
<tr><td></td><td></td><td>
<table>
<tr><th>Item</th><th>Mean compliance rate, previous period</th><th>Mean compliance rate, current period</th></tr>
<tr><td>14.</td><td>92%</td><td>99%</td></tr>
<tr><td>15.</td><td>89%</td><td>98%</td></tr>
<tr><td>16.</td><td>95%</td><td>99%</td></tr>
</table>

Chart reviews by this monitor found compliance in all six cases.
</td></tr>
<tr><td>D.7.a.v</td><td>development of relapse prevention plan (i.e., Personal Wellness Recovery Plan or Wellness Recovery Action Plan) for mental illness symptoms, including the individual's recognition of precursors and warning signs and symptoms and precursors for dangerous acts;</td><td>
NSH reported the following mean compliance rates:
<table>
<tr><td>17.</td><td>Individual's development of relapse prevention plan for mental illness symptoms</td><td>98%</td></tr>
<tr><td>18.</td><td>Individual's recognition of precursors and warning signs and symptoms (that may mediate) future dangerous acts</td><td>98%</td></tr>
</table>

Comparative data showed improved compliance since the last review as follows:
<table>
<tr><th>Item</th><th>Mean compliance rate, previous period</th><th>Mean compliance rate, current period</th></tr>
<tr><td>17.</td><td>90%</td><td>98%</td></tr>
<tr><td>18.</td><td>81%</td><td>98%</td></tr>
</table>

This monitor found compliance in five charts (DRM, GR, MB, RS and TM) and partial compliance in one (BS).
</td></tr>
<tr><td>D.7.a.vi</td><td>willingness to achieve understanding of substance abuse issues and to develop an effective relapse prevention plan (as defined above);</td><td>NSH reported a mean compliance rate of 98%, compared to 88% during the last review.

Chart reviews by this monitor found compliance in all three charts to</td></tr>
</table>

		which this requirement was applicable was applicable (GR, RS and TM).
D.7.a.vii	previous community releases, if the individual has had previous CONREP revocations;	NSH reported a mean compliance rate of 97%, compared to 79% during the last review. Chart reviews by this monitor found compliance in all three charts to which this requirement was applicable was applicable (GR, RS and TM).
D.7.a. viii	social support, financial resources, family conflicts, cultural marginalization, and history of sexual and emotional abuse, if applicable; and	NSH reported a mean compliance rate of 97%, compared to 75% during the last review. This monitor found compliance in five charts (BS, DRM, GR, MB and TM) and partial compliance in one (RS).
D.7.a.ix	relevant medical issues, all self-harm behaviors, risks for self harm and risk of harm to others, to inform the courts and the facility where the individual will be housed after discharge.	NSH reported a mean compliance rate of 95% with this requirement. The compliance rate was 70% during the last review. This monitor found compliance in all six charts.
D.7.b	Each State hospital shall develop and implement policies and procedures to ensure an interdisciplinary approach to the development of court submissions for individuals admitted to the hospital pursuant to Penal Code Section 1370, "incompetent to stand trial" ("IST"), based on accurate information and individualized risk assessments. Consistent with the right of an individual accused of a crime to a speedy trial, the focus of the IST hospitalization shall be the stabilization of the symptoms of mental illness so as to enable the individual to understand the legal proceedings and to assist his or her attorney in the preparation of the defense. The forensic reports	**Compliance:** Substantial.

	should include the following:	
D.7.b.i	relevant clinical description of initial presentation, if available, which caused the individual to be deemed incompetent to stand trial by the court;	**Current findings on previous recommendations:** **Recommendation 1, July 2008:** Continue training of the WRPTs regarding implementation of all requirements related to PC 1370 reports. **Findings:** Same as in D.7.a.i. **Recommendations 2 and 3, July 2008:** • Monitor this requirement using the DMH PC 1026 Auditing Form based on a 100% sample. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). **Findings:** NSH used the DMH PC 1370 Court Report Auditing Form to assess compliance (June to November 2008). The average sample was 100% of PC 1370 reports. The facility's data showed maintenance of compliance greater than 90% since the last review. The mean compliance rates and comparative data for the requirements of D.7.b.ii to D.7.b.iv are provided in each corresponding cell below. **Other findings:** This monitor reviewed the charts of six individuals (JSW, KRT, PG, RLM, SLC and WGS) who were admitted under PC 1370. The review found compliance in five charts (JSW, KRT, RLM, SLC and WGS) and partial compliance in one (PG).

		Current recommendations: 1. Continue training of the WRPTs regarding implementation of all requirements related to PC 1370 reports. 2. Monitor this requirement using the DMH PC 1026 Auditing Form based on a 100% sample. 3. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).
D.7.b.ii	clinical description of the individual at the time of admission to the hospital;	The facility's data showed maintenance of compliance greater than 90% since the last review. This monitor found compliance in five charts (JSW, KRT, RLM, SLC and WGS) and partial compliance in one (PG).
D.7.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	The facility's data for all four components of this requirement showed maintenance of compliance greater than 90% since the last review. This monitor found compliance in five charts (JSW, KRT, RLM, SLC and WGS) and partial compliance in one (PG).
D.7.b.iv	all self-harm behaviors and relevant medical issues, to inform the courts and the facility where the individual will be housed after discharge.	The facility's data for all components of this requirement showed maintenance of compliance greater than 90% since the last review. This monitor found compliance in five charts (JSW, KRT, RLM, SLC and WGS) and partial compliance in one (PG).
D.7.c	Each State hospital shall establish a Forensic Review Panel (FRP) to serve as the internal body that reviews and provides oversight of facility practices and procedures regarding the forensic status of all individuals admitted pursuant to Penal Code 1026 and 1370. The FRP shall review and	**Current findings on previous recommendation:** **Recommendation, July 2008:** Continue current practice.

	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	**Findings:** In addition to the activities outlined under Recommendation 1 in D.7.a.i, NSH has continued its current practice as follows: 1. The FRP has continued to review 100% of all PC 1026 and 1370 reports. 2. Senior clinicians from each program have continued their participation in the FRP, including review of reports written by clinicians in their own programs, thereby providing a system for "local" feedback, supervision and follow-up. 3. Court report writers with a persistent pattern of non-compliance have been referred to the senior professionals in the specific discipline for further corrective actions. **Compliance:** Substantial. **Current recommendation**: Continue current practice.
D.7.c.i	The membership of the FRP shall include Director of Forensic Psychiatry, Facility Director or designee, Medical Director or designee, Chief of Psychology or designee, Chief of Social Services or designee, Chief of Nursing Services or designee, and Chief of Rehabilitation Services or designee. The Director of Forensic Psychiatry shall serve as the chair and shall be a board certified forensic psychiatrist. A quorum shall consist of a minimum of four FRP members or their designee.	**Current findings on previous recommendation:** **Recommendation, July 2008:** Continue current practice. **Findings:** NSH has continued its current practice. The following is a summary of current status: 1. The facility has a Chief of Forensic Psychiatry who is the permanent Chair of the FRP. This professional is board-eligible in Forensic Psychiatry and is currently in the process of obtaining board certification.

		2. The facility has maintained compliance with the minimum interdisciplinary membership of the FRP. 3. NSH records indicated that all FRP meetings have had a minimum of four FRP members in attendance. 4. FRP members have continued to receive formal and informal training in forensic processes as outlined in the previous report. In addition, other training activities were provided as outlined under Recommendation 1 in D.7.a.i. **Compliance:** Substantial. **Current recommendations**: 1. Continue current practice. 2. Ensure that the Chair of the FRP is board-certified in Forensic Psychiatry.

E. Discharge Planning and Community Integration		
		Summary of Progress: NSH made some progress in a number of areas but has not improved significantly since the previous review.
E	Taking into account the limitations of court-imposed confinement, the State shall pursue actively the appropriate discharge of individuals under the State's care at each State hospital and, subject to legal limitations on the state's control of the placement process, provide services in the most integrated, appropriate setting in which they reasonably can be accommodated, as clinically appropriate, that is consistent with each individual's needs.	**Methodology:** <u>Interviewed</u>: 1. Carmen Caruso, Clinical Administrator 2. Cindy Black, Director, Standards Compliance 3. Donna M. Robeson, LCSW, Director of Social Work 4. [redacted], RN, MBA, EdD, Executive Director 5. John Wyman, LCSW, Senior Social Worker 6. Katie Cooper, PsyD, Enhancement Plan Coordinator 7. Michael Comini, LCSW, Section Leader Performance Enhancement 8. Monique Jansma, LCSW, Acting Senior Supervisor, Program V 9. Rebecca Baumer, LCSW, Acting Senior Supervisor, Program IV <u>Reviewed</u>: 1. Charts of the following 35 individuals: AA, ANA, BB, BFL, BJB, BL, BR, BS, CDK, CH, CHH, CS, DN, DR, EB, EH, GAR, JAU, JHM, JLH, JLS, JWM, LAC, MG, MR, PSS, RDZ, RLM, RM, SFL, SSP, VBH, VH, VLC and VQ 2. Discharge Planning and Community Integration Tracking Sheet 3. Discharge Planning and Community Integration Training Module 4. List of individuals who met discharge criteria in the last six months 5. List of individuals who met discharge criteria in the last six months and are still hospitalized <u>Observed</u>: 1. Life Skills Mall Group 2. PSSC/ETRC meeting

		3. Reality Orientation Mall Group 4. Relaxation Technique Mall Group 5. Shift Lead Meeting 6. Substance Abuse/Recovery Mall Group 7. WRPC for JF (unit T-4, Program 5) 8. WRPC for RJ (unit T-8, Program 1)
E.1	Each State hospital shall identify at the 7-day therapeutic and rehabilitation service planning conference, and address at all subsequent planning conferences, the particular considerations for each individual bearing on discharge, including:	**Compliance:** Partial.
E.1.a	those factors that likely would foster successful discharge, including the individual's strengths, preferences, and personal life goals;	**Current findings on previous recommendation:** **Recommendation, July 2008:** Link the individual's life goals to one or more focus/foci of hospitalization, with associated objectives and interventions. **Findings:** According to the Chief of Social Work, audit instructions were modified to reflect the requirement that one or more objectives be aligned with life goals in the individual's WRP. NSH conducted training and mandatory workshop for the Social Work staff in October and November 2009 to review deficiencies and discuss ways to improve performance. Sample copies of good documentation on Discharge and Community Integration recommendations were distributed to the Social Work staff. Using item 1 from the DMH Discharge Planning and Community Integration Auditing form, NSH assessed its compliance based on an average sample of 35% of the WRPs due each month of this review period (June to November 2008). The table below is a summary of the data:

1.	*Those factors that likely would foster successful discharge, including the individual's strengths, preferences, and personal life goals.*	71%
1.a	*There is at least one objective that is aligned with the individual's personal life goals that are states on the first page of the WRP; and*	81%
1.b	*The interventions will use the individual's strengths and preferences to achieve the respective objective.*	78%

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

	Previous period	Current period
Mean compliance rate		
1.	66%	71%
Compliance rate in last month of period		
1.	68%	81%
1.a	N/A	94%
1.b	N/A	85%

This monitor reviewed 13 charts (ANA, BR, CH, CS, EB, EH, JAU, JLH, MG, PSS, VBH, VH and VQ). Five of the WRPs in the charts (EB, JAU, JLH, PSS and VBH) had linked the individual's life goals to one or more of the focus/foci of hospitalization, with associated objectives and interventions. The remaining eight (ANA, BR, CH, CS, EH, MG, VH and VQ) did not link the individual's life goals to any focus and/or developed associated objectives and interventions.

According to the Chief of Social Work, barriers to better performance stem from WRPTs not listing strengths for all interventions

		recommended for the individual in the intervention sections of the WRP. As for the life goals, the Social Work Chief cited life goals that were not appropriate for interventions (for example, "I want to have a beer" or "I have no goal"). To improve performance, NSH is having the seniors work with WRPT leaders on addressing elements of this recommendation. In addition, using data derived from the Plato analysis, underperforming teams will meet with supervisors to overcome the barriers to WRP completion. **Compliance:** Partial. **Current recommendation**: Link the individual's life goals to one or more focus/foci of hospitalization, with associated objectives and interventions.
E.1.b	the individual's level of psychosocial functioning;	**Current findings on previous recommendations:** **Recommendation 1, July 2008:** Ensure that the level of psychosocial functioning (functional status) is included in the individual's Present Status section of the case formulation section of the WRP. **Findings:** According to the Mall Director, the WRPTs have yet to use the cognitive information on individuals from the Integrated Assessments: Psychology Section to assign individuals to Mall services based on cognitive levels. Using item 2 from the DMH Discharge Planning and Community Integration Auditing form, NSH assessed its compliance based on an average sample of 25% of the WRPs due each month of this review

period (June to November 2008). The table below is a summary of the data:

2.	*The individual's level of psychosocial functioning*	87%
2.a	*The individual's level of psychosocial functioning is mentioned in the Present Status section of the WRP, and*	92%
2.b	*The interventions linked to the discharge criteria are provided at the level of the individual's psychosocial functioning**	91%

*According to the Chief of Social Work, the audit tool was changed in November 2008, removing item 2.b.

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

	Previous period	Current period
Mean compliance rate		
2.	93%	87%
2.a	N/A	92%
2.b	N/A	91%
Compliance rate in last month of period		
2.	96%	96%
2.a	N/A	N/A
2.b	N/A	N/A

This monitor reviewed 15 charts (AA, ANA, BS, CH, CS, EB, EH, JAU, JLH, MG, MR, PSS, VBH, VH and VQ). The individual's level of psychosocial functioning was included in the present status sections of the 13 of the WRPs (AA, BS, CH, CS, EH, JAU, JLH, MG, MR, PSS, VBH, VH and VQ) and not satisfactorily documented in the remaining two (ANA and EB).

		Recommendation 2, July 2008: Implement the DMH WRP Manual in developing and updating the case formulation. **Findings:** This monitor reviewed seven charts (BJB, EB, CDK, BL, PSS, RLM and RL). The case formulation in three of the WRPs in the charts (BL, PSS, and RLM) met minimal criteria. There were a number of deficits by way of insufficient and/or incorrect information in the remaining four (BJB, EB, CDK, and RL). For example, the information under RLM's "Functional" section merely read, "He is very disheveled and he does not keep up with his ADLs." This does not give a full picture of the individual or capture his capabilities. Information under "Precipitating Factors" for CDK read, "Mr. K. denied use of substances. He has no substance-related arrests/convictions in the past." **Compliance:** Partial. **Current recommendations**: 1. Ensure that the level of psychosocial functioning (functional status) is included in the individual's Present Status section of the case formulation section of the WRP. 2. Implement the DMH WRP Manual in developing and updating the case formulation.
E.1.c	any barriers preventing the individual from transitioning to a more integrated environment, especially difficulties raised in previously unsuccessful placements; and	**Current findings on previous recommendations:** **Recommendations 1-3, July 2008:** • Ensure that discharge barriers, especially difficulties in previously unsuccessful placements, are discussed with the individual at scheduled WRPCs.

- Include skill training and supports in the WRP so that the individual can overcome the stated barriers.
- Report to the WRPT, on a monthly basis, the individual's progress made in overcoming the barriers to discharge.

Findings:
Using item 3 from the DMH Discharge Planning and Community Integration Auditing form, NSH assessed its compliance based on an average sample of 35% of the WRPs due each month of this review period (June to November 2008). The table below is a summary of the data:

3.	*Any barriers preventing the individual from transitioning to more integrated environment, especially difficulties raised in previously unsuccessful placements.*	48%
3.a	*The individual's barriers to discharge, including difficulties encountered in previous placements are mentioned in the Present Status Section of the WRP.*	70%
3.b	*These barriers are listed in Focus 11, with appropriate objectives and interventions.*	50%

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

	Previous period	Current period
Mean compliance rate		
3.	44%	48%
3.a	N/A	70%
3.b	N/A	50%

Compliance rate in last month of period		
3.	46%	76%
3.a	N/A	96%
3.b	N/A	78%

This monitor reviewed 16 charts (AA, ANA, BR, CH, CS, EB, EB-2, EH, JAU, JLH, MG, MR, PSS, VBH, VH and VQ). Eleven of the WRPs in the charts (AA, ANA, BR, CH, CS, JAU, JLH, MR, PSS, VH and VQ) contained documentation indicating that discharge barriers were discussed with the individual, identified the skills and supports that the individual needs, and reported the individual's progress in overcoming the barriers to discharge. Such was not the case in the remaining five (EB, EB-2, EH, MG and VBH).

According to the Chief of Social Work, mean compliance with this recommendation was low because auditors failed to recognize that while transition aspects of community integration were covered under Focus 11, non-transition aspects (for example, assaultiveness under Focus 3) come under other foci and need to be reviewed and audited. NSH plans to draw attention to the auditors regarding the non-transition barriers under foci other than Focus 11, and to improve the auditing of this recommendation.

Compliance:
Partial.

Current recommendations:
1. Ensure that discharge barriers, especially difficulties in previously unsuccessful placements, are discussed with the individual at scheduled WRPC's.
2. Include skill training and supports in the WRP so that the individual can overcome the stated barriers.

		3. Report to the WRPT, on a monthly basis, the individual's progress made in overcoming the barriers to discharge.
E.1.d	the skills and supports necessary to live in the setting in which the individual will be placed.	**Current findings on previous recommendation:** **Recommendation, July 2008:** Ensure that the skills and supports necessary for the individual to live in the setting in which he/she will be placed are documented in the Present Status section of the individual's WRP. **Findings:** Using item 4 from the DMH Discharge Planning and Community Integration Auditing form, NSH assessed its compliance based on an average sample of 35% of the WRPs due each month of this review period (June to November 2008). The table below is a summary of the data:

4.	*The skills and supports necessary to live in the setting in which the individual will be placed.*	60%
4.a	*The Present Status section of the individual's WRP includes the anticipated discharge placement*	68%
4.b	*The scheduled PSR groups listed in the interventions include skills and supports the individual will need in the anticipated placement.*	72%

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

	Previous period	Current period
Mean compliance rate		
4.	24%	60%
4.a	N/A	68%

4.b	N/A	72%
Compliance rate in last month of period		
4.	40%	87%
4.a	N/A	95%
4.b	N/A	90%

This monitor reviewed five charts (BFL, BJB, DN, LAC and SFL). All five WRPs in the charts addressed the skills and supports that the individual needs to live in the setting in which s/he will be placed.

According to the Chief of Social Work, the department has identified the staff who underperformed despite the training and plans to provide close monitoring and mentoring to improve their performance. NSH will have the seniors meet with the underperforming staff and work with them to improve their skills. NSH will also communicate via e-mail with the WRPT leaders and the WRP Social Workers when audits show deficiencies and have the WRPTs correct the deficits.

Compliance:
Partial.

Current recommendation:
Ensure that the skills and supports necessary for the individual to live in the setting in which he/she will be placed are documented in the Present Status section of the individual's WRP.

E.2	Each State hospital shall ensure that, beginning at the time of admission and continuously throughout the individual's stay, the individual is an active participant in the discharge planning process, to the fullest extent possible, given the individual's level of functioning and legal status.	**Current findings on previous recommendation:** **Recommendation, July 2008:** Continue to train the Social Work Department on engaging the individual as an active participant in the discharge planning process.

Findings:
Using item 12 from the DMH WRP Observation Monitoring Form, NSH assessed its compliance based on an average sample of 23% of the WRCs due each month of this review period (June to November 2008). The table below is a summary of the data:

12.	*Each state hospital shall ensure that, beginning at the time of admission and continuously throughout the individual's stay, the individual is an active participant in the discharge planning process, to the fullest extent possible, given the individual's level of functioning and legal status.*	3%
12.a	*The WRPT asks the individual for his or her input into the evaluation of progress on each objective related to discharge.*	12%
12.b	*The WRPT asks the individual if he or she is able to easily understand the materials presented in the PSR Mall groups or individual therapy that are related to discharge criteria.*	8%

Comparative data showed declines in from already low levels of compliance since the last review as follows:

	Previous period	Current period
Mean compliance rate		
12.	5%	3%
Compliance rate in last month of period		
12.	7%	2%
12.a	21%	13%
12.b	13%	8%

This monitor observed two WRPCs (JF and RJ). JF's WRPT engaged

		the individual in discussing his discharge matters, and RJ's WRPT did not cover the individual's discharge matters fully (the team modified the conference process to accommodate the individual's initial reluctance to attend the conference and to avoid aggravating his hostile attitude at the conference). This monitor also reviewed four charts (CHH, RDZ, SSP and VLC). None of the WRPs contained documentation indicating that the individual was a participant in the discussion of his/her discharge matters or understood the barriers and what he/she had to do to overcome the barriers. **Compliance:** Partial. **Current recommendation**: Continue to train the Social Work Department on engaging the individual as an active participant in the discharge planning process.
E.3	Each State hospital shall ensure that, consistent with generally accepted professional standards of care, each individual has a professionally developed discharge plan that is integrated within the individual's therapeutic and rehabilitation service plan, that addresses his or her particular discharge considerations, and that includes:	**Compliance:** Partial.
E.3.a	measurable interventions regarding these discharge considerations;	**Current findings on previous recommendation:** **Recommendation, July 2008:** Ensure that all discharge criteria and their related intervention(s) are measurable. **Findings:** Using item 6 from the DMH Discharge Planning and Community Integration Auditing form, NSH assessed its compliance based on an

average sample of 35% of the WRPs due each month of this review period (June to November 2008). The table below is a summary of the data:

	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:	
6.	*Measurable interventions regarding these discharge considerations*	42%
6.a	*The interventions are aligned with their respective objectives, and*	88%
6.b	*All objectives are written in a way that explains what the individual will do or learn, and how it will be measured.*	45%

Comparative data showed improvement from the previous review period:

	Previous period	Current period
Mean compliance rate		
6.	38%	42%
6.a	N/A	88%
6.b	N/A	45%
Compliance rate in last month of period		
6.	39%	59%
6.a	N/A	N/A
6.b	N/A	N/A

		This monitor reviewed 13 charts (CS, DR, GAR, JHM, JLH, JWM, LAC, MG, MR, RDZ, SSP, VH and VLC). Three of the WRPs in the charts (JWM, MG and SSP) had developed the discharge criteria and interventions in measurable terms. The remaining ten (CS, DR, GAR, JHM, JLH, LAC, MR, RDZ, VH and VLC) had one or more of the discharge criteria and or interventions that were unobservable/ unmeasurable. **Compliance:** Partial. **Current recommendation**: Ensure that all discharge criteria and their related intervention(s) are measurable.
E.3.b	the staff responsible for implement the interventions; and	**Current findings on previous recommendation:** **Recommendation, July 2008:** For those active treatment interventions where a discipline is specified rather than the staff member's name and discipline, clearly state the name of the staff member responsible. **Findings:** Using item 7 from the DMH Discharge Planning and Community Integration Auditing form, NSH assessed its compliance based on an average sample of 25% of the WRPs due each month of this review period (June to November 2008). The following is a summary of the data: 7. *The staff responsible for implementing the interventions* 81%

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<td>Comparative data showed improvement in compliance since the last review as follows:
<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>7.</td><td>73%</td><td>81%</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>7.</td><td>74%</td><td>98%</td></tr>
</table>
Five of the six charts (BR, CS, JLH, MG, MR and VH) reviewed by this monitor identified the staff members responsible for implementing the active treatment interventions.

To improve compliance, NSH intends to continue with the training and monitoring to further improve compliance to this recommendation.

Compliance:
Partial.

Current recommendation:
For those active treatment interventions where a discipline is specified rather than the staff member's name and discipline, clearly state the name of the staff member responsible.</td>
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<tr>
<td>E.3.c</td>
<td>The time frames for completion of the interventions.</td>
<td>Current findings on previous recommendation:

Recommendation, July 2008:
Ensure that the interventions are reviewed at least monthly.

Findings:
Using item 8 from the DMH Discharge Planning and Community Integration Auditing form, NSH assessed its compliance based on an</td>
</tr>
</table>

average sample of 35% of the WRPs due each month of this review period (June to November 2008). The table below is a summary of the data:

	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:	
8.	*The time frames for completion of interventions*	74%

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

	Previous period	Current period
Mean compliance rate		
8.	67%	74%
Compliance rate in last month of period		
8.	66%	98%

Four (BR, MG, MR and VH) of the six charts (BR, CS, JLH, MG, MR and VH) reviewed by this monitor listed the appropriate time frame for reviewing the interventions, and two of them (CS and JLH) did not have the right time frame to coincide with the next conference.

According to the Chief of Social Work, time frames for completion of interventions will be automatically populated in the WRP by WaRMSS beginning in November 2008.

		Compliance: Partial. **Current recommendation**: Ensure that interventions are reviewed at least monthly.
E.4	Each State hospital shall provide transition supports and services consistent with generally accepted professional standards of care. In particular, each State hospital shall ensure that:	**Compliance:** Partial.
E.4.a	individuals who have met discharge criteria are discharged expeditiously, subject to the availability of suitable placements; and	**Current findings on previous recommendations:** **Recommendation 1, July 2008:** Continue to reduce the overall number of individuals still hospitalized after referral for discharge has been made. **Findings:** Discussion with the Chief of Social Work and documentation review found that since the last review period, NSH has standardized its tracking and monitoring tables and the information is linked with WaRMSS to produce the required information and populate key information on individuals who are discharge-ready. The WaRMSS table includes information including the individual's name, program and unit, discharge readiness date, status of availability of suitable placements, and current efforts to find placement. This monitor's documentation review found that 72 individuals referred for discharge were still hospitalized, the individual with the longest stay since referral for discharge is BD, who was referred in March 2006. According to the Chief of Social Work, the individual passed the COT interview but release was refused by the court. Apparently, a writ was filed on December 23, 2008, without any decision. Social Work staff is following up and continuing to pursue BD's discharge.

		Recommendation 2, July 2008: Identify and resolve system factors that act as barriers to timely discharge. **Findings:** The only internal factor the Chief of Social Work was able to identify as a barrier was the improper documentation in the WRPs for individuals who are discharge-ready. The external barriers remain the same, including court matters, CONREP activities, and suitable placements. The Social Work department has been working with these entities to reduce the waiting time. **Current recommendations**: 1. Continue to 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.
E.4.b	Individuals receive adequate assistance in transitioning to the new setting.	**Current findings on previous recommendation:** **Recommendation 1, July 2008:** Develop and implement documentation guidelines to ensure that individuals receive adequate assistance when they transition to the new setting. **Findings:** Using item 10 from DHM Discharge Planning and Community Integration Auditing Form, NSH audited an average of two charts per month for each month of this review period (June to November 2008). The table below is a summary of the data: *Each State hospital shall provide transition supports*

	and services consistent with generally accepted professional standards of care. In particular, each State hospital share ensure that:	
10.	*Individuals receive adequate assistance in transitioning to the new setting.*	67%
10.a	*The Present Status section of the individual's WRP describes the assistance needed to transition to the discharge setting; and*	75%
10.b	*Identifies the persons (i.e. agency staff) responsible for providing transitional assistance.*	67%

Comparative data showed mixed changes in compliance for the main item since the last review as follows

	Previous period	Current period
Mean compliance rate		
10.	60%	67%
10.a	N/A	75%
10.b	N/A	67%
Compliance rate in last month of period		
10.	67%	40%
10.a	N/A	40%
10.b	N/A	25%

This monitor reviewed six charts (BR, CS, JLH, MG, MR and VH). Five of the WRPs in the charts (BR, CS, JLH, MG and MR) identified and/or provided individuals with the necessary assistance to transition to the new setting.

According to the Chief of Social Work, the barriers to improved compliance include inaccessibility of reports from WaRMSS showing

		individuals meeting discharge criteria, and improper documentation in the WRPs when individuals are discharge-ready. To improve compliance, NSH plans to link the Social Work database to WaRMSS to track individuals recommended for discharge, and to distribute tables to program management to enable WRPTs to accurately indicate in the WRPs those individuals who are discharge-ready. **Current recommendation:** Develop and implement documentation guidelines to ensure that individuals receive adequate assistance when they transition to the new setting.
E.5	For all children and adolescents it serves, each State hospital shall:	The requirements of Section E.5 are not applicable to NSH because it does not serve children or adolescents.
E.5.a	develop and implement policies and protocols that identify individuals with lengths of stay exceeding six months; and	
E.5.b	establish a regular review forum, which includes senior administration staff, to assess the children and adolescents identified in § V.E.1 above, to review their treatment plans, and to create an individualized action plan for each such child or adolescent that addresses the obstacles to successful discharge to the most integrated, appropriate placement as clinically and legally indicated.	

F. Specific Therapeutic and Rehabilitation Services	
	Summary of Progress on Psychiatric Services: 1. NSH has decreased the overall incidence of some high-risk medication uses (long-term benzodiazepines and anticholinergics). 2. NSH has implemented a 14-day time limit on orders for PRN benzodiazepine medications. 3. NSH has developed four Drug Utilization Evaluations that meet current generally accepted standards. 4. NSH has developed adequate Intensive Case Analyses of ADRs that meet specified threshold criteria. 5. NSH has developed an AD regarding the assessment of individuals suffering from TD. The AD meets current generally accepted standards. **Summary of Progress on Psychological Services:** 1. NSH has established the ETRC/PSSC joint meetings. This meeting should address issues of tracking and serving individuals with challenging behaviors and who meet the trigger threshold. 2. Documentation of PBS plans in the present status and interventions sections of the individuals' WRPs has improved. 3. The number of Neuropsychology Focused Assessments increased significantly. 4. The PBS teams have significantly improved their interdisciplinary collaboration, especially with Psychiatry. **Summary of Progress on Nursing Services:** 1. NSH has implemented the position of the Clinical Oversight Nurse to assist the unit staff with clinical issues. 2. NSH has implemented a very promising process for change of shift report.

	Summary of Progress on Rehabilitation Therapy Services: 1. A draft plan outlining a process for F.4.aii has been developed and is pending approval and implementation. 2. An F.4 Monitoring tool has been developed and implemented. 3. Data analysis based on requisite audit samples for each area of F4 (with the exception of F.4.a.ii) has been initiated. This process should continue to be developed to ensure that the facility provides a thorough and meaningful analysis of all sub-items below 90% compliance, with appropriate plans of correction to improve compliance implemented as needed. This self-assessment should be consistent with the self-assessment specifications found in the introduction of this report. **Summary of Progress on Nutrition Services:** 1. Review of data from the Meal Accuracy report shows substantial compliance with tray accuracy. 2. Curricula have been developed for Nutrition-related Mall groups. **Summary of Progress on Pharmacy Services:** NSH has achieved substantial compliance with EP requirements in this section. **Summary of Progress on General Medical Services:** 1. NSH has facilitated an appropriate continuing medical education program regarding the assessment and management of individuals suffering from delirium. The program was based on findings in the last report. 2. NSH has initiated an appropriate template for the quarterly medical reassessments. 3. NSH has initiated an appropriate mechanism to aggregate and review internal monitoring data (Audit-Driven Corrective Action Monthly Report). 4. NSH has implemented adequate revisions of its Physician Ordering

	System. 5. NSH has initiated appropriate data-based links to its physician ordering and laboratory information systems. **Summary of Progress on Infection Control:** 1. Infection Control continues to maintain substantial compliance in a number of areas. 2. The implementation of the Infection Control liaison nurse has helped increase compliance regarding the WRPs. **Summary of Progress on Dental Services** 1. Dental Services has continued to maintained substantial compliance in a number of areas. 2. A system is being developed by the Refusal Work Group in conjunction with the Dental Department to address dental refusals as well as other service refusals.

1. Psychiatric Services		
		Methodology: Interviewed: 1. Patricia Tyler, MD, Acting Medical Director 2. Steve Weule, Supervising Registered Nurse for Standards and Compliance Reviewed: 1. The charts of the following 40 individuals: AIR, AKL, BC, BSC, BTW, CAD, CMK, CRH, DEB, DR, DRZ, ETR, GR, GR-2, GSP, GVA, JMR, LC, LRF, LRJ, MAG, MAW, MNR, MWS, RAC, RJJ, RLH, RLH-2, RMP, RR, RVG, RWJ, SLH, TKK, VH, VLC, WFG, WJT, WLR and WTA 2. AD #560, Tardive Dyskinesia, effective October 23, 2008 3. NSH list of individuals with psychotropic medications, diagnoses and attending physicians 4. NSH database regarding intra-class and inter-class polypharmacy 5. DMH Admission Psychiatric Assessment Auditing Form 6. DMH Admission Psychiatric Assessment Auditing Form Instructions 7. NSH Admission Psychiatric Assessment Auditing summary data (June to November 2008) 8. DMH Integrated Assessment: Psychiatry Section Auditing Form 9. DMH Integrated Assessment: Psychiatry Section Auditing Form Instructions 10. NSH Integrated Psychiatric Assessment Auditing summary data (June to November 2008) 11. DMH Monthly Physician Progress Note (PPN) Auditing Form 12. NSH Monthly PPN Auditing summary data (June to November 2008) 13. DMH Nursing Services Monitoring Form (PRN medications) 14. NSH Nursing PRN medications auditing summary data (June to November 2008)

		15. DMH Nursing Services Monitoring Form (Stat medications) 16. NSH Nursing Stat medications auditing summary data (June to November 2008) 17. DMH Benzodiazepine Auditing Form 18. NSH Benzodiazepine Auditing summary data (June to November 2008) 19. DMH Anticholinergic Auditing Form 20. NSH Anticholinergic Auditing summary data (June to November 2008) 21. DMH Polypharmacy Auditing Form 22. NSH Polypharmacy Auditing summary data (June to November 2008) 23. NSH Medication Monitoring New Generation Antipsychotics (NGA) Auditing Form 24. NSH NGA Auditing summary data (June to November 2008) 25. NSH database regarding individuals diagnosed with tardive dyskinesia 26. DMH Tardive Dyskinesia (TD) Auditing Form 27. NSH TD Auditing summary data (June to November 2008) 28. NSH Adverse Drug Reaction Reports (June to November 2008) 29. NSH Intensive Case Analyses regarding ADRs and MVRs (June to November 2008) 30. NSH last ten completed ADR reporting forms 31. NSH Medication Evaluation Review Format--New Onset Diabetes Mellitus 32. NSH Medication Evaluation Review Format--Benzodiazepines 33. NSH Medication Evaluation Review Format--Anticholinergics 34. NSH Medication Evaluation Review Format--Ziprasidone Follow-Up 35. NSH DUE Data Collection Tool--Ziprasidone Follow-Up DUE Instructions 36. NSH Data Collection Tool--Ziprasidone Follow-UP DUE 37. Minutes of the meetings of the Pharmacy and Therapeutics (P&T) Committee on June 26, July 17, September 9, October 14 and

		November 18, 2008
F.1.a	Each State hospital shall develop and implement policies and procedures to ensure system-wide monitoring of the safety, efficacy, and appropriateness of all psychotropic medication use, consistent with generally accepted professional standards of care. In particular, policies and procedures shall require monitoring of the use of psychotropic medications to ensure that they are:	**Current findings on previous recommendations:** **Recommendations 1 and 2, July 2008:** • Finalize individualized guidelines for all psychotropic and anticonvulsant medications listed in the formulary. • Ensure that the individualized medication guidelines are continually revised, as appropriate, to reflect current literature, relevant clinical experience and professional practice guidelines. **Findings:** NSH has developed draft guidelines for the use of lithium, venlafaxine, bupropion and mirtazapine and the monitoring of serum lipase and amylase. The facility reported that these were submitted to the Psychopharmacology Advisory Committee (PAC) for finalization. **Recommendation 3, July 2008:** Finalize the DMH auditing form regarding the use of new generation antipsychotic medications. **Findings:** The DMH has finalized this instrument and NSH began implementation in December 2008. The indicators are consistent with current standards. **Recommendation 4, July 2008:** Monitor these requirements using the standardized DMH tools based on at least a 20% sample. **Findings:** NSH used the previously mentioned DMH Admission Psychiatric Assessment, Integrated Assessment: Psychiatry Section and Monthly

		PPN Auditing Forms to monitor compliance. The average samples were 77%, 49% and 13% of each assessment type, respectively. Compliance data are summarized in each cell below. **Recommendation 5, July 2008:** Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period). **Findings:** The facility's plan of correction is the same as that outlined in D.1.a. **Compliance:** Partial. **Current recommendations**: 1. Finalize individualized guidelines for all psychotropic and anticonvulsant medications listed in the formulary. 2. Ensure that the individualized medication guidelines are continually revised, as appropriate, to reflect current literature, relevant clinical experience and professional practice guidelines. 3. Monitor this requirement using the DMH Admission Psychiatric Assessment, DMH Integrated Assessment: Psychiatric Section and Monthly Physician Progress Note Auditing Forms based on at least 20% samples. 4. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). 5. Provide a summary outline of any improvements in practice made as a result of review by the facility of internal monitoring data.

F.1.a.i

specifically matched to current, clinically justified diagnoses or clinical symptoms;

Admission Psychiatric Assessment		
8.	*Plan of care includes:*	76%
8.a	*Regular psychotropic medications, with rationale;*	87%
8.b	*PRN and/or Stat medication as applicable, with specific behavioral indications;*	69%
8.c	*Special precautions to address risk factors, as indicated.*	88%

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

	Previous period	Current period
Mean compliance rate		
8.	40%	76%
Compliance rate in last month of period		
8.	58%	83%
8.a	67%	91%
8.b	63%	79%
8.c	81%	94%

NSH reported that both practice deficiencies and auditing errors contributed to current compliance ratings. Based on these findings, NSH reported that the facility plans the following actions:

1. Retraining of auditors; and
2. At the time of this review, the Physician Ordering System Committee was considering a proposal that would ensure that PRN/Stat orders for psychotropic medications would not be validated without a specific behavioral indication.

Integrated Psychiatric Assessment		
7.	*Diagnostic formulation is documented.*	53%
10.	*Psychopharmacology treatment plan includes:*	50%
10.a	*Current target symptoms;*	86%
10.b	*Specific medication to be used;*	94%
10.c	*Dosage titration schedules, if indicated;*	93%
10.d	*Adverse reactions to monitor for;*	65%
10.e	*Rationale for anticholinergics, benzodiazepines, polypharmacy and new generation antipsychotics in an at-risk population, if indicated;*	74%
10.f	*Response to medication since admission, if applicable, including PRN and Stat medications;*	74%
10.g	*Medication consent issues were addressed.*	95%

For those indicators with a mean compliance rate of less than 90%, comparative data showed mixed results in compliance since the last review. The following table summarizes the data:

	Previous period	Current period
Mean compliance rate		
7.	38%	53%
10.	30%	50%
Compliance rate in last month of period		
7.	48%	47%
10.	60%	65%
10.a	85%	91%
10.d	74%	76%
10.e	71%	90%
10.f	67%	89%

NSH reported that the following corrective actions were implemented

in January 2009:

1. The facility provided practitioners with model examples of diagnostic formulations.
2. Senior Psychiatrists began reviewing Integrated Assessments written by their supervisees and providing applicable feedback and training.

Monthly PPN		
2.b	*The current target symptoms which are the focus of treatment are identified in the progress note.*	94%
6.a.1	*The risks, benefits and rationale for the current psychopharmacology plan including anticholinergics, benzodiazepines, and polypharmacy are documented.*	68%
6.a.2	*There is a clear description of the reasoning for continuing the current medication regimen and the proposed future plans, such as augmentation, dose tapering, change in medication, etc.*	78%

For those indicators with a mean compliance rate of less than 90%, comparative data showed improvements in compliance since the last review. The following table summarizes the data:

	Previous period	Current period
Mean compliance rate		
6.1.a	62%	68%
6.1.b	76%	78%
Compliance rate in last month of period		
6.1.a	58%	66%
6.1.b	71%	79%

The facility's action plan is described in D.1.a above.

<table>
<tr><td>F.1.a.ii</td><td>prescribed in therapeutic amounts, as dictated by the needs of the individual served;</td><td>
<table>
<tr><th colspan="3">Monthly PPN</th></tr>
<tr><td>2.h.2</td><td>Current psychotropic medication dosage/laboratory monitoring/diagnostic testing and consultation protocols are followed as indicated (as per DMH Psychotropic guidelines).</td><td>84%</td></tr>
</table>

The facility reported a mean compliance rate of 84% compared to 85% during the last review. The rate for the last month of this period decreased to 83% from 86% during the last review.

The facility reported that during the previous review period, approximately 25% of practitioners did not consistently write monthly notes but that at the time of the current review, this had decreased to 5% of practitioners. The practitioners who recently began writing monthly notes have started to receive ADCAP results to facilitate targeted mentoring and training.
</td></tr>
<tr><td>F.1.a.iii</td><td>tailored to each individual's symptoms;</td><td>Same as in F.1.a.i.</td></tr>
<tr><td>F.1.a.iv</td><td>monitored for effectiveness against clearly identified target variables and time frames;</td><td>
<table>
<tr><th colspan="3">Monthly PPN</th></tr>
<tr><td>2.b</td><td>Identified target symptoms are documented.</td><td>94%</td></tr>
<tr><td>2.c</td><td>Participation in treatment is documented.</td><td>86%</td></tr>
<tr><td>2.d</td><td>Progress towards objective in the Wellness and Recovery Plan [is documented].</td><td>84%</td></tr>
</table>

For those indicators with a mean compliance rate of less than 90%, comparative data showed small increases in compliance since the last review. The following table summarizes the data:
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<table>
<tr><td></td><td></td><td>
<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>2.c</td><td>85%</td><td>86%</td></tr>
<tr><td>2.d</td><td>79%</td><td>84%</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>2.c</td><td>84%</td><td>94%</td></tr>
<tr><td>2.d</td><td>81%</td><td>94%</td></tr>
</table>

The facility's action plan is described in F.1.a.i.
</td></tr>
<tr><td>F.1.a.v</td><td>monitored appropriately for side effects;</td><td>
<table>
<tr><td colspan="3">Monthly PPN</td></tr>
<tr><td>6.b</td><td>Monitoring of side effects [is documented].</td><td>78%</td></tr>
<tr><td>6.c</td><td>AIMS is completed.</td><td>80%</td></tr>
</table>

Comparative data showed improvements in compliance since the last review as follows:
<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>6.b</td><td>76%</td><td>78%</td></tr>
<tr><td>6.c</td><td>65%</td><td>80%</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>6.b</td><td>70%</td><td>83%</td></tr>
</table>

The facility did not provide data on the comparison of compliance rates from last month to last month for item 6.c.

The facility's action plan is described in F.1.a.i.
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<table>
<tr><td>F.1.a.vi</td><td>modified based on clinical rationales;</td><td>
<table>
<tr><td colspan="3">Monthly PPN</td></tr>
<tr><td>6.a.1</td><td>The risks, benefits and rationale for the current psychopharmacology plan including anticholinergics, benzodiazepines, and polypharmacy are documented.</td><td>68%</td></tr>
<tr><td>6.a.2</td><td>There is a clear description of the reasoning for continuing the current medication regimen and the proposed future plans, such as augmentation, dose tapering, change in medication, etc.</td><td>78%</td></tr>
</table>

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

<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>6.a.1</td><td>62%</td><td>68%</td></tr>
<tr><td>6.a.2</td><td>76%</td><td>78%</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>6.a.1</td><td>58%</td><td>67%</td></tr>
<tr><td>6.a.2</td><td>71%</td><td>79%</td></tr>
</table>

The facility's action plan is described in F.1.a.i.
</td></tr>
<tr><td>F.1.a.vii</td><td>are not inhibiting individuals from meaningfully participating in treatment, rehabilitation, or enrichment and educational services as a result of excessive sedation; and</td><td>
<table>
<tr><td colspan="3">Monthly PPN</td></tr>
<tr><td>2.c</td><td>Participation in treatment is documented.</td><td>86%</td></tr>
<tr><td>6.b</td><td>Monitoring of side effects [is documented].</td><td>78%</td></tr>
<tr><td>6.c</td><td>AIMS is completed.</td><td>80%</td></tr>
</table>

Comparative data showed improvements in compliance since the last review as follows:
</td></tr>
</table>

	Previous period	Current period
Mean compliance rate		
2.c	85%	86%
6.b	76%	78%
6.c	64%	80%
Compliance rate in last month of period		
2.c	84%	94%
6.b	70%	83%
6.c	66%	88%

The facility's action plan is described in F.1.a.i.

F.1.a.viii	Properly documented.	

Admission Psychiatric Assessment	8.a, 8.b and 8.c	83%
Integrated Assessment (Psychiatry)	7 and 10	53%
Monthly PPN	2.b, 2.c, 2.d, 2.h.2, 6.a.1, 6.a.2, 6.b and 6.c	79%

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

	Previous period	Current period
Mean compliance rate		
Admission Psychiatric Assessment	48%	83%
Integrated Assessment (Psychiatry)	33%	53%
Monthly PPN	77%	79%

F.1.b	Each State hospital shall monitor the use of PRN and Stat medications to ensure that these medications are administered in a manner that is clinically justified and are not used as a substitute for appropriate long-term treatment of the individual's condition.	**Current findings on previous recommendations:** **Recommendation 1, July 2008:** Provide documentation of procedure/instruction to ensure that all PRN orders for psychotropic medications are limited to no more than 15 days of use before the orders are reviewed and rewritten as necessary. This time limit should be gradually shortened to three days of use. **Findings:** The following is a summary of the facility's actions since the previous review: 1. NSH initiated a 14-day limit for each order of PRN benzodiazepine use (September 2008). 2. NSH initiated a 30-day limit for each order of anticholinergics. This timeline was designated based on literature suggesting that EPS-like symptoms can occur beyond two weeks (January 2009). **Recommendation 2, July 2008:** Monitor this requirement using the DMH Monthly PPN Auditing Form based on at least a 20% sample and present data for the relevant sub-indicators. **Findings:** NSH used the DMH Monthly PPN Auditing Form (June to November 2008) to audit this requirement. The average sample size was 13% of individuals hospitalized for 90 or more days. The following table summarizes the data:

Monthly PPN		
7.	*Timely review of the use of "pro re nata" or "as needed" ("PRN") and "Stat" (i.e., emergency psychoactive) medications and adjustment of regular*	59%

	treatment, as indicated, based on such use:	

The facility reported a mean compliance rate of 59% compared to 40% during the last review. The rate for the last month of this period increased to 71% from 32% during the last review.

Recommendation 3, July 2008:
Present data based on the Nursing Services Monitoring Auditing Forms for PRN and Stat medications that clearly delineates compliance with the following:

a. Safe administration of PRN medication;
b. Documentation of circumstances requiring PRN medication;
c. Documentation of the individual's response to PRN medication;
d. Safe administration of Stat medications;
e. Documentation of the circumstances requiring Stat administration of medications;
f. Documentation of the individual's response to Stat medication.

Findings:
The facility used the DMH Nursing Services Monitoring Form for PRN medication uses (June to November 2008) to audit this requirement. The average sample size was 22% of PRN medications given each month month. The following table summarizes the data:

Nursing Services PRN		
1.	*Safe administration of PRN medication.*	47%
1.a.	*If PRN was administered, it was administered based on a complete physician's order.*	57%
1.c.	*The nursing staff administered the correct medication, dose, form, and route, at the correct time, on the correct date, for the correct indication, to the correct individual.*	83%
2.	*Documentation of the circumstances requiring PRN*	39%

	medication.	
3.	*Documentation of the individual's response to PRN medication.*	51%

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

	Previous period	Current period
Mean compliance rate		
1.	9%	47%
2.	28%	39%
3.	33%	51%
Compliance rate in last month of period		
1.	8%	53%
1.a.	34%	61%
1.c.	85%	86%
2.	30%	57%
3.	32%	64%

The facility also used the DMH Nursing Services Monitoring Form for Stat medication uses (June to November 2008) to audit this requirement. The average sample size was 24% of Stat medications given each month. The data are not presented in this report because of inconsistencies in the information provided.

Recommendation 4, July 2008:
Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period).

		Findings: In addition to the corrective actions outlined in D.1.a, NSH reported the following: 1. The facility intends to utilize a Clinical Oversight Nurse to review the documentation of all administrations of PRN and Stat medications (on a daily basis) beginning in February 2009. NSH reported that development of mentoring and training activities will be based on these reviews. 2. In January 2009, the Medical Director submitted a proposal to the P&T Committee suggesting that the Committee recommend to the Medical Executive Committee that the pharmacy be authorized to decline to validate orders written for behavioral PRNs that do not include specific behavioral indicators. **Compliance:** Partial. **Current recommendations**: 1. Include data on the sub-indicators for item 7 on the DMH Monthly PPN Auditing Form. 2. Ensure that valid and reliable data are provided based on the DMH Nursing Services Monitoring Form for Stat medication uses. 3. Provide documentation of procedure/instruction to ensure that time limits for PRN orders are gradually shortened to three days of use. 4. Monitor this requirement using the DMH Monthly Physician Progress Note auditing form and the DMH Nursing Services Monitoring Forms for PRN and Stat medication uses based on at least a 20% sample. 5. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).

		6. Provide a summary outline of any improvements in practice made as a result of review by the facility of internal monitoring data.
F.1.c	Each State hospital shall monitor the psychiatric use of benzodiazepines, anticholinergics, and polypharmacy to ensure clinical justification and attention to associated risks.	**Current findings on previous recommendations:** **Recommendation 1, July 2008:** Monitor these requirements using the standardized DMH tools based on at least a 20% sample. **Findings:** NSH used the DMH Benzodiazepine, Anticholinergic and Polypharmacy Audit Forms (June to November 2008) to assess compliance with this requirement. The following table summarizes the data:

Benzodiazepine (average sample has varied depending on the indicator, ranging from 14% to 38% of all individuals receiving regularly scheduled benzodiazepines)		
1.	*Indication for regularly scheduled use of benzodiazepine clearly documented in medical record*	82%
2.	*Benzodiazepine used for individuals with alcohol / drug use problems justified in PPN*	45%
3.	*Benzodiazepine used for individuals with cognitive disorders justified in PPN*	39%
	Routine Benzodiazepine use for more than two months, PPN clearly documents the risks of:	
4.	*Drug dependence*	29%
5.	*Cognitive decline*	32%
6.	*Sedation*	33%
7.	*Gait unsteadiness/falls if indicated*	32%
8.	*Respiratory depression (for those with underlying respiratory problems e.g. COPD)*	29%
9.	*Toxicity if used in individuals with liver impairment (if using long acting agents)*	17%

10.	*Treatment modified in an appropriate and timely manner to ensure proper indications and to minimize risk.*	69%

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

Benzodiazepine	Previous period	Current period
Mean compliance rate		
1.	65%	82%
2.	32%	45%
3.	45%	39%
4.	22%	29%
5.	22%	32%
6.	25%	33%
7.	28%	32%
8.	25%	29%
9.	50%	17%
10.	56%	69%
Compliance rate in last month of period		
1.	56%	71%
2.	82%	50%
3.	96%	50%
4.	59%	25%
5.	38%	29%
6.	47%	35%
7.	66%	25%
8.	96%	50%
9.	88%	0%
10.	80%	83%

Anticholinergics (Average sample size has varied depending on the indicator. Overall, an average of 12% of the records of individuals receiving regularly scheduled anticholinergic medications was audited.)

1.	*Indication for use of anticholinergic clearly documented in PPN (N = All individuals on any of the four anticholinergics)*	80%
	Regularly scheduled anticholinergics for more than two months clearly documented in the PPN risks of: (N= All individuals over age 60 and with cognitive impairment of any type for 2-6.)	
2.	*Cognitive impairment*	30%
3.	*Sedation*	20%
4.	*Gait unsteadiness/falls*	14%
5.a	*Blurred vision*	22%
5.b	*Constipation*	15%
5.c	*Urinary retention*	19%
6.	*Worsening narrow angle glaucoma*	35%
	Regularly scheduled anticholinergic use for more than two months clearly document in PPN risks of: (N= all individuals on anticholinergics for more than two months regardless of age or cognitive status for 7-13.)	
7.	*Cognitive impairment*	32%
8.	*Sedation as indicated*	30%
9.	*Gait unsteadiness/falls (as indicated)*	23%
10.a	*Blurred vision*	22%
10.b	*Constipation*	21%
10.c	*Urinary retention*	23%
11.	*Worsening narrow angle glaucoma, if present*	18%

12.	*Substance abuse/dependence if listed on Axis I*	35%
13.	*Worsening TD if present*	36%
14.	*Dosage is within DMH psychotropic medication policy (unless TRC/MRC consult was obtained. N= all individuals on the four anticholinergics for 14.*	98%
15.	*Treatment modified in an appropriate and timely manner to ensure proper indications and minimize risk. N= all individuals on anticholinergics for more than two months regardless of age or cognitive status for 15.*	68%

For those indicators with a mean compliance rate of less than 90%, comparative data showed mixed results in compliance since the last review. The following table summarizes the data:

Anticholinergic	Previous period	Current period
Mean compliance rate		
1.	71%	80%
2.	27%	30%
3.	22%	20%
4.	32%	14%
5.a	18%	22%
5.b	15%	15%
5.c	15%	19%
6.	48%	35%
7.	20%	32%
8.	14%	30%
9.	19%	23%
10.a	13%	22%
10.b	13%	21%
10.c	11%	23%
11.	24%	18%

12.	14%	35%
13.	37%	36%
15.	50%	68%
Compliance rate in last month of period		
1.	64%	82%
2.	60%	0%
3.	40%	0%
4.	60%	0%
5.a	60%	0%
5.b	60%	0%
5.c	60%	0%
6.	60%	0%
7.	33%	18%
8.	50%	12%
9.	50%	7%
10.a	33%	18%
10.b	33%	12%
10.c	33%	18%
11.	75%	0%
12.	43%	50%
13.	100%	0%
15.	60%	69%

Polypharmacy (Average sample size was 15% of all individuals prescribed medication meeting the definition of inter- or intra-class polypharmacy.)

1.	*Target symptoms were clearly identified.*	68%
2.	*Documentation in PPN justifies the need for inter-class polypharmacy.*	62%
3.	*Documentation in PPN justifies the need for intra-class for polypharmacy.*	69%
4.a	*The PPN documents the risks of the polypharmacy*	17%

	including drug-to-drug interactions	
4.b	*The PPN documents the risk of cumulative side-effects*	32%

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

Polypharmacy	Previous period	Current period
Mean compliance rate		
1.	58%	68%
2.	49%	62%
3.	50%	69%
4.a	10%	17%
4.b	18%	32%
Compliance rate in last month of period		
1.	43%	79%
2.	30%	79%
3.	70%	76%
4.a	0%	36%
4.b	16%	55%

Recommendation 2, July 2008:
Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period).

Findings:
NSH reported benzodiazepine use decreased nearly 30% during this review period. However, the facility indicated that practitioners who continue to prescribe benzodiazepines do not tend to document risks in a comprehensive manner, resulting in lower compliance ratings during

		this review period. NSH also reported that anticholinergic use declined 26% during this review period. However, the facility reported the same trend related to documentation as described in the previous paragraph. NSH has analyzed trends related to practitioner use of benzodiazepines and anticholinergics and has increased mentoring and training of those practitioners as applicable. Additionally, beginning in January 2009, Senior Psychiatrists have provided specific consultation to their supervisees related to the care of individuals prescribed more than four psychotropic medications. **Other findings:** This monitor reviewed the facility's databases regarding individuals receiving long-term treatment with the following regimens: 1. Benzodiazepines in presence of diagnoses of substance use disorders and/or cognitive disorders; 2. Anticholinergic medications for elderly individuals and/or individuals diagnosed with cognitive disorders; and 3. Various forms of polypharmacy. The review found an overall decrease in the utilization of benzodiazepine and anticholinergic medications compared to the last review period. This monitor reviewed the charts of 23 individuals who have received the above types of medication regimens during this review period. There continued to be a general pattern of long-term regular treatment with benzodiazepines (lorazepam and/or clonazepam) and/or anticholinergic medications (benztropine and/or trihexyphenidyl) and/or polypharmacy without documented justification and/or

assessment of the individuals for the risks associated with this practice.

The following tables outlines these reviews (diagnoses are listed only if they signified conditions that increased the risk of use):

Benzodiazepine use:

Individual	Medication(s)	Diagnosis
CAD	Lorazepam	Polysubstance Dependence
CRH	Lorazepam	Polysubstance Dependence
DEB	Lorazepam	Alcohol Abuse
ETR	Clonazepam (and lorazepam PRN)	Cognitive Disorder NOS
MAW	Lorazepam (and lorazepam PRN)	Borderline Intellectual Functioning
RAC	Lorazepam	Amphetamine Abuse
RLH(1)	Lorazepam	Mild Mental Retardation
RVG	Lorazepam (and lorazepam PRN)	R/O Cognitive Impairment
VLC	Lorazepam (and lorazepam PRN)	Polysubstance Dependence and Mild Mental Retardation

Anticholinergic use:

Individual	Medication(s)	Diagnosis
DRZ	Trihexyphenidyl (and hydroxyzine PRN and chlor-promazine PRN).	Mild Mental Retardation

LRF	Trihexyphenidyl	Dementia Due To General Medical Condition With Behavioral Disturbance
LRJ	Benztropine	Mild Mental Retardation
RLH(2)	Benztropine	Mild Mental Retardation
SLH	Benztropine	Borderline Intellectual Functioning

Anticholinergic use for elderly individuals:

Individual	Medication(s)	Diagnosis
BTW	Benztropine (and benztropine PRN).	Borderline Intellectual Functioning
MNR	Benztropine	Benign Prostatic Hypertrophy
WLR	Trihexyphenidyl	

Polypharmacy use:

Individual	Medication(s)	Diagnosis
CMK	Clonazepam, duloxetine, lithium, quetiapine, risperidone, trazodone and divalproex, quetiapine PRN and risperidone PRN	
GR(1)	Clonazepam, quetiapine, risperidone, sertraline, trazodone, mirtazapine and clonazepam PRN.	Alcohol Dependence
LC	Benztropine, clonazepam, clozapine, divalproex, haloperidol, olanzapine PRN and lorazepam PRN,	
RWJ	Risperidone, quetiapine, lorazepam, benztropine, lorazepam PRN, haloperidol PRN and diphenhydramine PRN	Alcohol Abuse

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<tr><td>VH</td><td>Clozapine, risperidone, divalproex, lorazepam and lorazepam PRN.</td><td>Cocaine Abuse and Borderline Intellectual Functioning</td></tr>
<tr><td>WFG</td><td>Bupropion, duloxetine, olanzapine and divalproex,</td><td></td></tr>
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Compliance
Partial.

Current recommendations:
1. Monitor this requirement using the Benzodiazepine, Anticholinergic and Polypharmacy Audit Forms based on at least 20% samples.
2. Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.
3. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period.
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<td>F.1.d</td>
<td>Each State hospital shall ensure the monitoring of the metabolic and endocrine risks associated with the use of new generation antipsychotic medications.</td>
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Current findings on previous recommendations:

Recommendation 1, July 2008:
Finalize the DMH tool regarding the monitoring of new generation antipsychotics for use across facilities.

Findings:
Same as F.1.a.

Recommendation 2, July 2008:
Monitor these requirements using the standardized DMH tools based on at least a 20% sample.
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Findings:
The facility used the NSH New Generation Antipsychotic Medications Auditing Form (June to November 2008) to assess compliance with this requirement. The average sample was 7% of the individuals receiving any one or combination of the following medications: aripiprazole, clozapine, olanzapine, risperidone, quetiapine, paliperidone and ziprasidone. The following table summarizes the data:

2.	*Family/personal risk factors addressed in PPN (if medication started within last 90 days)*	93%
2.a	*Dose initiation meets requirements*	97%
2.b	*Dose titration meets requirements*	95%
3.	*Justification for use documented in PPN for individuals with diagnosis of (for olanzapine, risperidone, quetiapine)*	44%
3.a	*Dyslipidemia*	51%
3.b	*Diabetes*	50%
3.c	*Obesity*	46%
4.	*Justification for use documented in PPN for individuals on risperidone with hyperprolactinemia.*	34%
5.	*Appropriate monitoring for postural hypotension for individual >60y/o with BP<90/60 on quetiapine, clozapine*	30%
6.	*ECG within previous 12 months if on Clozaril.*	34%
7.	*Appropriate baseline and regular monitoring of:*	87%
7.a	*Body Mass Index*	91%
7.b	*Waist Circumference*	88%
8.	*Appropriate Labs:*	74%
8.a	*Lipid Panel*	88%
8.b	*HgbA1C*	80%
8.c	*Prolactin level if on risperidone*	73%
9.	*If individual is female, annual breast exam*	63%

10.	*If an unstable seizure disorder present and on Clozaril, was appropriate action taken*	47%

For those indicators with a mean compliance rate of less than 90%, comparative data showed improvements in compliance since the last review. The following table summarizes the data:

	Previous period	Current period
Mean compliance rate		
3.	37%	44%
4.	15%	34%
5.	25%	30%
6.	33%	34%
7.	85%	87%
8.	53%	74%
9.	55%	63%
10.	--	47%

A comparison between the mean compliance rates at the current and previous reviews for Item 10 and between compliance rates from month to last month could not be made due to inconsistent data presented by the facility.

Recommendation 3, July 2008:
Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period).

Findings:
In addition to the ADCAP corrective action process described previously, NSH reported that Nurse Practitioners would begin ordering some of the laboratory monitoring for side effects of NGAs

to improve compliance in this area.

Other findings:
This monitor reviewed the charts of 12 individuals who received new-generation antipsychotic agents and suffered from a variety of metabolic disorders. The following table outlines the initials of the individuals, the medication(s) used and the metabolic disorder(s):

Individual	Medication(s)	Diagnosis
AIR	Olanzapine	Hyperlipidemia
AKL	Risperidone	Adult-Onset Type Diabetes Mellitus
BSC	Olanzapine	Diabetes Mellitus and Obesity
DR	Olanzapine	Morbid Obesity
GR-2	Risperidone and quetiapine	Hyperlipidemia and Obesity
GVA	Quetiapine	Adult-Onset Type Diabetes Mellitus and Obesity
MAG	Risperidone	Obesity and Hyperlipidemia
RMP	Olanzapine and risperidone	Metabolic Syndrome
RR	Risperidone (and olanzapine PRN)	Diabetes Mellitus and Obesity
TKK	Olanzapine	Diabetes Mellitus and Obesity
WJT	Ziprasidone	Adult-Onset Type Diabetes Mellitus and Obesity
WTA	Risperidone	Obesity

In general, the facility provided adequate laboratory monitoring of the metabolic indicators, blood counts and vital signs in individuals at risk. During this review period, the facility appeared to have improved its laboratory monitoring of the risks of pancreatic dysfunction. However, this monitor found that the facility has not made progress in correcting the pattern of process deficiencies that was outlined in

		previous reports. These deficiencies must be corrected to achieve substantial compliance. The following are examples: 1. The psychiatric progress notes did not address the relevant risks vs. benefits of continued treatment with olanzapine despite persistent hypercholesterolemia and hyperlipidemia in an individual (AIR). 2. The psychiatric progress notes did not track the prolactin level or the clinical status relevant to the risk of hyperprolactinemia in female individuals receiving high risk treatment with risperidone and diagnosed with diabetes mellitus and obesity (RR) and adult-onset type diabetes mellitus (AKL). 3. The psychiatric progress notes did not track the weight status or address the risks vs. benefits of continued treatment with olanzapine despite diagnosis of morbid obesity in an individual (DR). 4. The psychiatric progress notes did not address the recent significant elevation of serum triglycerides in an individual diagnosed with diabetes mellitus and obesity and receiving high risk treatment with olanzapine (BSC). 5. The psychiatric progress notes did not specify the weight status of an individual diagnosed with obesity and receiving high risk treatment with risperidone (WTA). 6. Most of the charts reviewed did not include laboratory findings for the past 11 months as required by the facility's filing guidelines. This process deficiency makes it difficult for treating physicians to track the changes in laboratory values. 7. There was no evidence that a prolactin level was obtained to monitor female individuals who were receiving high risk treatment with risperidone and olanzapine (one individual [RMP] was diagnosed with metabolic syndrome and the other [GR-2] was diagnosed with hyperlipidemia and obesity). The psychiatric progress notes did not track the relevant clinical status of these individuals. 8. The psychiatric progress notes did not track the weight status of

		an individual diagnosed with obesity and hyperlipidemia and receiving treatment with quetiapine (GVA). 9. The psychiatric progress notes contained a statement that "psychotropic monitoring laboratory data" were "not applicable" in an individual who was diagnosed with hyperlipidemia and obesity and receiving high risk treatment with risperidone and quetiapine (GR2). **Compliance** Partial. **Current recommendations**: 1. Ensure that data from the NSH New Generation Antipsychotic Medications Audit Tool are consistent when presenting information in two formats (by medication and by month). 2. Monitor this requirement using the DMH tool regarding the monitoring of new generation antipsychotics based on at least a 20% sample. 3. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period. 4. Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.
F.1.e	Each State hospital shall ensure regular monitoring, using a validated rating instrument (such as AIMS or DISCUS), of tardive dyskinesia (TD); a baseline assessment shall be performed for each individual at admission with subsequent monitoring of the individual every 12 months while he/she is receiving antipsychotic medication, and every 3 months if the test is positive, TD is present, or the individual has a history of TD.	**Current findings on previous recommendations:** **Recommendations 1-3 July 2008:** • Develop and implement systems to ensure accurate identification of all individuals with current diagnosis or history of TD. • Ensure consistent implementation of recommendations made by the TD clinic. • Ensure that the TD statement/policy/procedure addresses management strategies.

Findings:
A summary of NSH's actions since the previous review follows:

1. NSH's neurologist began personally assessing (through use of the AIMS) all new admissions for TD in January 2009.
2. A quality improvement process based on communication between the TD clinic neurologist and Senior Psychiatrists was instituted to monitor implementation of recommendations from the TD clinic.
3. The Medical Director drafted a revision of the TD R&R to include TD management strategies. The revision is consistent with generally accepted standards of care.

Recommendations 4 and 5, July 2008:
- Monitor this requirement based on a 100% sample and identify the target population for all indicators.
- Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period).

Findings:
NSH used the DMH TD Auditing Form (June to November 2008) to assess compliance with this requirement. The average sample for item 1 was 84% of new admissions each month. Average sample size for the remaining items was not available as the facility has yet to identify the target population. The following table summarizes the data:

1.	*A baseline assessment shall be performed for each individual at admission.*	98%
2.	*Subsequent monitoring of the individual every 12 months while he/she is receiving antipsychotic medication.*	90%
3.	*Monitoring of the individual is conducted every three months if the test (AIMS or DISCUS) is positive, TD*	49%

	is present, or the individual has a history of TD.	
4.	*If an older generation antipsychotic is used there is evidence in monthly physician progress note of justification of using the older generation medication.*	61%
5.	*A neurology consultation / TD Clinic evaluation was completed as indicated.*	65%
6.	*Monthly progress notes for the past 3 months indicate that antipsychotic treatment has been modified to reduce risk or there is documentation of rationale for continuation.*	72%
7.	*Diagnosis of TD is listed on Axis I and/or III (for current diagnosis)*	49%
8.	*Tardive Dyskinesia is included in Focus 6 of the WRP.*	42%
9.	*The WRP reflect objectives and interventions for Tardive Dyskinesia.*	42%

For those indicators with a mean compliance rate of less than 90%, comparative data showed mixed results in compliance since the last review. The following table summarizes the data:

	Previous period	Current period
Mean compliance rate		
3.	44%	49%
4.	60%	61%
5.	59%	65%
6.	60%	72%
7.	65%	49%
8.	58%	42%
9.	58%	42%
Compliance rate in last month of period		
3.	44%	54%

4.	67%	70%
5.	72%	69%
6.	72%	88%
7.	92%	58%
8.	58%	58%
9.	60%	55%

The facility's action plan to improve compliance is described in D.1.a and F.1.a above. In addition the facility identified current neurology staffing (one half-time neurologist) as a barrier to compliance. NSH also reported that the facility intends to retrain auditors on changes in TD referral requirements to ensure valid and reliable data collection.

Other findings:
This monitor reviewed the charts of six individuals (BC, ETR, GSP, JMR, MWS and RJJ) who were currently diagnosed with Tardive Dyskinesia as per the WRPs and/or the psychiatric progress notes. The facility has a database that identified 24 individuals as having current diagnosis of TD at the time of the tour. The facility's database did not identify individuals meeting the criteria of having a history of TD or current abnormal AIMS score.

This review found that the facility's practice was adequate in the following areas:

1. The completion of admission AIMS tests in all cases,
2. The use of safer antipsychotic treatment alternatives in a few individuals (JMR and MWS); and
3. Avoidance of unjustified long-term treatment with anticholinergic agents in all cases.

However, the review found a pattern of deficiencies as follows:

		1. The facility's database did not identify some individuals who were currently diagnosed with TD (e.g. BC). 2. The psychiatric progress notes did not include or address a current diagnosis of TD (MWS). The motor function as documented in the mental status examination of this individual was not assessed. 3. The psychiatric progress notes did not track the status of involuntary movements in an individual diagnosed with current TD as per the psychiatric note (e.g. BC). 4. There was no evidence that a neurology consultation was completed for several individuals who were diagnosed with TD (e.g. BC). 5. Some WRPs did not include a focus statement or objectives/ interventions to address current diagnosis of TD (MWS). 6. The WRP of GSP included TD-related objective (and interventions) that were not appropriate or attainable for the individual (e.g. requesting PRN medications to control the symptoms of TD). 7. The AIMS tests were not completed quarterly as required in all the charts reviewed. 8. One WRP (JMR) did not include a focus, objectives or interventions that address TD. **Compliance** Partial. **Current recommendations**: 1. Develop and implement systems to ensure accurate identification of all individuals with current diagnosis or history of TD 2. Ensure consistent implementation of recommendations made by the TD clinic 3. Ensure that the TD statement/policy/procedure addresses management strategies. 4. Monitor this requirement using the DMH Tardive Dyskinesia Monitoring Form based on at least a 100% sample and identify the target population for all indicators.

		5. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period. 6. Provide a summary outline of any improvements in practice made as a result of review by the facility of internal monitoring data.
F.1.f	Each State hospital shall ensure timely identification, reporting, data analyses, and follow up remedial action regarding all adverse drug reactions ("ADR").	**Current findings on previous recommendations:** **Recommendation 1, July 2008:** Present summary data to address the following: a. Number of ADRs reported during the review period compared with the number during the previous period; b. Classification of ADRs by outcome category compared with the number during the previous period c. Clinical information regarding each ADR that was classified as severe and the outcome to the individual involved; d. Information regarding any intensive case analysis done for each reaction that was classified as severe and for any other reaction. e. Outline of intensive case analysis including description of ADR, recommendations and actions taken. **Findings:** During this review period (June to November 2008), NSH reported 496 ADRs compared to 520 during the previous period (January to May 2008). The classification by outcome and probability showed that nine ADRs (2% of total) met criteria for severe reactions and 20 ADRs (4% of total) were rated as definite reactions using the probability scale. The facility did not provide comparative data for these indicators as requested. Of the nine severe ADRs, none resulted in permanent sequelae to the individual involved. The intensive case analyses involved the following:

		1. Levaquin-induced seizure resulting in hospitalization and consideration of alternate medications in the future; 2. Toxic lithium level caused by dehydration, renal insufficiency and possible rhabdomyolysis resulting in hospitalization and process changes related to timing of ICAs; 3. Ibuprofen-induced GI bleed in an individual with end-stage cirrhosis resulting in hospitalization and consideration of alternate medications in the future; 4. Glyburide/Metformin-induced hypoglycemia in anorexic individual refusing glucose monitoring resulting in hospitalization and review/revision of process for holding diabetic medication for individuals not eating; 5. Metformin-induced lactic acidosis in a dehydrated elderly individual resulting in hospitalization and staff training; 6. Depakote-induced high ammonia causing altered mental status resulting in hospitalization, dose reduction and increased laboratory monitoring; 7. Clozaril-induced moderate granulocytopenia resulting in hospitalization and consideration of process change toward electronic access to laboratory data;and 8. Benazepril-induced hypotensive episode resulting in increased monitoring of the individual's fluid intake. The facility's ICAs employed adequate methodology. **Recommendation 2, July 2008:** Provide analysis of patterns and trends, with corrective/educational actions related to ADRs. **Findings:** NSH did not provide information related to this recommendation.

		Compliance: Partial. **Current recommendations**: 1. Present summary data to address the following: a. Number of ADRs reported during the review period compared with the number during the previous period; b. Classification of ADRs by outcome category compared with the number during the previous period, c. Clinical information regarding each ADR that was classified as severe and the outcome to the individual involved; d. Information regarding any intensive case analysis done for each reaction that was classified as severe and for any other reaction, e. Outline of intensive case analysis including description of ADR, recommendations and actions taken. 2. Provide analysis of patterns and trends, with corrective/educational actions related to ADRs.
F.1.g	Each State hospital shall ensure drug utilization evaluation ("DUE") occurs in accord with established, up-to-date medication guidelines that shall specify indications, contraindications, and screening and monitoring requirements for all psychotropic medications; the guidelines shall be in accord with current professional literature. A verifiably competent psychopharmacology consultant shall approve the guidelines and ensure adherence to the guidelines.	**Current findings on previous recommendations:** **Recommendation 1, July 2008:** Provide summary data on DUEs conducted during the review period, including topic, findings, recommendations and actions taken. **Findings:** During this review period, NSH conducted four DUEs. These DUEs involved a review of the association of new onset diabetes mellitus with prescription of atypical antipsychotics, NSH's utilization of benzodiazepines, NSH's utilization of anticholinergics and a follow-up DUE on prescription of ziprasidone. The DUEs were consistent with generally accepted standards.

		Recommendation 2, July 2008: Same as in F.1.a. **Findings:** Same as in F.1.a. **Compliance** Partial. **Current recommendation:** Provide summary data on DUEs conducted during the review period, including topic, findings, recommendations and actions taken.
F.1.h	Each State hospital shall ensure documentation, reporting, data analyses, and follow-up remedial action regarding actual and potential medication variances ("MVR") consistent with generally accepted professional standards of care.	**Current findings on previous recommendations:** **Recommendation 1, July 2008:** Implement the new data collection policy and procedure, tool and instructions regarding reporting of variances. **Findings:** NSH has implemented the new data collection tool. The facility reported that Medication Variance Reporting has been incorporated into nursing training. **Recommendation 2, July 2008:** Present data to address to address the following: a. Total number of actual and potential variances during the review period compared with numbers reported during the previous period; b. Number of variances by category (e.g. prescription, administration, documentation, etc) and by potential vs. actual; c. Clinical information regarding each variance (category E or above) and the outcome to the individual involved; d. Information regarding any intensive case analysis done for each

		reaction that was classified as category E or above and for any other reaction; and e. Outline of ICAs, including description of variance, recommendations and actions taken. **Findings:** Comparative analysis for this area was not possible as data collection during the previous review period was conducted using a different tool. NSH reported 1,917 MVRs between June 2008 and November 2008 but did not indicate the primary source for this data in the progress report. However, inconsistencies were noted upon examination of the data. For example, the sum of the incidents of Outcome A through Outcome I sums to 1,911 rather than 1,917. Additionally, the total number of MVRs in the key indicator report was 2,013 for the same period. Two variances reached category E or above. Both outcomes were coded as Category F. The medication variances resulted in each individual's transfer to an external medical hospital. Both returned to NSH within two days with no permanent sequelae. NSH completed 2 ICAs during this review period in relation to the 2 Category F MVRs. **Recommendation 3, July 2008:** Provide analysis of patterns and trends, with corrective/educational actions related to MVRs. **Findings:** NSH noted the following trends and implemented the corresponding actions: 1. According to the facility's progress report, over 90% of MVRs were due to missing initials on MARs. [This proportion conflicts,

		however, with key indicator data showing than 83% of MVRs were due to documentation errors.] The facility reported that it emphasizes the importance of this aspect during nursing trainings. Additionally, nightly chart audits were initiated to consistently identify missing initials. 2. NSH identified MVRs associated with long-acting medications administered by injection as an area of focus during this review period. A corrective action, requiring two signatures by licensed nursing staff for these administrations, was implemented. Additionally, the facility reported that P&T intends to complete a DUE on long-acting injectables within the next six months. **Compliance** Partial. **Current recommendations**: 1. Present data to address to address the following: a. Total number of actual and potential variances during the review period compared with numbers reported during the previous period, b. Number of variances by category (e.g. prescription, administration, documentation, etc) and by potential vs. actual, c. Clinical information regarding each variance (category E or above) and the outcome to the individual involved, d. Information regarding any intensive case analysis done for each reaction that was classified as category E or above and for any other reaction; and e. Outline of ICAs, including description of variance, recommendations and actions taken. 2. Ensure that the data presented is valid and reliable. 3. Provide analysis of patterns and trends, with corrective/ educational actions related to MVRs.

F.1.i	Each State hospital shall ensure tracking of individual and group practitioner trends, including data derived from monitoring of the use of PRNs, Stat medications, benzodiazepines, anticholinergics, and polypharmacy, and of ADRs, DUE, and MVR consistent with generally accepted professional standards of care.	**Current findings on previous recommendation:** **Recommendation, July 2008:** Same as in F.1.a through F.1.h. **Findings:** Same as in F.1.a through F.1.h. **Compliance:** Partial. **Current recommendations**: Same as in F.1.a through F.1.h.
F.1.j	Each State hospital shall ensure feedback to the practitioner and educational/corrective actions in response to identified trends consistent with generally accepted professional standards of care.	**Current findings on previous recommendation:** **Recommendation, July 2008:** Same as above. **Findings:** Same as above. **Compliance** Partial. **Current recommendations**: Same as above.
F.1.k	Each State hospital shall ensure integration of information derived from ADRs, DUE, MVR, and the Pharmacy & Therapeutics, Therapeutics Review, and Mortality and Morbidity Committees consistent with generally accepted professional	**Current findings on previous recommendation:** **Recommendation, July 2008:** Same as above.

	standards of care.	**Findings:** Same as above. **Compliance** Partial. **Current recommendations**: Same as above.
F.1.l	Each State hospital shall ensure that all physicians and clinicians are verifiably competent, consistent with generally accepted professional standards of care, in appropriate medication management, interdisciplinary team functioning, and the integration of behavioral and pharmacological treatments.	**Current findings on previous recommendation:** **Recommendation, July 2008:** Same as in D.1.b, D.1.c, D.1.f.viii and F.1.a through F.1.h. **Findings:** Same as in D.1.b, D.1.c, D.1.f.viii and F.1.a through F.1.h. **Compliance** Partial. **Current recommendations**: Same as in D.1.b, D.1.c, D.1.f.viii and F.1.a through F.1.h.
F.1.m	Each State hospital shall review and ensure the appropriateness and safety of the medication treatment, consistent with generally accepted professional standards of care, for:	**Compliance** Partial.
F.1.m.i	all individuals prescribed continuous anticholinergic treatment for more than two months;	**Current findings on previous recommendation:** **Recommendation, July 2008:** Same as in F.1.c.

		Findings: Same as in F.1.c. **Current recommendations**: Same as in F.1.c.
F.1.m.ii	all elderly individuals and individuals with cognitive disorders who are prescribed continuous anticholinergic treatment regardless of duration of treatment;	Same as in F.1.c.
F.1.m.iii	all individuals prescribed benzodiazepines as a scheduled modality for more than two months;	Same as in F.1.c.
F.1.m.iv	all individuals prescribed benzodiazepines with diagnoses of substance abuse or cognitive impairments, regardless of duration of treatment; and	Same as in F.1.c.
F.1.m.v	all individuals with a diagnosis or evidencing symptoms of tardive dyskinesia.	**Current findings on previous recommendation:** **Recommendation, July 2008:** Same as F.1.e. **Findings:** Same as F.1.e. **Current recommendations**: Same as F.1.e.
F.1.m.vi	all individuals diagnosed with dyslipidemia, and/or obesity, and/or diabetes mellitus who are prescribed new generation antipsychotic medications	**Current findings on previous recommendation:** **Recommendation, July 2008:** Same as in F.1.d. and F.1.g.

		Findings: Same as in F.1.d. and F.1.g. **Current recommendations**: Same as in F.1.d. and F.1.g.
F.1.n	Each State hospital shall ensure that the medication management of individuals with substance abuse disorders is provided consistent with generally accepted professional standards of care.	**Current findings on previous recommendation:** **Recommendation, July 2008:** Same as in C.2.o and F.1.c. **Findings:** Same as in C.2.o and F.1.c. **Compliance** Partial. **Current recommendations**: Same as in C.2.o and F.1.c.
F.1.o	Metropolitan State Hospital shall provide a minimum of 16 hours per year of instruction, through conferences, seminars, lectures and /or videotapes concerning psychopharmacology. Such instruction may be provided either onsite or through attendance at conferences elsewhere.	

2. Psychological Services		
	Each State hospital shall provide adequate and appropriate psychological supports and services that are derived from evidence-based practice or practice-based evidence and are consistent with generally accepted professional standards of care, to individuals who require such services; and:	**Methodology:** <u>Interviewed</u>: 1. Anne Hoff, PhD, Senior Supervising Psychologist 2. Carmen Caruso, Clinical Administrator 3. Cindy Black, Director, Standards and Compliance 4. Edna Mulgrew, PhD, Senior Supervising Psychologist, BCC 5. Jim Jones, PhD, Chief of Psychology 6. Kathleen Patterson, PhD, Senior Supervising Psychologist 7. Katie Cooper, PsyD, Enhancement Plan Coordinator <u>Reviewed</u>: 1. The charts of the following 39 individuals: AA, AS, BFL, BJB, BSC, CC, CD, CHH, DC, DCH, DFH, DH, DN, GA, GAR, GLF, GR, GS, GVA, JB, JHM, JM, JMU, JWM, KNZ, KT, LAC, MP, MR, MWP, PB, RDZ, RRW, RW, SFL, SPP, TR, VH, VLC, and VTD 2. Behavioral guidelines developed and implemented in the last six months 3. By Choice Individual Satisfaction Survey results 4. By Choice Training Documentation 5. DCAT database on facility-wide referrals 6. Functional assessments completed in the last six months 7. Graphical presentation of PBS Plan Baseline/Outcome data 8. List of individuals by primary/preferred language other than English 9. List of individuals referred for neuropsychological assessment 10. List of individuals utilizing higher than threshold level of S/R and/or psychiatric PRN/stat medication for maladaptive behaviors in the last six months 11. List of individuals who have a diagnosis of a disorder affecting cognitive functioning 12. PBS plans developed and/or revised during this review period

		13. Physicians Progress Notes showing discussion in relation to PBS plans 14. Psychology Specialty Services Committee meeting minutes 15. Staff certification and fidelity checks 16. Structural and Functional Assessment <u>Observed</u>: 1. Life Skills Mall Group 2. PSSC/ETRC meeting 3. Reality Orientation Mall Group 4. Relaxation Technique Mall Group 5. Shift Lead Meeting 6. Substance Abuse/Recovery Mall Group 7. WRPC for JF (unit T-4, Program 5) 8. WRPC for RJ (unit T-8, Program 1)
F.2.a	Each State hospital shall ensure that it has positive behavior support teams (with 1 team for each 300 individuals, consisting of 1 clinical psychologist, 1 registered nurse, 2 psychiatric technicians (1 of whom may be a behavior specialist), and 1 data analyst (who may be a behavior specialist) that have a demonstrated competence, consistent with generally accepted professional standards of care, in the following areas:	**Current findings on previous recommendations:** **Recommendation 1, July 2008:** Continue to recruit additional PBS team members until all PBS teams are fully staffed. **Findings:** Currently, NSH has four full PBS teams (all clinical staff members have been hired, a data analyst is yet to be recruited) and one DCAT. The current number of teams and the number of residents in the facility during this review period puts the team-to-individual ratio at the required 1:300 level. **Recommendation 2, July 2008:** Continue to train all PBS team members until they achieve competency.

		Findings: NSH has continued to train its PBS staff. Training has been ongoing through the facility's CRIPA consultant and its psychology consultant, Angela Adkins. This monitor's interview with the PBS and DCAT staff found that they had a good working knowledge and understanding of the PBS system. The PBS teams have improved in their functional analysis format, methods, and data collection system. However, there are deficits in the area of graphing, analyzing and interpreting the data, including: 1. Graphs are not labeled to be stand-alone documents; 2. No discussion or analysis is found on the course and cycle of the behaviors to better understand the setting events and/or establish operations of the target behaviors; and 3. There is no baseline data on replacement behaviors. A number of PBS plans are weak in certain areas: 1. Events effecting significant changes in behaviors are not labeled on all graphs (good examples of such notation can be found in AA, DH and GR); 2. Prevention strategies are too generic and do not specifically target the identified antecedents, setting events, and/or triggers; 3. Replacement behaviors are not part of the prevention and/or the intervention strategies; 4. Most interventions use reactive and management strategies and do not include active treatments (for example, one of the causes for JB's target behavior is stated as, " He has not developed more mature and adequate coping skills," but nowhere in the prevention and intervention sections is there any provision for the learning and the practice of the specific coping skills; and 5. When addressing multiple target behaviors, the preventions and

		intervention strategies often were not linked to the target behaviors. **Compliance:** Partial. **Current recommendations:** 1. Continue to recruit additional PBS team members until all PBS teams are fully staffed. 2. Continue to train all PBS team members until they achieve competency.
F.2.a.i	the development and use of positive behavior support plans, including methods of monitoring program interventions and the effectiveness of the interventions, providing staff training regarding program implementation, and, as appropriate, revising or terminating the program; and	**Current findings on previous recommendations:** **Recommendations 1 and 2, July 2008:** • Continue with training and certification of staff responsible for implementing the PBS plans. • Provide documentation that staff in all treatment settings have been trained to competency on all PBS plans. Continue to conduct fidelity checks prior to implementation of PBS plans. **Findings:** Interview of the Chief of Psychology and documentation review on staff training revealed that the PBS and DCAT trained a total of 481 staff from many disciplines (for example, RN, OA, PT, MD, PhD, SW, RT, PTA, and Janitors) responsible for implementing behavioral intervention plans on 17 units in the facility. The PBS/DCAT members also trained 20 Mall services staff. NSH continues to conduct fidelity checks both before and after implementation of PBS plans. **Recommendation 3, July 2008:** Ensure that outcome data is updated in the Present Status section of the case formulation and the PBS plan is identified in the intervention

		section of the WRP. **Findings:** According to the Chief of Psychology and the PBS team members, the PSSC Coordinator met with the Senior Program Psychologists and WRPT psychologists to review the steps/process involved in attaining compliance with this requirement. According to the Chief of Psychology, the Senior Psychologists attended training with the WRP trainer on the psychologist's role in the WRP and the inclusion of PBS and Behavior Guidelines in the WRP. The WRP psychologists then worked with their WRPTs to revise their WRPCs to address this requirement. This monitor reviewed charts of nine individuals with PBS plans (AA, DC, DCH, GVA, JMU, MP, MR, RRW and TR). All nine plans were discussed in the present status section of the case formulation section of the individuals' WRPs, and eight of the plans were identified in the interventions sections of the individuals' WRPs. **Compliance:** Substantial. **Current recommendations**: 1. Continue with training and certification of staff responsible for implementing the PBS plans. 2. Provide documentation that staff in all treatment settings have been trained to competency on all PBS plans. Continue to conduct fidelity checks prior to implementation of PBS plans. 3. Ensure that outcome data is updated in the present status section of the case formulation and the PBS plan is identified in the interventions section of the WRP.

F.2.a.ii	the development and implementation of a facility-wide behavioral incentive system, referred to as "By Choice" that encompasses self-determination and choice by the individuals served.	**Current findings on previous recommendations:** **Recommendation 1, July 2008:** Continue to monitor the implementation of the By Choice program to ensure that the program is being implemented as required by the DMH WRP Manual. **Findings:** According to the By Choice coordinator, NSH has continued to monitor By Choice competency fidelity data on a monthly basis since the last review period. NSH has trained all 180 newly hired staff during this review period on the By Choice incentive system. NSH conducts quarterly monitoring to assess Fidelity of Implementation by the By Choice staff. NSH reported the data obtained from the monitoring of the last two quarters during this review period (June to November 2008). The table below showing the number of By Choice staff (N), the number of By Choice staff audited (n), and the mean percent compliance (%C) obtained in each quarter is a summary of the facility's data. Fidelity of Implementation by By Choice Staff | | Jun-Aug | Sep-Nov | | N | 8 | 8 | | n | 8 | 8 | | %S | 100% | 100% | | %C | 90% | 95% | The data in the table above show that the By Choice staff know their duties and perform those duties (manage the incentive store, keep the inventory, run the database, etc) with a high degree of fidelity. Using questions 1-10 from the Fidelity of Implementation by Direct

Care Staff Competency and Fidelity Staff Monitoring Form, NSH monitored a sample of 11% of the Level of Care staff for each month of this review period (June to November 2008), reporting an overall mean compliance rate of 78%. The table below is a summary of the mean compliance obtained for each item on the monitoring items:

1.	*Staff correctly states the current point cycle.*	69%
2.	*Staff correctly states the procedure for assigning participation levels on point cards.*	69%
3.	*Staff correctly states the criteria for assigning FP, MP and NP for the current cycle.*	52%
4.	*Staff correctly assigns a participation level and marks an individual's card per the By Choice Manual.*	90%
5.	*Staff can locate a current By Choice Manual in their worksite.*	87%
6.	*Staff correctly states the difference between "baseline" point card and a reallocated point card.*	79%
7.	*Staff correctly states where the point reallocation documentation is located.*	81%
8.	*Staff can locate a current BY COICE Manual in their work site.*	86%
9.	*There is a system to orient new individuals to the By Choice Incentive Program.*	78%
10.	*Staff are able to state their unit's incentive store hours of operation.*	48%

In the table above, it is interesting to note that only 69% of the respondents correctly stated the procedure for assigning points(item 2), and 52% of the respondents correctly stated the criteria for assigning points (item 3), and yet 90% of the respondents were able to correctly assign the points per the individual's participation (item 4).

To increase compliance, NSH plans to continue with the current

training and mentoring procedures to improve staff practice in correctly implementing the program.

Using items 1-8 from the Fidelity of Implementation by Individuals Form, NSH monitored a sample of 11% of the individuals in the facility for each month of this review period (June to November 2008), reporting an overall mean compliance of 66%. The table below is a summary of the mean compliance obtained for each item on the monitoring items:

1.	*The individual is holding his/her own point card.*	69%
2.	*The individual states, to the best of his/her ability, how points are earned.*	85%
3.	*The individual states, to the best of his/her ability, how points are spent.*	83%
4.	*The individual states, to the best of his/her ability, the expectations for earning FP, MP, or NP for the current cycle.*	25%
5.	*The individual states, to the best of his/her ability, the possible number of points that may be earned each day.*	90%
6.	*The individual states, to the best of his/her ability, how the points are reallocated for his/her point card.*	53%
7.	*The individual states, to the best of his/her ability, the hours that their incentive store is open.*	78%
8.	*The individual can identify, to the best of his/her ability, the cycles of "high priority" on his/her point card.*	54%

As shown in item 4 in the table above, only 25% of the individuals correctly stated what levels of participation earn them the different point levels. It is important to remind individuals about their level of participation and the By Choice points associated with the level of

participation. This should be done regularly at the beginning of each Mall group, since many of the individuals may not have been at the session when this was announced, may not have been attentive, may not have been in a frame of mind to focus on what was said or may have joined the group later in the cycle. Furthermore, the nature of participation would differ according to the type of activity (for example, homework, role-play, lecture, or watching TV).

NSH conducts Individual Satisfaction Survey on a Quarterly basis. Using 21% of the sample of individuals residing in the facility, NSH assessed satisfaction of the individuals to the By Choice incentive system (June 2008, Quarterly Survey). The table below shows the results of the survey:

1.	*Is the point system helpful to you?*	93%
2.	*Do staff explain how you earn "FP," "MP" or "NP" for all your activities?*	76%
3.	*Do staff tell you if you earned an "FP," "MP" or "NP" for all your activities?*	67%
4.	*Are you satisfied with the number of points you can earn for each cycle or group?*	80%
5.	*Do you like what is offered in the incentive stores?*	94%
6.	*Do you hold on to your point card during the day?*	85%
7.	*Do you discuss how you want your points allocated when you meet with your team during your conferences?*	58%

It is of note that in item 7 of the table above, only 58% of the individuals reported being involved in their point allocation. WRPTs should ensure that the individual makes the final allocation of points with guidance and support of the WRPT.

Recommendation 2, July 2008:
Ensure that the program has additional resources, including computers and software necessary for the program to function efficiently.

Findings:
According to the By Choice Coordinator, the By Choice program has most of the resources needed for the program to function efficiently. The inventory control system needs to be automated, and that system is in development.

Recommendation 3, July 2008:
By Choice point allocation should be determined by the individual at the individual's WRPC, with facilitation by the staff, and documented in the Present Status section of the individual's WRP.

Findings:
Using item 16 from the DMH WRP Clinical Chart Auditing Form, NSH assessed its compliance based on an average sample of 3% of the census in the facility in each month (June to November 2008). The table below is a summary of the data:

16.	*The By Choice point allocation is updated monthly in the individual's Wellness and Recovery Plan.*	84%
16.a	*There is documentation that By Choice point allocation is updated monthly in the Present Status section of the case formulation in the individual's Wellness and Recovery Plan.*	84%
16.b	*There is documentation that the individual determines the point allocation.*	N/A

The lack of data for indicator 16.b was an oversight that the facility will rectify in the next review period.

		This monitor reviewed 14 charts (AA, BFL, BJB, BSC, CD, DH, GLF, GS, KNZ, LAC, SFL, TR, VH and VTD). Twelve of the WRPs in the charts (AA, BFL, BJB, BSC, CD, DH, DN, GS, KNZ, LAC, SFL and VTD) contained the individual's By Choice documentation in the Present Status section of the individual's WRP, and two of them (GLF and TR) did not have any documentation regarding By Choice. Documentation in a number of them (for example, CD, KNZ and SFL) was not comprehensive. Documentation for CD read, "He continues to use By Choice successfully;" documentation for KNZ read, "Participated and benefits in By Choice;" and documentation for SFL read, "Ms. L is happy with her current point allocation." Only two of the 14 WRPs (GS and LAC) indicated that the individual was involved in or determined the By Choice point allocation. **Compliance:** Partial. **Current recommendations**: 1. Continue to monitor the implementation of the By Choice program to ensure that the program is being implemented as required by the DMH WRP Manual. 2. Ensure that the program has additional resources, including computers and software necessary for the program to function efficiently. 3. By Choice point allocation should be determined by the individual at the individual's WRPC, with facilitation by the staff, and documented in the Present Status section of the individual's WRP.
F.2.b	Each State Hospital shall ensure that the Chief of Psychology has the clinical and administrative responsibility for the Positive Behavior Supports Team and the By CHOICE incentive program.	**Current findings on previous recommendation:** **Recommendation, July 2008:** Continue current practice.

		Findings: The Chief of Psychology at NSH continues to hold the clinical and administrative responsibility for the Positive Behavior Support Team and the By Choice incentive program. **Compliance:** Substantial. **Current recommendation:** Continue current practice.
F.2.c	Each State Hospital shall ensure that:	**Compliance:** Partial.
F.2.c.i	behavioral assessments include structural and functional assessments and, as necessary, functional analysis;	**Current findings on previous recommendation:** **Recommendation, July 2008:** Continue to use the WaRMSS, EIOR, and HSS logs, and PSSC to track and monitor individuals in need of behavioral interventions. **Findings:** This monitor's review of trigger data and interviews with the Chief of Psychology and the Compliance Director found that NSH is using the WaRMSS, EIOR, HSS logs, and the PSSC to track and monitor individuals in need of behavioral interventions. However, a good number of individuals meeting trigger thresholds were not picked up for behavioral assessments. In addition, this monitor found that in some cases (for example DN and RDZ) WRPTs failed to properly refer individuals with challenging behaviors for behavioral assessments. PBS teams in collaboration with WRPTs and other staff dealing with trigger data and assessments need to resolve the barriers to identifying and assessing individuals in need of behavioral interventions.

Using item 5 from the DMH Psychology Services Monitoring Form, NSH assessed its compliance based on an average sample of 100% of the PBS assessments completed during each month during the review period (June to November 2008). The table below is a summary of the data:

5.	*PBS assessments include structural and functional assessments, and as necessary, functional analysis*	100%
5.a	*Pertinent records were reviewed (e.g., individual's chart/record, meeting notes, anecdotal records, evaluations, previous interventions),*	100%
5.b	*Structural assessments (e.g., ecological, sleep, medication effects, mall attendance) were conducted, as needed, to determine broader variables affecting the individual's behavior,*	100%
5.c	*Functional assessment interviews were conducted with people (e.g., individual, parents and family members, therapists and care staff, teachers) who often interact with the individual within different settings and activities, as needed.*	100%
5.d	*Direct observations were conducted across relevant circumstances (e.g., multiple settings, over time) and by more than one observer, as appropriate,*	100%
5.e	*Other assessment tools (e.g., rating scales, checklists) were used to produce objective information regarding events preceding and following the behavior of concern, as well as ecological and motivational variables that may be affecting the individual's behavior, as needed, and*	100%
5.f	*If necessary, suspected maintaining variables were manipulated to assess the motivation(s) for the individual's behavior.*	n/a

		Comparative data showed improvement in compliance for item 5 from 75% in the prior review period. This monitor's findings from review of eight PBS plans and their associated structural and functional assessments (AS, DCH, DH, GR, JU, KT, TR, and VC) were in agreement with the facility's data. **Current recommendation**: Continue to use the WaRMSS, EIOR, and HSS logs, and PSSC to track and monitor individuals in need of behavioral interventions.
F.2.c.ii	hypotheses of the maladaptive behavior are based on structural and functional assessments;	**Current findings on previous recommendation:** **Recommendation, July 2008:** Ensure that hypotheses of maladaptive behavior are based on reliable data. **Findings:** Using item 6 from the DMH Psychology Services Monitoring Form, NSH assessed its compliance based on an average sample of 100% of the PBS assessments completed during each month (June to November 2008). The table below is a summary of the data: 6. *Hypotheses of the maladaptive behavior are based on structural and functional assessments* 100% 6.a *There is at least one written hypothesis of the functions of the behavior, and* 100% 6.b *The hypothesis is aligned with findings based on structural and/or functional assessments* 100% Comparative data showed improvement in compliance for item 6 from 56% in the prior review period.

<table>
<tr><td></td><td></td><td>This monitor reviewed eight PBS plans (AS, DCH, DH, GR, JU, KT, TR, and VC). The review found that all eight plans had structural and functional assessments conducted using appropriate methodologies. Those that were written included at least one hypothesis statement, and most of the hypotheses were fairly aligned with the findings from the structural and functional assessment data.

Current recommendation:
Ensure that hypotheses of maladaptive behavior are based on reliable data.</td></tr>
<tr><td>F.2.c.iii</td><td>There is documentation of previous behavioral interventions and their effects;</td><td>Current findings on previous recommendation:

Recommendation, July 2008:
Document previous behavioral interventions and their effects.

Findings:
Using item 7 from the DMH Psychology Services Monitoring Form, NSH assessed its compliance based on an average sample of 100% of the PBS assessments completed each month during the review period (June to November 2008). The table below is a summary of the data:

<table>
<tr><td>7.</td><td>There is documentation of previous behavioral interventions and their effects</td><td>100%</td></tr>
<tr><td>7.a</td><td>There is documentation of previous behavioral interventions, and</td><td>100%</td></tr>
<tr><td>7.b</td><td>The effects of these interventions.</td><td>100%</td></tr>
</table>

Comparative data showed improvement in compliance for item 6 from 80% in the prior review period.

This monitor reviewed eight structural and functional assessments (AS,</td></tr>
</table>

		DCH, DH, GR, JU, KT, TR, and VC). Contrary to NSH's data, only one (VC) of the eight structural and functional assessments documented the individual's previous behavioral interventions and the effects of the interventions. **Current recommendation**: Document previous behavioral interventions and their effects.
F.2.c.iv	behavioral interventions, which shall include positive behavior support plans, are based on a positive behavior supports model and do not include the use of aversive or punishment contingencies;	**Current findings on previous recommendation:** **Recommendation, July 2008:** Continue to conduct all behavioral interventions based on a positive behavior supports model without the use of aversive or punishment contingencies. **Findings:** Using item 8 from the DMH Psychology Services Monitoring Form, NSH assessed its compliance based on an average sample of 100% of the PBS plans and the Behavior Guidelines implemented each month during the review period (June to November 2008). The following is a summary of the data: 8. *Behavioral interventions, which shall include positive behavior support plans, are based on a positive behavior supports model and do not include the use of aversive or punishment contingencies* — 100% Comparative data showed maintenance of compliance at 100% since the last review period. This monitor's findings from review of a number of PBS plans and behavior guidelines (DCH, DFH, GA, GAR, JWM, KT, MR, MR, MWP, PB, RRW, VH, VH and VLC) are in agreement with the facility's data. All

<table>
<tr><td></td><td></td><td>behavioral interventions were modeled using positive strategies, and did not include the use of aversive or punishment contingencies.

Current recommendation:
Continue to conduct all behavioral interventions based on a positive behavior supports model without the use of aversive or punishment contingencies.</td></tr>
<tr><td>F.2.c.v</td><td>behavioral interventions are consistently implemented across all settings, including school settings;</td><td>Current findings on previous recommendation:

Recommendation, July 2008:
Continue to implement all behavioral interventions consistently across all settings, including Mall, vocational and education settings.

Findings:
Using item 9 from the DMH Psychology Services Monitoring Form, NSH assessed its compliance based on an average sample of 100% of the PBS plans and the Behavior Guidelines implemented each month during the review period (June to November 2008). The following is a summary of the data:

<table>
<tr><td>9.</td><td>Behavioral interventions are consistently implemented across all settings, including school settings.</td><td>100%</td></tr>
</table>

Comparative data showed maintenance of compliance at 100% since the last review period.

As the the table above shows, NSH reported that the behavior intervention plans were consistently implemented across settings. Most of the plans were implemented in the individual's unit.

Current recommendation:
Continue to implement all behavioral interventions consistently across</td></tr>
</table>

		all settings, including Mall, vocational and education settings.
F.2.c.vi	triggers for instituting individualized behavioral interventions are specified and utilized, and that these triggers include excessive use of seclusion, restraint, or psychiatric PRN and Stat medication for behavior control;	**Current findings on previous recommendation:** **Recommendation, July 2008:** Document and present data to show that the system of using trigger data to initiate a Behavior Guideline or obtain PBS consultation is functioning as intended. **Findings:** Using item 10 from the DMH Psychology Services Monitoring Form, NSH assessed its compliance based on an average sample of 13% of the individuals who triggered one or more of the thresholds for seclusion, restraint, or psychiatric PRN and Stat medication for behavior control (June to November 2008). The table below is a summary of the data: 10. *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* 10.a *A referral has been made to the Coordinator of Psychology Specialist Services, and* 31% 10.b *Appropriate assessment and/or interventions have been initiated* 17% As the table above shows, the Psychology Department is not adequately tracking and/or addressing the needs of all the individuals who meet trigger threshold. The Chief of Psychology and the PBS team members interviewed by this monitor indicated that there is failure by the WRPTs and/or the team psychologists to make appropriate and timely referrals when individuals meet trigger thresholds.

		WRPTs should heed the status of an individual's challenging behaviors, and address these behaviors through specific foci aligned with appropriate objectives and interventions, as well as make appropriate referrals for a behavioral assessment. A number of individuals (for example, DN and RDZ) were dismissed by the WRPTs as not needing PBS plans or Behavior Guidelines even though the notes in the Present Status section contradict the decision. For example, the documentation for DN under Behavioral Guidelines/PBS Plan stated, "No behavioral guidelines/PBS plan at this time. Mr. N's assaultive behaviors, if present, tend to be impulsive rather than instrumental." However, other statements contradict this assertion. For example, under the Functional Section, statements indicated that DN "needs several prompts to take shower that leads to argument and verbal abuse towards staff," and documentation under the Barriers to Discharge section stated that DN "can be verbally and physically aggressive when he does not get what he wants, his intrusiveness and altercations with peers has increased." DN exhibits significant challenging behaviors and the situations and settings in which the behaviors are exhibited are not convincingly all "impulsive." DN could benefit from replacement skills and learning alternate ways to obtain attention, and the staff could use techniques to deal with DN's behaviors in systematic and consistent ways. To improve compliance, NSH has established a Program Review Committee for each of the five programs in the facility. These committees are to review individuals with challenging behaviors as well as those who meet trigger thresholds and ensure that referrals are made when warranted. NSH now has integrated the Enhanced Trigger Review Committee (ETRC) and the Psychology Specialty Service Committee (PSSC) meetings. The combined meeting is expected to improve the tracking of and services to the individuals who meet trigger thresholds, exhibit challenging behaviors and require support.

		Current recommendation: Document and present data to show that the system of using trigger data to initiate a Behavior Guideline or obtain PBS consultation is functioning as intended.
F.2.c.vii	positive behavior support teams and team psychologists integrate their therapies with other treatment modalities, including drug therapy;	**Current findings on previous recommendation:** **Recommendation, July 2008:** Continue with current efforts to integrate all behavioral interventions with other treatment modalities, including drug therapy. **Findings:** Using item 11 from the DMH Psychology Services Monitoring Form, NSH assessed its compliance based on an average sample of 100% of the PBS plans implemented for each month of this review period (June to November 2008). The following is a summary of the data: 11. *Positive Behavior Support teams and team psychologists integrate their therapies with other treatment modalities, including drug therapy.* 100% Comparative data showed maintenance of mean compliance at 100% from the prior review period. This monitor's findings from review of Psychology and Psychiatry notes (JWM, KT, PB, VH and VLC) are in agreement with the facility's data. Psychologists at NSH now routinely meet and engage with members of other disciplines to obtain relevant data to determine the functions of an individual's challenging behaviors, and to develop an integrated intervention plan. Particularly, two cases (JWM and VLC) drew this monitor's attention. VLC's team had done an excellent job of pursuing the leads to solve problems, engaging the WRPT in developing and implementing the plan, and working as a team to reduce barriers to plan

		implementation. A number of progress notes and e-mails between the PBS team and dietician on JWM showed good collaboration to address JWM's reinforcer (food as snack). **Current recommendation**: Continue with current efforts to integrate all behavioral interventions with other treatment modalities, including drug therapy.
F.2.c.viii	all positive behavior support plans are specified in the objectives and interventions sections of the individual's Wellness and Recovery Plan;	**Current findings on previous recommendation:** **Recommendation, July 2008:** Specify PBS plans in the objectives and interventions sections of the individual's WRP Plan as outlined in the DMH PBS Manual. **Findings:** Using item 12 from the DMH Psychology Services Monitoring Form, NSH assessed its compliance based on an average sample of 100% of the PBS plans and Behavior Guidelines implemented for each month of this review period (June to November 2008). The table below is a summary of the data:

12.	*All positive behavior support plans are specified in the objectives and interventions sections of the individual's Wellness and Recovery Plan*	70%
12.a	*There is an objective in the WRP that specifies in behavioral, observable and/or measurable terms that the individual will learn alternative ways of behaving, and*	70%
12.b	*There are at least two interventions in the WRP aligned with the objective, one of which is an active treatment and refers to a Behavior Guideline or PBS plan and the other is a reference to the implementation of the Behavior Guideline or PBS*	65%

		plan in the therapeutic milieu. There is no comparative data. NSH did not present data for previous reviews in the same format. This monitor's review of five WRPs of individuals with PBS/behavior guidelines developed and implemented during this review period (CC, LAC, SFL, TR and VH) found that four of the five WRPs (CC, LAC, SFL and VH) contained documentation of the behavioral intervention in the objectives and interventions sections of the individual's WRP. To improve compliance, the PSSC Coordinator will meet with Program Seniors and PBS Team Leaders to train on new PBS and PSSC databases used to tracking these requirements. Furthermore, Program Seniors are to provide direction to WRPT psychologists on including the PBS plans in the objectives and interventions sections of individuals' WRP plans. **Current recommendation**: Specify PBS plans in the objectives and interventions sections of the individuals WRP Plan as outlined in the DMH PBS Manual.
F.2.c.ix	all positive behavior support plans are updated as indicated by outcome data and reported at least quarterly in the Present Status section of the case formulation in the individual's Wellness and Recovery Plan	**Current findings on previous recommendation:** **Recommendation, July 2008:** Update all PBS plans as indicated by outcome data and document it at every scheduled WRPC in the Present Status section of the individual's case formulation. **Findings:** Using item 13 from the DMH Psychology Services Monitoring Form, NSH assessed its compliance based on an average sample of 100% of the PBS plans and Behavior Guidelines implemented for each month of

<table>
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<td>this review period (June to November 2008). The table below is a summary of the data:
<table>
<tr><td>13.</td><td>All positive behavior support plans are updated as indicated by outcome data and reported at least quarterly in the Present Status section of the case formulation in the individual's Wellness and Recovery Plan</td><td>73%</td></tr>
<tr><td>13.a</td><td>There are quantitative outcome data for the plan</td><td>73%</td></tr>
<tr><td>13.b</td><td>The outcome data are documented monthly in the Present Status section of the case formulation of the individual's WRP, and</td><td>73%</td></tr>
<tr><td>13.c</td><td>The Behavior Guidelines and PBS plans are updated, as indicated by the outcome data</td><td>73%</td></tr>
</table>
Comparative data showed a modest increase in mean compliance from 67% in the prior review period.

This monitor reviewed five WRPs of individual's with PBS plans/ behavior guidelines (CC, LAC, SFL, TR and VH). Outcome data and discussion were found in all five.

To increase compliance, NSH will instruct the Program Seniors to work with the WRPT psychologists to ensure that the PBS outcome data information is included in the individual's WRP.

Current recommendation:
Update all PBS plans as indicated by outcome data and document it at every scheduled WRPC in the Present Status section of the individual's case formulation.</td>
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<tr>
<td>F.2.c.x</td>
<td>all staff has received competency-based training on implementing the specific</td>
<td>Current findings on previous recommendations:</td>
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	behavioral interventions for which they are responsible, and performance improvement measures are in place for monitoring the implementation of such interventions.	**Recommendation 1, July 2008:** Continue current practice. **Findings:** Using item 14 from the DMH Psychology Services Monitoring Form, NSH assessed its compliance based on an average sample of 100% of the PBS plans developed and implemented for each month of this review period (June to November 2008). The table below is a summary of the data:

14.	*All staff has received competency-based training on implementing the specific behavioral interventions for which they are responsible, and performance improvement measures are in place for monitoring the implementation of such interventions.*	100%
14.a	*There is a list of certified staff trained to implement the PBS plan,*	100%
14.b	*There is a training database with details of the training and competency scores for the certified staff,*	100%
14.c	*Staff not reaching competency standards have been retrained until competency is reached before they implement the PBS plan, and*	100%
14.d	*There is monthly fidelity of implementation or behavioral rehearsal data on each PBS plan.*	100%

This monitor's review of the staff training and fidelity data (AS, DC, DH, GR, JB, JM, KT, MP, PB and RW) found that all staff responsible for implementing these PBS plans were trained and certified by the PBS team members. The monitor's findings are in agreement with the facility's data.

		Current recommendation: Continue current practice.
F.2.c.xi	all positive behavior support team members shall have as their primary responsibility the provision of behavioral interventions;	**Current findings on previous recommendation:** **Recommendation, July 2008:** Maintain current service provision. **Findings:** The PBS team members at NSH continue to have as their primary responsibility the provision of behavioral services. The PBS teams also facilitate one PSR Mall group per week. According to the Chief of Psychology, PBS team members are assigned to their usual PBS duties when required to do mandatory overtime. **Compliance:** Substantial. **Current recommendation**: Maintain current service provision.
F.2.c.xii	the By CHOICE point allocation is updated monthly in the individual's Wellness and Recovery Plan.	**Current findings on previous recommendation:** **Recommendation, July 2008:** Ensure that By Choice point allocation is updated monthly in the individual's WRP. **Findings:** Using item 16 from the DMH WRP Clinical Chart Auditing Form, NSH assessed its compliance based on an average sample of 3% of the census for the month (June to November 2008). The following is a summary of the data:

		16. *The By Choice point allocation is updated monthly in the individual's Wellness and Recovery Plan* — 84% NSH needs to increase its sample size. Comparative data showed progress in compliance since the last review as follows: Previous period / Current period Mean compliance rate 16. 40% / 84% Compliance rate in last month of period 16. 52% / 100% This monitor reviewed nine charts (CHH, DN, GAR, JHM, JWM, LAC, RDZ, SPP and TR). Six of the WRPs in the charts (DN, JHM, LAC, RDZ, SPP and TR) had updated the individual's By Choice point allocation in the Present Status section of the individual's WRP. The remaining three (CHH, GAR and JWM) did not fulfill this requirement. **Current recommendation**: Ensure that By Choice point allocation is updated monthly in the individual's WRP.
F.2.d	Each State hospital shall ensure that it has at least one developmental and cognitive abilities team (DCAT; consisting of 1 clinical psychologist, 1 registered nurse, 1 social worker, 1 psychiatric technician, and 1 data analyst (who may be a behavior specialist) who have a demonstrated competence, consistent with generally accepted professional standards of care, in assessing	**Current findings on previous recommendation:** **Recommendation, July 2008:** Continue current practice. **Finding:** NSH has a DCAT. The DCAT has continued to receive training on PBS and related topics. Training has been provided by facility consultant

	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.	Angela Adkins via teleconference in June, July, September, October, and November 2008. The DCAT continues to provide cognitive assessments as well as PSR Mall services. **Compliance:** Substantial. **Current recommendation**: Continue current practice.
F.2.e	Each State Hospital shall develop and implement a Behavioral Consultation Committee (BCC), chaired by the Chief of Psychology, and co-chaired by the Chief of Psychiatry, to review the Wellness and Recovery Plan and maladaptive behavior(s) of the individuals who have not made timely progress on positive behavior support plans. The Chief of Psychology is responsible for the functions of this committee, together with members of the positive behavior support team (in functions of the committee that relate to individuals under the care of those team members). The committee membership shall include all clinical discipline heads, including the medical director, as well as the clinical administrator of the facility.	**Current findings on previous recommendation:** **Recommendation, July 2008:** Continue current practice. **Findings:** As of August 1, 2008, NSH has revamped its structure of this process and replaced the Behavioral Consultation Committee (BCC) with the Psychological Specialty Services Committee (PSSC). This monitor's interview of staff and review of the PSSC meeting minutes found that the PSSC has been meeting regularly since its inception. The membership as outlined in SO 262 has generally been in attendance at these meetings. The meeting minutes showed that individuals with severe challenging behaviors were reviewed at the meetings and action taken and followed up on during subsequent meetings. NSH has also established a database to track and follow up on the cases that were reviewed at the PSSC meetings. **Compliance:** Substantial.

		Current recommendation: Continue current practice.
F.2.f	Each State Hospital shall ensure that it has sufficient neuropsychological services for the provision of adequate neuropsychological assessment of individuals with persistent mental illness.	**Current findings on previous recommendations:** **Recommendations 1 and 2, July 2008:** • Ensure that neuropsychologists provide cognitive remediation and cognitive retraining groups in the PSR Mall. • Increase the number of neuropsychologists to meet the demand for neuropsychological services. **Findings:** The neuropsychology service at NSH currently is not running any cognitive remediation and cognitive retraining groups in the PSR Malls due to shortage of staffing. NSH currently has one neuropsychologist. This has affected the assessments and services that neuropsychologists are required to perform. The facility is in need of at least four neuropsychologists to provide adequate assessment and services in a timely manner to all the individuals in the facility. According to the Chief of Psychology, he has interviewed and selected three neuropsychologists, but he is unable to hire them at this time due to funding restrictions. This has rendered the facility unable to provide needed/required services. The table below shows the number of referrals for neuropsychological assessments due for completion in each of the review months, the number of neuropsychological assessments completed in each of the review months, and the average time (in months) taken to complete the referrals.

		Jun	Jul	Aug	Sep	Oct	Nov	Mean
18.a.i	*Number of neuro-psychological*	11	11	14	14	11	13	12

		assessments due for completion in the review month							
		18.a.ii	*Of those in 18.a.i, number completed*	2	0	3	2	2	2	2
		18.a.iii	*Average time taken from referral to completion for all neuropsychological assessments during the current evaluation period*						9 months	

As the table above shows, the sole neuropsychologist is unable to complete the neuropsychology assessment requests in a timely manner. The average time taken from referral to completion of the assessments was nine months, and the expected time for completion is one month. A review of the neuropsychology referral waiting list found that there were nine referrals on the waiting list, and one of the referrals has been on the wait list for six months.

Compliance:
Partial.

Current recommendations:
1. Ensure that neuropsychologists provide cognitive remediation and cognitive retraining groups in the PSR Mall.
2. Increase the number of neuropsychologists to meet the demand for neuropsychological services.

F.2.g	All clinical psychologists with privileges at any State Hospital shall have the authority to write orders for the implementation of positive behavior support plans, consultation for educational or other testing, and positive behavior support plan updates.	**Current findings on previous recommendation:** **Recommendation, July 2008:** Continue current practice. **Findings:** NSH has fully implemented this recommendation. A number of physician's progress notes review by this monitor (DCH, DFH, GA, GAR,

		JWM, KT, MR, MWP, PB, RRW, VH and VLC) contained documentation indicating that the PBS team members are writing orders for PBS plan implementation. **Compliance:** Substantial. **Current recommendation**: Continue current practice

3. Nursing Services		
	Each State hospital shall provide adequate and appropriate nursing care and services consistent with generally accepted professional standards of care to individuals who require such services.	**Methodology:** Interviewed: 1. Artheria C. Morrell, RN, Nursing Coordinator, Program IV 2. Carmen Caruso, Clinical Administrator 3. Catherine Mangapot, RN 4. Charlene Paulson, RN, BSN, Assistant Coordinator of Nursing Services 5. David Schmite, RN, Acting Program Assistant, Program IV 6. [redacted], RN, MBA, EdD, Executive Director 7. Elizabeth Clark, Program Director, Program IV 8. George Watanabe, Training Officer III 9. Jean S. Unajan, RN 10. June Grover, RN, BSN, Nursing Coordinator, Program V 11. Lily Franco, RN, Health Services Supervisor 12. Linda Goodwin, Acting Nurse Administrator 13. Michael D. Stolp, Program Director, Program V 14. Michelle Patterson, Health Services Supervisor 15. Natalie Allen, RN, Psychiatric Nursing Education Director 16. Pat Young, Headquarters 17. Simy Suresh Antony, RN 18. Socorro Soberano-Bausanta, RN 19. Steve Weule, RN Supervisor 20. T.C. Hulsey, Interim Program Director, Program II 21. Valerie Perkins, PT, Nursing Coordinator, Program II Reviewed: 1. NSH's progress report and data 2. Nursing Policy and Procedures: Provision of Nursing Care to Individuals with a Medical Condition; Registered Nurse and Physician Communication About Physical Status Change; Transfer to and Return from Another Facility or Acute Medical Unit (A3) for Evaluation and/or Medical Surgical Treatment;

		3. DMH RN Change in Physical Status Note form 4. DMH Nursing Transfer Note form 5. Sick Call/Referral Log form 6. PRN/Stat Note form 7. Draft Nursing policies: Change of Shift Report/Hand-Off Communication; Registered Nurse Progress Note for Assessment and Evaluation; Nursing Weekly Progress Note; Nursing Staff Assignments for Individual Care 8. Training rosters for new employees 9. Training rosters for NP 113, Care of the Individual in Bed-Bound Status 10. Current MTRs and Control Sheets for Units A1, A3, A8 and A10, 10. Medical records for the following 50 individuals: AG, AJM, AM, AS, ATA, AZ, BJB, BJC, BSC, CCS, CHH, CW, DC, DHH, DJS, DLP, DP, DS, DWW, EAL, EH, ELH, ERD, ERM, EV, GFL, JDK, JEB, JHM, JJB, JWS, KC, LG, LMK, MAW, MET, MQT, MTH, NJ, PN, RDZ, RH, RRW, RT, SRP, SSP, TJM, TKK, VH and WRB <u>Observed</u>: 1. 8 a.m. medication administration on Units T2 and T3 2. Two WRPCs (Program II, Unit Q11 and Program III, Unit T2) 3. Shift report on Unit T11, Program III
F.3.a	Each State hospital shall develop and implement policies and protocols regarding the administration of medication, including pro re nata ("PRN") and "Stat" medication (i.e., emergency use of psychoactive medication), consistent with generally accepted professional standards of care, to ensure:	**Compliance:** Partial.
F.3.a.i	safe administration of PRN medications and Stat medications;	**Current findings on previous recommendation:**

Recommendation, July 2008:
Continue to monitor this requirement.

Findings:
Data from the DMH Nursing Services Monitoring PRN audit, based on an average sample of 22% of PRNs administered each month (June-November 2008), indicated the following:

1.	*Safe administration of PRN medications*	47%
1.a	*PRN medication was administered based on a complete physician's order.*	57%
1.c	*The nurse administered correct medication, dose, form, and route, on the correct date, and for correct indication to the correct individual.*	83%

Although the compliance rates remain low for most items, there has been an increase in compliance for all the items and sub-items:

	Previous period	Current period
Mean compliance rate		
1.	9%	47%
Compliance rate in last month of period		
1.	8%	53%
1.a	34%	61%
1.c	85%	86%

Data from the DMH Nursing Services Monitoring Stat audit, based on an average sample of 24% of Stats administered each month (June-November 2008), indicated the following:

1.	*Safe administration of Stat medications*	55%

1a.	*Stat medication was administered based on a complete physician's order.*	46%
1c.	*The nurse administered correct medication, dose, form, and route, on the correct date, and for correct indication to the correct individual.*	90%

Again, although the compliance rates remain low for most items, there has been an increase in compliance for all the items and sub-items:

	Previous period	Current period
Mean compliance rate		
1.	13%	55%
Compliance rate in last month of period		
1.	7%	61%
1.a	43%	55%
1.c	85%	90%

NSH identified as a barrier to compliance the fact that the physicians were not writing PRN or Stat orders that included specific behaviors. The facility is now reviewing data by Program to determine areas that are in need of focused training to address compliance issues. Also, the Acting Medical Director is now reviewing copies of incomplete orders monthly at the Psychiatric Key Indicator meeting and the Chief Psychiatrist addresses this with the physicians.

In January 2009, the Pharmacy and Therapeutic Committee submitted a proposal to the Medical Executive Committee recommending that the pharmacy could decline to validate orders written for generic PRNs. Also, in February 2009 the unit Clinical Oversight Nurse (CON) and/or unit Health Services Specialist (HSS) began a daily review of PRN and Stat medications given to ensure that the required documentation is present. Audit findings will be given to the Unit Supervisors and the Nursing

		Coordinators will discuss the compliance data and improvement plans weekly. In addition, review of PRN and STAT medication documentation will be included in the nightly audit. A review of 120 PRNs and/or Stat medications orders for 36 individuals (AG, AJM, AS, ATA, AZ, BJB, BJC, BSC, CCS, DHH, DLP, DP, DS, DWW, EAL, ELH, ERD, ERM, EV, GFL, JDK, JEB, JJB, LG, LMK, MAW, MET, MQT, MTH, PN, RRW, RT, SRP, TKK, VH and WRB) found that 48 did not identify specific individual behaviors. In addition, 81 incidents recorded in the IDNs did not include all the appropriate documentation requirements; the correct notation of Stat or PRN, the name of the medication administered, the dosage administered, the route given, the exact time given, or no IDN was found documenting that the PRN or Stat medication was given. **Current recommendation**: Continue to monitor this requirement.
F.3.a.ii	documentation of the circumstances requiring PRN and Stat administration of medications;	**Current findings on previous recommendations:** **Recommendations 1 and 2, July 2008:** • Provide required information in progress report. • Continue to monitor this requirement. **Findings:** Compliance data from the DMH Nursing Services Monitoring PRN audit, based on an average sample of 22% of PRNs administered each month (June-November 2008), indicated the following: 2. *Documentation of all the circumstances requiring PRN administration of medication.* 39% 2.b *In the IDN, there is a comprehensive assessment of the individual prior to the PRN medication.* 39%

NSH's data showed a moderate increase in compliance:

	Previous period	Current period
Mean compliance rate		
2.	28%	39%
Compliance rate in last month of period		
2.	30%	57%
2.b	30%	57%

See F.3.a.i for NSH's actions to improve compliance.

A review of 70 incidents of PRN medications for 36 individuals (AG, AJM, AS, ATA, AZ, BJB, BJC, BSC, CCS, DHH, DLP, DP, DS, DWW, EAL, ELH, ERD, ERM, EV, GFL, JDK, JEB, JJB, LG, LMK, MAW, MET, MQT, MTH, PN, RRW, RT, SRP, TKK, VH and WRB) found that 26 incidents included adequate documentation of the circumstances requiring the PRN in the IDNs.

Compliance data from the DMH Nursing Services Monitoring Stat audit, based on an average sample of 24% of Stats administered each month (June-November 2008), indicated the following:

2.	*Documentation of all the circumstances requiring Stat administration of medication.*	43%
2.b	*In the IDN, there is a comprehensive assessment of the individual prior to the Stat medication.*	43%

The facility's data showed a slight increase in compliance:

	Previous period	Current period
Mean compliance rate		
2.	40%	43%
Compliance rate in last month of period		
2.	44%	48%
2.b	44%	48%

See F.3.a.i for NSH's actions to improve compliance.

A review of 50 incidents of Stat medications for 16 individuals (AJM, ATA, AZ, BJB, BSC, DLP, DP, ELH, JDK, JJB, LMK, MAW, MQT, SRP, TKK and WRB) found that 23 incidents included adequate documentation of the circumstances requiring the Stat medication in the IDNs.

Current recommendation:
Continue to monitor this requirement.

F.3.a.iii

documentation of the individual's response to PRN and Stat medication.

Current findings on previous recommendation:

Recommendation, July 2008:
See F.3.a.ii.

Findings:
Compliance data from the DMH Nursing Services Monitoring PRN audit, based on an average sample of 22% of PRNs administered each month (June-November 2008), indicated the following:

3.	*Documentation of the individual's response to PRN medications.*	51%
3.b.i.	*In the MTR, there is a brief description of the individual's response to the administered PRN*	53%

	medication which was documented within one hour of the administration.	
3.b.ii	*In the IDN, there is a comprehensive assessment of the individual's response to the administered PRN medication.*	90%

NSH's data showed a general increase in compliance:

	Previous period	Current period
Mean compliance rate		
3.	33%	51%
Compliance rate in last month of period		
3.	32%	64%
3.b.i	32%	68%
3.b.ii	91%	90%

See F.3.a.i for NSH's actions to improve compliance.

A review of 70 incidents of PRN medications for 36 individuals (AG, AJM, AS, ATA, AZ, BJB, BJC, BSC, CCS, DHH, DLP, DP, DS, DWW, EAL, ELH, ERD, ERM, EV, GFL, JDK, JEB, JJB, LG, LMK, MAW, MET, MQT, MTH, PN, RRW, RT, SRP, TKK, VH and WRB) found a comprehensive assessment in the IDNs of the individual's response to the PRN in 58 incidents.

Compliance data from the DMH Nursing Services Monitoring Stat audit, based on an average sample of 24% of Stats administered each month (June-November 2008), indicated the following:

3.	*Documentation of the individual's response to Stat medications.*	52%
3.a	*In the MTR, there is a brief description of the individual's response to the administered Stat*	54%

	medication which was documented within one hour of the administration.	
3.b	*In the IDN, there is a comprehensive assessment of the individual's response to the administered Stat medication.*	85%

NSH's data showed an increase in compliance for this item and sub-items:

	Previous period	Current period
Mean compliance rate		
3.	34%	52%
Compliance rate in last month of period		
3.	26%	69%
3.b.i	28%	72%
3.b.ii	70%	84%

See F.3.a.i for NSH's actions to improve compliance.

A review of 50 incidents of Stat medications for 16 individuals (AJM, ATA, AZ, BJB, BSC, DLP, DP, ELH, JDK, JJB, LMK, MAW, MQT, SRP, TKK and WRB) found a comprehensive assessment in the IDNs of the individual's response to the Stat medication in 24 incidents.

Current recommendation:
Continue to monitor this requirement.

F.3.b	Each State hospital shall ensure that all failures to properly sign the Medication Treatment Record (MTR) or the controlled medication log are treated as medication variances, and that appropriate follow-up occurs to prevent recurrence of such variances.	**Current findings on previous recommendation:** **Recommendation, July 2008:** See F.3.a.ii.

		Findings: NSH's data regarding medication variances indicated that the population (N) was the total number of missing initials found during spot checks of the MTRs and the sample (n) was the total number of MVRs generated by the HSSs for missing initials found during Spot Checks. Thus, the compliance rate was 100%. However, the data does not indicate if any of the missing initials found on the spot checks had MVRs initiated by the unit staff/medication nurses to accurately reflect the reliability of the Medication Variance System. Consequently, there is no way to determine if the Medication Variance System is capturing all variances. A review of the current MTRs and Controlled Sheets for Units A1, A3, A8 and A10 found one missing signature from the controlled medication log and 55 missing initials on the MTRs. The facility could not produce the associated MVRs. **Compliance:** Noncompliance. **Current recommendations**: 1. Restructure MVR data to accurately reflect reliability of the Medication Variance System. 2. Continue to monitor this requirement.
F.3.c	Each State hospital shall ensure that all nursing interventions are fully integrated into the therapeutic and rehabilitation service plan and that nursing interventions are written in a manner aligned with the rest of the interventions in the therapeutic and rehabilitation service plan, in particular, in observable, behavioral, and/or measurable terms. No nursing care plans other than the nursing interventions integrated in the	**Current findings on previous recommendations:** **Recommendation 1, July 2008:** Implement strategies addressing low compliance rates with this requirement. **Findings:** Since the last review, the case manager has been reviewing the WRPs regarding the interventions implemented utilizing the WRP worksheet

	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.	prior to the conference. The clinical oversight nurse (CON) and the RN case manager reviews the WRPC worksheet prior to the conference to ensure that clinical assessments are incorporated. **Recommendation 2, July 2008:** Continue to monitor this requirement. **Findings:** See C.2.l. **Compliance:** Partial. **Current recommendation**: See C.2.l.
F.3.d	All nursing staff working with an individual shall be familiar with the goals, objectives and interventions for that individual.	**Current findings on previous recommendation:** **Recommendation, July 2008:** See F.3.c. **Findings:** Data from the DMH Nursing Staff Familiarity Monitoring audit, based on an average sample of 22% of the total number of nursing staff on the AM/PM shift, indicated the following: 6. *Nursing Staff working with an individual shall be familiar with the goals, objectives and interventions.* 52% 6.a *Nursing staff working with an individual are able to discuss the individual's goals (foci of hospitalization).* 88% 6.b *Nursing staff working with an individual are able to discuss the individual's objectives.* 62%

6.c	*Nursing staff working with an individual are able to discuss the individual's interventions in the therapeutic milieu.*	67%

NSH's data showed increases in this item and sub-items:

	Previous period	Current period
Mean compliance rate		
6.	35%	52%
Compliance rate in last month of period		
6.	36%	57%
6.a	49%	93%
6.b	38%	70%
6.c	39%	79%

NSH indicated that a barrier to compliance was the evening and night shifts' lack of familiarity with the Wellness and Recovery Planning requirements; the assessments of those shifts are not adequately integrated into the WRPs. Also, the facility identified as a barrier the lack of an organized communication system in place between the nursing staff completing the assessments and nursing staff attending the conferences. NSH's plan of correction includes reinforcing the role of the RN, PT, and LVN in providing their observations during the WRPCs. Worksheets for the WRPCs were developed and implemented for the PTs/LVNs to provide a structure for presenting information at the WRPCs. Central Nursing Services reviewers and WRP trainers from Standards Compliance developed a resource binder for nurses that contains examples of foci statements, objectives and interventions and other relevant WRP information. Also, mentoring of unit staff was implemented in November 2008. All nursing staff is projected to be mentored by February 2009, and mentoring will be provided on an ongoing basis.

		Observations of two WRPCs (Program II, Unit Q11 and Program III, Unit T2), found that little information was provided by the RN and PT for the WRPC on unit T2. The RN and PT for the WRPC on Unit Q11 provided much more individual-specific information regarding their assessments. **Compliance:** Partial. **Current recommendation**: Continue to monitor this requirement.
F.3.e	Each State hospital shall ensure that nursing staff timely monitor, document and report the status of symptoms, target variables, health, and mental health status, of individuals in a manner that enables interdisciplinary teams to assess each individual's status, and response to interventions, and to modify, as appropriate, individuals' therapeutic and rehabilitation service plans. Each State Hospital shall ensure that all nursing shift changes include a review of changes in status of individuals on the unit.	**Current findings on previous recommendation:** **Recommendation, July 2008:** Continue to monitor this requirement. **Findings:** Data from the DMH Medicine Medical Transfer Audit form, based on a 97% sample of individuals transferred to community hospitals each month (June-November 2008), indicated the following: 1. *There is an appropriate documentation by the nurse that identifies the symptoms of concern and notification of the physician.* 87% 1.a *There is an appropriate identification of the change in the individual's condition including vital signs.* 96% 1.b *There is documentation of when the change in the individual's status changed.* 94% 1.c *There is documentation of when the physician was notified and the physician's name.* 85% 1.d *There is timely (immediate for emergent* 95%

	conditions and no later than one hour for urgent conditions) notification by the nurse to the physician.	
1.e	*There is documentation in the record when the individual was transferred from the DMH hospital to the acute medical facility including date and time.*	96%
7.	*The WRP was updated to reflect the individual's current status following hospitalization or emergency room treatment.*	30%

NSH's data showed mixed changes in compliance (sub-items 1.a-1.e were not audited during the last review period):

	Previous period	Current period
Mean compliance rate		
1.	93%	87%
7.	40%	30%
Compliance rate in last month of period		
1.	93%	100%
1.a	N/A	100%
1.b	N/A	100%
1.c	N/A	100%
1.d	N/A	100%
1.e	N/A	100%
7.	19%	50%

The barrier to compliance was identified as a lack of communication between the physicians and the WRPTs. In November 2008, the physicians began attending the morning meeting to increase communication and information exchange. The Medical Director and

		Medical Auxiliary Services Director are developing methods to address low compliance regarding status updates in the WRP after hospitalization or emergency room (ER) visits. A review of the records of 12 individuals transferred to a community emergency room/hospital (AG, AM, CW, DC, DJS, EH, JDK, JWS, KC, NJ, RH and TJM) found the following: AG: 1. Good assessment documented prior to transfer to hospital; 2. Name of physician notified of status change not documented; 3. Good assessment upon return from hospital. AM: 1. Exact site of wound not documented; 2. No mention in IDN if foreign object remained in wound upon transfer to hospital; 3. Could not locate IDN documenting return from hospital. CW: 1. Received at least 12 PRNs for complaints of abdominal pain within five days; aside from the pain scale assessment (between zero, no pain to ten, the most pain), no description or further assessment of the pain was documented; 2. Significant drop in pulse and blood pressure (BP) noted; no additional assessment of status documented; 3. Name of physician paged regarding drop in BP not documented; 4. No documentation that abnormal vital signs were retaken to verify values; 5. Late entry contradicts documented effectiveness of pain PRN and did not include the reason that the individual requested a PRN; 6. PRNs not consistently documented as when they were actually given; 7. No assessment documented upon transfer to the hospital;

		8. Good assessment documented upon return from hospital. DC: 1. No neuro checks documented for a change in mental status; 2. Mental status not documented prior to transfer to hospital. DJS: 1. No status or assessment documented prior to transfer to hospital for altered mental status/confusion; 2. No status or assessment upon return from hospital or indication if the individual was as confused upon return as when hospitalized. EH: 1. Weak note describing individual's status upon transfer to hospital; 2. Generic note in IDNs upon return from hospital regarding individual's status; 3. Vital signs upon return form hospital noted "WNL" [within normal limits]; no baseline vital signs established for comparison after a hospitalization for medication toxicity. JDK: 1. No description or assessment of individual documented in IDNs during seizure activity; 2. No status or assessment documented prior to transfer to hospital; 3. Site not documented for Ativan injection that was given; 4. Documentation regarding return from hospital noted vital signs "WNL" with no specific values documented and thus no baseline vital signs for comparison after a hospitalization. JWS: 1. Documentation of neuro assessment after a fall was "WNL"; no specific data provided on what was assessed (e.g. pupils, grasp, balance, mental status) and what the findings were;

		2. Although note prior to hospital transfer stated "RN assessment done", no actual assessment was documented in IDN aside from vital signs; 3. Episode of confusion noted in IDNs after initial hospital visit; however, no indication the physician was notified; 4. No status or assessment documented prior to second transfer to hospital for evaluation. KC: 1. No assessment documented (e.g. bowel sounds, location of pain, last bowel movement) for complaints of stomach pain prior to giving PRN Maalox; 2. No assessment or vital signs documented prior to transfer to hospital. NJ: 1. No assessment or status documented at the time of transfer to the hospital for a seizure; the note indicated that vital signs were taken but no values were recorded; 2. Name of physician notified of status change not documented. RH: 1. Documentation prior to transfer to hospital lacking an assessment of mental status but included other good components in the assessment; 2. No vital signs or mental status assessment documented upon return from hospital; 3. Name of physician notified of status change not documented. TJM: 1. Documentation in margins of RN Change in Physical Status Note was illegible and should have been documented appropriately; 2. Vital signs and neuro checks noted to be "WNL" when the change of status was described in IDNs.

		In addition, there was some documentation in the notes upon individuals' returns to the facility, albeit inconsistent, of the reason for the hospitalization and/or diagnosis given from the hospital upon discharge. In addition, a few of the cases included a brief daily IDN indicating that the individual was still in the hospital. Overall, these findings demonstrate that there continues to be significant problematic issues regarding Nursing assessment and documentation of change in medical conditions. These findings do not support NSH's data. No shift report-related data was presented regarding a) report from the outgoing shift to the oncoming shift of the target variable exhibited by the individual or b) intra-shift discussion of individual-specific interventions to ensure continuum of care across shifts. However, the Statewide Nursing Work Group has been working on establishment of a standardized shift change process. Thus far, approved components of this process include nursing staff assignments, a Kardex, use of a projected Kardex, change of shift report worksheets, an RN progress note for assessment and evaluation and a Nursing weekly progress note. Implementation of this process began January 15, 2009. Although a shift report on Unit T11, Program III was observed to take more than an hour, which is not reflective of the usual timeframes for a shift report, the process showed significant promise. A copy of each individual's Kardex with pertinent medical/psychiatric clinical information was projected so all staff could see the Axis diagnoses and WRP objectives when hearing report. Although a number of issues were not updated on some of the Kardexes, having the clinical and WRP information in view should assisted the staff in reporting relevant information during the change of shift. The new template for change of shift report was newly implemented at the time of the review and needs to be continued.

		Compliance: Partial. **Current recommendations**: 1. Develop and implement a plan of correction addressing the deficiencies found regarding assessment and documentation of change of status. 2. Continue to develop the process for change of shift report. 3. Continue to monitor this requirement.
F.3.f	Each State hospital shall develop and implement a system to monitor nursing staff while administering medication to ensure that:	**Compliance:** Partial.
F.3.f.i	nursing staff are knowledgeable regarding each individual's prescribed medications;	**Current findings on previous recommendation:** **Recommendation, July 2008:** Continue to monitor this requirement. **Findings:** Data from the DMH Medication Administration Monitoring audit, based on an average sample of 28% of level of care nursing staff who are licensed and medication-certified, indicated the following:

8.	*Nursing staff are knowledgeable regarding each individual's prescribed medications.*	69%
8.a	*If a medication requires vital sign assessment prior to administration, the nursing staff is observed reviewing this reading.*	98%
8.b	*If a medication requires a blood glucose level prior to administration, the nursing staff is observed reviewing this reading.*	94%
8.c	*The nursing staff is able to answer questions about*	71%

		one medication that is administered to the individual. (The question may include purpose of medication, common side effects, etc.)

NSH's data demonstrated a slight decrease in the mean compliance score:

	Previous period	Current period
Mean compliance rate		
8.	74%	69%
Compliance rate in last month of period		
8.	60%	77%
8.a	96%	100%
8.b	95%	100%
8.c	62%	77%

The barrier to compliance for this item was identified as a lack of nursing staff knowledge of individuals' medications. NSH's plan of correction included implementing in January 2009 the use of laminated medication information on each unit as a quick reference when administering medication. Also, the Nursing Coordinators, Unit Supervisors and HSSs will be given a list of the licensed staff who do not meet the medication administration requirements for retraining. The Unit Supervisors and Nursing Coordinators will continue to monitor this requirement.

See F.3.a.i regarding findings for medication observations.

Current recommendation:
Continue to monitor this requirement.

F.3.f.ii	education is provided to individuals during medication administration;	**Current findings on previous recommendation:**

Recommendation, July 2008:
Continue to monitor this requirement.

Findings:
Data from the DMH Medication Administration Monitoring audit, based on an average sample of 28% of level of care nursing staff who are licensed and medication-certified, found the following:

9.	*Education is provided to individuals during medication administration.*	56%
9.a	*If an individual asks a question, the nursing staff is able to competently answer the question.*	91%
9.b	*When an individual has been prescribed a new medication, the nursing staff provides education about the medication.*	81%
9.c	*Nursing staff makes at least one inquiry or comment to the individual about his or her medication at each medication administration.*	58%

NSH's data showed variability in compliance rates:

	Previous period	Current period
Mean compliance rate		
9.	66%	56%
Compliance rate in last month of period		
9.	56%	60%
9.a	91%	89%
9.b	87%	78%
9.c	54%	62%

See F.3.a.i for additional findings regarding medication administration.

		Current recommendation: Continue to monitor this requirement.
F.3.f.iii	nursing staff are following the appropriate medication administration protocol; and	**Current findings on previous recommendation:** **Recommendation, July 2008:** Continue current practice. **Findings:** Data from the DMH Medication Administration Monitoring audit, based on an average sample of 28% of level of care nursing staff who are licensed and medication-certified, found the following: 10. *Nursing Staff are following the appropriate medication administration protocol.* 100% 10.a *The correct medications are administered.* 100% 10.b *The medications are administered to the correct individual.* 100% 10.c *The medications are administered in the ordered form.* 100% 10.d *The medications are administered by the correct route.* 100% 10.e *The medications are administered at the correct time.* 100% 10.f *The medications are administered on the correct date.* 100% 10.g *The medications are administered for the right indication.* 100% NSH's data showed full compliance for this item and sub-items:

	Previous period	Current period
Mean compliance rate		
10.	99%	100%
Compliance rate in last month of period		
10.	100%	100%
10.a	100%	100%
10.b	100%	100%
10.c	100%	100%
10.d	100%	100%
10.e	100%	100%
10.f	100%	100%
10.g	100%	100%

This monitor's observations of medication administration (F.3.a.i) and review of the MTRs (F.3.b) do not support NSH's compliance data. From discussions with Nursing at NSH, there appears to some recognition that 100% compliance regarding appropriate medication protocol is inaccurate in light of all the data regarding medication management and the findings from this review. Nursing needs to review how this requirement is being audited and scored to ensure that accurate compliance data is being generated.

Other findings:
This monitor observed 8 a.m. medication administration on Units T-2 and T-3. On Unit T-3 that the medication nurse was signing the MTR prior to the individual actually taking the medication. This nurse had been floated from another unit and said he was not familiar with the individuals on the unit and was afraid he would make a mistake if he did not initial the MTR at the time he pulled the medication from the cart rather than initialing after the individual actually took the medications. On Unit T-2, the medication nurse was not consistently checking the MTR and the

		medication prior to administering the medications. Both medication nurses provided minimal medication education to the individuals or asked about the effectiveness or side effects of the medications. **Current recommendations**: 1. Review the auditing process for this requirement to ensure accurate compliance data. 2. Continue to monitor this requirement.
F.3.f.iv	medication administration is documented in accordance with the appropriate medication administration protocol.	**Current findings on previous recommendations:** **Recommendation 1, July 2008:** Ensure that auditors are accurately reporting data regarding the documentation of medication administration. **Findings:** This recommendation was not addressed in NSH's progress report. **Recommendation 2, July 2008:** Continue to monitor this requirement. **Findings:** Data from the DMH Medication Administration Monitoring audit, based on an average sample of 28% of level of care nursing staff who are licensed and medication-certified, found the following: 11. *Medication administration is documented in accordance with the appropriate medication administration protocol.* 86% 11.a *Medications are documented upon administration, prior to administering medications to the next individual.* 89% 11.b *Nursing staff correctly documents the MTR to* 93%

		reflect what actually occurred.

NSH's data showed an overall slight decrease in compliance:

	Previous period	Current period
Mean compliance rate		
11.	94%	86%
Compliance rate in last month of period		
11.	89%	83%
11.a	90%	85%
11.b	92%	91%

See F.3.f.iii for relevant review findings and F.3.f.i for NSH's barrier to compliance and plan of correction.

Current recommendation:
See F.3.f.iii.

F.3.g	Each State hospital shall ensure that individuals remain in a "bed-bound" status only for clinically justified reasons.	**Current findings on previous recommendations:** **Recommendation 1, July 2008:** Implement training as planned. **Findings:** Training roster verified that in July and September 2008, staff on units A3 and A4 received training on NP 113, Care of the Individual in Bed-Bound Status. **Recommendation 2, July 2008:** Continue to monitor this requirement.

<table>
<tr><td></td><td></td><td>Findings:
Data from the DMH Nursing Bed-Bound Monitoring audit, based on a 100% sample (four individuals) of all bed-bound individuals during the review months (June-November 2008), indicated the following:

<table><tr><td>12.</td><td>There is a physician's order justifying the clinical reason for the bed -bound status.</td><td>100%</td></tr></table>
A review of the records of four bed-bound individuals (CHH, JHM, RDZ and SSP) found that all contained the appropriate physician's order as well as documentation in the WRP addressing the clinical need for temporary bed rest.

Compliance:
Substantial.

Current recommendation:
Continue current practice.</td></tr>
<tr><td>F.3.h</td><td>Each State hospital shall ensure that, before they work directly with individuals, all nursing and psychiatric technicians have successfully completed competency-based training regarding:</td><td>Compliance:
Partial.</td></tr>
<tr><td>F.3.h.i</td><td>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;</td><td>Current findings on previous recommendation:

Recommendation, July 2008:
Continue to monitor this requirement.

Findings:
NSH's training rosters verified that as of November 2008, 98% of new hires received and passed the required training, which is an increase in compliance from the last review period (79%).</td></tr>
</table>

		Current recommendation: Continue to monitor this requirement.
F.3.h.ii	the provision of a therapeutic milieu on the units and proactive, positive interventions to prevent and de-escalate crises; and	**Current findings on previous recommendation:** **Recommendation, July 2008:** Continue to monitor this requirement. **Findings:** NSH indicated that data for this requirement was in cell F.3.h.i. However, no data was provided regarding the Prevention and Management of Assaultive Behavior (PMAB) Training (now called Therapeutic Strategy Interventions [TSI]). **Current recommendations**: 1. Provide data regarding the Prevention and Management of Assaultive Behavior (PMAB) Training (now called Therapeutic Strategy Interventions [TSI]). 2. Continue to monitor this requirement.
F.3.h.iii	positive behavior support principles.	**Current findings on previous recommendation:** **Recommendation, July 2008:** Continue to monitor this requirement. **Findings:** See F.3.h.i. **Other findings:** In addition to the training of new employees during this review period, NSH has provided Positive Behavior Support (PBS) training for 20 PBS plans to 481 WRPT members on 17 units, 17 Dieticians and 20 staff in the

		Treatment Malls. In addition, Program III staff were trained on "Responding Positively to Challenging Behaviors" and 39 WRPT members were trained on "Borderline Personality Disorder." In Program IV, a total of 54 staff on the Skilled Nursing Facility unit were trained on the Behavior Guidelines of all the individuals residing on the unit. **Current recommendation**: Continue to monitor this requirement.
F.3.i	Each State hospital shall ensure that, prior to assuming their duties and on a regular basis thereafter, all staff responsible for the administration of medication has successfully completed competency-based training on the completion of the MTR and the controlled medication log.	**Current findings on previous recommendation:** **Recommendation, July 2008:** Continue to monitor this requirement. **Findings:** Training rosters verified that 70% of existing licensed nursing staff completed the annual training for this requirement. Also see F.3.h.i for new employee training. No barriers to compliance or plan of correction were provided. **Compliance:** Partial. **Current recommendation:** Continue to monitor this requirement.

4. Rehabilitation Therapy Services		
	Each State hospital shall provide adequate, appropriate, and timely rehabilitation therapy services to each individual in need of such services, consistent with generally accepted professional standards of care.	**Methodology:** Interviewed: 1. Beverly Lynn, Acting Senior Rehabilitation Therapist 2. Camille Gentry, Acting Senior Rehabilitation Therapist 3. Derek Widener, Physical Therapy Assistant 4. Jason Emery, Physical Therapist 5. Karen Breckenridge, Physical Therapist 6. Leslie Chautelle Loveless, Physical Therapy Assistant 7. Nora Tallent, Occupational Therapist 8. Phyllis Moore, Acting Senior Rehabilitation Therapist 9. Reggie Ott, Chief of Rehabilitation Services 10. Robert Newman, Acting Senior Rehabilitation Therapist 11. Susan Atherton, Speech Therapist Reviewed: 1. DMH Rehabilitation Therapy F.4 Audit Tool and instructions 2. DMH MH-C 9090 POST Monthly Progress Note 3. F.4 Audit data for June-November 2008 4. NSH Mall Course Schedule for Rehabilitation Therapy PSR Mall groups for week of review 5. Records for the following 18 individuals participating in observed Mall groups: AC, BMS, CEG, CHB, FBG, FG, GMT, JDT, JTC, MBB, MER, MPP, NBP, PAM, PG, RJA, WLW and WWC 6. List of individuals who received direct Physical Therapy services from June-November 2008 7. Records for the following six individuals who received direct Physical Therapy services between June-November 2008: BMS, CEC, DP, SP, WAB and WFO 8. List of individuals who received direct Speech Therapy services from June-November 2008 9. Records for the following six individuals who received direct

		Speech Therapy services from June-November 2008: ARL, DM, DS, JH, RW and TTR 10. List of individuals who received direct Occupational Therapy services from June-November 2008 11. Records for the following five individuals who received direct Occupational Therapy services from June-November 2008: BSC, JAH, JH, JJR and OH 12. List of individuals with 24-hour Rehabilitation Support Plans 13. Records for the following eight individuals with 24-hour Rehabilitation Support Plans: BMS, DJS, JAC, JSY, JWS, RH, RJ and SL 14. DMH MH-C 9091 24-Hour Rehabilitation Support Plan guidelines and instructions 15. Course Outline for Women's Support PSR Mall group 16. Course Outline for Self Awareness through Music PSR Mall group 17. Curriculum for Managing Diabetes PSR Mall group 18. Course Outline for Anger Management PSR Mall group 19. Rehabilitation Therapy training binder <u>Observed</u>: 1. Women's Support PSR Mall group 2. Anger Management PSR Mall group 3. Self Awareness through Music PSR Mall group 4. Self Esteem through Art PSR Mall group 5. Managing Diabetes PSR Mall group 6. Mural/Banner PSR Mall group 7. Mind Body Fitness PSR Mall group
F.4.a	Each State hospital shall develop and implement policies and procedures, consistent with generally accepted professional standards of care, related to the provision of rehabilitation therapy services that address, at a minimum:	**Compliance:** Partial.

F.4.a.i	the provision of direct services by rehabilitation therapy services staff; and	**Current findings on previous recommendations:** **Recommendation 1, July 2008:** Implement formats for progress notes for Occupational, Physical and Speech Therapy direct treatment that are consistent with those at the other state hospitals as well as with individual discipline practice act requirements. **Findings:** The DMH-approved POST Team progress note was implemented in October 2008 for all POST disciplines (Physical, Occupational and Speech Therapy). However, reviews of records of individuals with POST notes revealed that many notes lacked adequate qualitative and quantitative content to accurately document and describe individual progress. **Recommendation 2, July 2008:** Ensure that all Rehabilitation Therapists and Vocational Rehabilitation staff is trained to competency regarding "Lesson Plan and Curriculum Development", and that all POST team members are trained to competency on writing "Strength-Based Objectives & Interventions." **Findings:** The facility reported that as of November 2008, 48 out of 62 Rehabilitation Therapists and 7 out of 14 POST team therapists were trained to competency (at least 85% on post-test) on training materials related to writing strength-based objectives and interventions. **Recommendation 3, July 2008:** Implement the F.4 audit tool, and establish inter-rater agreement. **Findings:** The F.4 audit tool was implemented on 10/6/08. Inter-rater

agreement was reported to be 100%.

Other findings:
Using the DMH F.4 Monitoring Tool, NSH assessed its compliance based on an average sample (stratified by discipline) of 21% of individuals participating in Occupational, Physical, and Speech Therapy direct treatment for each month for the review period of June-November 2008 (total of 128 out of 707). The following table outlines the indicators with corresponding mean compliance rates for June-November 2008:

1.	*The provision of direct services by rehabilitation therapy services staff*	
1.a	*There is an appropriate Focus of Hospitalization (typically Focus 6).*	57%
1.b	*The objective aligned with this focus of hospitalization is functional for the individual and written in behavioral, objective, observable, and/or measurable terms.*	31%
1.c	*The intervention aligned with this objective states what OT, PT, and SLP will do to assist the individual in achieving the objective.*	31%
1.d	*There is documentation in the Present Status Section of the individual's WRP of the current status of interventions provided by the OT, PT, and SLP.*	34%

No comparable data were available from the last evaluation period.

The facility plans to improve compliance with items 1.a-1.d by training and mentoring POST team therapists on audit results and by providing POST team therapists access to the WaRMMS system to enable them to directly input recommendations, foci, objectives and interventions

into the WRP document. Implementation of the training aspect of this plan was initiated in December 2008, and the facility plans to begin implementation of POST team WaRMSS access in February 2009.

The data below presents the number of scheduled vs. completed appointments for direct services provided by OT, PT, and SLP for the week of 11/3/08:

	Scheduled	Provided
PT	138	97
OT	57	55
SLP	22	22

An analysis of barriers to compliance and/or possible plan of correction to improve compliance regarding the number of hours of treatment scheduled versus provided was not provided by the facility.

A review of records of six receiving direct Physical Therapy treatment individuals (BMS, CEC, DP, SP, WAB and WFO) to assess for compliance with provision of direct services found all records in partial compliance with F.4.a.i criteria. All records reviewed contained evidence that treatment activities were aligned with assessed needs. Identified patterns of deficiencies that the facility should focus on in order to improve compliance include the following:

1. Foci, objectives and interventions are not consistently included in the WRP.
2. Documentation of progress in Physical Therapy treatment is not consistently documented in the present status section of the WRP.
3. Objectives and treatment activities are not consistently changed and/or updated as needed.
4. Progress notes are not consistently comprehensive and complete.

		A review of records of five individuals receiving direct Occupational Therapy treatment (BSC, JAH, JH, JJR and OH) to assess for compliance with provision of direct services found all records in partial compliance with F.4.a.i criteria. All records reviewed contained evidence that treatment activities were aligned with assessed needs. Identified patterns of deficiencies that the facility should focus on in order to improve compliance include the following: 1. Objectives are not consistently functional, behavioral, observable and measurable. 2. Foci, objectives and interventions are not consistently included in the WRP. 3. Documentation of progress in Occupational Therapy treatment is not consistently documented in the present status section of the WRP. 4. Objectives and treatment activities are not consistently changed and/or updated as needed. 5. Progress notes are not consistently comprehensive and complete. A review of records of six individuals receiving direct Speech Therapy treatment (ARL, DM, DS, JH, RW and TTR) to assess for compliance with provision of direct services found all records in partial compliance with F.4.a.i criteria. All records reviewed contained evidence that treatment activities were aligned with assessed needs. Identified patterns of deficiencies that the facility should focus on in order to improve compliance include the following: 1. Objectives are not consistently functional, behavioral, observable and measurable. 2. Foci, objectives and interventions are not consistently included in the WRP. 3. Documentation of progress in Speech Therapy treatment is not consistently documented in the present status section of the WRP.

		4. Objectives and treatment activities are not changed and/or updated as needed. 5. Progress notes are not consistently comprehensive and complete. **Current recommendation**: Provide quality direct services by Occupational, Physical, and Speech Therapy staff to ensure that there is alignment between assessment findings and treatment activities, changes to programs are made as needed, adequate foci, objectives and interventions are aligned and incorporated into the WRP, and progress with direct services are documented in the present status section of the WRP.
F.4.a.ii	the oversight by rehabilitation therapists of individualized physical therapy programs implemented by nursing staff.	**Current findings on previous recommendations:** **Recommendation 1, July 2008:** Develop and implement a procedure for nursing staff provision of indirect Physical and Occupational Therapy programs. **Findings:** A draft procedure for the Individualized Nursing Physical/ Occupational Plan (INPOP) has been developed and is pending revision and implementation. **Recommendation 2, July 2008:** Develop and implement a database to track individuals receiving these services, as well as when staff has received competency-based training/return demonstration, and how often the individual should be re-assessed by the Physical or Occupational Therapist to determine the continued appropriateness of the program. **Findings:** A database meeting the criteria of Recommendation 2 has been developed and is pending population as the new process is implemented.

		Current recommendations: 1. Revise and implement a procedure for nursing staff provision of indirect Physical and Occupational Therapy programs with Physical and Occupational Therapy oversight that is available to all individuals who require it facility-wide. 2. Populate and implement a facility-wide database to track individuals receiving these services, as well as when staff has received competency-based training/return demonstration if indicated, and how often the individual should be re-assessed by the Physical or Occupational Therapist to determine the continued appropriateness of the program.
F.4.b	Each State hospital shall provide competency-based training to nursing staff, as appropriate, on the use and care of adaptive equipment, transferring, and positioning, as well as the need to promote individuals' independence.	**Current findings on previous recommendation:** **Recommendation, July 2008:** Ensure that competency-based training on the use and care of adaptive equipment, transferring, and positioning, as well as the need to promote individuals' independence, occurs as needed. **Findings:** Currently, there does not seem to be a system to determine on a facility-wide basis which nurses require training related to physical rehabilitation. The facility reported that all nursing staff on unit A-4 has been trained to competency (at least 85% on post-test) on the training materials provided in each area related to adaptive equipment, transferring, positioning, and promoting independence (including range of motion, therapeutic exercise, standing and ambulation, dysphagia, 24-hour rehabilitation supports, and activities of daily living). Training of Nursing staff on other units is pending completion. The following table outlines each area, training date, and number of staff trained:

Training	Dates	Number Trained/ Number Trained to Competency
Adaptive Equipment	11/20/08	9/9
	11/18/08	8/8
Transferring	10/30/08	8/8
	09/02/08	11/11
	11/04/08	11/11
Positioning	8/26/08	12/12
	10/06/08	8/8
	10/23/08	9/9
	11/04/08	8/8
Promote Individuals' Independence	7/02/08	10/10
	7/03/08	7/7
	7/08/08	9/9
	8/21/08	13/13
	8/28/08	12/12
	9/04/08	11/11
	9/09/08	11/11
	9/16/08	12/12
	10/21/08	5/5
	11/04/08	25/25
	11/06/08	11/11
	11/06/08	10/10
	11/12/08	8/8

Training was verified by review of training rosters and post-tests.

Compliance:
Partial.

		Current recommendations: 1. Develop and implement a system to identify which nurses require training in the use and care of adaptive equipment, transferring, and positioning, as well as the need to promote individuals' independence on a facility wide basis. 2. Ensure that competency-based training on the use and care of adaptive equipment, transferring, and positioning, as well as the need to promote individuals' independence, occurs as needed
F.4.c	Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.	**Current findings on previous recommendations:** **Recommendation 1, July 2008:** Ensure that for all individuals receiving treatment by Rehabilitation Therapists in PSR Mall groups, progress towards objectives is documented in the WRP and focus, objectives, and interventions are modified as needed. **Findings:** Using the DMH F.4 Monitoring Tool, NSH assessed its compliance based on an average sample (stratified by discipline) of 20% of individuals participating in Rehabilitation Therapy and Vocational Rehabilitation PSR Mall groups for each month for the review period of June-November 2008 (total of 379 out of 1947). The following table outlines the indicators with corresponding mean compliance rates for July-October 2008:

4.	*Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.*	
4.a	*There is an appropriate Focus of Hospitalization.*	91%
4.b	*The objective aligned with this focus of hospitalization is functional for the individual and written in behavioral, observable, and/or*	62%

	measurable terms.	
4.c	*The intervention in the PSR Mall Aligned with this objective states the name of the RT mall facilitator, group name, time and place, and the individual's strengths that will be used by the RT staff to assist the individual in achieving this objective.*	75%
4.d	*There is documentation in the Present Status Section of the individual's WRP of interventions provided by the RT and Voc Rehab.*	36%

No comparable data from last evaluation period were available for review.

The facility attributed poor compliance with 4.b-4.d to lack of training in these areas, and plans to improve compliance by increasing training of Rehabilitation Therapists regarding writing objectives and interventions and ensuring the inclusion of essential WRP information related to progress using the learning lab.

Recommendation 2, July 2008:
Ensure that for all Rehabilitation Therapist-led PSR Mall groups, foci, objectives and interventions are aligned.

Findings:
A review of records of 12 individuals participating in Rehabilitation Therapist-led PSR Mall groups (AC, CEG, CHB, FBG, FG, GMT, JDT, MBB, MER, NBP, PAM and WLW) to assess for compliance with alignment of foci, objectives and interventions found ten records (AC, CHB, FBG, FG, GMT, JDT, MBB, NBP, PAM and WLW) in substantial compliance and two records (CEG and MER) not in compliance.

		Recommendation 3, July 2008: Develop and implement a database to track individuals with 24-hour plans, as well as when staff has received competency-based training/return demonstration, and how often the individual should be re-assessed by the POST team member(s) to determine the continued appropriateness of the plan. **Findings:** A database has been developed and was implemented in late October 2008. Auditing of 24-hour plans began in November 2008. **Recommendation 4, July 2008:** Ensure that all individuals with current Integrated Restorative Care Plans are reviewed to ensure that they meet the criteria for the new 24-hour Rehabilitation Support plans, with conversion to the new format as clinically indicated. **Findings:** This recommendation has been partially met. The process of reviewing all individuals with Integrated Restorative Care Plans to identify those that meet the criteria for a new 24-hour Rehabilitation Support Plan and subsequent conversion to the new format has been initiated. A review of records of eight individuals (BMS, DJS, JAC, JSY, JWS, RH, RJ and SL) found that plans for six individuals met facility criteria for a 24-hour support plan. **Other findings:** Using the DMH F.4 Monitoring Tool, NSH assessed its compliance based on an average sample of 100% of individuals with 24-hour Rehabilitation Therapy support plans to assess compliance with timely and adequate provision of Rehabilitation Therapy Services for each month for the review period of June-November 2008 (total of 2). The following table outlines the indicators with corresponding mean

compliance rates for July-November 2008:

4b.	*Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.*	
a.	*The 24-hour Rehabilitation Support Plan was implemented within 28 days of referral.*	100%
b.	*The 24-hour Rehabilitation Support Plan was updated, and the rationale documented in the Present Status section of the WRP*	100%

No comparable data were available from the last evaluation period.

A review of records of eight individuals with 24-hour Rehabilitation Support plans (BMS, DJS, JAC, JSY, JWS, RH, RJ and SL) to assess for compliance with provision of timely and adequate Rehabilitation Therapy services found seven records (BMS, DJS, JAC, JSY, JWS, RJ and SL) in partial compliance and one record (RH) not in compliance.

The table below presents the number of scheduled vs. actual hours of PSR Mall services provided by RT and Vocational Rehab during the week of 10/20/08.

	Scheduled	Provided
RT - Long Term	559	296
RT - Admissions	68	47
Voc Rehab	377	266

Analysis regarding barriers to compliance or possible plan of correction to improve compliance regarding the number of hours of treatment scheduled versus provided was not provided.

A review of the records of 18 individuals participating in PSR Mall

		groups led by Rehabilitation Therapists (AC, BMS, CEG, CHB, FBG, FG, GMT, JDT, JTC, MBB, MER, MPP, NBP, PAM, PG, RJA, WLW and WWC) to assess for compliance with provision of timely and adequate Rehabilitation Therapy services found all records in partial compliance. All records reviewed contained evidence that treatment activities were aligned with assessed needs. Identified patterns of deficiencies that the facility should focus on in order to improve compliance include the following: 1. Objectives are not consistently functional, behavioral, observable and measurable. 2. Foci, objectives and interventions are not consistently included in the WRP. 3. Documentation of progress is not consistently documented in the present status section of the WRP. **Compliance:** Partial. **Current recommendations**: 1. Ensure that for all individuals receiving treatment by Rehabilitation Therapists in PSR Mall groups, progress towards objectives is documented in the present status section of the WRP, and quality foci, objectives, and interventions are documented in the WRP and are aligned. 2. Provide training to Rehabilitation Therapy staff on writing quality foci, objectives and interventions based on content of the revised PSR Mall Manual. 3. Ensure that all individuals with 24-hour Rehabilitation Support plans meet criteria for 24-hour plans, and receive timely and adequate Rehabilitation Therapy services.

F.4.d	Each State hospital, consistent with generally accepted professional standards of care, shall ensure that each individual who requires adaptive equipment is provided with equipment that meets his/her assessed needs and promotes his/her independence, and shall provide individuals with training and support to use such equipment.	**Current findings on previous recommendation:** **Recommendation, July 2008:** Ensure that each individual who requires adaptive equipment is provided with equipment that meets his/her assessed needs and promotes his/her independence, and provide individuals with training and support to use such equipment. **Findings:** Using the DMH F.4 Monitoring Tool, NSH assessed its compliance with items e. through h. based on an average sample of 100% of individuals added to the adaptive equipment database for each month for the review period of June-November 2008 (total of 112). Using the same tool, NSH assessed its compliance with indicator i. based on an average sample of 100% of individuals within the adaptive equipment database who required re-assessment for each month for the review period of June-November 2008 (total of 2). The following table outlines the indicators with corresponding mean compliance rates for June-November 2008: e. *The individual was assessed for the appropriateness of adaptive equipment by an RT professional* 98% f. *The individual was provided with the equipment as per the doctor's order* 97% g. *The individual's level of functioning related to independence versus supports needed was assessed.* 87% h. *Training for the individual on the use of adaptive equipment was provided.* 98% i. *Reassessment of adaptive equipment, if clinically indicated* 100% No comparable data were available from the last evaluation period.

		Compliance: Partial. **Current recommendation**: Ensure that each individual who requires adaptive equipment is provided with equipment that meets his/her assessed needs and promotes his/her independence, and provide individuals with training and support to use such equipment.

5. Nutrition Services		
	Each State hospital shall provide the individuals it serves, particularly those experiencing weight-related problems, adequate and appropriate dietary services consistent with generally accepted professional standards of care.	**Methodology:** Interviewed: 1. Craig Saewong, Registered Dietitian 2. Dana M. Scruggs, Registered Dietitian 3. Emiko Taki, Registered Dietitian 4. Heidi Vogelsang, Registered Dietitian 5. Joan Merrill, Registered Dietitian 6. Kumiko Kato, Registered Dietitian 7. Lynn Wurzel, Registered Dietitian 8. Noriko Takenawa, Registered Dietician 9. Robin Carboni, Registered Dietitian 10. Veronica Oteyza, Registered Dietitian 11. Wen Pao, Registered Dietitian Reviewed: 1. Lists of individuals with Nutrition Care Assessments due from June-November 2008 for each assessment type 2. Records for the following 66 individuals with type D.5.a-j.ii assessments from June –November 2008: AAK, ACG, AEP, AJM, ANA, AZ, BT, CC, CD, DBC, DHP, DS, DS, DSY, GA, GDM, GG, GRF, HDE, HP, HV, IH, ITS, JAC, JAO, JEH, JJJ, JR, JT, KAL, LLH, MBD, MH, MHJ, MJM, MRS, MWS, NH, NKB, OJR, PC, PGW, RAC, RC, RF, RJ, RKH, RLJ, RLM, RLN, RM, RM-2, SCL, SPS, SR, TBS, TCG, TJ, TOM, TTS, UDH, VM, VM, WET, WGS and WKN 3. Meal Accuracy Report audit data from June-November 2008 4. Nutrition Care Monitoring Tool audit data from June-November 2008 regarding Nutrition Education Training and response to MNT (weighted mean across assessment sub-types) 5. Audit data for June-November 2008 regarding WRP integration of Nutrition Services recommendations 6. Facility training data and competency scores for RNs and

<table>
<tr><td></td><td></td><td>Dietitians, as well as raw data binders</td></tr>
<tr><td>F.5.a</td><td>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.</td><td>Current findings on previous recommendation:

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

Findings:
Using the DMH Nutrition Care Monitoring Tool, NSH assessed its compliance with these indicators based on an average sample of 26% of Nutrition Assessments (all types) due each month for the review period of June-November 2008 (total of 609 out of 2337). The following table presents these indicators with corresponding mean compliance rates for June-November 2008:

<table>
<tr><td>7.</td><td>Nutrition education is documented</td><td>94%</td></tr>
<tr><td>8</td><td>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</td><td>98%</td></tr>
</table>

The facility maintained high compliance from the prior review period (95% and 96% for items 7 and 8 respectively).

Other findings:
A review of the records of 66 individuals with completed Nutrition Care assessments across sub-types (AAK, ACG, AEP, AJM, ANA, AZ, BT, CC, CD, DBC, DHP, DS, DS, DSY, GA, GDM, GG, GRF, HDE, HP, HV, IH, ITS, JAC, JAO, JEH, JJJ, JR, JT, KAL, LLH, MBD, MH, MHJ, MJM, MRS, MWS, NH, NKB, OJR, PC, PGW, RAC, RC, RF, RJ, RKH, RLH, RLJ, RLM, RM, RM-2, SCL, SPS, SR, TBS, TCG, TJ, TOM, TTS, UDH, VM, VM, WET, WGS and WKN) to assess compliance with documentation of provision of Nutrition Education Training and documentation of response to Medical Nutrition Training found six</td></tr>
</table>

		records in partial compliance (GDM, MBD, NKB, OJR, RLH and TBS), three records (JJJ, RC and RF) not in compliance, and the remaining 57 records in substantial compliance. Although record reviews and review of key indicator data indicating an upward trend in weight gain reveal the need for the provision of PSR Mall groups related to healthy eating, weight management, and diabetes management, no Nutrition PSR Mall groups are currently being offered. Curricula and lesson plans have been developed for these groups, and the groups should be implemented based on need during the upcoming Mall cycle. According to Meal Accuracy Report data, 94% of trays (regular and modified diets) audited from June-November 2008 (total of 1613 out of 6873, for a 23% sample) were 100% accurate. Ninety-six percent of trays were 100% accurate in the prior review period. **Compliance:** Partial. **Current recommendations**: 1. Implement the provision of Nutrition PSR Mall groups based on individual need. 2. Continue current efforts to achieve compliance.
F.5.b	Each State hospital shall ensure that one or more treatment team members demonstrate competence in the dietary and nutritional issues affecting the individuals they serve and the development and implementation of strategies and methodologies to address such issues.	**Current findings on previous recommendation:** **Recommendation, July 2008:** Continue current efforts to achieve compliance. **Findings:** Using the DMH Nutrition Care Monitoring Tool, NSH assessed its compliance with WRP integration based on an average sample of 26% of

Nutrition Assessments (all types) due each month for the review period of June-November 2008 (total of 447 out of 2015). The following table presents these indicators with corresponding mean compliance rates for June-November 2008:

19.	*The WRP has at least ONE Focus that pertains to nutrition recommendations as clinically indicated*	66%
20.	*The WRP has at least one objective and interventions linked to the Focus that pertains to the nutrition recommendation as clinically indicated*	46%

	Previous period	Current period
Mean compliance rate		
19.	45%	66%
20.	45%	46%
Compliance rate in last month of period		
19.	55%	80%
20.	55%	81%

The facility attributed low compliance with items 19 and 20 to the inability of clinical dietitians to access WaRMSS to input WRP data. The facility plans to improve compliance by enabling Dietitians to communicate input regarding recommendations, foci, objectives and interventions to the WRPT through accessing the WaRMSS WRP module.

According to facility report, all nurses due for New Employee training during the review period (46) were trained to competency on incorporating the nutrition component into the WRP process. This was verified by review of the training binder.

		Other findings: A review of records of 11 individuals (CC, DBC, HDE, JAO, JR, JT, LLH, OJR, SCL, TJ and UDH) with completed Nutrition Care assessments across sub-types to assess compliance with having an adequate focus, objective and intervention integrated into the WRP found two records (JR and OJR) in substantial compliance, four records (HDE, JT, SCL and TJ) in partial compliance and five records (CC, DBC, JAO, LLH and UDH) not in compliance with having an adequate focus, objective and intervention integrated into the WRP. Identified patterns of deficiencies that the facility should focus on in order to improve compliance include the following: 1. WRP Nutrition objectives are not consistently specific, behavioral, observable and measurable. 2. WRP Nutrition foci, objectives and interventions are not included in the WRP. **Compliance:** Partial. **Current recommendation**: Continue current efforts to achieve compliance.
F.5.c	Each State hospital shall develop and implement policies and procedures to address the needs of individuals who are at risk for aspiration or dysphagia, including but not limited to, the development and implementation of assessments and interventions for mealtimes and other activities involving swallowing.	**Current findings on previous recommendation:** **Recommendation, July 2008:** Continue current practice. **Findings:** The DMH Statewide Dietetics Department Policy: Dysphagia and Aspiration Management addresses the dietitian's role in the team process regarding dysphagia and aspiration prevention and management and appears to meet generally accepted standards of practice.

		Compliance: Substantial. **Current recommendation**: Continue current practice.
F.5.d	Each State hospital shall ensure that staff with responsibilities for assessments and interventions regarding aspiration and dysphagia has successfully completed competency-based training commensurate with their responsibilities.	**Current findings on previous recommendation:** **Recommendation, July 2008:** Continue current practice. **Findings:** According to facility report, all seven new dietitians (interns) were trained to competency on 9/2/08 on the DMH Statewide Dietetics Department Policy: Dysphagia and Aspiration Management. This was verified by review of the training binder. **Compliance:** Substantial. **Current recommendation**: Continue current practice.
F.5.e	Each State hospital shall develop and implement policies and procedures requiring treatment of the underlying causes for tube feeding placement, and ongoing assessment of the individuals for whom these treatment options are utilized, to determine the feasibility of returning them to oral intake status.	**Current findings on previous recommendation:** **Recommendation, July 2008:** Continue current practice. **Findings:** The DMH Statewide Dietetics Department Policy for Tube Feeding appears to meet accepted standards of practice.

		Compliance: Substantial. **Current recommendation**: Continue current practice.

6. Pharmacy Services		
	Each State hospital shall provide adequate and appropriate pharmacy services consistent with generally accepted professional standards of care. Each State hospital shall develop and implement policies and procedures that require:	**Methodology:** Interviewed: 1. Dolly Matteucci, Hospital Administrator 2. John Banducci, Director, Pharmacy Department Reviewed: 1. NSH data regarding recommendations made by the pharmacists and physicians' response to these recommendations (June to November 2008) 2. Summary description of each of the pharmacists' recommendations that were not responded to or acted upon by physicians during this reporting period
F.6.a	Upon the prescription of a new medication, pharmacists to conduct reviews of each individual's medication regimen and, as appropriate, make recommendations to the prescribing physician about possible drug-to-drug interactions, side effects, and need for laboratory work and testing; and	**Current findings on previous recommendations:** **Recommendations 1 and 2, July 2008:** • Monitor this requirement based on a 100% sample. • Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period). **Findings:** NSH presented data regarding recommendations made by pharmacists during this review period. The data showed an increase in the number of these recommendations from 216 during the last review to 285 during this review. The range of these recommendations has also improved since the last review. The following outlines the numbers of each type of recommendation: 1. Drug-to-drug interactions: 15 2. Side-effects: 10

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<table>
<tr><td>3.</td><td>Need for lab work and testing</td><td>44</td></tr>
<tr><td>4</td><td>Contraindications</td><td>1</td></tr>
<tr><td>5</td><td>Drug allergy</td><td>2</td></tr>
<tr><td>6.</td><td>Dose adjustment</td><td>68</td></tr>
<tr><td>7.</td><td>Indication for medication</td><td>9</td></tr>
<tr><td>8.</td><td>Polypharmacy</td><td>6</td></tr>
<tr><td>9.</td><td>Drug-food interaction</td><td>10</td></tr>
<tr><td>10.</td><td>Incomplete orders</td><td>13</td></tr>
<tr><td>11</td><td>Confusing orders needing clarification</td><td>49</td></tr>
<tr><td>12</td><td>Duplicate orders</td><td>22</td></tr>
<tr><td>13</td><td>Other</td><td>37</td></tr>
<tr><td colspan="2">Total number of recommendations*</td><td>285</td></tr>
</table>

Compliance:
Substantial.

Current recommendations:
1. Continue current practice.
2. Provide data analysis, including comparative data regarding the number and type of pharmacists' recommendations during the review period.
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<tr>
<td>F.6.b</td>
<td>Physicians to consider pharmacists' recommendations, and for any recommendations not followed, document in the individual's medical record an adequate clinical justification.</td>
<td>
Current findings on previous recommendations:

Recommendations 1 and 2, July 2008:
• Monitor this requirement based on a 100% sample.
• Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period).

Findings:
NSH reported that the number of recommendations that received acceptable physician's response was 268 (out of 285 recommendations).
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</table>

The data showed that only 6% of the recommendations were not followed or rationale not documented compared to 18% during the last review period. The following is a summary of the data:

Recommendations followed	244
Recommendations not followed, but rationale documented	24
Recommendations not followed and rationale/ response not documented	17

Other findings:
This monitor reviewed the facility's data regarding four recommendations that were made by the pharmacist without action by the physicians in response to the recommendations. The review did not find evidence of harm to the individuals in any case. However, all such recommendations require response from the medical staff, including justification of the decision not to follow the recommendation.

Compliance:
Substantial.

Current recommendations:
1. Continue current practice.
2. Provide data, including comparative data regarding the physicians' responses to pharmacists' recommendations during the review period.

7. General Medical Services		
		Methodology: <u>Interviewed</u>: 1. Abishai Rumano, MD, Acting Chief Physician and Surgeon 2. Dennis Hawley, MD, Physician and Surgeon 3. Hong-Shen Yeh, MD, Physician and Surgeon 4. Jason Bermak, MD, Staff Psychiatrist 5. Manveen Sekhon, MD, Physician and Surgeon 6. Mu Chou, MD, Physician and Surgeon 7. Rajeev Sachdev, MD, Physician and Surgeon 8. William Kocsis, MD, Physician and Surgeon <u>Reviewed</u>: 1. The charts of the following 10 individuals who were transferred to an outside medical facility during this reporting period: AG, AJM, BJB, CW, DC, DS, EH, JDK, JWS and NJ 2. DMH SO 136, Provision of Medical Care to Individuals, effective November 18, 2008 3. AD 599, Provision of Medical Care to Individuals, effective January 29, 2009 4. AD 568, Transfer to and Return from Another Facility for Evaluation and/or Medical or Surgical Treatment, effective January 29, 2009 5. AD 666, Registered Nurse and Physician Communication About Physical Status Change, effective January 29, 2009 6. DMH Physician Note: Transfer to Outside Facility for Emergency or Other Services Template 7. Physician Quarterly Review Medical Progress Note template, implemented January 2009 8. DMH Physician Order Form (Transfer to Outside Facility) Template. 9. DMH Nursing Transfer Note Template

		10. DMH RN Change in Physical Status Note Template, effective October 2008 11. NSH medical and psychiatric night/weekend and holiday coverage schedule (July to November 2008) 12. DMH Medical-Surgical Progress Notes Auditing Form 13. DMH Medical-Surgical Progress Notes Auditing Form Instructions 14. NSH Medical-Surgical Progress Notes Auditing summary data (June to November 2008) 15. DMH Medical Transfer Auditing Form 16. DMH Medical Transfer Auditing Form Instructions 17. NSH Medical Transfer Auditing summary data (June to November 2008) 18. DMH Integration of Medical Conditions into WRP Auditing Form 19. DMH Integration of Medical Conditions into WRP Auditing Form Instructions 20. NSH Integration of Medical Conditions into WRP Auditing summary data (June to November 2008) 21. NSH data regarding timeliness of consultations off-site (June to November 2008) 22. DMH Diabetes Mellitus Auditing Form 23. DMH Diabetes Mellitus Auditing Form Instructions 24. NSH Diabetes Mellitus Auditing summary data (June to November 2008) 25. DMH Hypertension Auditing Form 26. DMH Hypertension Auditing Form Instructions 27. NSH Hypertension Auditing summary data (June to November 2008) 28. DMH Dyslipidemia Auditing Form 29. DMH Dyslipidemia Auditing Form Instructions 30. NSH Dyslipidemia Auditing summary data (June to November 2008) 31. DMH Asthma/COPD Auditing Form 32. DMH Asthma/COPD Auditing Form Instructions 33. NSH Asthma/COPD Auditing summary data (June to November

		2008) 34. NSH Cardiac Disease Monitoring Form 35. NSH Cardiac Disease Monitoring summary data (June to November 2008) 36. NSH Preventive Care Monitoring Form 37. NSH Preventive Care Monitoring summary data (June to November 2008)
F.7.a	Each State hospital shall provide adequate, appropriate, and timely preventive, routine, specialized, and emergency medical care to all individuals in need of such services, consistent with generally accepted professional standards of care. Each State hospital shall ensure that individuals with medical problems are promptly identified, assessed, diagnosed, treated, monitored and, as monitoring indicates is necessary, reassessed, diagnosed, and treated, consistent with generally accepted professional standards of care.	**Current findings on previous recommendations:** **Recommendation 1, July 2008:** Finalize and implement DMH Special Order#136, Provision of Medical Care to Individuals. **Findings:** DMH Special Order136, Provision of Medical Care to Individuals was finalized and implemented in November 2008. **Recommendation 2 and 3, July 2008:** • Develop and implement revised AD/Policies and Procedures that adequately address all the areas of deficiencies listed above and provide supporting documentation with specific references. • Implement corrective actions to address the monitor's findings of deficiencies in this report, including the new medical and nursing care protocols and the RN Significant Change in Condition Assessment Note template. **Findings:** NSH reported the following actions during this review period: 1. Implementation of the RN Significant Change in Physical Status Assessment Note template occurred on November 1, 2008. 2. A gerontologist was hired and assigned to the forensic geropsych

unit in November 2008.

3. Nurse Practitioners have been credentialed and can now order routine immunizations, laboratory work, and other medical tests.

Other findings:

This monitor reviewed the charts of 10 individuals who were transferred to an outside medical facility during this reporting period (AG, AJM, BJB, CW, DC, DS, EH, JDK, JWS and NJ). The following table outlines the individuals' initials, date/time of physician evaluation at the time of transfer and the reason for the transfer:

Individual	Date/time of MD evaluation	Reason for transfer
1.	08/31/08, no time documented	Decreased alertness
2.	09/28/08, 14:35	Removal of pencil from abdomen
3.	11/11/08, 15:00	Recurrent seizure activity
4.	06/20/08, 13;150	Obstructive jaundice
5.	06/30/08, 11:15	Altered mental status
6.	07/02/08, 09:15	Altered mental status
7.	06/29/08, 11:50	Lithium toxicity
8.	08/01/08, 16:15	New onset seizure
9.	10/30/08, 14:30	Altered mental status
10.	06/13/08, 23:40	Recurrent seizure activity

The review found general evidence of timely and appropriate medical care in most charts. However, this monitor found a persistent pattern of process deficiencies regarding the delivery of medical services. These deficiencies must be corrected to achieve substantial compliance with this requirement. The following are examples:

1. The physician's acceptance note included inadequate information regarding the circumstances of treatment trials that antedated

		the occurrence of status epilepticus in an individual without known history of seizure disorder. Additionally, there was no evidence of a documented evaluation by the regular physician and surgeon at any time to address the differential diagnosis and evaluate the possible factors contributing to the seizure activity. Consequently, the WRP included inappropriate focus, objectives and interventions regarding the seizure disorder. 2. There was no evidence that an individual who required multiple abdominal surgeries for ingestion of foreign bodies had received adequate behavioral interventions prior to the most recent episode. 3. Some physicians made careless and unsigned entries in the progress notes section of the medical record. 4. The evaluation note did not document a review of laboratory status and any changes in recent medication trials in an individual who was transferred to an outside facility because of an unexplained decrease in alertness. The individual was later diagnosed with encephalopathy secondary to hyperammonemia. The psychiatric progress notes did not document that safer treatment alternatives that were aligned with the psychiatric diagnosis were considered. The individual has continued to receive this treatment after experiencing encephalopathy presumed to be secondary to pharmacotherapy. 5. The facility's current medication guidelines regarding the use of divalproex did not address the laboratory monitoring of ammonia levels. 6. There was no evidence that the treating physician considered a recommendation made by a neurologist to consider an alternative anticonvulsant regimen for an individual who was suffering from recurrent seizure activity on the current regimen and who had history of traumatic brain injury and cognitive dysfunction. 7. The treating physician and surgeon gave inaccurate information regarding recent medication history for an individual who

		experienced decreased level of alertness, falls and unsteady gait and was diagnosed with progressive dementia of the Alzheimer's type. 8. The nursing assessment of an individual who developed seizure activity did not include an adequate description of the individual's status. 9. There was no evidence of any laboratory monitoring of serum sodium levels in an individual who was suffering from water intoxication. He was transferred to an outside facility due to grand mal seizure activity and was found to have significant hyponatremia upon arrival to that facility. 10. There was no documentation by nursing of an assessment of the change in the physical status of an individual who was later diagnosed with lithium toxicity. 11. There was no evidence of any laboratory monitoring of serum lithium levels since admission in an individual who had known history of severe lithium toxicity and received ongoing treatment with lithium. The individual was transferred to an outside facility after experiencing recurrent lithium toxicity that was verified upon arrival to that facility. 12. Some of the physicians were unable to find documentation by other physicians related to the transfer of individuals to other facilities and return transfer to NSH. **Compliance** Partial. **Current recommendations**: Ensure proper oversight of medical services to correct this monitor's clinical findings of deficiencies (listed in Other Findings above).
F.7.b	Each State hospital shall develop and implement protocols and procedures, consistent with generally	Please see sub-cells for compliance findings.

	accepted professional standards of care, that:	
F.7.b.i	require the timely provision of initial and ongoing assessments relating to medical care, including but not limited to, vision care, dental care, and laboratory and consultation services;	**Current findings on previous recommendations:** **Recommendation 1, July 2008:** Monitor quarterly medical reassessments based on a 100% sample and identify the target population for all indicators. **Findings:** NSH used the DMH Medical-Surgical Progress Notes Auditing Form (June to November 2008) to assess compliance with this requirement. The average sample was 20% of individuals with at least one diagnosis on Axis III. The following table summarizes the data: 1. *There is a quarterly note that documents reassessment of the individual medical status.* 94% 2. *Significant conditions for which the individual is at risk for complications are identified.* 94% 3. *If applicable, the on call (after hours) physician documents in the PPN necessary communication between the regular medical physician and the on-call (after hours) physician regarding changes in the individual's physical condition.* N/A **Recommendation 2, July 2008:** Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period). **Findings:** No areas of low compliance were noted.

		Compliance Partial. **Current recommendations**: 1. Monitor this requirement using the DMH Medical-Surgical Progress Note Auditing Form based on at least a 20% sample. 2. Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period) 3. Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.
F.7.b.ii	require the timely provision of medical care, including but not limited to, vision care, dental care, and laboratory and consultation services; timely and appropriate communication between nursing staff and physicians regarding changes in an individual's physical status; and the integration of each individual's mental health and medical care;	**Current findings on previous recommendations:** **Recommendation 1, July 2008:** Monitor this requirement using the DMH Medical Transfer Auditing Form and the facility's audit regarding timeliness of consultations off-site based on at least a 20% sample. **Findings:** NSH used the DMH Medical Transfer Auditing Form (June to November 2008) to assess compliance with this requirement. The average sample was 100% of individuals transferred to an external facility. The following table summarizes the data:

1.	*There is appropriate documentation by the nurse that identifies the symptoms of concern and notification of the physician.*	87%
2.	*There is appropriate and timely response and documentation from the transferring physician meeting the standards of care for the condition being transferred.*	87%

3.	*Sufficient information is provided to the accepting facility in order to ensure continuity of care.*	99%
4.	*Sufficient information is provided by the external facility (acute medical care facility/emergency department) at the time of discharge in order to ensure the continuity of care.*	99%
5.	*Upon return from acute medical treatment, the accepting physician provides an appropriate note describing the course of treatment provided at the acute medical facility.*	96%
6.	*Timely written progress notes by the regular medical physician shall address the treatment provided at the acute medical facility and follow-up treatment provided at the DMH hospital.*	97%
7.	*The WRP was updated to reflect the individual's current status following hospitalization or emergency room treatment.*	30%

For those indicators with a mean compliance rate of less than 90%, comparative data showed mixed changes in compliance since the last review. The following table summarizes the data:

	Previous period	Current period
Mean compliance rate		
1.	93%	87%
2.	89%	87%
7.	40%	30%
Compliance rate in last month of period		
1.	93%	100%
1.a	N/A	100%
1.b	N/A	100%

1.c	N/A	100%
1.d	N/A	100%
1.e	N/A	100%
2.	100%	92%
2.a	N/A	92%
2.b	N/A	100%
2.c	N/A	100%
2.d	N/A	100%
2.e	N/A	100%
2.a.1	N/A	100%
7.	19%	50%

NSH also used the DMH Integration of Medical Conditions into the WRP Auditing Form (June to November 2008) to assess compliance with this requirement. The average sample was 17% of the WRPs for individuals with at least one diagnosis on Axis III held each month. The following table summarizes the data:

1.	*All medical conditions listed in Axis III are included on the Medical Conditions form.*	63%
2.	*The WRP includes a focus statement, objective and intervention for each medical condition listed on the Medical Conditions form.*	57%
3.	*There is an appropriate focus statement for each medical condition or diagnosis.*	43%
4.	*There is an appropriate objective for each medical condition or diagnosis.*	45%
5.	*There are appropriate intervention(s) for each objective.*	41%

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

	Previous period	Current period
Mean compliance rate		
1.	71%	63%
2.	59%	57%
3.	63%	43%
4.	73%	45%
5.	73%	41%
Compliance rate in last month of period		
1.	89%	75%
2.	89%	64%
3.	92%	41%
4.	92%	49%
5.	92%	27%

NSH presented data regarding the timeliness of consultation referrals. The facility reviewed an average sample of 20% of the referrals to off-site consultants/services. The data showed an increase in percentage of appointments scheduled within two weeks from 34% to 50% and a decrease in the average number of days to scheduled appointment from 17 to 15 days.

Recommendation 2, July 2008:
Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period).

Findings:
NSH reported that the facility had identified several barriers and corrective actions. The following is a summary:

1. NSH reported that the facility's practice did not facilitate

		communication between the PCP and other members of the WRPT. As a corrective action, the PCP started attending morning meetings in November 2008. 2. In relation to the DMH Integration of Medical Conditions into the WRP Auditing Form, errors were noted in auditing during the previous review period which inflated those ratings. Retraining of auditors was scheduled for January 2009 along with inter-rater reliability checks. NSH reported that unreliable audits would no longer be included in the sample. 3. Additionally, the facility stated that implementation of the Risk Profile will prompt WRPTs to include appropriate foci, objectives and interventions for medical diagnoses. **Compliance** Partial. **Current recommendations**: 1. Develop a process to assess the timeliness and appropriateness of specialty clinics. 2. Standardize the monitoring tools regarding the medical emergency response system and drills for use across state facilities and provide monitoring data based on this tool. 3. Monitor this requirement using the DMH Medical Transfer Auditing Form, DMH Integration of Medical Conditions into the WRP Auditing Form and NSH Audit of Timeliness of Consultations and Referrals to Off-Site Medical Consultants/Services Form based on at least 20% samples. 4. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period. 5. Provide a summary outline of any improvements in practice made as a result of review by the facility of internal monitoring data.

F.7.b.iii	define the duties and responsibilities of primary care (non-psychiatric) physicians;	**Current findings on previous recommendation:** **Recommendation, July 2008:** Same as in F.7.a. **Findings:** Same as in F.7.a. **Compliance** Partial. **Current recommendation**: Same as in F.7.a.
F.7.b.iv	ensure a system of after-hours coverage by primary care physicians with formal psychiatric training (i.e., privileging and proctorship) and psychiatric backup support after hours; and	**Current findings on previous recommendation:** **Recommendation, July 2008:** Continue current practice. **Findings:** NSH has continued current practice as evidenced by a review of the facility's records regarding after-hours coverage during this review period. **Compliance:** Substantial. **Current recommendation**: Continue current practice.
F.7.b.v	endeavor to obtain, on a consistent and timely basis, an individual's medical records after the individual is treated in another medical facility.	**Current findings on previous recommendation:**

<table>
<tr><td></td><td></td><td>Recommendation, July 2008:
Same as in F.7.b.ii.

Findings:
Same as in F.7.b.ii.

Compliance
Partial.

Current recommendation:
Same as in F.7.b.ii.</td></tr>
<tr><td>F.7.c</td><td>Each State hospital shall ensure that physicians monitor each individual's health status indicators in accordance with generally accepted professional standards of care, and, whenever appropriate, modify their therapeutic and rehabilitation service plans to address any problematic changes in health status indicators.</td><td>Current findings on previous recommendations:

Recommendation 1, July 2008:
Monitor specific medical conditions including Diabetes Mellitus, Hypertension, Dyslipidemia and Asthma/COPD using the standardized tools based on at least a 20% sample.

Findings:
NSH used the DMH standardized tools regarding the management of diabetes mellitus, hypertension, dyslipidemia and asthma/COPD (June to November 2008) to assess compliance with this requirement. The average sample was 20% of the records of individuals diagnosed with these disorders. The following table summarizes the data:

<u>Diabetes Mellitus:</u>

<table>
<tr><td>1.</td><td>The individual has been evaluated and supporting documentation is completed at least quarterly.</td><td>88%</td></tr>
<tr><td>2.</td><td>HgbA1C was ordered quarterly.</td><td>87%</td></tr>
<tr><td>3.</td><td>The HgbA1C is equal to or less than 7%.</td><td>97%</td></tr>
<tr><td>4.</td><td>Blood sugar is monitored regularly.</td><td>99%</td></tr>
</table></td></tr>
</table>

5.	*Urinary micro albumin is monitored annually.*	46%
6.	*If the urine micro albumin level is greater than 30, ACE or ARP is prescribed, if not otherwise contraindicated.*	44%
7.	*The lipid profile is monitored on admission or time of diagnosis and at least annually.*	98%
8.	*LDL is less than 100mg/dl or there is a plan of care in place to appropriate treat the LDL.*	81%
9.	*Blood pressure is monitored weekly.*	63%
10.	*If blood pressure is greater than 130/80, there is a plan of care in place to appropriately lower the blood pressure.*	95%
11.	*An eye exam by an ophthalmologist/optometrist was completed at least annually.*	73%
12.	*Podiatry care was provided by a podiatrist at least annually.*	87%
13.	*A dietary consultation was considered and the recommendation followed, as applicable.*	87%
14.	*Diabetes is addressed in Focus 6 of the WRP.*	94%
15.	*Focus 6 for Diabetes has appropriate objectives and interventions for this condition.*	91%

For those indicators with a mean compliance rate of less than 90%, comparative data showed mixed changes in compliance since the last review. The following table summarizes the data:

	Previous period	Current period
Mean compliance rate		
1.	64%	88%
2.	77%	87%
5.	24%	46%

6.	30%	44%
8.	87%	81%
9.	47%	63%
11.	72%	73%
12.	69%	87%
13.	92%	87%
Compliance rate in last month of period		
1.	77%	89%
2.	82%	94%
2.a	N/A	94%
2.b	N/A	100%
5.	30%	49%
5.a	N/A	49%
5.b	N/A	100%
6.	44%	50%
8.	90%	86%
8.a	N/A	89%
8.b	N/A	94%
9.	57%	49%
11.	72%	68%
12.	74%	88%
13.	87%	91%
13.a	N/A	100%
13.b	N/A	91%

Asthma/COPD:

1.	*The individual has been evaluated and supporting documentation completed at least quarterly.*	70%
2.	*For individuals with a diagnosis of COPD, a baseline chest x-ray has been completed.*	82%
3.	*If a rescue inhaler is being used more than two days a*	100%

	week, the individual has been assessed and an appropriate plan of care has been developed.	
4.	*If the individual is currently a smoker, a smoking cessation program has been discussed and included in the WRP.*	N/A
5.	*Asthma or COPD is addressed in focus 6 of the WRP.*	69%
6.	*Focus 6 for Asthma/COPD has appropriate objectives and interventions.*	70%
7.	*The individual has been assessed for a flu vaccination.*	76%
8.	*If the individual has a diagnosis of COPD, a Pneumococcal vaccine has been offered, unless contraindicated.*	54%

For those indicators with a mean compliance rate of less than 90%, comparative data showed improvement in mean compliance since the last review. The following table summarizes the data:

	Previous period	Current period
Mean compliance rate		
1.	45%	70%
2.	74%	82%
5.	65%	69%
6.	65%	70%
7.	59%	76%
8.	20%	54%
Compliance rate in last month of period		
1.	65%	68%
1.a	N/A	68%
1.b	N/A	69%
2.	88%	86%
2.a	N/A	86%

2.b	N/A	100%
5.	62%	82%
6.	57%	79%
6.a	N/A	79%
6.b	N/A	79%
6.c	N/A	78%
7.	60%	71%
8.	29%	100%

Hypertension:

1.	*The individual has been evaluated and supporting documentation completed at least quarterly.*	77%
2.	*Blood pressure is monitored weekly.*	88%
3.	*Blood pressure is less than 140/90 or there is an appropriate plan of care in place to reduce blood pressure.*	98%
4.	*If the individual is 40 or older, aspirin has been ordered unless contraindicated.*	59%
5.	*Hypertension is addressed in Focus 6 of the WRP.*	86%
6.	*Focus 6 for Hypertension has appropriate objectives and interventions.*	86%
7.	*A dietary consult was considered and the recommendation was followed, as applicable.*	81%
8.	*The BMI is less than or equal to 25 and the waist circumference is less than 40 for males and less than 35 for females or a weight management program has been initiated.*	90%
9.	*An exercise program has been initiated.*	79%
10.	*If the individual is currently a smoker, smoking cessation has been discussed and included in the WRP.*	N/A

Comparative data showed mostly improvements in mean compliance since the last review. The following table summarizes the data:

	Previous period	Current period
Mean compliance rate		
1.	53%	77%
2.	75%	88%
4.	40%	59%
5.	78%	86%
6.	75%	86%
7.	88%	81%
9.	74%	79%
10.	19%	N/A
Compliance rate in last month of period		
1.	73%	83%
2.	78%	83%
4.	41%	57%
5.	88%	93%
6.	78%	96%
6.a	N/A	96%
6.b	N/A	96%
6.c	N/A	96%
7.	75%	87%
7.a	N/A	93%
7.b	N/A	92%
9.	64%	85%
10.	11%	N/A

<u>Dyslipidemia:</u>

1.	*The individual has been evaluated and supporting*	80%

	documentation completed at least quarterly.	
2.	*A lipid panel was ordered at least quarterly.*	88%
3.	*The HDL level is >40(M) or >50(F) or a plan of care is in place.*	97%
4.	*The LDL level is ≤ 130 or a plan of care is in place.*	97%
5.	*The Triglyceride level is ≤ 200 or a plan of care is in place.*	97%
6.	*Dyslipidemia is addressed in focus 6 of the WRP.*	88%
7.	*Focus 6 for Dyslipidemia has appropriate objectives and interventions for this condition.*	86%
8.	*A dietary consultation was considered and the recommendation followed, as applicable.*	84%
9.	*BMI is less than or equal to 25 and the waist circumference is less than 40 (males) and less than 35 (females) or a weight management program has been initiated.*	94%
10.	*An exercise program has been initiated.*	85%
11.	*If non-pharmacological interventions have been ineffective to control Dyslipidemia, medications have been considered or initiated.*	99%

For those indicators with a mean compliance rate of less than 90%, comparative data showed mostly improvements in compliance since the last review. The following table summarizes the data:

	Previous period	Current period
Mean compliance rate		
1.	50%	80%
2.	72%	88%
6.	86%	88%
7.	83%	86%

8.	88%	84%
10.	78%	85%
Compliance rate in last month of period		
1.	66%	85%
2.	71%	97%
2.a	N/A	97%
2.b	N/A	97%
6.	83%	91%
7.	79%	88%
7.a	N/A	88%
7.b	N/A	88%
7.c	N/A	88%
8.	83%	91%
8.a	N/A	97%
8.b	N/A	94%
10.	74%	94%

Recommendation 2, July 2008:
Monitor cardiac disease and preventive care using the new NSH tools.

Findings:
The facility used the NSH standardized tools regarding the management of Cardiac Disease and Preventative Care (June to November 2008) to assess compliance with this requirement. The average sample was 33% of the records of individuals diagnosed with cardiac disease. Neither average sample size nor comparative data for the Preventative Care monitoring form could be calculated due to a change in the tool during the review period. The following table summarizes the data:

Cardiac Disease:

1.	*Did the patient receive CAD symptom and activity assessment?*	87%
2.	*Did the patient receive at least one lipid profile in last year?*	95%
3.	*Did the patient receive lipid-lowering therapy for anyone with LDL > 100?*	86%
4.	*Does the patient have a LDL-C level <130mg/dl?*	89%
5.	*Does the patient have a LDL-C <100mg/dl?*	73%
6.	*Was antiplatelet therapy prescribed?*	86%
7.	*Was beta blocker prescribed after MI or contraindication documented?*	96%
8.	*Was ACE inhibitor (or ARB) prescribed?*	57%

For those indicators with a mean compliance rate of less than 90%, comparative data showed improvement in mean compliance since the last review. The following table summarizes the data:

	Previous period	Current period
Mean compliance rate		
1.	81%	87%
3.	41%	86%
4.	75%	89%
5.	62%	73%
6.	64%	84%
8.	54%	57%
Compliance rate in last month of period		
1.	95%	85%
3.	67%	84%
4.	92%	87%

5.	70%	80%
6.	72%	94%
8.	45%	91%

Preventive Care:

1.	*If the individual indicated that he/she is a smoker on the Admission Medical H&P, has Smoking Cessation Medical Assistance been initiated, as documented in a psychiatric Progress Note within the previous 6 months and/or on the WRP, including documentation of each of the following: advising the patient to quit smoking, discussion of cessation medication and discussion of smoking cessation strategies?*	N/A
2.	*If the patient has a BMI >27, has weight loss prevention assistance been initiated, as documented in a psychiatric Progress note within the previous 6 months and/or on the most recent WRP, including each of the following: a dietary consult, restricted caloric diet, discussion of physical activity and advising physical activity?*	58%
3.	*If the individual is 50 or older or is medically debilitated, has the individual been offered a flu shot in the past year as documented on the Preventive Care Tracking Form?*	59%
4.	*If the individual is 65 or older, has a pneumococcal vaccine by ordered in the previous two years as documented on the Preventive Care Tracking Form?*	63%
5.	*If the individual is a women age 50 or older or has a family history of breast cancer as indicated on the Admission H&P, has a mammogram been ordered within the past year as documented on the Preventive Care Tracking Form?*	43%

6.	*If the individual is age 51 or older, has colorectal cancer screening been done as evidenced by documentation on the Preventive Care Tracking Form of one of the following four items having been done or ordered:* *(1) fecal occult blood test during the past year,* *(2) flexible sigmoidoscopy during the past four years,* *(3) double contrast barium enema during the past four years or* *(4) colonoscopy during the past nine years?*	18%
7.	*If the individual is a woman age 21 or older, has a pap smear been done within the previous two years as documented on the Preventive Care Tracking Form?*	55%
8.	*If the individual is a woman age 16 or older, has one Chlamydia tests been done/ordered within the previous year as documented on the Preventive Care Tracking Form?*	46%
9.	*If the individual is a woman 65 or older, has osteoporosis testing been done as evidenced by a bone density test during the previous year as evidenced on the Preventive Care Tracking Form?*	22%

Neither average sample size nor comparative data could be calculated for Preventive Care monitoring due to a change in the tool during the review period.

Recommendation 3, July 2008:
Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period).

		Findings: The facility completed analysis and trending of the audit data and reported the following: 1. The Audit Driven Corrective Action Plan (ADCAP) was implemented in September 2008. Compliance has increased since implementation. 2. In November 2008, Nurse Practitioners assumed responsibility for ordering labs for individuals with diabetes mellitus, ordering flu vaccines and arranging dietary consults for individuals with hypertension. NSH reported this should increase compliance with those areas. 3. The facility reported that an inability to acquire flu vaccine until November 2008 negatively influenced compliance rates on relevant indicators. 4. NSH reported that the Physician Quarterly Review Medical Progress Note template was implemented in January 2009 in an effort to improve compliance. 5. The facility indicated that NSH would complete further research in order to reach consensus on the appropriate indications of ACE inhibitors in the treatment of cardiac disease and modify the auditing tool as applicable. **Compliance** Partial. **Current recommendations**: 1. Monitor this requirement using the DMH and NSH standardized tools for specific medical conditions, based on at least 20% samples. 2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period.

		3. Provide a summary outline of any improvements in practice made as a result of review by the facility of internal monitoring data.
F.7.d	Each State Hospital shall monitor, on a continuous basis, outcome indicators to identify trends and patterns in the individual's health status, assess the performance of medical systems, and provide corrective follow-up measures to improve outcomes.	**Current findings on previous recommendations:** **Recommendation 1, July 2008:** Implement a Physician Performance profile for physicians and surgeons and utilize the data in the processes of reappointment and reprivileging. **Findings:** NSH reported that the Individual Physician Compliance profile was developed and implemented in June 2008. **Recommendation 2, July 2008:** Continue to update practice guidelines guided by current literature and relevant clinical experience. **Findings:** The facility developed and implemented the Cardiac Disease and Preventative Care audits during the current review period. NSH stated that the facility intends to develop practice guidelines for water intoxication within the next six months. **Recommendation 3, July 2008:** Provide peer review data analysis regarding practitioner and group trends, with corrective actions, as indicated. **Findings:** See discussion of ADCAP results throughout this report. **Recommendation 4, July 2008:** Identify trends and patterns in the health status of individuals based

		on clinical and process outcomes, with corrective actions, as indicated. **Findings:** NSH reported that the Medical Key Indicator Committee has been reviewing clinical and process outcomes during this review period. In November 2008, the function of the committee was subsumed by Medical Risk Management Committee (MRMC). The facility indicated that data analysis from this committee will be presented at the next review. **Recommendation 5, July 2008:** Finalize efforts to automate data systems to facilitate data collection and analysis. **Findings:** NSH reported two improvements during the review period: 1. NSH developed the audit-driven corrective action plan (ADCAP) monthly report. 2. The facility developed a database link to the Physician Ordering System. This provides single-topic reports on individuals in need of vaccines, labs and consultations. **Compliance** Partial. **Current recommendations**: 1. Implement a Physician Performance profile for physicians and surgeons and utilize the data in the processes of reappointment and reprivileging. 2. Continue to update practice guidelines guided by current literature and relevant clinical experience. 3. Provide peer review data analysis regarding practitioner and group

		trends, with corrective actions as indicated. 4. Identify trends and patterns in the health status of individuals based on clinical and process outcomes, with corrective actions as indicated. 5. Finalize efforts to automate data systems to facilitate data collection and analysis.

8. Infection Control		
	Each State hospital shall develop and implement infection control policies and procedures to prevent the spread of infections or communicable diseases, consistent with generally accepted professional standards of care.	**Methodology:** Interviewed: 1. Charlene Paulson, RN, BSN, Assistant Coordinator of Nursing Services 2. [redacted], RN, MBA, EdD, Executive Director 3. Gordon Wells, RN, PHN I 4. Linda Goodwin, Acting Nurse Administrator 5. Maj Yazidi, RN, PHN I, HSS 6. Michelle Patterson, RN, Health Services Supervisor 7. Robert Kolker, RN, PHN II Reviewed: 1. NSH's progress report and data 2. Infection Control Key Indicator data 3. Infectious Disease Meeting minutes dated 6/17/08, 8/19/08 and 10/21/08 4. Infection Control Committee Meeting minutes dated 6/17/08 and 9/16/08 5. Memo to Nursing dated 7/29/08 addressing Focus 6, objectives and interventions 6. Infection Control Audit Report June 1, 2008 through November 30, 2008 7. Nursing Coordinator Meeting minutes dated 5/19/08 and 9/8/08 8. NSH Risk Reduction Oversight Committee minutes dated 7/1/08 and 8/19/08 9. Nursing Policy and Procedure Committee meeting minutes dated 5/22/08, 7/3/08 and 7/10/08 10. Refusal Work Group notes from 5/29/08, 7/3/08 and 8/21/08 11. Health Services Specialist Meeting minutes dated 10/7/08 12. Medical records for the following 117 individuals: AAK, AMP, AMS, ANT, AS, ASP, AYT, BAG, BB, BCM, BMS, BTB, BTF, CAD, CB, CC,

		CD, CDD, CH, CML, CN, CR, CTM, DAC, DAP, DFS, DG, DJD, DMC, DMT, DP, DS, DSP, DTH, DWC, DWH, EAB, EAF, EDG, EDM, EHR, EL, ELW, EWH, FTP, GJR, GLG, GMW, GRM, GT, HSP, ID, JC, JCS, JD, JDC, JIH, JKB, JKC, JKR, JMA, JRS, JRU, JSC, JST, JT, JTR, JV, JVV, KAH, LAZ, LG, LHG, MAG, MDJ, MG, MH, ML, MM, MMT, MRC, MS, MV, NH, NJJ, OAP, OMC, PAW, PB, PPW, RCC, RDK, REJ, RHJ, RHT, RJW, RK, RL, RLM, RM, RO, RW, SA, SDB, SEK, SKB, SLC, SMF, SPN, TB, TBS, TGG, TRS, VEM, WDA, WJG and WT
F.8.a	Each State hospital shall establish an effective infection control program that:	**Compliance:** Please see sub-cells below.
F.8.a.i	actively collects data regarding infections and communicable diseases;	**Current findings on previous recommendation:** **Recommendation 1, July 2008:** Provide data analysis, barriers to compliance, and specific plans of correction as required by the Court Monitor in the progress report for next review. **Findings:** See below. **Recommendation 2, July 2008:** Continue to monitor this requirement. **Findings (by test/disease):** **<u>Admission PPD</u>** Data from the DMH IC Admission PPD Auditing Form, based on an average sample of 94% of individuals admitted to the hospital with a negative PPD in the review months (June-November 2008), indicated the following:

1.	*Notification by the unit via a PPD form is sent to the Infection Control Department for all PPD readings.*	99%
2.	*PPDs were ordered by the physician during the admission procedure.*	99%
3.	*PPDs were administered by the nurse within 24 hours of the physicians order.*	97%
4.	*1st step PPDs were read by the nurse within 7 days of administration.*	98%
5.	*2nd step PPDs were read by the nurse within 48-72 hours of administration.*	96%

NSH's data demonstrated an increase in compliance for all items:

	Previous period	Current period
Mean compliance rate		
1.	84%	99%
2.	88%	99%
3.	82%	97%
4.	92%	98%
5.	59%	96%
Compliance rate in last month of period		
1.	89%	100%
2.	92%	100%
3.	92%	100%
4.	100%	100%
5.	89%	93%

F.8.a.ii: Assesses these data for trends
No problematic trends were identified.

F.8.a.iii: Initiates inquiries regarding problematic trends
None required.

F.8.a.iv: Identifies necessary corrective action
None required.

F.8.a.v: Monitors to ensure that appropriate remedies are achieved
The Infection Control Department will continue to monitor these items for compliance.

A review of the records of 27 individuals admitted during the review period (AMP, ANT, AYT, BCM, CC, CML, CTM, DJD, DMC, DWH, ELW, GT, JKC, JRS, JVV, MDJ, MG, NH, RCC, REJ, RL, RLM, SEK, SLC, SPN, TBS and WT) found that all contained a physician's order for PPD upon admission and 25 were administered within 24 hours. Also, 25 of the first-step PPDs and 23 of the second-step PPDs were read timely.

Annual PPD
Data from the DMH IC Annual PPD Auditing Form, based on an average sample of 62% of individuals needing an annual PPD during the review months (June-November 2008), indicated the following:

1.	*Notification by the unit via a PPD form sent to the Infection Control Department for all PPD readings.*	97%
2.	*PPDs were ordered by the physician during the annual review procedure.*	98%
3.	*PPDs were administered by the nurse within 24 hours of the order.*	99%
4.	*PPDs were read by the nurse within 48-72 hours of administration.*	99%

NSH's data demonstrated an increase in compliance for all items:

	Previous period	Current period
Mean compliance rate		
1.	75%	97%
2.	77%	98%
3.	74%	99%
4.	82%	99%
Compliance rate in last month of period		
1.	100%	100%
2.	93%	100%
3.	93%	100%
4.	97%	100%

F.8.a.ii: Assesses these data for trends
No problematic trends were identified.

F.8.a.iii: Initiates inquiries regarding problematic trends
None required.

F.8.a.iv: Identifies necessary corrective action
None required.

F.8.a.v: Monitors to ensure that appropriate remedies are achieved
The Infection Control Department will continue to monitor these items for compliance.

A review of the records of 25 individuals requiring annual PPDs (AMS, ASP, BB, BMS, CDD, CH, CR, DAC, DP, DS, DTH, EDM, EL, EWH, GJR, ID, JDC, LG, MMT, MRC, PB, PPW, RW, SKB and TRS) found that all contained a physician's order and all tests were timely given and read.

Hepatitis C

Data from the DMH IC Hepatitis C Auditing Form, based on an average sample of 97% of individuals admitted to the hospital who were positive for Hepatitis C in the review months (June-November 2008), indicated the following:

1.	*Notification by the lab was made to the Infection Control Department identifying the individual with a positive Hepatitis C Antibody.*	100%
2.	*Notification by the lab was made to the unit housing the individual that he/she has a positive Hepatitis C Antibody test.*	100%
3.	*Hepatitis C Tracking sheet was initiated or the Public Health database was updated for each individual testing positive for Hepatitis C Antibody.*	100%
4.	*The individual's medication plan was evaluated and immunizations for Hepatitis A and B were considered.*	81%
5.	*A Focus 6 is opened for Hepatitis C.*	94%
6.	*Appropriate objective is written to include treatment as required by the Hepatitis C Tracking Sheet.*	73%
7.	*Appropriate interventions are written to include treatment as required by the Hepatitis C Tracking Sheet, or as required by the WRP Manual.*	81%

NSH's data demonstrated several significant increases in mean compliance:

	Previous period	Current period
Mean compliance rate		
1.	100%	100%
2.	98%	100%
3.	60%	100%

4.	56%	81%
5.	80%	94%
6.	30%	73%
7.	35%	81%
Compliance rate in last month of period		
1.	100%	100%
2.	100%	100%
3.	100%	100%
4.	100%	50%
5.	77%	100%
6.	46%	67%
7.	46%	100%

F.8.a.ii: Assesses these data for trends
Inconsistencies in the evaluation of the medication plan continue to keep compliance rates low for item 4. In addition, consideration for immunizations for Hepatitis A and Hepatitis B has not been consistent. Problematic issues continue regarding items 6 and 7; objectives are not consistently and appropriately written or linked to the interventions.

F.8.a.iii: Initiates inquiries regarding problematic trends
The Infection Control Department reviewed each new Hepatitis C case and the WRPs to evaluate reasons for non-compliance. The Infection Control auditor assumed the role of liaison with unit nursing staff to identify and address these issues.

F.8.a.iv: Identifies necessary corrective action
NSH's Medical Director has reminded the PCPs that they are to make referrals to specialists. In addition, the Nurse Practitioners now are ordering the immunizations. Also, IC developed sample objectives and interventions to assist unit staff when writing WRPs. The Nursing Intervention Training, which includes the use of these sample objectives, began in December 2008. This training was also provided to the HSSs in

September 2008. The IC liaison has been assisting and reviewing the WRP objectives and interventions.

F.8.a.v: Monitors to ensure that appropriate remedies are achieved

An Audit-Driven Corrective Action Plan (ADCAP) has been initiated to monitor the PCPs regarding item 4. NSH will continue to monitor all items for compliance.

A review of the charts of 18 individuals who were admitted Hepatitis C positive (BB, CB, CD, DG, DSP, GLG, JCS, JTR, KAH, LAZ, MG, PAW, RK, RM, RO, VEM, WDA and WJG) found that 13 contained documentation that the medication plan and immunizations were evaluated and had appropriate objectives and interventions in the WRPs.

HIV Positive

Data from the DMH IC HIV Positive Auditing Form, based on a 100% sample of individuals who were positive for HIV antibody (three individuals) in the review months (June-November 2008), indicated the following:

1.	*Notification by the lab was made to the infection control department identifying the individual with a positive HIV Antibody.*	100%
2.	*Notification was made to the unit housing the individual that he/she has a positive HIV Antibody test.*	100%
3.	*If the individual was admitted with a diagnosis of HIV positive, a referral was made to the appropriate clinic during the admission process.*	100%
4.	*If the individual was diagnosed with HIV during hospitalization, a referral was made to the appropriate clinic.*	N/A
5.	*The individual is seen initially and followed up, as clinically indicated, by the appropriate clinic every*	100%

	three months for ongoing care and treatment, unless another timeframe is ordered by the physician.	
6.	*A Focus 6 is opened for HIV (unspecified viral illness).*	100%
7.	*Appropriate objective is written to address the progression of the disease.*	100%
8.	*Appropriate interventions are written.*	100%

NSH's data demonstrated increases in compliance or maintenance of mean compliance of 100% for all items:

	Previous period	Current period
Mean compliance rate		
1.	100%	100%
2.	100%	100%
3.	100%	100%
4.	N/A	N/A
5.	100%	100%
6.	75%	100%
7.	75%	100%
8.	75%	100%
Compliance rate in last month of period		
1.	100%	100%
2.	100%	100%
3.	100%	100%
4.	N/A	N/A
5.	100%	100%
6.	100%	100%
7.	100%	100%
8.	100%	100%

F.8.a.ii: Assesses these data for trends
There were no new cases of HIV in June-August 2008. No problematic trends were identified.

F.8.a.iii: Initiates inquiries regarding problematic trends
None required.

F.8.a.iv: Identifies necessary corrective action
None required.

F.8.a.v: Monitors to ensure that appropriate remedies are achieved
NSH's IC Department will continue to monitor these items.

A review of the records of three individuals admitted during the review period with HIV (JD, MM and TB) found that all were in compliance regarding clinic referrals and follow-up and all had appropriate objectives and interventions in the WRPs.

Immunizations
Data from the DMH IC Immunization Auditing Form, based on an average sample of 70% of individuals admitted to the hospital during the review months (June-November 2008), indicated the following:

1.	*Notification by the lab was made to the Infection Control Department of an individual's immunity status.*	95%
2.	*Notification by the lab was made to the unit housing the individual of his/her immunity status.*	99%
3.	*Immunizations were ordered by the physician within 30 days of receiving notification by the lab.*	42%
4.	*Immunizations were administered by the nurse within 24 hours of the physician order and completed within time frames.*	87%

The facility's data demonstrated an overall increase in mean compliance rates:

	Previous period	Current period
Mean compliance rate		
1.	88%	95%
2.	92%	99%
3.	37%	42%
4.	18%	87%
Compliance rate in last month of period		
1.	100%	92%
2.	97%	92%
3.	74%	50%
4.	33%	100%

F.8.a.ii: Assesses these data for trends
Compliance is low regarding immunizations being ordered by the physician within 30 days of receiving notification by the lab. Compliance regarding immunizations being administered with 24 hours trended upward to 100% for the last three months of the review period.

F.8.a.iii: Initiates inquiries regarding problematic trends
Further analysis of item 3 data showed that the low compliance was due to the laboratory sending the lab results late. The Laboratory Supervisor retired in October 2008 and the laboratory technician assigned to the Physician Order System (POS) entry had resigned. The consequent delay in POS entry resulted in low compliance. In addition, it was found that the POS admission lab and non-standardized vaccination orders were confusing to physicians and nursing staff.

F.8.a.iv: Identifies necessary corrective action
The Public Health staff met with the current acting Lab Supervisor and

		POS programmer and resolved the issue. A recommendation was made to the POS Committee that all lab orders related to immune status should be "Required" on admission panel in POS and that a standardized order for immunizations is created in POS to rectify the existing confusion. There are plans for the Lab to purchase a new Lab Information System. In addition, the Medical Director has reminded the physicians and NPs to timely review immune status and lab results for needed immunizations. A system is being developed to ensure this will be done regularly and timely. F.8.a.v: Monitors to ensure that appropriate remedies are achieved An Audit-Driven Corrective Action Plan (ADCAP) for the PCPs is being implemented to monitor item 4 data and IC will continue to audit these items. A review of the charts of 18 individuals (BB, CB, CD, DG, DSP, GLG, JCS, JTR, KAH, LAZ, MG, PAW, RK, RM, RO, VEM, WDA and WJG) found that 11 contained documentation that the immunizations were ordered by the physician within 30 days of receiving notification by the lab and that immunizations were timely administered in 14 cases. **Immunization Refusals** NSH's data from the DMH IC Immunization Refusal Auditing Form could not be interpreted since mean scores for all items were presented as 100%, yet the compliance data for items 2-5 in November 2008 was 0%. In addition, NSH's progress report indicated problematic trends for these items, thus confirming that the data was inaccurate. F.8.a.ii: Assesses these data for trends Although NSH's data could not be interpreted, it was determined that the overall tracking system for immunization refusals was inconsistent. Also, objectives and interventions addressing refusals were not consistently incorporated into the individuals' WRPs.

F.8.a.iii: Initiates inquiries regarding problematic trends
NSH identified the need for coordination of a unified system to track refusals with EP staff and training and oversight to ensure that WRP objectives are written in objective, behavioral and measurable terms and linked to the interventions.

F.8.a.iv: Identifies necessary corrective action
A tracking system revision for refusals was completed in September 2008 to improve this issue. Also, sample objectives and interventions were developed and the Nursing Intervention Training was implemented in December 2008. The Infection Control liaison now assists unit nursing staff with writing appropriate objectives and interventions.

F.8.a.v: Monitors to ensure that appropriate remedies are achieved
The IC Department will continue to monitor these items.

A review of the records of 10 individuals that refused immunizations (AAK, AS, DMT, EAF, EDG, JKR, MV, RDK, RHT and SMF) found that five were in compliance regarding documentation in the WRP.

MRSA
Data from the DMH IC MRSA Auditing Form, based on a 100% sample (15 individuals) of individuals in the hospital who test positive for MRSA during the review months (June-November 2008), indicated the following:

1.	*Notification by the lab was made to the Infection Control Department when an individual has a positive culture for MRSA.*	100%
2.	*Notification by the lab was made to the unit housing the individual that a positive culture for MRSA was obtained.*	100%
3.	*The individual is placed on contact precaution per*	100%

	MRSA policy.	
4.	*The appropriate antibiotic was ordered for treatment of the infection(s).*	100%
5.	*The public health office contacts the unit RN and provides MRSA protocol and guidance for the care of the individual.*	100%
6.	*A Focus 6 is opened for MRSA.*	81%
7.	*Appropriate objective is written to include prevention of spread of infection.*	91%
8.	*Appropriate interventions are written to include contact precautions.*	91%

NSH's data showed that overall there has been an increase in mean compliance rates:

	Previous period	Current period
Mean compliance rate		
1.	80%	100%
2.	76%	100%
3.	92%	100%
4.	100%	100%
5.	100%	100%
6.	82%	81%
7.	50%	91%
8.	50%	91%
Compliance rate in last month of period		
1.	100%	100%
2.	100%	100%
3.	100%	100%
4.	100%	100%
5.	100%	100%

6.	100%	0%
7.	100%	0%
8.	100%	0%

F.8.a.ii: Assesses these data for trends
In the November data, there was no Focus 6 opened for the single case of MRSA identified during that month, resulting in 0% compliance scores.

F.8.a.iii: Initiates inquiries regarding problematic trends
A review of the case showed that the lesion healed before the culture results were known to the physician, thus Focus 6 was not opened.

F.8.a.iv: Identifies necessary corrective action
Sample objectives and interventions were developed and training (Nursing Intervention Training) was implemented in December 2008. The Infection Control liaison now assists unit nursing staff with writing appropriate objectives and interventions.

F.8.a.v: Monitors to ensure that appropriate remedies are achieved
Infection Control will continue to monitor these items for compliance.

A review of the records for 12 individuals with MRSA (CR, DFS, JC, JIH, JRU, JV, LHG, NJJ, OMC, RHJ, RJW and TGG) found that all were placed on contact precautions and on the appropriate antibiotic, and eight had MRSA appropriately addressed in their WRPs

Positive PPD
Data from the DMH IC Positive PPD Auditing Form, based on an average sample of 81% of individuals in the hospital who had a positive PPD test during the review months (June-November 2008), demonstrated the following:

1.	*Notification by the unit via a PPD form is sent to*	92%

	Public Health Office for all PPD readings.	
2.	*All positive PPDs received PA and Lateral Chest X-ray.*	100%
3.	*All positive PPDs received an evaluation by the Med-Surg Physician.*	100%
4.	*If active disease is identified, then individual is transferred to medical isolation and appropriate treatment is provided.*	N/A
5.	*If LTBI is present, there is a Focus 6 opened.*	68%
6.	*If LTBI is present, there are appropriate objectives written to provide treatment and to prevent spread of the disease.*	66%
7.	*If LTBI is present, there are appropriate interventions written to prevent the progression of the disease.*	64%

Items for which data is available showed mixed changes in mean compliance (items 5-7 from the previous review period were "N/A" due to revisions made to the auditing tool; thus no comparative data were available):

	Previous period	Current period
Mean compliance rate		
1.	97%	89%
2.	80%	100%
3.	54%	100%
4.	N/A	N/A
5.	N/A	68%
6.	N/A	66%
7.	N/A	64%
Compliance rate in last month of period		
1.	100%	100%

2.	100%	100%
3.	100%	100%
4.	N/A	N/A
5.	N/A	100%
6.	N/A	100%
7.	N/A	90%

F.8.a.ii: Assesses these data for trends
There were no cases of active disease identified during the review period, making item 4 not applicable. Incorporation of LTBI (latent TB infection) in the WRP has increased steadily during this review period and was at or near 100% compliance for the last two months (October-November 2008).

F.8.a.iii: Initiates inquiries regarding problematic trends
No problematic trends were identified.

F.8.a.iv: Identifies necessary corrective action
No corrective action was required.

F.8.a.v: Monitors to ensure that appropriate remedies are achieved
The IC Department will continue to monitor these items.

Review of records for 15 individuals who had a positive PPD (AYT, BAG, BTB, CAD, DAP, EAB, FTP, GMW, HSP, JDC, JMA, JSC, MH, OAP and WT) found all had the required chest x-rays and documentation of an evaluation from the physician; nine had appropriate objectives and interventions in the WRP.

Refusal of Admitting or Annual Lab Work or Diagnostic Tests
Data from the DMH IC Refused Admitting or Annual Lab Work or Diagnostic Test Audit, based on a 96% sample of individuals in the hospital who refuse their admission lab work, admission PPD, or annual

PPD during the review months (June-November 2008), indicated the following:

1.	*Notification by the unit that the individual refused his/her admission or annual lab work or admission or annual PPD, is sent to the Infection Control Department.*	98%
2.	*There is a Focus opened for the lab work or PPD refusal.*	26%
3.	*There are appropriate objectives written for the lab work or PPD refusal.*	50%
4.	*There are appropriate interventions written for the lab work or PPD refusal.*	50%

NSH's data showed an increase in compliance, however, items 2-4 remain low:

	Previous period	Current period
Mean compliance rate		
1.	77%	98%
2.	3%	26%
3.	3%	50%
4.	3%	50%
Compliance rate in last month of period		
1.	90%	100%
2.	10%	67%
3.	10%	100%
4.	10%	100%

F.8.a.ii: Assesses these data for trends

The tracking system for PPD refusals has been inconsistent. Compliance

		regarding addressing refusals in the WRPs has been inconsistent although some progress has been made. F.8.a.iii: Initiates inquiries regarding problematic trends A unified tracking system for refusals was developed in conjunction with EP staff. F.8.a.iv: Identifies necessary corrective action The tracking system for refusals was completed in September 2008. Also, sample objectives and interventions were developed and training, (Nursing Intervention Training) was implemented in December 2008. The Infection Control liaison now assists unit nursing staff with writing appropriate objectives and interventions. F.8.a.v: Monitors to ensure that appropriate remedies are achieved The IC Department will continue to monitor these items. A review of the records of 14 individuals who have refused admitting or annual labs/diagnostics (BTF, CN, DWC, EHR, GRM, JKB, JST, JT, MAG, MG, ML, MS, SA and SDB) found that the refusals were addressed the WRPs of four individuals. **Sexually Transmitted Diseases** There were no individuals at NSH with an active STD during the review period s. **Compliance:** Partial. **Current recommendations**: 1. Provide accurate data regarding immunizations. 2. Continue to monitor this requirement.

F.8.a.ii	assesses these data for trends;	**Current findings on previous recommendation:** **Recommendation, July 2008:** Continue current practice. **Findings:** See F.8.a.i. **Other findings:** Key indicator data regarding Hepatitis C indicated a 21% increase between October and December. However, the data provided by the IC Department in the progress report regarding individuals admitted with Hepatitis C did not reflect this. In addition, the key indicator data regarding MRSA indicated an increase in individuals diagnosed with MRSA from 35 to 47 in November 2008. Again, the data provided by IC in the progress report did not indicate this increase. By the end of the review, Standards Compliance reported that the discrepancies were due to data differences between two databases. However, the IC Department was not able to clarify the etiology of the data errors. **Compliance:** Partial. **Current recommendations**: 1. Review and analyze Key Indicator Infection Control data to ensure that it accurately reflects trends regarding Infection Control issues. 2. Continue to monitor this requirement.
F.8.a.iii	initiates inquiries regarding problematic trends;	**Current findings on previous recommendation:** **Recommendation, July 2008:** Continue current practice.

		Findings: See F.8.a.i. **Compliance:** Substantial. **Current recommendation**: Continue to monitor this requirement
F.8.a.iv	identifies necessary corrective action;	**Current findings on previous recommendation:** **Recommendation, July 2008:** Continue current practice. **Findings:** See F.8.a.i. **Compliance:** Substantial. **Current recommendation**: Continue to monitor this requirement
F.8.a.v	monitors to ensure that appropriate remedies are achieved; and	**Current findings on previous recommendation:** **Recommendation, July 2008:** See F.8.a.i. **Findings:** See F.8.a.i. **Other findings:** NSH's minutes from the Infection Control Committee meetings,

		Infectious Disease Meetings and the Infection Control Audit Report validate that the IC Department continuously monitors corrective actions and recommendations regarding problematic trends. Also see F.8.a.i. **Compliance:** Substantial. **Current recommendation**: Continue to monitor this requirement.
F.8.a.vi	integrates this information into each State hospital's quality assurance review.	**Current findings on previous recommendation:** **Recommendation, July 2008:** Continue current practice. **Findings:** Review of minutes from the NSH Risk Reduction Oversight Committee, Nursing Coordinator Meetings, Nursing Policy and Procedure Committee, and Health Services Specialist Meetings verify that IC issues have been discussed and plans of action have been implemented and integrated into the different departments and into the facility's Risk Reduction Oversight Committee. **Compliance:** Substantial. **Current recommendation**: Continue to monitor this requirement.

9. Dental Services		
	Each State hospital shall provide individuals with adequate, appropriate and timely routine and emergency dental care and treatment, consistent with generally accepted professional standards of care.	**Methodology:** Interviewed: Craig B. Story, DDS, Chief Dentist Reviewed: 1. NSH progress report and data 2. List if individuals who had extractions 3. List of individuals refusing dental services 4. List of individuals needing preventative and restorative dental treatment 5. List of individuals admitted to NSH 6. Dental log of missed appointments 7. Medical records for the following 82 individuals: AEM, AFD, AKW, AMS, ANT, ASP, ATA, BB, BB-2, BMS, BRS, BWS, CAG, CDD, CH, CR, DAC, DAL, DDA, DEL, DEP, DH, DKG, DP, DRP, DS, DTH, EAD, EAL, EDM, EL, EWH, GJR, GRW, HFH, HJS, ID, JCM, JCM-2, JDC, JMH, JPM, JR, KB, KJ, KRT, LG, LK, LRK, MAM, MB, MDF, MLC, MM, MMT, MO, MRC, MTD, PA, PB, POH, PPW, PRG, RH, RM, RVT, RW, RWB, RWJ, SC, SFS, SG, SKB, SP, SYV, TB, TBS, TJC, TRS, TSD, VC and ZK
F.9.a	Each State hospital shall retain or contract with an adequate number of qualified dentists to provide timely and appropriate dental care and treatment to all individuals it serves;	**Current findings on previous recommendation:** **Recommendation, July 2008:** Continue to monitor this requirement. **Findings:** NSH continues with 3.5 FTE Dentists and 1.5 Dental Hygienists, which is the same staffing as the last review. Although overall most compliance rates increased as projected from the last review due to an increase in dental staffing in the second quarter of 2008, the Dental Department acknowledges problems regarding timely follow-up care for individuals with

		problems identified on admission or during the annual examination (see F.9.b.i); needing to add preventative care (Oral Hygiene Instruction) during annual exams (see F.b.9.iii) and addressing individuals who refuse dental services (see F.9.e). **Compliance:** Partial. **Current recommendation**: Continue to monitor this requirement.
F.9.b	Each State hospital shall develop and implement policies and procedures that require:	**Compliance:** Partial.
F.9.b.i	comprehensive and timely provision of dental services;	**Current findings on previous recommendations:** **Recommendation 1, July 2008:** Increase sample size to 20%. **Findings:** NSH has significantly increased the sample size for this data to a range of 80% to 100%. **Recommendation 2, July 2008:** Collect data for the full review period. **Findings:** NSH has collected data for this requirement for the full review period (June-November 2008). **Recommendation 3, July 2008:** Continue to monitor this requirement.

Findings:
NSH's data from the DMH Dental Services Audit Form, based on a 100% sample of individuals scheduled for a comprehensive dental exam during the review months (June-November 2008), is summarized in the table below:

1.a	*Comprehensive dental exam was completed*	95%
1.a.i	*Oral hard and soft tissue exam*	100%
1.a.ii	*Review of x-rays*	96%
1.a.iii	*Periodontal exam*	99%
1.a.iv	*Review of prosthetics, if present*	99%

A review of the records of 20 individuals (AKW, ANT, ATA, BB, BWS, DAL, DKG, DRP, HJS, JR, KRT, LRK, MLC, MM, RVT, RWJ, SFS, SP, SYV and TBS) found that 19 had had comprehensive dental exams. There were no dental notes found in the chart for one individual (BWS).

NSH's data from the DMH Dental Services Audit Form, based on an average sample of 80% of individuals who had been in the hospital for 90 days or less during the review period (June-November 2008), indicated that 95% of admissions exams were performed timely. This is a significant increase from 68% in the previous review period.

A review of the records of 20 individuals (AKW, ANT, ATA, BB, BWS, DAL, DKG, DRP, HJS, JR, KRT, LRK, MLC, MM, RVT, RWJ, SFS, SP, SYV and TBS,) found that 18 were timely seen for their admission exam. There were no dental notes found in the chart for one individual (BWS) and one individual was not timely seen (ANT).

NSH's data from the DMH Dental Services Audit Form, based on a 100% sample of individuals due for annual routine dental examination during the review months (June-November 2008), is summarized below:

1.c	*Annual date of examination was within anniversary*	89%

	month of admission	

NSH's data demonstrated a significant increase in compliance regarding the timeliness of annual dental exams:

	Previous period	Current period
Mean compliance rate		
1.c	61%	89%
Compliance rate in last month of period		
1.c	54%	93%

A review of the records of 25 individuals due for an annual dental exam during the review period (AMS, ASP, BB, BMS, CDD, CH, CR, DAC, DP, DS, DTH, EDM, EL, EWH, GJR, ID, JDC, LG, MMT, MRC, PB, PPW, RW, SKB and TRS) found that 22 were completed timely.

NSH's data from the DMH Dental Services Audit Form, based on a 100% sample of individuals with dental problems identified on admission or annual examination during the review months (June-November 2008), is summarized below:

1.d	*Individuals with identified problems on admission or annual examination receive follow-up care, as indicated, in a timely manner*	63%

NSH's data demonstrated a significant decrease in compliance for this sub-item:

	Previous period	Current period
Mean compliance rate		
1.d	100%	63%

		<table><tr><td colspan="3">Compliance rate in last month of period</td></tr><tr><td>1.d</td><td>100%</td><td>70%</td></tr></table> The facility reported that barriers to compliance were the continued demands of exams and emergent treatment which limit the number of follow-up appointments that can be made. NSH's follow-up care is prioritized based on urgency and thus those most urgent (Level 1) are scheduled ahead of lower priority levels. No plan of correction was provided. NSH's data from the DMH Dental Services Audit Form, based on a 100% sample of individuals with dental problems identified during their hospital stays other than on admission or annual examination during the review months (June-November 2008) indicated that 97% of individuals received timely follow-up care. This is an increase from 79% in the last review period. A review of the records of 45 individuals (AKW, AMS, ANT, ASP, ATA, BB, BB-2, BMS, BWS, CDD, CH, CR, DAC, DAL, DKG, DP, DRP, DS, DTH, EDM, EL, EWH, GJR, HJS, ID, JDC, JR, KRT, LG, LRK, MLC, MM, MMT, MRC, PB, PPW, RVT, RW, RWJ, SFS, SKB, SP, SYV, TBS and TRS) found that 37 were timely seen for follow-up care. **Current recommendations**: 1. Provide comparison data for sub-items, barriers to compliance and plans of corrections as appropriate. 2. Continue to monitor this requirement.
F.9.b.ii	documentation of dental services, including but not limited to, findings, descriptions of any treatment provided, and the plans of care:	**Current findings on previous recommendation:** **Recommendation, July 2008:** Continue to monitor this requirement.

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Findings:
NSH's data from the DMH Dental Services Audit Form, based on a 100% sample of individuals scheduled for follow-up dental care during the review months (June-November 2008), is summarized below:

<table>
<tr><td>2.a</td><td>The current status</td><td>100%</td></tr>
<tr><td>2.b</td><td>Findings of the examination</td><td>100%</td></tr>
<tr><td>2.c</td><td>Plan of care</td><td>100%</td></tr>
<tr><td>2.d</td><td>The plans of care are consistent with examination findings</td><td>100%</td></tr>
</table>

NSH maintained high compliance from the prior period for items 2.a through 2.c and increased compliance for item 2.d from 88% in the prior period to 100% in the current period.

A review of the records of 45 individuals (AKW, AMS, ANT, ASP, ATA, BB, BB-2, BMS, BWS, CDD, CH, CR, DAC, DAL, DKG, DP, DRP, DS, DTH, EDM, EL, EWH, GJR, HJS, ID, JDC, JR, KRT, LG, LRK, MLC, MM, MMT, MRC, PB, PPW, RVT, RW, RWJ, SFS, SKB, SP, SYV, TBS and TRS) found that 43 were in compliance with the documentation requirements.

Current recommendation:
Continue current practice.
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<tr>
<td>F.9.b.iii</td>
<td>use of preventive and restorative care whenever possible; and</td>
<td>
Current findings on previous recommendations:

Recommendation 1, July 2008:
Collect data for the full review period.

Findings:
NSH collected data for preventive care for the full review period (June-November 2008). Although data for restorative care was also collected, the criterion for this item was changed and thus data was provided only for
</td>
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October and November 2008.

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

Findings:
NSH's data using the DMH Dental Services Audit Form, based on a 51% sample of individuals due for annual routine dental examinations during the review months (June-November 2008), indicated the following:

3.a	*Preventive care was provided, including but not limited to cleaning, root planning, sealant, fluoride application or Oral Hygiene Instruction (OHI)*	52%

No comparison data was provided. NSH's progress report indicated that a barrier to compliance for this item is that monitoring does not capture preventive dental care that is provided by the Dental Department outside the annual exams. The plan of correction includes bringing this issue to the statewide Dental Committee for discussion and ensuring that dental staff document oral hygiene instruction at all annual appointments.

A review of the records of 25 individuals who received an annual dental exam (AMS, ASP, BB, BMS, CDD, CH, CR, DAC, DP, DS, DTH, EDM, EL, EWH, GJR, ID, JDC, LG, MMT, MRC, PB, PPW, RW, SKB and TRS) found that preventive care was provided to 11 individuals.

NSH's data from the DMH Dental Services Audit Form, based on a 28% sample of individuals scheduled for Level 1 restorative dental care during the review months of October and November 2008 when the new tool was implemented for this item, indicated the following:

3.c	*Restorative care was provided including permanent or temporary restorations (fillings)*	95%

<table>
<tr>
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<td>A review of the records of 45 individuals (AKW, AMS, ANT, ASP, ATA, BB, BB-2, BMS, BWS, CDD, CH, CR, DAC, DAL, DKG, DP, DRP, DS, DTH, EDM, EL, EWH, GJR, HJS, ID, JDC, JR, KRT, LG, LRK, MLC, MM, MMT, MRC, PB, PPW, RVT, RW, RWJ, SFS, SKB, SP, SYV, TBS and TRS) found that 40 received restorative care.

Current recommendation:
Continue to monitor this requirement.</td>
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<tr>
<td>F.9.b.iv</td>
<td>tooth extractions be used as a treatment of last resort, which, when performed, shall be justified in a manner subject to clinical review.</td>
<td>Current findings on previous recommendation:

Recommendation, July 2008:
Continue current practice.

Findings:
NSH's data from the DMH Dental Services Audit Form, based on a 100% sample of individuals who had tooth extraction during the review months (June-November 2008), indicated the following:

<table>
<tr><td>4.a</td><td>Periodontal conditions, requirement for denture construction, non-restorable tooth, or severe decay</td><td>100%</td></tr>
<tr><td>4.b</td><td>If none of the above reasons is included, other reason stated is clinically appropriate</td><td>100%</td></tr>
</table>

NSH's data demonstrates maintenance of compliance for item 4.a. Item 4.b was not on the previous monitoring tool.

A review of 18 individuals who had tooth extractions during the review period (AEM, AFD, BRS, DEP, JCM, JMH, JPM, KB, LK, MB, MMT, MO, PRG, RH, RM, TJC, TSD and ZK) found that all were in compliance.</td>
</tr>
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<table>
<tr><td></td><td></td><td>Current recommendation:
Continue current practice.</td></tr>
<tr><td>F.9.c</td><td>Each State hospital shall ensure that dentists demonstrate, in a documented fashion, an accurate understanding of individuals' physical health, medications, allergies, and current dental status and complaints.</td><td>
Current findings on previous recommendations:

Recommendation 1, July 2008:
Develop a plan of correction addressing item 5.e.

Findings:
NSH did not address this recommendation; however, their data indicated that mean compliance significantly increased from 48% in the last review period to 99% in the current period.

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

Findings:
NSH's data from the DMH Dental Services Audit Form, based on a 100% sample of individuals who received comprehensive dental examination or follow-up dental care during the review months (June-November 2008), is summarized below:
<table>
<tr><td>5.a</td><td>Physical health impact on dental service</td><td>99%</td></tr>
<tr><td>5.b</td><td>Medications</td><td>99%</td></tr>
<tr><td>5.c</td><td>Allergies that impact on dental service</td><td>98%</td></tr>
<tr><td>5.d</td><td>General condition of current oral environment</td><td>99%</td></tr>
<tr><td>5.e</td><td>When individual complaint is noted within the findings, there is documentation related to exam results</td><td>99%</td></tr>
</table>

NSH maintained high compliance from the prior period for items 5.a through 5.d and increased compliance for item 5.e from 48% in the prior period to 99% in the current period.
</td></tr>
</table>

<table>
<tr><td></td><td></td><td>A review of the records for 45 individuals (AKW, AMS, ANT, ASP, ATA, BB, BB-2, BMS, BWS, CDD, CH, CR, DAC, DAL, DKG, DP, DRP, DS, DTH, EDM, EL, EWH, GJR, HJS, ID, JDC, JR, KRT, LG, LRK, MLC, MM, MMT, MRC, PB, PPW, RVT, RW, RWJ, SFS, SKB, SP, SYV, TBS and TRS) found that 44 were in compliance with the documentation requirements.

Compliance:
Substantial.

Current recommendation:
Continue current practice.</td></tr>
<tr><td>F.9.d</td><td>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.</td><td>Current findings on previous recommendation:

Recommendation, July 2008:
See F.9.e.

Findings:
NSH's data from the DMH Dental Services Audit Form, based on a 100% sample of individuals scheduled for a dental appointment during the review months (June-November 2008), indicated the following:

<table>
<tr><td>6.a</td><td>The individual attended the scheduled appointment</td><td>69%</td></tr>
</table>

NSH's comparison data showed little change from the prior review period:

<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>6.a</td><td>71%</td><td>69%</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>6.a</td><td>80%</td><td>74%</td></tr>
</table>
</td></tr>
</table>

		NSH's analysis showed that nearly 30% of all dental appointments are missed and refusals are the major reason for missed appointments. The data for this item demonstrated a slight decrease in compliance. NSH's plan of correction includes Dental Services' submission of names of individuals who have refused dental services to the Enhancement Plan Office for notification of the appropriate WRPT, beginning in September 2008. A review of the missed dental appointment logs for June-November 2008 verified that the majority of missed appointments were due to refusals, not transportation or staffing issues. **Compliance:** Partial. **Current recommendation**: Continue to monitor this requirement.
F.9.e	Each State hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to overcome individual's refusals to participate in dental appointments.	**Current findings on previous recommendations:** **Recommendation 1, July 2008:** Ensure that the Dental Department is involved in the development of a plan of correction addressing this requirement. **Findings:** Since the last review, the Chief Dentist reported that he has been a member of the hospital-wide work group addressing refusals of all types of services and provides input regarding missed dental appointments and strategies to reduce the number of refusals, adequately addressing this recommendation. **Recommendation 2, July 2008:** Continue to monitor this requirement.

Findings:
NSH's data from the DMH Dental Services Audit Form for a 100% sample of individuals scheduled but refused to attend dental appointment during each month June-November 2008) is summarized below:

7.	*Each state hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to overcome individual's refusals to participate in dental appointments*	42%

Data collection for this item began in May 2008, so comparison data for the full previous review period is not available. The compliance rates for May 2008 and November 2008 were 39% and 30% respectively.

NSH's progress report indicated that by implementing the system in September 2008 whereby the names of individuals who have refused dental services are submitted to the EP office for WRPT notification, the number of refusals has decreased and are expected to continue to decrease over the next review period. Although this has helped reduce refusals, NSH indicated that there are still problems educating individuals regarding dental care. In February, the Mall Director plans to implement a number of Wellness Groups addressing dental hygiene and there will be continued follow-up monitoring of WRP addressing of refusals, with this data provided to the Clinical Management Team.

A review of 20 individuals who refused dental appointments (CAG, DDA, DEL, DH, EAD, EAL, GRW, HFH, JCM-2, KJ, MAM, MDF, MTD, PA, POH, RWB, SC, SG, TB and VC) found that eight had an open focus with interventions addressing refusals included in their WRPs.

Compliance:
Partial.

		Current recommendation: Continue to monitor this requirement.

G. Documentation		
G	Each State hospital shall ensure that an individual's records accurately reflect the individual's response to all treatment, rehabilitation and enrichment activities identified in the individual's therapeutic and rehabilitation service plan, including for children and adolescents, their education plan, consistent with generally accepted professional standards of care. Each State hospital shall develop and implement policies and procedures setting forth clear standards regarding the content and timeliness of progress notes, transfer notes, school progress notes, and discharge notes, including, but not limited to, an expectation that such records include meaningful, accurate, and coherent assessments of the individual's progress relating to treatment plans and treatment goals, and that clinically relevant information remains readily accessible.	**Summary of Progress:** Please refer to Sections D, E, F and H for judgments on the progress NSH has made towards aligning documentation practices with the requirements of the EP.

H. Restraints, Seclusion, and PRN and Stat Medication		
H		**Summary of Progress:** 1. NSH has improved the accuracy of data regarding seclusion, restraint, and PRN and Stat medications. 2. NSH has demonstrated improvement in and continues to implement strategies regarding WRP review and modification for individuals meeting the trigger criteria for restraint. 3. While compliance is not yet substantial, the facility has demonstrated broad improvement in decision-making and documentation related to the use of seclusion and restraint.
H	Each State hospital shall ensure that restraints, seclusion, psychiatric PRN medications, and Stat medications are used consistent with generally accepted professional standards of care.	**Methodology:** <u>Interviewed</u>: 4. Cindy Black, Standards Compliance Director 5. Laura I. Borja, RN, SCD Auditor 6. Linda Goodwin, Acting Nurse Administrator 7. Melva Wright, Psychiatric Technician, SCD Auditor 8. Michelle Patterson, Health Service Specialist 9. Nolen Oribello, RN, SCD Auditor 10. Steve Weule, Supervising Registered Nurse <u>Reviewed</u>: 1. NSH's progress report and data 2. Comprehensive Nursing Enhancement Plan Review training curricula addressing "fading" 3. Training rosters 4. Seclusion or Restraint Trigger Monitor form 5. Notice of Non-Competency with Competency Validation memo 6. Seclusion and Restraint Documentation Improvement Outline 7. WaRMSS data 8. Medical records for the following 38 individuals: AA, AC, AG, AL, AS,

		BJB, BJC, CCD, DBC, DEH, DH, DP, DSH, EH, ERM, GIR, GR, JB, JJB, JJY, JM, JMU, KT, MKS, ML, MP, MR, NH, OJR, PB, RRW, RW, SRP, TJ, TR, VC, VH and WRB
H.1	Each State hospital shall revise, as appropriate, and implement policies and procedures regarding the use of seclusion, restraints, psychiatric PRN medications, and Stat Medications consistent with generally accepted professional standards of care. In particular, the policies and procedures shall expressly prohibit the use of prone restraints, prone containment and prone transportation and shall list the types of restraints that are acceptable for use.	**Current findings on previous recommendation:** **Recommendation, July 2008:** Continue to monitor this requirement. **Findings:** No incidents of prone restraint, containment or transportation were found during this review. NSH recently revised the Comprehensive Nursing Enhancement Plan Review training to include prohibition of the use of "fading." **Compliance:** Substantial. **Current recommendation**: Continue to monitor this requirement.
H.2	Each State hospital shall ensure that restraints and seclusion:	**Compliance:** Partial.
H.2.a	are used in a documented manner and only when individuals pose an imminent danger to self or others and after a hierarchy of less restrictive measures has been considered in a clinically justifiable manner or exhausted;	**Current findings on previous recommendations:** **Recommendation 1, July 2008:** Conduct re-training as planned. **Findings:** Training roster review verified that NSH provided mandatory training regarding seclusion and restraint during September and October 2008 to 885 staff out of 1018 (53 were excused, 80 were unexcused). Those who

missed the training will be rescheduled.

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

Findings:
The facility reported data from the DMH Seclusion/Restraint Audit, based on a 66% sample of initial seclusion orders for June-November 2008. The table below summarizes NSH's data:

2.	*Restraints and seclusion are used in a documented manner.*	71%
2.a	*The IDN described specific behavior that was imminently dangerous to self or others, and*	90%
2.b	*The Physician's Order described specific behavior that was imminently dangerous to self or others.*	75%
3.	*Restraints and seclusion are used only when the individual posed an imminent danger to self or others.*	94%
3.a	*The justification for seclusion was to prevent harm to self*	97%
3.b	*Did not include prevention of harm from others.*	98%
4.	*Restraints and seclusion are used after a hierarchy of less-restrictive measures has been considered in a clinically justifiable manner or exhausted.*	83%
4.a	*The IDN described specific, less-restrictive interventions that were tried prior to the use of restraints or seclusion, or there is clinical justification when less-restrictive interventions were not used.*	87%
4.b	*The IDN described the individual's specific response to each intervention used, or there is clinical justification when less- restrictive interventions were not used.*	85%

NSH's data demonstrated significant increases in compliance:

	Previous period	Current period
Mean compliance rate		
2.	46%	71%
4.	63%	83%
Compliance rate in last month of period		
2.	58%	71%
2.a	74%	93%
2.b	79%	81%
4.	63%	81%
4.a	N/A	N/A
4.b	N/A	N/A

NSH identified as barriers to compliance the facts that some physician orders still need to include specific behaviors and some nursing staff are not consistently documenting a clear hierarchy of interventions. The facility also identified issues with observation records not being completed appropriately across all programs and units. NSH has broken the data down by units and programs to identify those with problematic trends. NSH's plan of correction included implementing mentoring in October 2008 by the senior psychiatrist regarding writing orders for specific behaviors for seclusion and restraints. Also, the Health Services Specialists (HSSs) are reviewing episodes of seclusion and restraint during the actual episode to identify, monitor and mentor unit staff involved in seclusion or restraint episodes. A unit breakdown of the Seclusion and Restraint Monitoring data will be presented at the Nursing Enhancement Plan Meeting. Individual staff issues regarding compliance will be referred to the Nursing Coordinators for performance review.

A review of 30 episodes of seclusion for 13 individuals (AC, BJB, CCD,

DBC, DEH, DP, DSH, EH, ERM, MKS, NH, TJ and WRB) found that the documentation for 25 episodes supported the decision to place the individual in seclusion. Less restrictive alternatives attempted were documented in 16 episodes and 19 had orders that included specific behaviors.

The DMH Seclusion/Restraint Audit, based on a 67% sample of initial restraint orders for June-November 2008, indicated the following:

2.	*Restraints and seclusion are used in a documented manner.*	75%
2.a	*The IDN described specific behavior that was imminently dangerous to self or others, and*	94%
2.b	*The Physician's Order described specific behavior that was imminently dangerous to self or others.*	77%
3.	*Restraints and seclusion are used only when the individual posed an imminent danger to self or others.*	97%
3a.	*The justification for restraint was to prevent harm to self*	98%
3b.	*Did not include prevention of harm from others.*	99%
4.	*Restraints and seclusion are used after a hierarchy of less-restrictive measures has been considered in a clinically justifiable manner or exhausted.*	83%
4.a	*The IDN described specific, less-restrictive interventions that were tried prior to the use of restraints or seclusion, or there is clinical justification when less-restrictive interventions were not used.*	84%
4.b	*The IDN described the individual's specific response to each intervention used, or there is clinical justification when less- restrictive interventions were not used.*	84%

<table>
<tr>
<td></td>
<td></td>
<td>NSH's comparison data indicated several significant increases in compliance:

<table>
<tr><th></th><th>Previous period</th><th>Current period</th></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>2.</td><td>52%</td><td>75%</td></tr>
<tr><td>4.</td><td>79%</td><td>83%</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>2.</td><td>49%</td><td>78%</td></tr>
<tr><td>2.a</td><td>86%</td><td>98%</td></tr>
<tr><td>2.b</td><td>54%</td><td>78%</td></tr>
<tr><td>4.</td><td>85%</td><td>92%</td></tr>
<tr><td>4.a</td><td>N/A</td><td>N/A</td></tr>
<tr><td>4.b</td><td>N/A</td><td>N/A</td></tr>
</table>

See above for identified barriers to compliance and plan of correction.

A review of 45 episodes of restraint for 15 individuals (AL, BJB, BJC, DBC, EH, JJB, JJY, JMU, ML, OJR, PB, RW, SRP, VH and WRB) found that the documentation for 32 episodes supported the decision to place the individual in restraint. Less restrictive alternatives attempted were documented in 27 episodes and 25 had orders that included specific behaviors.

Current recommendation:
Continue to monitor this requirement.</td>
</tr>
<tr>
<td>H.2.b</td>
<td>are not used in the absence of, or as an alternative to, active treatment, as punishment, or for the convenience of staff;</td>
<td>**Current findings on previous recommendation:**

Recommendation, July 2008:
Continue to monitor this requirement.</td>
</tr>
</table>

Findings:
The DMH Seclusion/Restraint Audit, based on a 66% sample of initial seclusion orders for June-November 2008, indicated the following:

5.	*Restraints and seclusion are not used in the absence of, or as an alternative to, active treatment.*	76%
5.a	*There is a Focus of Hospitalization that targets the behavior that required the individuals to be placed in Seclusion*	86%
5.b	*There is a linked objective.*	83%
5.c	*There is a linked intervention (any formal group, individual therapy, or behavioral intervention) for the target behavior that required the individual to be placed in seclusion.*	79%
6.	*Restraints and seclusion are not used as punishment.*	62%
6.a	*The staff did not use restraints or seclusion in an abusive manner.*	96%
6.b	*The staff did not keep the individual in restraints or seclusion even when the individual was calm.*	59%
6.c	*The staff did not use restraints or seclusion in a manner to show a power differential that exists between staff and the individual.*	99%
6.d	*The staff did not use restraints or seclusion as coercion.*	99%
7.	*Restraints and seclusion are not used for the convenience of staff.*	N/A

NSH's comparison data showed significant increases in compliance:

	Previous period	Current period
Mean compliance rate		
5.	50%	76%
6.	42%	62%
7.	N/A	N/A
Compliance rate in last month of period		
5.	68%	74%
5.a	84%	91%
5.b	74%	79%
5.c	74%	74%
6.	42%	75%
6.a	95%	100%
6.b	47%	63%
6.c	95%	100%
6.d	95%	100%
7.	N/A	N/A

Barriers to compliance included that WRPTs are not consistently developing a focus, objective, and interventions related to behaviors that have resulted in seclusion and /or restraint. Observation records are not appropriately completed regarding behavior codes and accurate descriptions of behaviors. In addition, NSH identified that individuals have been maintained in seclusion or restraint while the documentation failed to support the need for continued seclusion or restraint. An accurate evaluation of the individual is not consistently reflected in the observation records. Unit monitoring and mentoring of staff performance has not held staff accountable. Item 7 is N/A due to the facility awaiting statewide approval of the Seclusion and Restraint Preference and Family Notification form. The WRP trainer will contact WRPTs and seniors to ensure focus, objective and interventions are included the WRPs. See

H.2.a for additional planned corrective actions.

A review of 30 episodes of seclusion for 13 individuals (AC, BJB, CCD, DBC, DEH, DP, DSH, EH, ERM, MKS, NH, TJ and WRB) found that 10 individuals' WRPs contained documentation addressing behaviors, objectives and interventions and documentation in 14 incidents indicated that the individual was released when calm.

The DMH Seclusion/Restraint Audit, based on a 67% sample of initial restraint orders for June-November 2008, indicated the following:

5.	*Restraints and seclusion are not used in the absence of, or as an alternative to, active treatment.*	82%
5.a	*There is a Focus of Hospitalization that targets the behavior that required the individuals to be placed in Seclusion*	89%
5.b	*There is a linked objective.*	85%
5.c	*There is a linked intervention (any formal group, individual therapy, or behavioral intervention) for the target behavior that required the individual to be placed in seclusion.*	82%
6.	*Restraints and seclusion are not used as punishment.*	68%
6.a	*The staff did not use restraints or seclusion in an abusive manner.*	98%
6.b	*The staff did not keep the individual in restraints or seclusion even when the individual was calm.*	68%
6.c	*The staff did not use restraints or seclusion in a manner to show a power differential that exists between staff and the individual.*	100%
6.d	*The staff did not use restraints or seclusion as coercion.*	100%
7.	*Restraints and seclusion are not used for the convenience of staff.*	N/A

NSH's comparison data showed increases in compliance across indicators:

	Previous period	Current period
Mean compliance rate		
5.	63%	82%
6.	52%	68%
7.	N/A	N/A
Compliance rate in last month of period		
5.	75%	80%
5.a	78%	92%
5.b	75%	84%
5.c	75%	80%
6.	59%	75%
6.a	95%	100%
6.b	63%	72%
6.c	89%	98%
6.d	94%	100%
7.	N/A	N/A

See above for barriers to compliance and the facility's plan of correction.

A review of 45 episodes of restraint for 15 individuals (AL, BJB, BJC, DBC, EH, JJB, JJY, JMU, ML, OJR, PB, RW, SRP, VH and WRB) found that 12 individuals' WRPs contained documentation addressing behaviors, objectives and interventions and documentation in 21 incidents indicated that the individual was released when calm.

Current recommendation:
Continue to monitor this requirement.

H.2.c	are not used as part of a behavioral intervention; and	**Current findings on previous recommendation:** **Recommendation, July 2008:** Continue current practice. **Findings:** The DMH Psychology Services Monitoring Audit, based on a 100% sample of Behavior Guidelines and Positive Behavior Support Plans developed during the review period (June-November 2008), indicated 100% compliance with the requirement that behavioral interventions are based on a positive behavior support model and do not include the use of aversive or punishment contingencies. NSH maintained high compliance from the last review, during which the mean compliance rate was 97%. A review of PBS plans for 20 individuals (AA, AG, AL, AS, DBC, DH, GIR, GR, JB, JM, JMU, KT, MP, MR, PB, RRW, TR, VC and VH) found that all were in compliance. **Current recommendation**: Continue current practice.
H.2.d	are terminated as soon as the individual is no longer an imminent danger to self or others.	**Current findings on previous recommendation:** **Recommendation, July 2008:** Continue to monitor this requirement. **Findings:** The DMH Seclusion/Restraint Audit, based on a 66% sample of initial seclusion orders for June-November 2008, indicated the following: 9. *Restraints and seclusion are terminated as soon as the individual is no longer an imminent danger to self or others.* — 44%

9.a	*The individual was released from restraints or seclusion as soon as the violent or dangerous behavior that created the emergency was no longer displayed or met the release criteria on the restraints or seclusion order.*	51%
9.b	*The individual did not continue to be in restraints or seclusion after remaining calm for 15 minutes.*	62%
9.c	*The individual did not continue to be in restraints or seclusion because he/she was unable to contract for safety.*	94%
9.d	*The individual did not continue to be in restraints or seclusion because he/she was unable to agree to cease using offensive language.*	92%
9.e	*The individual did not continue to be in restraints or seclusion because he/she did not cease making verbal threats.*	90%
9.f	*The individual did not continue to be in restraints or seclusion because he/she was not able to say he/she recognizes what behavior prompted the restraints or seclusion episode.*	97%
9.g	*The individual did not continue to be in restraints or seclusion because he/she was unable to say he/she is sorry for his/her actions.*	99%

NSH's comparison data slight improvement in mean compliance and mixed changes from the last month of the previous period to the last month of the current period:

	Previous period	Current period
Mean compliance rate		
9.	40%	44%
Compliance rate in last month of period		

9.	42%	62%
9.a	53%	65%
9.b	47%	77%
9.c	100%	96%
9.d	95%	96%
9.e	90%	96%
9.f	100%	92%
9.g	100%	100%

See H.2.a for barriers to compliance and the facility's plan of correction, and H.2.b for chart review findings.

The DMH Seclusion/Restraint Audit, based on a 67% sample of initial restraint orders for June-November 2008, indicated the following:

9.	*Restraints and seclusion are terminated as soon as the individual is no longer an imminent danger to self or others.*	54%
9.a	*The individual was released from restraints or seclusion as soon as the violent or dangerous behavior that created the emergency was no longer displayed or met the release criteria on the restraints or seclusion order.*	61%
9.b	*The individual did not continue to be in restraints or seclusion after remaining calm for 15 minutes.*	69%
9.c	*The individual did not continue to be in restraints or seclusion because he/she was unable to contract for safety.*	94%
9.d	*The individual did not continue to be in restraints or seclusion because he/she was unable to agree to cease using offensive language.*	92%
9.e	*The individual did not continue to be in restraints*	86%

	or seclusion because he/she did not cease making verbal threats.	
9.f	*The individual did not continue to be in restraints or seclusion because he/she was not able to say he/she recognizes what behavior prompted the restraints or seclusion episode.*	97%
9.g	*The individual did not continue to be in restraints or seclusion because he/she was unable to say he/she is sorry for his/her actions.*	99%

NSH's comparison data showed increases in compliance:

	Previous period	Current period
Mean compliance rate		
9.	34%	54%
Compliance rate in last month of period		
9.	37%	62%
9.a	59%	62%
9.b	59%	70%
9.c	93%	96%
9.d	82%	96%
9.e	76%	90%
9.f	92%	98%
9.g	97%	98%

See H.2.a for barriers to compliance and the facility's plan of correction, and H.2.b for chart review findings.

Current recommendation:
Continue to monitor this requirement.

H.3	Each State hospital shall comply with 42 C.F.R. § 483.360(f), requiring assessments by a physician or licensed clinical professional of any individual placed in seclusion or restraints within one hour. Each State hospital shall also ensure that any individual placed in seclusion or restraints is continuously monitored by a staff person who has successfully completed competency-based training on the administration of seclusion and restraints.	**Current findings on previous recommendation:** **Recommendation, July 2008:** Continue to monitor this requirement. **Findings:** The DMH Seclusion/Restraint Audit, based on a 66% sample of initial seclusion orders for June-November 2008, indicated the following:

10.	*Each State Hospital shall comply with 42 C.F.R., 483.360(f) requiring assessments by a physician or licensed clinical professional of any individual placed in seclusion or restraints within one hour.*	70%
10.a	*The order was obtained within 15 minutes from the initiation of restraints or seclusion.*	99%
10.b	*The RN conducted an assessment within 15 minutes of the initiation of restraints or seclusion, and documented in the IDN.*	82%
10.c	*The Physician conducted a face-to-face evaluation of the individual in restraints or seclusion within one hour from the initiation of restraints or seclusion and documented in the Physician's Progress Note.*	86%

NSH's comparison data indicated a significant increase in mean compliance from the previous period:

	Previous period	Current period
Mean compliance rate		
10.	37%	70%
Compliance rate in last month of period		
10.	42%	81%

10.a	100%	100%
10.b	47%	98%
10.c	95%	81%

NSH's analysis of the data indicated that after-hours physicians had a higher rate of compliance than the majority of unit-assigned physicians regarding responding to restraint or seclusion within one hour. NSH's plan of correction included having the senior psychiatrist providing mentoring and supervision beginning in October 2008. Also, in January 2009 this item was added to the supervisor's review form for performance review.

A review of 30 episodes of seclusion for 13 individuals (AC, BJB, CCD, DBC, DEH, DP, DSH, EH, ERM, MKS, NH, TJ and WRB) found compliance in 22 episodes.

The DMH Seclusion/Restraint Audit, based on a 67% sample of initial restraint orders for June-November 2008, indicated the following:

10.	*Each State Hospital shall comply with 42 C.F.R., 483.360(f) requiring assessments by a physician or licensed clinical professional of any individual placed in seclusion or restraints within one hour.*	76%
10.a	*The order was obtained within 15 minutes from the initiation of restraints or seclusion.*	99%
10.b	*The RN conducted an assessment within 15 minutes of the initiation of restraints or seclusion, and documented in the IDN.*	88%
10.c	*The Physician conducted a face-to-face evaluation of the individual in restraints or seclusion within one hour from the initiation of restraints or seclusion and documented in the Physician's Progress Note.*	86%

<table>
<tr>
<td></td>
<td></td>
<td>NSH's comparison data indicated a significant increase in mean compliance from the previous period:

<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>10.</td><td>49%</td><td>76%</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>10.</td><td>58%</td><td>88%</td></tr>
<tr><td>10.a</td><td>100%</td><td>100%</td></tr>
<tr><td>10.b</td><td>72%</td><td>100%</td></tr>
<tr><td>10.c</td><td>76%</td><td>88%</td></tr>
</table>

See above for barriers to compliance and plan of correction.

A review of 45 episodes of restraint for 15 individuals (AL, BJB, BJC, DBC, EH, JJB, JJY, JMU, ML, OJR, PB, RW, SRP, VH and WRB) found compliance in 35 episodes.

No data was provided addressing competency-based training on the administration of seclusion and restraints.

Compliance:
Partial.

Current recommendation:
Continue to monitor this requirement.</td>
</tr>
<tr>
<td>H.4</td>
<td>Each State hospital shall ensure the accuracy of data regarding the use of restraints, seclusion, psychiatric PRN medications, or Stat medications.</td>
<td>Current findings on previous recommendations:

Recommendations 1-3, July 2008:
• Provide supporting data to verify compliance.
• Provide documentation addressing the accuracy of seclusion and</td>
</tr>
</table>

		restraint data. • Continue to monitor this requirement. **Findings:** NSH audits the MAR documentation of PRN/Stat medications given on the unit against the PRN/Stat data entered into the WaRMSS system. Seclusion and restraint episode data are verified for accuracy by the Standards Compliance reviewers by comparing the Emergency Interventions Reports with the seclusion/restraint data in WaRMSS. NSH reported 97% accuracy for PRN/Stat data and 93% accuracy for seclusion and restraint data. A review of 75 seclusion/restraint episodes and 120 PRN/Stat medications from the medical records found that all were included in the WaRMSS data system. **Compliance:** Substantial. **Current recommendation:** Continue to monitor this requirement.
H.5	Each State hospital shall revise, as appropriate, and implement policies and procedures to require the review within three business days of individuals' therapeutic and rehabilitation service plans for any individuals placed in seclusion or restraints more than three times in any four-week period, and modification of therapeutic and rehabilitation service plans, as appropriate.	**Current findings on previous recommendations:** **Recommendation 1, July 2008:** Assess barriers to compliance and develop a plan of correction for this requirement. **Findings:** This recommendation was adequately addressed in the data below. **Recommendation 2, July 2008:** Continue to monitor this requirement.

Findings:
NSH reported the following data from the DMH Restraint Audit, based on a 100% sample of individuals who were in seclusion more than three times in 30 days for June-November 2008.

13.	*Required to review within three business days of individuals' therapeutic and rehabilitation service plans for any individuals placed in seclusion or restraints more than three times in any four-week period, and modification of therapeutic and rehabilitation service plans, as appropriate*	
13.a	*The review was held within three business days for any individual who had four or more episodes of Seclusion or Restraints within the last 30 days*	40%
13.b	*The Present Status in the Case Formulation section of the WRP documented that a review of the incident(s) was done*	45%
13.c	*If the team decided to revise the WRP, a statement as to what part of the WRP was revised, OR if the team decided not to revise the WRP, a brief clinical justification as to why, was documented in the Present Status in the Case Formulation Section of the WRP*	22%

While still low, compliance increased significantly from the previous review period :

	Previous period	Current period
Mean compliance rate		
13.	0%	40%
13.a	0%	45%

		13.b 0% 22% 13.c 0% 17% Compliance rate in last month of period 13. 0% 78% 13.a 0% 89% 13.b 0% 100% 13.c 0% 100% NSH indicated that a barrier to compliance is that the present status sections of some WRPs are incomplete and lack updated information regarding seclusion and restraint. The plan of correction includes sending the Program Directors, Nursing Coordinators and WRPTs trigger notifications regarding the required review. In December 2008, weekly program trigger reviews were implemented by the Program Review Committee (PRC), Enhanced Trigger Review Committee/Psychology Specialist Services Committee (ETRC/PSSC). A review of records eight individuals who met the trigger criteria for restraint/seclusion during the review period (AS, BJB, DBC, DP, JJB, JMU, VH and WRB) found three records in compliance. **Compliance:** Partial. **Current recommendation**: Continue to monitor this requirement.
H.6	Each State hospital shall develop and implement policies and procedures consistent with generally accepted professional standards of care governing the use of psychiatric PRN medication and Stat medication, requiring that:	**Compliance:** Partial.

H.6.a	such medications are used in a manner that is clinically justified and are not used as a substitute for adequate treatment of the underlying cause of the individual's distress.	**Current findings on previous recommendation:** **Recommendation, July 2008:** See H.5. **Findings:** See F.1.b. **Current recommendations**: 1. Same as in F.1.b. 2. Continue to monitor this requirement.
H.6.b	PRN medications, other than for analgesia, are prescribed for specified and individualized behaviors.	**Current findings on previous recommendation:** **Recommendation, July 2008:** See H.5. **Findings:** See F.1.b **Current recommendations**: 1. Same as in F.1.b. 2. Continue to monitor this requirement.
H.6.c	PRN medications are appropriately time limited.	**Current findings on previous recommendation:** **Recommendation, July 2008:** Continue to monitor this requirement. **Findings:** See F.1.b under "Since last review" for NSH's data.

		Current recommendations: 1. Same as in F.1.b. 2. Continue to monitor this requirement.
H.6.d	nursing staff assess the individual within one hour of the administration of the psychiatric PRN medication and Stat medication and documents the individual's response.	**Current findings on previous recommendation:** **Recommendation, July 2008:** Continue to monitor this requirement. **Findings:** See F.3.a.iii for NSH's data and this monitor's findings. **Current recommendations**: See F.3.a.iii.
H.6.e	A psychiatrist conducts a face-to-face assessment of the individual within 24 hours of the administration of a Stat medication. The assessment shall address reason for Stat administration, individual's response, and, as appropriate, adjustment of current treatment and/or diagnosis.	**Current findings on previous recommendation:** **Recommendation, July 2008:** Same as in D.1.f, F.1.b and H.6.a. **Findings:** Same as in D.1.f, F.1.b and H.6.a **Current recommendations**: Same as in D.1.f, F.1.b and H.6.a.
H.7	Each State hospital shall ensure that all staff whose responsibilities include the implementation or assessment of seclusion, restraints, psychiatric PRN medications, or Stat medications successfully complete competency-based training regarding implementation of all such policies and the use of less restrictive interventions.	**Current findings on previous recommendation:** **Recommendation, July 2008:** Continue to monitor this requirement. **Findings:** See F.3.h.i and F.3.h.ii for NSH data and this monitor's findings.

		Compliance: Partial. **Current recommendation**: See F.3.h.ii.
H.8	Each State hospital shall:	**Compliance:** Substantial.
H.8.a	develop and implement a plan to reduce the use of side rails as restraints in a systematic and gradual way to ensure individuals' safety; and	**Current findings on previous recommendation:** **Recommendation, July 2008:** Continue current practice. **Findings:** NSH has eliminated the beds with full side rails that constituted a restraint. The only beds with side rails have half rails that do not constitute a restraint. **Current recommendation**: Continue current practice.
H.8.b	ensure that, as to individuals who need side rails, their therapeutic and rehabilitation service plans expressly address the use of side rails, including identification of the medical symptoms that warrant the use of side rails, methods to address the underlying causes of such medical symptoms, and strategies to reduce the use of side rails, if appropriate.	**Current findings on previous recommendation:** **Recommendation, July 2008:** See H.8.a. **Findings:** See H.8.a. **Current recommendation**: See H.8.a.

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I. Protection from Harm		
I	Each State hospital shall provide the individuals it serves with a safe and humane environment and ensure that these individuals are protected from harm.	**Summary of Progress:** 1. The investigations completed by the Office of Special Investigations show significant improvement in quality and timeliness and in the completeness and readability of the investigation reports. This is likely due, in part, to the weekly supervision of open investigations provided by the Supervising Special Investigator and his careful editing of the reports. 2. OSI investigations are identifying misconduct not specified in the initial allegation and demonstrate particular attention to the failure on the part of staff members to report abuse and neglect. Investigations conclude with recommendations for referral to Human Resources, training recommendations and recommendations for revisions in policies/procedures. 3. The Incident Review Committee is reviewing all OSI investigations and making recommendations to improve their quality. This feedback and the work of the Supervising Special Investigator can be credited with the improved performance of the Office. 4. Some graphed data showing patterns in incidents related to aggression has been produced for review by the Incident Review Committee and the Quality Council. 5. The facility has begun implementation of Special Order 262: Risk Management. The convening of Program Review Committees and the combined PSSC/Enhanced Trigger Review Committee had begun 4-5 weeks prior to this review. Preparations are underway for the Medical Risk Management Committee to begin reviewing individuals in June 2009. The committee members are presently devising tools for assessing medical risk. 6. The facility is adapting an information system used at Atascadero State Hospital that will facilitate the full implementation of the Risk Management system. It will replace the present manual system of tracking individuals through committee notes and will track the process electronically.

		7. When the facility recognized the problems in the data from Quick Hits, it immediately took action and corrected the trigger data for December 2008. A group immediately convened to formulate a plan for addressing the facility-wide problem. 8. The facility has continued to improve the environment. It has reconfigured some units, making them smaller, and has increased the number of open units. The facility continues to make improvements in the environment of Unit A-1. Related to the reduction of suicide and safety hazards, the facility continues to replace shower fixtures with push-button on-off valves and to replace wardrobes with new ones that do not use a lock and chain to secure. The facility is replacing bedroom chairs with no-throw chairs and installing nightstands with no metal gliders. All inward-facing V-shaped closing fixtures at the top of bedroom doors have been replaced with fixtures on the public (hallway) side of the door.

1. Incident Management		
I.1	Each State hospital shall develop and implement across all settings, including school settings, an integrated incident management system that is consistent with generally accepted professional standards of care.	**Methodology:** Interviewed: 1. C. Black, Director, Standards Compliance 2. C. Caruso, Clinical Administrator 3. D. Chupinski, Standards Compliance 4. D. Hauscarriague, Supervising Special Investigator 5. D. Johnson, Supervising Special Investigator 2, DMH Central Office 6. D. Matteucci, Hospital Administrator 7. J. Shearer, Chief of Hospital Security, DMH Central Office 8. K. Cooper, Enhancement Plan Coordinator 9. M. McCandless, Standards Compliance Coordinator 10. M. McQueeney, Assistant Hospital Administrator 11. P. Tyler, MD, Medical Director Reviewed: 1. Mortality Interdisciplinary Reviews and all related materials for seven deaths 2. Incident Review Committee minutes for October—December 2008 3. Office of Special Investigations Recommendations Tracking Form 4. Incident Review Committee Recommendations Tracking Form (June—December 2008) 5. 12 investigation reports completed by the Office of Special Investigations 6. Incident pattern data 7. Selected personnel and training information for 14 staff members 8. Nine Headquarter Reportable Briefs 9. Rights Acknowledgements in the clinical records of 14 individuals 10. Quality Council Minutes (December 2008 and January 2009)

I.1.a	Each State hospital shall review, revise, as appropriate, and implement incident management policies, procedures and practices that are consistent with generally accepted professional standards of care. Such policies, procedures and practices shall require:	**Compliance:** Partial.
I.1.a.i	that each State hospital not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of individuals;	**Current findings on previous recommendation:** **Recommendation, July 2008:** Implement the plan [described in this cell of Report 5] to mitigate the likelihood of taking action based on false WaRMSS data regarding allegations of abuse. **Findings:** Substantial problems were found in the validity of the Quick Hits data regarding behavior triggers, which include allegations of abuse and neglect. As an example, the December 2008 trigger data cited 27 allegations of abuse/neglect. Further review of this figure, which was significantly higher than in any of the previous 12 months, found that 81% (17) were in error and represented incidents in which one individual was the victim of another individual's aggression. Staff members entering data into Quick Hits were not using the Incident Management definitions of abuse, which restrict the alleged abuser to someone other than another individual—most often a staff member. Rather, they were using the licensing definition of dependent adult abuse, which has no such restriction. See also I.2.b.iii for additional examples of problems with Quick Hits data. **Other findings:** See I.1.a.v for discussion of the attention to failure to report

		allegations of abuse/neglect/exploitation. **Current recommendation**: Undertake a facility-wide training effort and any other measures necessary to correct the errors being made in the Quick Hits database.
I.1.a.ii	identification of the categories and definitions of incidents to be reported, and investigated; immediate reporting by staff to supervisory personnel and each State hospital's executive director (or that official's designee) of serious incidents, including but not limited to, death, abuse, neglect, and serious injury, using standardized reporting across all settings, including school settings;	**Current findings on previous recommendation:** **Recommendation, July 2008:** Continue current practice. **Findings:** Some problems still remain in reconciling the Standards Compliance SIR database with the Office of Special Investigations database for allegations of abuse and neglect. Each month, a Standards Compliance staff member identifies those incidents that appear on the OSI investigations list and not on the SIR listing. When this omission occurs, Standards Compliance makes a determination whether the incident meets the SIR definitions and, if it does, requests that the unit prepare an incident reporting form (SIR). In one incident reviewed, Standards Compliance made a poor decision in this regard. An allegation of physical abuse, although investigated by the Office of Special Investigations (OSI), was determined not to require an incident report and therefore was not entered into the SIR database. This incident involved the 9/25/08 allegation of physical abuse made by VS in which she alleged that she was handled roughly during a restraint. She sustained bruises on her arms. Reportedly, Standards Compliance determined that the allegation was not credible in view of the individual's delusions. Independent of this finding, Standards Compliance had determined that beginning November 2008 it would record the rationale for

		determining that an event did not meet the SIR/Incident Management definitions. **Current recommendations**: 1. Continue with plans to document and review the rationale when determining that an event does not meet SIR definitions. 2. Ensure that no allegation of abuse in which the individual sustains an injury consistent with the allegation is determined to be attributable to the individual's mental state and thereby fails to meet the SIR definition of an abuse/neglect allegation. 3. DMH should expedite as much as possible the implementation of the statewide Incident Management System, so that the facilities will be using one database. This will provide a single numbering system and eliminate the need to reconcile multiple databases. 4. Undertake staff training and any other necessary steps to improve the accuracy of the Quick Hits data.
I.1.a.iii	mechanisms to ensure that, when serious incidents such as allegations of abuse, neglect, and/or serious injury occur, staff take immediate and appropriate action to protect the individuals involved, including removing alleged perpetrators from direct contact with the involved individuals pending the outcome of the facility's investigation;	**Current findings on previous recommendations:** **Recommendation 1, July 2008:** Provide a statement in the investigation of allegations of A/N that addresses whether the named staff member was reassigned and a rationale for the decision. **Findings:** The investigations reviewed did not include a rationale for the decision of whether to remove a named staff member. However, the actual determination was documented in nine of the 12 investigations reviewed. Staff members were reassigned or placed on administrative leave in four of the investigations reviewed, per the investigation report.

		Recommendation 2, July 2008: Seek legal counsel, if necessary, in developing a definition of and criteria for determining whether an allegation is credible. **Findings:** The facility reports that it was not necessary to seek legal counsel regarding this matter. See I.1.a.ii for a problem that arose in making the credibility determination in one incident. **Current recommendation:** Provide a rationale for the decision of whether to remove a named staff member until the investigation is completed.
I.1.a.iv	adequate competency-based training for all staff on recognizing and reporting potential signs and symptoms of abuse or neglect, including the precursors that may lead to abuse;	**Current findings on previous recommendations:** **Recommendation 1, July 2008:** Take necessary action to ensure that staff members complete annual A/N training. **Findings:** See the table below. Eleven of the 14 staff members reviewed (79%) had completed abuse/neglect training within the last year. The facility reports that in 2008 through November 30, 1498 employees had received annual abuse/neglect training. **Recommendation 2, July 2008:** Ensure that the annual A/N training stresses the need to use the revised definitions in coding A/N allegations in WaRMSS. **Findings:** See the description in I.1.a.i of the problem in the entry of abuse/neglect data into Quick Hits.

Other findings:
As presented below, 11 of the 14 staff members reviewed have completed abuse/neglect training in the last 12 months:

	Date of:			
Staff member*	Hire	Background clearance	Signing of Mandatory Reporter	Most recent A/N training
_A	2/27/89	Unknown	2/27/89	1/14/09
_C	9/2/08	7/22/08	9/2/08	9/10/08
_R	11/1/06	8/21/06	11/1/06	9/2/08
_M	3/10/08	12/1/07	3/10/08	8/14/08
_D	7/1/02	4/2/02	7/1/02	8/13/08
_M	6/18/07	5/28/07	6/18/07	7/28/08
_E	8/1/07	2/23/07	8/1/07	7/24/08
_U	5/1/01	3/27/01	5/1/01	2/28/08
_D	5/11/99	2/4/99	5/11/99	2/11/08
_S	12/15/83	Unknown	4/25/86 and 12/16/89	2/11/08
_E	2/1/06	12/12/05	2/1/06	1/4/08
_G	4/17/06	4/7/06	4/17/06	10/18/07
_M	10/2/06	9/12/06	10/2/06	9/5/07
_O	4/17/06	4/7/06	4/17/06	8/9/07

*Only last initials are provided to protect confidentiality.

Current recommendation:
Continue ensuring that staff members meet their obligation to complete annual abuse/neglect training.

I.1.a.v	notification of all staff when commencing employment and adequate training thereafter of their obligation to report abuse or neglect	**Current findings on previous recommendation:**

	to each State hospital and State officials. All staff persons who are mandatory reporters of abuse or neglect shall sign a statement that shall be kept with their personnel records evidencing their recognition of their reporting obligations. Each State hospital shall not tolerate any mandatory reporter's failure to report abuse or neglect;	**Recommendation 1, July 2008:** To avoid the appearance that measures taken in response to the failure to report allegations of A/N in a timely manner are arbitrary or capricious, establish a minimum response that will be applied in all cases where more serious action is not required. **Findings:** The facility has taken action on this recommendation and has determined that all staff members who fail to report abuse/neglect will, at a minimum, receive an instructional memorandum. **Recommendation 2, July 2008:** Ensure that investigations pursue allegations that incidents were not reported in a timely manner. **Findings:** There is evidence in the investigations reviewed that the failure to report is identified and pursued. One of the 12 investigations reviewed was opened specifically to address the allegation that two staff failed to report abuse/neglect. The allegation was sustained against both named staff. In two other investigations of abuse, the investigator identified and sustained a determination that staff members had failed to report an allegation of abuse. Disciplinary action is pending for four of the five staff members involved in these two investigations. The fifth staff member resigned after being served notice of Rejection During Probation. **Other findings:** See the table in the cell above for documentation that 14 of the 15 employees reviewed signed the mandatory reporter acknowledgement on the date of hire. The single exception is a staff member who was hired prior to the requirement. This staff member subsequently signed the acknowledgement later.

		Current recommendations: 1. Ensure that repeat failures to report A/N result in progressive discipline. 2. Continue current practices related to training on A/N and acknowledgement of Mandatory Reporter responsibilities for newly hired employees.
I.1.a.vi	mechanisms to inform individuals and their conservators how to identify and report suspected abuse or neglect;	**Current findings on previous recommendation:** **Recommendation, July 2008:** Continue current practice. **Findings:** In one of the 14 clinical records reviewed, the individual was not provided an opportunity within the last 12 months to indicate by his signature that s/he had reviewed her/his rights.

Individual	Date of most recent signing
EH	1/12/09
AM	Refused to sign on 1/9/09
JL	12/5/08
AE	11/19/08
PR	9/23/08
BG	9/16/08
BB	7/29/08
ET	7/15/08
DR	5/30/08
NF	4/29/08
EV	4/6/08
RR	Refused to sign on 2/20/08
RV	1/15/08

		CB | Refused to sign on 10/2/07 **Other findings:** In the January 2009 Cooperative Advisory Council survey completed by 71 individuals, two-thirds of the respondents replied that the grievance process at the facility worked to their satisfaction. This is a substantial increase over the 29% favorable response in the previous survey. **Current recommendation:** Continue current practice.
I.1.a.vii	posting in each living unit and day program site a brief and easily understood statement of individuals' rights, including information about how to pursue such rights and how to report violations of such rights;	**Current findings on previous recommendation:** **Recommendation, July 2008:** Ensure that rights and responsibilities are discussed with individuals during their annual WRPCs and ask that they sign the affidavit attesting that they understand their rights. **Findings:** See table in the cell above. **Other findings:** Each of the residential units visited had a posting of rights in Spanish and English in a common area. **Current recommendation:** Continue current practice.
I.1.a.viii	procedures for referring, as appropriate, allegations of abuse or neglect to law enforcement; and	**Current findings on previous recommendation:** **Recommendation, July 2008:** Continue current practice.

		Findings: This monitor found no reason to believe that procedures for referring allegations of abuse/neglect to law enforcement when appropriate were not followed. **Current recommendation**: Continue current practice.
I.1.a.ix	mechanisms to ensure that any staff person, individual, family member or visitor who in good faith reports an allegation of abuse or neglect is not subject to retaliatory action, including but not limited to reprimands, discipline, harassment, threats or censure, except for appropriate counseling, reprimands or discipline because of an employee's failure to report an incident in an appropriate or timely manner.	**Current findings on previous recommendation:** **Recommendation, July 2008:** Encourage the IRC, as it expands its duties, to be mindful of the possibility that a staff member or individual might be the victim of retaliatory threats or actions. **Findings:** The facility reports the IRC has discussed the problem of possible retaliation, and no instances of possible fear of retaliation were found in any of the 63 cases reviewed. No incidents reviewed by this monitor suggested fear of retaliation. **Current recommendation**: Continue current practice.
I.1.b	Each State hospital shall review, revise, as appropriate, and implement policies and procedures to ensure the timely and thorough performance of investigations, consistent with generally accepted professional standards of care. Such policies and procedures shall:	**Compliance:** Partial.
I.1.b.i	require investigations of all deaths, as well as allegations of abuse, neglect, serious injury,	**Current findings on previous recommendations:**

and theft. The investigations shall be conducted by qualified investigator(s) who have no reporting obligations to the program or elements of the facility associated with the allegation and have expertise in conducting investigations and working with persons with mental disorders;

Recommendation 1, July 2008:
Continue to refine the review of deaths, including procedures for ensuring the effective implementation of corrective measures identified by the Mortality Interdisciplinary Review Committee.

Findings:
Review of the reports of the Mortality Interdisciplinary Review Committee following the deaths of seven individuals revealed that some, but not all, of the recommendations had been followed to ensure implementation as described below. [Only those recommendations for which sufficient time for implementation has passed are included.]

Date of death	Recommendation	Follow-up
6/4/08	1. Insufficient medical coverage on Q-11 given acuity level. 2. No nursing documentation for five days prior to death. Present CPR log with Nursing Summary. 3. NSH MD did not declare individual dead→unnecessary transfer to hospital.	1. Will check budget/ allocation. No further info. 2. Ongoing. No further info. 3. Ongoing discussion. No further info.
7/3/08	DNR process needs to be clarified. Retrospective analysis of 44 deaths completed. Five recommendations made.	No further information.
7/16/08	HPO to keep chart on the unit long enough for staff	Resolved on 8/10/08.

	to copy family phone numbers.	
10/2/08	Get Advance Directives, if possible, on individuals on three units (specified).	Target date 11/16/08. No further info.

Recommendation 2, July 2008:
DMH should continue to address the legal questions raised by physicians and other licensed clinicians required to cooperate in the review of deaths.

Findings:
Consultation between the NSH Medical Director and the Court Monitor resulted in draft revisions to the Special Order that address some of the concerns voiced by physicians in this and other facilities. Specific suggested changes include:

- The Medical Death Summary will be completed by the Chief of Medical Services or the Chief of Psychiatry, depending on the circumstances of the case.
- Review of the Medical Death Summary and the Nursing Death summary would occur at the Medical Mortality Review Committee meeting. They will not be reviewed by the MIRC.
- The Medical Mortality Review Committee will issue two reports. One report addresses any gaps in the performance of specific staff members. This report is forwarded to the supervisor and Human Resources. The second report will focus on facility performance and identify performance improvement findings and recommendations. This report is forwarded to the MIRC. Both reports are provided to the Medical Executive Committee.
- The MIRC will review the Medical Mortality Review Committee's facility performance report.
- The Special Investigator's report will be reviewed by the Executive

Members of the MIRC (Executive Director, Medical Director, Clinical Administrator and the Nurse Administrator), not by the entire membership.

- The time frame for the summary report from the MIRC for the Executive Director's signature was increased from 10 business days after the death to 15 business days.

DMH will need to determine which, if any, of the suggested revisions will be accepted. Clearly, if the procedures are revised as suggested, the quality and utility of the MIRC review will be largely dependent on the clarity and thoroughness of the MMRC's facility performance report.

Other findings:
The timing of and attendance at the Mortality Interdisciplinary Review Committee meetings is presented below. The Special Order instituting the MIRC became effective on 3/17/08. Timeliness improved as the facility undertook full implementation of the Special Order.

Date of death	Date of MIRC	Attendance
6/4/08	6/24/08	Psychologist not present
7/3/08	7/17/08	PCP not present
7/16/08	7/25/08	All critical parties present
10/2/08	10/10/08	PCP not present
1/1/09	1/9/09	Attending psychiatrist not present
1/23/09	1/29/09	All critical parties present

Current recommendations:
1. DMH should determine whether to make any revisions to Special Order 205.05 and advise the facilities accordingly.
2. Ensure that attendance at the MIRC and the Medical Mortality Review Committee meetings meets the requirements of the Special Order.

		3. Continue to work on meeting the time frames in the Special Order.
I.1.b.ii	ensure that only the State Hospital staff who have successfully completed competency-based training on the conduct of investigations be allowed to conduct investigations of allegations of petty theft and all other unusual incidents;	**Current findings on previous recommendation:** **Recommendation, July 2008:** Continue with plans to provide Incident Management training to the remaining program and clinical staff. **Findings:** The facility reports that all program/clinical staff who investigate incidents have received incident management training. All allegations of A/N, deaths, and possible criminal activity are investigated by the hospital police and/or the Office of Special Investigations. **Current recommendation**: Continue current practice.
I.1.b.iii	investigations required by paragraph I.1.b.i, (above) provide for the safeguarding of evidence;	**Current findings on previous recommendation:** **Recommendation, July 2008:** When photos and other physical evidence are taken during an investigation, reference where they are stored. **Findings:** Several of the death investigations completed by the OSI specifically referenced the number of photos taken and where they were secured. **Current recommendation**: Continue current practice.
I.1.b.iv	investigations required by paragraph I.1.b.i, (above) require the development and implementation of standardized procedures	**Current findings on previous recommendation:**

	and protocols for the conduct of investigations that are consistent with generally accepted professional standards. Such procedures and protocols shall require that:	**Recommendation, July 2008:** Expand the work of the IRC to include a review of the entire investigation file of all incidents of alleged A/N, serious injuries and deaths, so that it can look critically at the quality of the investigation and the rationale for the determination and identify any recommendations for corrective, preventive actions. This review should not be limited to sustained cases. **Findings:** The IRC no longer limits its reviews to sustained cases, as determined by review of the minutes. **Other findings:** The IRC meeting minutes document a review of the quality of investigations and recommendations to improve them. Recommendations include, for example, instructing Special Investigators on the need for detail, avoiding making clinical findings unless quoting a clinical or medical expert, and avoiding presenting statements as facts without evidence to support them. **Current recommendation**: Continue current practice of IRC reviewing investigations to ensure that they meet quality standards.
I.1.b.iv.1	investigations commence within 24 hours or sooner, if necessary, of the incident being reported	**Current findings on previous recommendation:** **Recommendation, July 2008:** Reduce the amount of time between the reporting of the incident and the first interviews by the OSI. **Findings:** See the table in the cell below. The time between the report of the incident and the first interviews conducted by OSI varied widely,

		ranging from 4 to 40 days. **Other findings:** The facility data shows that in the period June—November 2008, 92% of the investigations were begun within 24 hours of the incident having been reported. The facility documented the reason for the delay in the five investigations that did not meet the time frame. Preliminary investigations are conducted by the hospital police, who turn the relevant investigations over to the Office of Special Investigations. **Current recommendation**: Make efforts to ensure that initial OSI interviews are conducted as proximate to the date of the report of the incident as possible.
I.1.b.iv. 2	investigations be completed within 30 business days of the incident being reported, except that investigations where material evidence is unavailable to the investigator, despite best efforts, may be completed within 5 business days of its availability;	**Current findings on previous recommendations:** **Recommendation 1, July 2008:** Continue current practice of completing OSI investigations within 30 business days. **Findings:** See the table below. Among the 12 investigations reviewed, five (42%) were completed within 30 business days. The facility reports that during the review period (June—November 2008), 92% of the completed investigations met the 30-business-day time frame. This figure is consistent with the OSI incident log. Further review of that log reveals that as of January 24, 2009, the OSI had 15 cases that had been open more than 30 business days. **Recommendation 2, July 2008:** Ensure that initial OSI interviews occur as near to the date on which the incident is reported as possible.

Findings:
See the table below for relevant dates in the 12 investigations reviewed. In five of the 12 investigations the first OSI interview was conducted within 7 days of the report of the incident.

Incident type	Date incident reported	Date of first OSI interview	Date investigation closed
Verbal abuse allegation	1/18/08	3/14/08	6/16/08
Neglect allegation	6/11/08	7/21/08	8/28/08
Verbal/psychological abuse allegation	6/24/08	7/3/08	8/08/08
Failure to report A/N allegation	7/10/08	7/21/08	8/21/08
Failure to follow procedures	7/15/08	8/25/08	9/9/08
Allegation of physical abuse	8/7/08	8/26/08	9/11/08
Physical and verbal abuse allegation	8/11/08	8/15/08	8/22/08
Neglect allegation	8/20/08	9/2/08	9/9/08
Allegation of sex abuse	9/11/08	9/17/08	9/22/08
Violation of Rights	9/25/08	10/2/08	10/22/08
Allegation of physical abuse	9/25/08	10/2/08	10/23/08
Neglect allegation	11/6/08	11/09/08	12/23/08

Other findings:
A July investigation was delayed 17 days because the assigned police officer needed a Spanish interpreter. When this became known, the NSH Chief of Police issued a memo stating that such a delay was unacceptable, as the facility had Spanish-speaking officers and the Dispatch officer has a list of interpreters. The police officer's delay resulted in the OSI not meeting the 30-business day timeline. This delay is accurately reflected in the facility's August audit of investigations.

		Current recommendations: 1. Ensure that initial OSI interviews occur as near to the date on which the incident is reported as possible. 2. Continue efforts to conclude investigations within 30 business days.
I.1.b.iv.3	each investigation result in a written report, including a summary of the investigation, findings and, as appropriate, recommendations for corrective action. The report's contents shall be sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly and separately:	**Current findings on previous recommendations:** **Recommendation 1, July 2008:** Revise AD 020 to clarify that the IRC is to receive a copy of the complete investigation report for serious incidents, regardless of whether they are unfounded or substantiated. **Findings:** This recommendation was implemented with the revision of AD 020 effective December 2008. The IRC reviews all OSI investigations, regardless of the determination. **Other findings:** The investigation summaries reviewed included recommendations for referral to Human Resources for disciplinary actions, recommendations for additional training and for policy/procedure changes and recommendations specific to avoiding a repeat of the incident. Examples include: • In the investigation summary of the sexual abuse allegation made by VS (9/25/08), the investigation closes with a recommendation that staff ensure a female staff member is present to accompany the individual to the bathroom. • Training for a named staff member was recommended in the investigation summary of the sexual abuse allegation made by NR (9/11/08) and in the investigation report regarding the alleged physical abuse of OJ (8/11/08).

		• A review of unit policies regarding letting individuals off the unit was also recommended in the NR investigation report. • A review of overtime usage was recommended in the investigation of the sexual assault allegation made by NR on 8/20/08. • A recommendation for the revision of Nursing Policy regarding Enhanced Observation was recommended as a result of the neglect incident occurring on 6/11/08. See also I.1.c. Facility tracking of completed recommendations yielded results that call for substantial improvement. **Current recommendations**: 1. Continue current practice of making recommendations to reduce the likelihood of future incidents and track implementation to ensure a timely response. 2. Take appropriate measures to ensure the timely completion of recommendations.
I.1.b.iv. 3(i)	each allegation of wrongdoing investigated;	**Current findings on previous recommendations:** **Recommendation 1, July 2008:** Continue current practice of specifically addressing each allegation of wrongdoing and ensure the synopsis addresses the allegation under investigation. **Findings:** In each of the 12 investigations reviewed, the allegation/conduct under investigation was clearly identified. Attention to the responsibility to identify misconduct that is not initially part of the allegation but which arises during the investigation was evident in three investigations reviewed. • One investigation of alleged sexual abuse found that the allegation

		was not sustained but that the named staff member had violated AD 378: Employee Ethics and Conduct—Professional Boundaries for calling the individual once on the phone when the staff member was no longer on duty. • A second investigation did not sustain an allegation of physical and verbal abuse, but did sustain a failure to report. • A third investigation deemed an allegation of sexual assault to be unfounded, but did sustain a neglect allegation for a staff member sleeping while providing 1:1 enhanced observation. **Current recommendation**: Continue current practice of identifying staff misconduct not specifically alleged in the incident report but which surfaces during the investigation.
I.1.b.iv. 3(ii)	the name(s) of all witnesses;	**Current findings on previous recommendations:** **Recommendation 1, July 2008:** Ensure that efforts are made to identify persons who may have seen or heard an incident. **Findings:** In the investigations reviewed, all identified witnesses were interviewed. In several instances, the investigator documented his/her effort to find additional witnesses: • In the investigation of an 8/20/08 incident of sexual contact between adults (kissing and groping) that allegedly occurred during a class, the investigator interviewed all six individuals in the room, asking them their position around the table and whether they saw or heard anything to suggest that the individual in question was in distress. • In the investigation of the 8/7/08 allegation of physical abuse, the

		investigator specifically asked both the individual and the named staff member if there might have been witnesses. • In the investigation of the allegation of verbal/psychological abuse (reported 6/24/08), the investigator identified individuals in the area and interviewed them and then interviewed individuals about a smoking cessation program that figured in the allegation. • During the investigation of the 11/6/08 allegation of neglect, the investigator asked a witness if any other persons might have also witnessed the events. The witness supplied five names. The investigator interviewed these people. • Referral of a staff member to EAP was made in one of the investigations review. [More specific information not provided to protect privacy.] Notwithstanding these efforts, when initial interviews do not follow shortly after the incident is reported, the chance of identifying additional witnesses is considerably diminished. **Recommendation 2, July 2008:** Ensure that all parties to an incident are interviewed. **Findings:** See above. **Current recommendation**: During the conduct of initial interviews, ask who might have heard or seen the incident.
I.1.b.iv. 3(iii)	the name(s) of all alleged victims and perpetrators;	**Current findings on previous recommendation:** **Recommendation, July 2008:** Continue current practice.

		Findings: The names of all alleged victims and all alleged perpetrators were identified in the investigations reviewed. **Other findings:** See also I.1.a.ii. Problems in reconciling the OSI log and the SIR database may result in persons involved in incidents not being entered into the SIR database. For example, the allegation of sexual contact (unwanted) between adults (8/20/08) was investigated by the OSI, but does not appear on the SIR listing of incidents. Thus, the names of two individuals do not appear in the SIR database as involved in this incident. The SIR database is the source for the behavioral trigger data. **Current recommendation**: Ensure that all incidents that are investigated by OSI have a completed SIR and are recorded in the SIR database.
I.1.b.iv. 3(iv)	the names of all persons interviewed during the investigation;	**Current findings on previous recommendation:** **Recommendation, July 2008:** See recommendations in I.1.b.iv.3(ii). **Findings:** The names of all persons interviewed were identified in the investigation reports reviewed along with the date, often the location of the interview, and a synopsis of the contents. **Current recommendation**: See recommendation in I.1.b.iv.3(ii).
I.1.b.iv. 3(v)	a summary of each interview;	**Current findings on previous recommendations:**

		Recommendation 1, July 2008: Take measures to ensure that interviews completed by Special Investigators are conducted as quickly as possible after the incident is reported. **Findings:** See the table in I.1.b.iv.2 showing the proximity of the first OSI interviews to the date the incident was reported. The findings show wide variability. **Recommendation 2, July 2008:** Avoid interviewing individuals and staff members in circumstances that jeopardize their ability to answer questions knowingly and freely. **Findings:** In the investigations reviewed, this monitor found no instances in which the interviews were compromised because the person was constrained from participating knowingly and freely. Individuals were not, for example, interviewed in restraints or when heavily medicated. **Current recommendation**: Ensure the timely conduct of interviews.
I.1.b.iv. 3(vi)	a list of all documents reviewed during the investigation;	**Current findings on previous recommendation:** **Recommendation, July 2008:** Continue current practice. **Findings:** All of the investigation reports reviewed contained a list of the documents reviewed during the investigation. For example, the investigator of the 11/6/08 allegation of neglect reviewed among other documents, the 1:1 observation logs, IDNs, physician orders, unit sign-in

		sheets, training records for six staff members and the unit floor plan. **Current recommendation**: Continue current practice.
I.1.b.iv. 3(vii)	all sources of evidence considered, including previous investigations and their results, involving the alleged victim(s) and perpetrator(s);	**Current findings on previous recommendations:** **Recommendation 1, July 2008:** Ensure that the incident history of both the alleged victim and the named staff member is reviewed and documented. **Findings:** Review of the incident history of the individual was documented in five of the 12 investigations reviewed. Review of the incident history of the named staff person was documented in eight. **Recommendation 2, July 2008:** Proceed with plans to put Protection from Harm 1 online. **Findings:** Current projections see Protection from Harm 1 becoming operational in June-July 2009. **Current recommendation**: Ensure that the incident history of both the alleged victim and the named staff member is reviewed and documented in the investigation report.
I.1.b.iv. 3(viii)	the investigator's findings, including findings related to the substantiation of the allegations as well as findings about staff's adherence to programmatic requirements; and	**Current findings on previous recommendation:** **Recommendation, July 2008:** IRC should review the investigation of alleged sexual abuse of ST on 4/11/08.

		Findings: The IRC reviewed this incident in November and requested the OSI to monitor the aggressor for additional incidents. **Other findings:** In addition to determinations related to abuse/neglect, investigators also considered violations of facility policy. For example, in the 11/06/08 investigation of the allegation of neglect, the following determinations were made: • Staff member #1. Neglect—sustained. Violation of AD related to Enhanced Observation—sustained. • Staff member #2. Neglect—sustained. Violation of AD related to falsifying records—sustained. Violation of AD related to reporting A/N—sustained. • Staff member #3. Violation of AD related to reporting A/N—not sustained. • Staff member #4. Violation of AD related to reporting A/N—sustained. Violation of AD related to misconduct, dishonesty and unprofessional conduct—sustained. • Staff member #5. Neglect—sustained. Violation of AD related to reporting A/N—not sustained. • Staff member #6. Violation of AD related to reporting A/N—sustained. **Current recommendation**: Continue current practice of identifying staff misconduct that violates facility policy.
I.1.b.iv. 3(ix)	the investigator's reasons for his/her conclusions, including a summary indicating how potentially conflicting evidence was	**Current findings on previous recommendations:**

	reconciled; and	**Recommendation 1, July 2008:** Do not permit interviews of persons who are in restraint. Do not permit interviews of persons whose reasoning and recall functions have been compromised by recently administered medications. **Findings:** This monitor found no instances in the investigations reviewed in which individuals were interviewed while in restraints or when their mental abilities were compromised by recently administered medications. **Recommendation 2, July 2008:** Take measures to resolve conflicting information. **Findings:** In one investigation reviewed, some findings that lay the foundation for the determination do not hold up to close scrutiny. NR alleged on 9/11/08 that she had had consensual sexual activity with a staff member on several occasions. She said the staff member had called her on the phone several times. [He admitted to one call.] She also said that she requested a transfer off the unit in order to get away from the staff member. Upon the investigator's request, NR took him to the dirty linen room where she said these incidents took place. The investigation did not sustain the allegation for the following reasons: • The room at the same time of day as NR said the meetings took place was not pitch dark like she said it was. • The room had three doors, not two as NR had described. • There were no witnesses. • Some of NR's answers to questions about what the man said while they were together were inconsistent. • NR requested the transfer before she made the allegation. Two of the reasons for not sustaining the case carry no weight: there

		were no witnesses and NR requested the transfer before making the allegation. One would not expect that either party would have engaged in the alleged behavior if witnesses were present. Secondly, NR said the activity had been going on for some time. It is not unreasonable that she may have wanted to free herself at some point prior to reporting the incidents. Thus, the timing of the transfer request is not inconsistent with her stated rationale for the request and may, in fact, support her allegation. NR became very upset as the investigation continued, and the decision was made not to question her further. The named staff member denied the allegation of sexual activity. He was asked a leading question about the clothing he was wearing at the time of the incidents in such a way that it may have influenced his answer. This monitor is not disputing the determination in this case—the investigation had to be halted before other evidence could be gathered—but rather the interpretation of several of facts upon which it rests. **Current recommendation**: Write rationales for determinations acknowledging and carefully weighing findings of fact, including those that support another theory of the case.
I.1.b.iv. 4	staff supervising investigations review the written report, together with any other relevant documentation, to ensure that the investigation is thorough and complete and that the report is accurate, complete, and coherent. Any deficiencies or areas of further inquiry in the investigation and/or report shall be addressed promptly. As necessary, staff	**Current findings on previous recommendation:** **Recommendation, July 2008:** In exercising its expanded duties, the Incident Review Committee, in reviewing the quality of investigations, should consider the elements of a comprehensive investigation as outlined in the EP.

	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.	**Findings:** The minutes of the IRC clearly document the committee's review of the timeliness and completeness of investigation. **Other findings:** Most of the investigations reviewed demonstrated improvement in the thoroughness of the investigation, including improved documentation of interviews, timeliness, and readability of the investigation reports. In response to these observations, the Supervising Special Investigator explained that he meets weekly with investigators to monitor the progress of investigations and carefully reviews and edits the investigation reports. **Current recommendation**: Continue to closely supervise the conduct of investigations and the preparation of reports.
I.1.c	Each State Hospital shall ensure that whenever disciplinary or programmatic action is necessary to correct a situation or prevent reoccurrence, each State hospital shall implement such action promptly and thoroughly, and track and document such actions and the corresponding outcomes.	**Current findings on previous recommendations:** **Recommendation 1, July 2008:** Add information about the incident type, date of recommendation, date completed, and responsible staff person to the tracking log for OSI investigations. **Findings:** The Special Investigations Recommendations tracking sheet (dated 1/14/09), reviewed by the IRC, identifies the subject, victim, recommendation and action taken. It tracked the recommendations made in 23 investigations from May—November 2008. Confirmation that recommendations had been implemented (as distinct from "will be" implemented) was documented for only three of the 23 investigations. This suggests that the facility is not able to ensure that programmatic and training recommendations made at the close of investigations are

		being implemented in a timely manner. **Recommendation 2, July 2008:** Ensure the tracking sheet addresses all recommendations. **Findings:** See above. **Other findings:** Human Resources reports that disciplinary action has been taken or is pending for 16 staff members found to have engaged in misconduct in the investigations reviewed. However, the timeliness of disciplinary actions is open to question. For example, two staff members have received counseling memos in investigation cases closed in August 2008, while discipline is still pending for two other staff members whose cases were also closed in the same month. Action is still pending in one case closed in June 2008. **Compliance:** Partial. **Current recommendations**: 1. Establish a system that ensures that programs respond in a timely manner indicating that recommendations resulting from investigations have been implemented or providing a rationale why not. This may require facility executive department intervention. 2. Review the disciplinary actions required in the cases reviewed to ensure that they are being implemented even-handedly and expeditiously. Document the results of this review.
I.1.d	Each State hospital shall have a system to allow the tracking and trending of investigation results. Trends shall be tracked by at least the following	**Compliance:** Partial.

	categories:	
I.1.d.i	type of incident;	**Current findings on previous recommendation:** **Recommendation, July 2008:** The IRC and other appropriate groups should continue to review pattern and trend reports on incidents. **Findings:** Graphed data reviewed by the IRC addressed peer-to-peer aggression and individual-to-staff aggression. Pattern data was presented related to time of day and location of incidents [see cells I.1.d.iv and I.1.d.v for more information]. No trending reports were prepared and reviewed. **Other findings:** The IRC minutes did not document that the graphed data (described in I.1.d.iv and I.1.d.v) was discussed and recommendations made to address the findings or requests to further refine the data to make it more useful. The Quality Council minutes documented a review of the data and a request for additional data for upcoming meetings. **Current recommendations**: 1. Determine how the facility will meet the EP requirement to produce, review and use tracking and trending data. 2. Document in the IRC minutes the discussion of the SIR incident data reports along with recommendations and referrals to other bodies for review.
I.1.d.ii	staff involved and staff present;	**Current findings on previous recommendation:** **Recommendation, July 2008:** Continue with plans to increase the number of reports produced and ensure their distribution to appropriate forums for review.

		Findings: There is no systematic tracking of staff members involved in incidents. Some investigation reports reviewed documented that a staff member's incident history had been reviewed. The facility reports that IRC members are aware of the need to look for staff who appear repeatedly in incidents. **Other findings:** The production of pattern data on staff involved and present during incidents will require enhancing the report-producing capability of the Record Management System or the introduction of the statewide Incident Management System. **Current recommendation**: Continue work on the statewide Incident Management system and the Record Management System to enable staff to extract the reports required by the EP.
I.1.d.iii	individuals directly and indirectly involved;	**Current findings on previous recommendation:** **Recommendation, July 2008:** Develop reports for review by the Incident Review Committee on individuals and staff who appear frequently in incidents. **Findings:** See cell I.1.d.ii. **Other findings:** As with staff members, there is no systematic tracking of individuals involved in incidents except through the trigger system, which does not capture all incidents. Tracking of individuals' full incident histories will await the statewide Incident Management system or amplification of the reports available through the Record Management System.

		Current recommendation: Continue work on both the Record Management System and the statewide Incident Management system so that facilities can begin to track the involvement of individuals and staff members in incidents.
I.1.d.iv	location of incident;	**Current findings on previous recommendation:** **Recommendation, July 2008:** Implement the plan to have the IRC look closely at the location of incidents and identify measures that might be influencing the data. IRC minutes should reflect this work. **Findings:** The IRC minutes include the graphed data described below but do not reflect discussion of the data or recommendations or requests for additional information. **Other findings:** This cell and the following cell reproduce, in a different format, data provided to the Incident Review Committee. While this monitor has added some analysis, it has been added recognizing that the IRC graphed data for January—November 2008 does not match the key indicator data. Specifically, there were 53 incidents of peer aggression resulting in a major injury in the IRC graphs, N= 53 and 55 incidents of peer aggression resulting in major injury in the key indicator data. SIR graphed data shows the location of aggressive acts to peers resulting in major injury for the period January—November 2008 as follows:

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<tr><th># incidents</th><th>Units</th></tr>
<tr><td>8</td><td>A-7</td></tr>
<tr><td>7</td><td>Q1-2</td></tr>
<tr><td>5</td><td>Q3-4, Q5-6</td></tr>
<tr><td>4</td><td>A-8, T-13</td></tr>
<tr><td>3</td><td>T-3, T-7, T-12</td></tr>
<tr><td>2</td><td>A-2, A-10, Q7-8, Q-9,</td></tr>
<tr><td>1</td><td>T-8, T-11, T-14</td></tr>
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Data for the period January—September 2008 shows that the greatest number of major injuries to staff stemming from aggressive acts occurred on Units A-10 (16 incidents), A-1 (12 incidents) and T-7 (10 incidents). [Data on location of incidents resulting in major injuries to staff as a result of aggression and aggressive acts to peers for January—November 2008 was not presented.]

Graphed data on the unit location of all aggressive acts to peers for the period January—September indicates that the highest numbers occurred on Q1-2 (55 incidents), Q5-6 (52 incidents) and Q7-8 (51 incidents). The next highest unit, T-13, was the site of 25 incidents.

Current recommendations:
1. Ensure the incident location data is discussed in the appropriate forums and ask for the assistance of the review committees established under the Risk Management Special Order if they can be helpful in reducing violence to peers and staff members.
2. Provide data on the high-risk units over time in order to see trends.
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<tr>
<td>I.1.d.v</td>
<td>date and time of incident;</td>
<td>
Current findings on previous recommendation:

Recommendation, July 2008:
Provide the information on location, day and time of incidents to the
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		appropriate committees for review and action. **Findings:** The Incident Review Committee minutes included a graphed report from the SIR database for the period January—November 2008 that showed 4:00 PM—7:00PM as the time period in which aggressive acts between peers resulting in major injury were most likely to occur. Over one-third (38%) of these acts of aggression occurred during this three-hour period. More aggressive acts to staff resulting in major injury occurred between 4:00PM—5:00PM than in any other one-hour period in January—September 2008. [Data through November 2008 was not presented.] Review of the graphed data for the time of day of aggressive acts to peers in the period January—November 2008 reveals that 3:00PM—4:00PM and 6:00PM—7:00PM are the most dangerous times. Over one-third (35%) of the 544 incidents occurred between 3:00PM—7:00PM. **Current recommendations**: 1. Provide analysis with the graphs. 2. Document in the IRC minutes the committee's review and analysis of the incident data reports as well as how the committee intends to present its findings to influence facility policy/procedures.
I.1.d.vi	cause(s) of incident; and	**Current findings on previous recommendations:** **Recommendation 1, July 2008:** Complete HQ briefs in a timely manner. **Findings:** Review of seven Headquarters Reportable Briefs finds that three met the 60–business-day timeline in SO 227.08: Special Incident Reports

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<table>
<tr><td>Incident date</td><td>Date of Final HQ Brief</td><td>Meets 60 business day timetable?</td></tr>
<tr><td>6/13/08</td><td>9/12/08</td><td>Yes</td></tr>
<tr><td>6/23/08</td><td>11/02/08</td><td>No</td></tr>
<tr><td>7/4/08</td><td>12/2/08</td><td>No</td></tr>
<tr><td>7/14/08</td><td>12/15/08</td><td>No</td></tr>
<tr><td>8/26/08</td><td>Not complete</td><td>No</td></tr>
<tr><td>8/27/08</td><td>11/19/08</td><td>Yes</td></tr>
<tr><td>8/23/08</td><td>11/12/08</td><td>Yes</td></tr>
</table>

The facility acknowledges delays in completing HQ Reportable Briefs.

Recommendation 2, July 2008:
Review the implementation of corrective measures on at least a sample basis.

Findings:
This recommendation has not yet been implemented.

Other findings:
A review of nine completed Headquarters Reportable Briefs found that the Analysis portion of Section III was not completed in seven.

Current recommendation:
Improve the timeliness and completeness of the HQ briefs. Identification of possible contributing factors, such as environmental conditions, restrictions, retaliation, etc. during police and OSI investigations would assist in improving the quality of the briefs.
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<td>I.1.d.vii</td>
<td>outcome of investigation.</td>
<td>Current findings on previous recommendations:</td>
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		Recommendation 1, July 2008: Include a thoughtful weighing of the evidence (to determine if the preponderance standard has been reached) when investigations are reviewed by the Incident Review Committee. **Findings:** The IRC minutes reflect thoughtful consideration and discussion of the quality of investigations. **Recommendation 2, July 2008:** Ensure that both repeat victims and aggressors are identified and an appropriate response is forthcoming. Spot-check implementation of these measures. **Findings:** Individuals who trigger repeatedly as aggressors will be reviewed under the newly implemented Risk Management hierarchy of interventions. There is no systematic identification of individuals who are repeatedly victimized. The Quality Council minutes state that Program Review Committees are "being asked to review each victim in instances of aggressive acts." This did not occur in the PRC meeting observed. Use of the ASH information system (being adapted for use at NSH) will be a critical tool in facilitating the review of interventions recommended when an individual has reached a trigger. **Current recommendations**: 1. Identify repeat victims and give them the same level of clinical attention as to repeat aggressors. Follow the directive in the Quality Council minutes for PRCs to review victims when they review aggressors. 2. Continue working on adapting the ASH information system for use at NSH.

I.1.e	Each State hospital shall ensure that before permitting a staff person to work directly with any individual, each State hospital shall investigate the criminal history and other relevant background factors of that staff person, whether full-time or part-time, temporary or permanent, or a person who volunteers on a regular basis. Facility staff shall directly supervise volunteers for whom an investigation has not been completed when they are working directly with individuals living at the facility. The facility shall ensure that a staff person or volunteer may not interact with individuals at each State hospital in instances where the investigation indicates that the staff person or volunteer may pose a risk of harm to such individuals.	**Current findings on previous recommendation:** **Recommendation, July 2008:** Develop guidelines that direct the reassignment of staff when allegations of misconduct have been made. **Findings:** Guidelines have not been developed. See also I.1.a.iii. **Other findings:** See the table in I.1.a.iv. Documentation of the criminal background checks was available for 12 of the 14 staff members reviewed. The two staff members for whom documentation was not available were hired in the 1980s. **Compliance:** Partial. **Current recommendation**: Develop guidelines/procedures for assessing whether staff reassignment is necessary when allegations of misconduct have been made.

2. Performance Improvement		
I.2	Each State hospital shall develop, revise as appropriate, and implement performance improvement mechanisms that enable it to comply fully with this Plan, to detect timely and adequately problems with the provision of protections, treatment, rehabilitation, services and supports, and to ensure that appropriate corrective steps are implemented. Each State hospital shall establish a risk management process to improve the identification of individuals at risk and the provision of timely interventions and other corrective actions commensurate with the level of risk. The performance improvement mechanisms shall be consistent with generally accepted professional standards of care and shall include:	**Methodology:** <u>Interviewed</u>: 1. C. Black, Standards Compliance Director 2. C. Caruso, Clinical Administrator 3. D. Chupinski, Standards Compliance 4. K. Cooper, Enhancement Plan Coordinator 5. K. Gardiner, Risk Manager 6. M. McCandless, Standards Compliance Coordinator 7. P. Tyler, MD, Medical Director <u>Reviewed</u>: 1. Historical trigger data 2. Trigger data on specific individuals 3. WaRMSS data, SIR data, OSI log, and Headquarters Briefs for the purpose of comparison 4. Quality Council minutes <u>Observed</u>: 1. Program 3 Review Committee meeting 2. PSSC/Enhanced Trigger Review Committee meeting
I.2.a	Mechanisms for the proper and timely identification of high-risk situations of an immediate nature as well as long-term systemic problems. These mechanisms shall include, but not be limited to:	**Compliance:** Partial.
I.2.a.i	data collection tools and centralized databases to capture and provide information on various categories of high-risk situations;	**Current findings on previous recommendations:** **Recommendation 1, July 2008:** Expedite to the degree possible the development of a hierarchy of interventions to be used by all of the facilities as the foundation of

		their Risk Management Systems. **Findings:** Special Order 262: Risk Management established a hierarchy of interventions for intervening on behalf of individuals who reach triggers. **Recommendation 2, July 2008:** Implement plans to have teams report the interventions put in place for individuals who have reached an enhanced supervision or suicide attempt trigger. **Findings:** See below. **Other findings:** At the time of the tour, the facility had begun implementation within the last 5-6 weeks of Special Order 262, which establishes a hierarchy of interventions for individuals who reach behavioral triggers. Program Directors began meeting weekly with the Unit Supervisors and critical team members to review individuals who had reached behavioral triggers. The attendees determine what, if any, interventions are needed (or have been implemented) and who will be responsible for ensuring their completion. The Risk Manager also attends these meetings and assists in keeping track of recommendations. The facility has also implemented the second level of intervention, the combined PSSC and Enhanced Trigger Review Committee meeting. These meetings also occur weekly and review individuals who meet the criteria specified in the Special Order or whom a team or program believes could benefit from this level of review. The Risk Manager also attends these meetings and assists with tracking recommendations. The facility is in the process of adapting a data system from ASH that will track the individuals presented at these meetings, the recommendations made (including to refer an individual to a higher level of review) and the staff

		member responsible for implementation. The Facility Review Committee (Level 3 review) had not yet met at the time of the tour nor had the Medical Risk Management Committee reviewed any individuals. Both the Program Review Committee meeting and the PSSC/Enhanced Trigger Review Committee meetings attended would have benefited from a clearer presentation of why the individual was being discussed; the presentation of specific data on the individual's behavior and information on medications, for example; and a synopsis at the conclusion of the discussion of actions to be taken, by whom and when. **Current recommendations**: 1. Advise staff members attending the Level 1 and Level 2 meetings to be prepared to present relevant and specific information to advance the discussion of an individual under their care. 2. Continue with plans for the full implementation of Special Order 262.
I.2.a.ii	establishment of triggers and thresholds that address different levels of risk, as set forth in Appendix A; and	**Current findings on previous recommendations:** **Recommendation 1, July 2008:** Include the review of the investigation by the IRC in the table. **Findings:** This recommendation may no longer be necessary as the IRC is reviewing all OSI investigations. **Recommendation 2, July 2008:** Proceed with the development and implementation of the Protection from Harm Special Order.

		Findings: The facility has begun implementation of the hierarchical system of review of incident-related triggers as cited in the Protection from Harm Special Order and described in the cell above. Implementation of Medical Risk Management is expected in June 2009. Presently committee members are developing a tool to be used to compile a medical risk profile specific to each individual. At the time of the tour, the tool addressed seven conditions. Use of the tool was expected to begin in February. When the tool has been piloted and found to meet its objectives, the Committee will begin meeting to review and provide direction for the care of individuals determined to be at high risk. The information system developed by ASH will aid in tracking and updating risk profiles. **Current recommendation**: Continue with preparatory work for full implementation of Medical Risk Management in early summer.
I.2.a.iii	identification of systemic trends and patterns of high risk situations.	**Current findings on previous recommendations:** **Recommendation 1, July 2008:** Identify individuals who are repeat victims and ensure that measures are taken to protect them. **Findings:** There is presently no systematic identification of repeat victims. The facility reports that the IRC will identify individuals who appear frequently in incidents. The Quality Council minutes (December 2008) state that Program Review Committees have been instructed to review victims as well as aggressors. As stated in I.1.d.vii, this did not occur during the PRC observed.

Recommendation 2, July 2008:
Ensure implementation of the violence abatement steps outlined in the April 2008 memo to Cindy Radavsky.

Findings:
These efforts at violence abatement continue and include implementation of a risk profile on all new admissions.

Other findings:
Behavioral trigger results contrasting review period 1 (June-October 2008) and review period 2 (January—May 2008) reveal an increase in the most recent period in four of the eight measures of aggression. [Total numbers for each trigger in the time period are presented.]

Trigger	Jan—May 2008	Jun—Oct 2008
Aggression to self resulting in major injury	12	12
Individuals with two or more aggressive acts to self in seven consecutive days	6	6
Individuals with four or more aggressive acts to self in 30 consecutive days	0	3
Peer-to-peer aggression resulting in major injury	26	23
Aggression to staff resulting in major injury	48	65
Individuals with two or more aggressive acts to others in seven consecutive days	37	51
Individuals with four or more aggressive acts to others in 30 consecutive days	6	15
Any suicide attempts	7	5

		Current recommendations: 1. Program Review Committees should follow the directive in the Quality Council minutes and review the victims when they review aggressors who have reached triggers. 2. Continue implementation of the Violence Abatement Plan and the Risk Management System with the goal of reducing violence in the facility.
I.2.b	Mechanisms for timely interventions and other corrective actions by teams and disciplines to prevent or minimize risk of harm to individuals. These mechanisms shall include, but not be limited to:	**Compliance:** Partial.
I.2.b.i	a hierarchy of interventions by clinical teams that correspond to triggers and thresholds;	**Current findings on previous recommendations:** **Recommendation 1, July 2008:** Continue sharing information among the subcommittees to coordinate responses. **Findings:** This recommendation is no longer helpful, as the facility has begun implementation of the Risk Management system described in Special Order 262. **Recommendation 2, July 2008:** Continue work on the statewide hierarchy of interventions in response to triggers. **Findings:** Special Order 262: Risk Management established a hierarchy of interventions in response to triggers. NSH has begun implementation of the incident-related portion of the Special Order and is engaged in preparatory work for implementation of the medical risk management

		portion of the Special Order. See I.2.a.i and I.2.a.ii. **Current recommendation:** Continue with current efforts to improve the performance of the Program Review Committees and to adapt the ASH information system for use at NSH, thereby enhancing the facility's ability to track the responses of risk management committees as individuals are reviewed.
I.2.b.ii	timely corrective actions by teams and/or disciplines to address systemic trends and patterns;	**Current findings on previous recommendation:** **Recommendation, July 2008:** Continue to identify high-risk issues within the committee structure, share information, and identify a multi-disciplinary corrective action whenever possible. **Findings:** Full implementation of the Risk Management system envisioned in Special Order 262 will accomplish the objective of this recommendation. **Other findings:** The Quality Council is the forum where system trends and patterns will be reviewed and recommendations for corrective actions identified. The Council had held two meetings at the time of the tour (December 2008 and January 2009.) **Current recommendation:** As the facility develops the capacity to produce these reports, provide the Quality Council with pattern and trend data and analyses.
I.2.b.iii	formalized systems for the notification of teams and needed disciplines to support appropriate interventions and other corrective actions;	**Current findings on previous recommendations:** **Recommendation 1, July 2008:** Implement plans to monitor the responses of WRPTs to triggers related

to enhanced supervision and suicide attempts.

Findings:
Prior to December 2008, there were no procedures in place to monitor the WRPTs' responses to any of the triggers. This is not to say that teams were not responding to the trigger notifications, only that there was no expectation that they would report their intervention/response. Approximately one in five trigger action sheets was returned.

Recommendation 2, July 2008:
Research the question of whether the trigger data for suicide attempts is accurate; identify and take actions to correct the cause of any problems.

Findings:
Matching the SIR database report on suicide attempt incidents with the trigger data yielded no discrepancy.

Other findings:
The facility continues to have reliable procedures for notifying WRPTs that an individual has reached a trigger. Trigger counts were within range when they were derived from the SIR database (January—November 2008). December data extracted from Quick Hits was seriously flawed as illustrated below. The data was recalculated using the SIR database and corrected while the court monitoring team was on site.

Trigger	Quick Hits 12/08 data	SIR 12/08 data
Aggression to self resulting in major injury	4	3
Two or more aggressive acts to self in seven consecutive days	3	0

Four or more aggressive acts to self in 30 consecutive days	2	0
Peer-to-peer aggression resulting in major injury	32	2
Two or more aggressive acts to others in seven consecutive days	20	7
Four or more aggressive acts to others in 30 days	9	2
Individuals having alleged abuse/neglect/ exploitation	27	5

Had the WRPTs been attentive to the trigger notifications, one would have expected that they would have been notifying Standards Compliance that the notifications were wrong, i.e. the individuals named had not engaged in the behavior on the date identified. This did not occur, leaving the conclusion that until late December/January, the WRPTs were not paying close attention to the trigger notifications. The facility does not dispute this conclusion.

In addition, close review of the November trigger data on peer aggression resulting in a major injury revealed that Quick Hits identified 23 incidents while the SIR database identified six. Of these six incidents, only three appeared on the Quick Hits list. Twenty of the Quick Hits entries were in error. This again strongly indicates the need for substantial training for staff members on the purpose and use of this data system. **Without improvement in this area, the Quick Hits data is unreliable and cannot be used to count behavioral triggers or to identify individuals who have reached a behavioral trigger.**

Current recommendation:
Take all measures necessary to ensure the accuracy of the Quick Hits data system.

I.2.b.iv	formalized systems for feedback from teams and disciplines to the standards compliance department regarding completed actions; and	**Current findings on previous recommendation:** **Recommendation, July 2008:** Implement plans to require a response from WRPTs to Standards Compliance when an individual reaches a trigger for suicide attempt and enhanced observation. **Findings:** The feedback component of the trigger notification system was not implemented until late November 2008. Prior to that time, trigger action sheets were rarely returned by the WRPTs. The facility's data shows that since June 2008, 95 (20%) of the 483 trigger action sheets were returned identifying the WRPTs intervention. **Current recommendations**: 1. Move to full implementation of the Risk Management system. 2. Continue working to adapt the ASH information system and begin using it for tracking purposes as quickly as possible.
I.2.b.v	monitoring and oversight systems to support timely implementation of interventions and corrective actions and appropriate follow up.	**Current findings on previous recommendation:** **Recommendation, July 2008:** Develop a plan for monitoring the timely implementation of corrective actions related to triggers. **Findings:** In late November 2008, the facility clarified the expectation that WRPTs are to respond to trigger action sheets identifying their treatment response. The newly implemented portion of the Risk Management system dealing with incidents requires a weekly Program Review Committee meeting to discuss and subsequently identify the treatment response. Presently these responses are recorded by the Program Director and the Risk Manager, who attends all of these

		meetings. In the future when the information system from Atascadero State Hospital has been formatted for use at NSH, the treatment responses will be tracked electronically. When individuals reach criteria specified in Special Order 262 or when a WRPT believes it requires additional clinical resources, the WRPT may request that the case be reviewed in the combined PSST/Enhanced Trigger Review Committee which also meets weekly. These meetings had been occurring for approximately four weeks at the time of the court monitoring tour. Minutes of these meetings are being kept manually until the ASH information system is adapted for use at NSH. **Current recommendations**: 1. Continue work on adapting the ASH information system for tracking Risk Management activities for use in NSH. 2. Use the information system to ensure that all teams and committees respond to triggers as described in the Risk Management Special Order. 3. The Clinical Administrator should monitor the quality of the reviews by attending at least a sample of the meetings.
I.2.c	Utilize, on an ongoing basis, appropriate performance improvement mechanisms to assess and address the facility's compliance with its identified service goals.	**Current findings on previous recommendation:** **Recommendation, July 2008:** Continue the development of the Risk Reduction Oversight Committee and its subcommittees. **Findings:** This Committee has been replaced by the hierarchical structure of interventions for high-risk individuals described in Special Order 262. **Other findings:** With only recent implementation of the incident-related provisions of

		the Risk Management system and the medical-related provisions still under development, it is too early to make judgments about the effectiveness of the system in providing a safe environment in which individuals receive skilled attention to their physical and mental health needs. These judgments are best left to when full implementation of Special Order 262 has been achieved. **Compliance:** Partial. **Current recommendation**: Continue all plans to fully implement Special Order 262.

3. Environmental Conditions		
I.3	Each State hospital shall develop and implement a system to review regularly all units and areas of the hospital to which individuals being served have access to identify any potential environmental safety hazards and to develop and implement a plan to remedy any identified issues, consistent with generally accepted professional standards of care. Such a system shall require that:	**Methodology:** Interviewed: 1. Several individuals and staff members during unit tours 2. Member of the Cooperative Advisory Council 3. M. McQueeney, Assistant Hospital Administrator Reviewed: 1. Clinical records of 11 individuals with the problem of incontinence 2. Hospital incontinence self-audit results by program 3. Monthly Environmental Issues/Risk report 4. Monthly Environmental Risk tracking report 5. Environment of Care compliance data for June—November 2008 6. Environment of Care Risk Reduction Report (January 2009) 7. Bi-annual Status Report on Temperature Control Problems 8. Nursing Policy and Procedure: Sexual Contact and Safety of Individuals (effective 12/8/08) Toured: Five residential units: A-1, A-7, A-9, Q 1-2, Q 7-8
I.3.a	Potential suicide hazards are identified and prioritized for systematic corrective action, and such action is implemented on a priority basis as promptly as feasible;	**Current findings on previous recommendations:** **Recommendation 1, July 2008:** Address the cleanliness issues noted. **Findings:** During the current tour, the common areas of the units visited were clean. For the most part, the bedrooms visited were also clean, although stark. This improvement may be due, at least in part, to new procedures that require the Program Director or his/her designee to conduct daily rounds. The findings from these tours are reported daily

		to the Clinical Administrator. The facility continues to make improvements in the environment on Unit A-1. **Recommendation 2, July 2008:** Remove handrails in units where they are not needed. **Findings:** Handrails in the hallway in A-1 have been removed. The facility plans to remove or replace with no-gap handrails the handrails along the hallways in other units. Handrails in the showers and bathrooms observed are no-gap. The facility reports that 93% of the handrails in shower and bathrooms are gap-free. **Other findings:** The facility has identified environmental issues that raise concern because they present a suicide hazard or a hazard to others since they can be used as a weapon. It prioritizes these issues using a 1—5 scale, with 5 being the highest priority. It is proceeding with projects to correct these hazards as resources become available. • The facility identified the replacement of wardrobes (a suicide hazard) as a high priority. It reports that the new wardrobes have been placed in six units. This monitor observed these during the tour. These wardrobes eliminate the combination lock and chain that are presently used on the older wardrobes. Outfitting all units with the new wardrobes is expected to be completed by the end of 2009. • In addition to wardrobes, the facility is distributing new nightstands (with no metal glides) and no-throw chairs. The facility has worked with a manufacturer to produce a one-piece bed with no moving parts, screws or bolts that has drainage access. The bed

		will be particularly useful to individuals who are incontinent. • Shower valves that do not present a suicide hazard (push-button valves) have been installed on the T and Q units. The A units have not yet had the old fixtures replaced. The facility expects to complete this work in September 2009. The facility also plans to replace the toilet stall door hinges with piano hinges by the fall of 2009. • Door hinges that swing into an individual's bedroom (V-shaped hinges at the top of the door) have been replaced with hinges that swing out into the hallway. This removed another suicide hazard. Of the 25 items in the Suicide and Risk Prevention portion of the Environment of Care Cumulative Compliance Report, all but five had compliance ratings of 90% or more. **Compliance:** Substantial. **Current recommendation**: Continue current practice.
I.3.b	All areas of the hospital that are occupied by individuals being served have adequate temperature control and deviations shall be promptly corrected;	**Current findings on previous recommendation:** **Recommendation, July 2008:** Continue current practice. **Findings:** The temperature on the units visited was comfortable. The bi-annual report on temperature control problems identified 78 complaints in 2008 that the environment was either too hot or too cold. Complaints of "too hot" outnumbered "too cold." Mechanical failures accounted for the problems.

		Compliance: Substantial, based on limited information. **Current recommendation**: Continue current practice.
I.3.c	Each State hospital reviews, revises, as appropriate, and implements procedures and practices so that individuals who are incontinent are assisted to change in a timely manner;	**Current findings on previous recommendations:** **Recommendation 1, July 2008:** Implement plans for receiving feedback on measures taken to improve staff performance in addressing incontinence. **Findings:** The facility reports that WRP trainers worked with RNs to develop foci, objectives and interventions related to incontinence. This work was completed at the end of October. **Recommendation 2, July 2008:** Clarify with auditors that only responses expressly indicating the negative are counted for question #6 on the monitoring form. **Findings:** The instructions for completing item #6 on the DMH Incontinence Monitoring Form (*Individual is able to verbalize goals and objectives related to the condition*) state that N/A should be used if the individual is non-verbal due to an identified condition. The Incontinence Analyzer Report does not identify the number of individual for whom N/A was the proper response for this item and for item #7 (*Individual verbalizes that staff act quickly to assist*). Thus, the reader cannot be certain if, or how, N/A responses were factored into the compliance percentages.

Other findings:
Review of the clinical records of 11 individuals identified by the facility as having the problem of incontinence found that 27% did not have an open focus and objectives and interventions for dealing with the problem.

Individual	Included in Focus 6?	Objective and Interventions?
DC	Yes	Yes
DT	Yes	Yes
IS	Yes	Yes
JH	Yes	Yes
MW	Yes	Yes
QE	Yes	Yes
RH	Yes	Yes
WF	Yes	Yes
PN	No	No
SL	No	No
WG	No	No

Objectives and interventions were scored "yes" when they addressed interventions in addition to assisting the individual in changing clothing.

These findings are consistent with the facility's self-audit for identification of the problem in Focus 6, which indicated mean compliance of 76% for the period June—November 2008. The facility's own data shows 29% compliance when scoring whether the objectives promote dignity and encourage self-reliance. This low compliance score may be due to the subjective nature of the judgment called for. Not to be overlooked, however, the facility's data shows a mean compliance rate of 98% in those criteria where the individual is observed by the auditor to ensure he/she is clean and odor-free.

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

Current recommendation:
Continue training and monitoring efforts to improve appropriate addressing of the problem of incontinence in WRPs.</td></tr>
<tr><td>I.3.d</td><td>Each State hospital thoroughly reviews and revises, as appropriate, its policy and practice regarding sexual contact among individuals served at the hospital. Each State hospital shall establish clear guidelines regarding staff response to reports of sexual contact and monitor staff response to incidents. Each State hospital documents comprehensively therapeutic interventions in the individual's charts in response to instances of sexual contact; and</td><td>Current findings on previous recommendation:

Recommendation, July 2008:
Implement plans to clarify expectations for staff performance when a sexual incident has occurred.

Findings:
NSH developed a new nursing policy: Sexual Contact and Safety of Individuals. Training on the new policy began in December 2008, and the facility reports that the Health Services Specialists trained 59 of their program nursing staff. Training on this policy will become part of new employee orientation for nursing staff. The policy requires that the IDN document the event and all interventions and that nursing staff will "ensure medical and psychological assessment and care as needed." It further requires the WRPTs to discuss and evaluate the need for additional action and interventions.

Other findings:
Review of the clinical records of 10 individuals involved in sexual incidents revealed that four incidents were described in a timely note and addressed by the WRPT, psychiatrist or psychologist.

<table>
<tr><th>Individual</th><th>Incident Date</th><th>Addressed in IDN?</th><th>Addressed by WRPT, psychologist or psychiatrist?</th></tr>
<tr><td>DH</td><td>9/1/08</td><td>Yes</td><td>Yes</td></tr>
<tr><td>EM</td><td>10/17/08</td><td>Yes</td><td>Yes</td></tr>
</table></td></tr>
</table>

GJ	8/26/08	Yes	Yes
MC	10/22/08	Yes	Yes
NI	8/12/08	Yes	N/A; denies incident, acknow-ledges event occurred in a dream
BL	9/22/08	Yes	No
JM	9/1/08	Yes	No
ML	9/22/08	Yes	No
PA	9/22/08	Yes	No
NI	8/22/08	Yes	No
TJ	8/24/08	No	No

These findings are consistent with the audit completed by the facility covering the period June—November 2008. Relevant facility finding include:

- WRPT discusses and evaluates need for additional pertinent action steps and interventions---29% compliance
- Psychological care provided—30% compliance
- Documentation in the chart of the event, action taken—71% compliance

The facility's mean data comparing the most recent review period with the one preceding it finds backsliding in 73% of the 22 audit items during the most recent review period. Comparison of the final month's audit results for each of the review periods is much more promising, with November 2008 results showing improvement in 12 of the 22 items over May 2008.

Compliance:
Partial.

		Current recommendation: Continue training and monitoring efforts to improve compliance with expectation for addressing sexual incidents.
I.3.e	Each State hospital develops and implements clear guidelines stating the circumstances under which it is appropriate to utilize staff that is not trained to provide mental health services in addressing incidents involving individuals. Each State hospital ensures that persons who are likely to intervene in incidents are properly trained to work with individuals with mental health concerns.	**Current findings on previous recommendation:** **Recommendation, July 2008:** Facilitate the required training of the non-clinical staff members who are conducting Mall groups. **Findings:** Using the facility's data, there appears to have been no progress in ensuring that non-clinical staff members conducting Mall groups completed the required training. In 2007, 10 staff members had completed the course requirements. In 2008, eight staff members had completed the course requirements. In 2008 the eight staff members represent 24% of the non-clinical staff members identified as providing Mall services. **Compliance:** Partial. **Current recommendation**: Continue efforts to make training available to non-clinical Mall providers and notify supervisors when attendance problems persist.

J. First Amendment and Due Process		
J		**Summary of Progress:** 1. Cooperative Advisory Council (CAC) members report that the facility leadership continues to be responsive to their questions and concerns. Senate members specifically praised the responsiveness of the Hospital Administrator and the Assistant Hospital Administrator in addressing their concerns regarding environmental issues. 2. Upon learning of several concerns expressed at the Senate meeting during the court monitor's tour, the Clinical Administrator took immediate action to ensure that individuals would be able to purchase postage stamps and to reassure individuals that the facility is recruiting a librarian so that "drop in" library hours can be extended. 3. January 2009 survey results show substantial improvement over the previous survey. 4. The hospital administration and the CAC continue to encourage the activities of Peacemakers and events to recognize them. 5. The administration, the Mall Director, and the CAC have worked cooperatively to make some changes to the Mall course offerings and scheduling.
J	Each State hospital unconditionally permits individuals to exercise their constitutional rights of free speech, including the right to petition the government for redress of grievances without State monitoring, and provides them due process.	**Methodology:** <u>Interviewed</u>: 1. Several individuals and staff during the tour of the units 2. Cooperative Advisory Council (CAC) Senate members 3. C. Caruso, Clinical Administrator 4. D. Gardiner, Risk Manager <u>Reviewed</u>: 1. CAC survey results

		2. CAC meeting minutes for July—December 2008 Attended: Senate meeting of the CAC
J		**Current findings on previous recommendations:** **Recommendation 1, July 2008:** Through discussion with the Council, determine the specific problems in accessing records. **Findings:** This meeting with the Council is reportedly scheduled for February 2009. **Recommendation 2, July 2008:** Implement plans already developed to open additional open units. **Findings:** In December 2008, T-17 was established as an open co-ed unit. At the conclusion of the Secure Treatment Area reorganization, there will be one open male unit in Program 1, two open male units in Program 2, and three co-ed open units in Program 3. **Recommendation 3, July 2008:** DMH should continue working with CONREP and other entities to open more placements. **Findings:** The facility reports that in the six-month report period, no new placements have been developed. Approximately six individuals have been released to CONREP each month during the last six months.

		Recommendation 4, July 2008: Discuss Mall scheduling with members of the Council. **Findings:** Several meetings between the Mall Director and the Council have occurred. The minutes show the Mall Director was the invited guest at the Council meetings on October 8 and December 17. He is reportedly due back in January 2009. **Recommendation 5, July 2008:** Advise the Council on the hours the law library is open and any other conditions for using it. **Findings:** The Clinical Administrator reported that the facility library has open drop-in hours in the late afternoon for approximately two hours each weekday. Facility staff are encouraged to escort groups of individuals to the library at other times. The facility will be recruiting a librarian. When someone is hired, weekend hours will be available. **Other findings:** The officers of the Council explained during the meeting that individuals' ability to send mail is restricted because it is difficult to purchase stamps. The Café reportedly does not keep an adequate supply on hand, resulting in individuals sometimes not being able to send mail. When this was brought to the attention of the Clinical Administrator, she immediately conferred with leadership at the Café and an agreement was reached that will ensure a sufficient supply of stamps is available to meet individuals' needs. The January 2009 survey results as reported by the facility include

the following. Most areas of review showed improvement over the previous survey.

	% Positive Responses	
Question	Jun 2008	Jan 2009
N=	85	71
Feel safe?	65	82
Environment clean & safe?	69	84
Treated with respect?	73	82
Substantive input into service planning?	60	82
Assisted in meeting recovery goals?	40	71
Able to communicate with family, attorneys and advocates?	69	87
Grievance procedures work?	29	66
Educated on abuse/neglect?	47	70
Mail is unopened and timely	66	36
Information/assistance in preparing writs?	26	36

In speaking with the Senate members about the problems with the mail, members said that mail is often late in being distributed.

Compliance:
Substantial, assuming the agreement concerning stamps available for purchase and questions related to access to records are satisfactorily resolved.

Current recommendation:
Continue current practice.