# REPORT 6

# PATTON STATE HOSPITAL

June 8-12, 2009

THE HUMAN POTENTIAL CONSULTING GROUP
ALEXANDRIA, VIRGINIA

NOTE

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

The Court Monitor is not in any way responsible for the services provided at Patton 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 Patton 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 |
| ANC | Absolute neutrophil count |
| ARNP | Advanced Registered Nurse Practitioner |
| ASH | Atascadero State Hospital |
| ASI | Addiction Severity Index |
| A-WRP | Admission Wellness and Recovery Plan |
| BCC | Behavioral Consultation Committee |
| BG | Behavior Guidelines |
| BMI | Body Mass Index |
| CA | Clinical Administrator |
| CAC | Cooperative Advisory Council |
| CAF | Corrective Action Form |
| CASAS | Comprehensive Adult Student Assessment Systems |
| CCA | Clinical Chart Auditing |
| 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 |
| CK | Creatine kinase |
| CM | Court Monitor |
| CON | Clinical Oversight Nurse |
| CONREP | Conditional Release Program |

| | |
|---|---|
| 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 |
| DO | Doctor of Osteopathy |
| DOJ | Department of Justice |
| DPH | Department of Public Health |
| DPS | Department of Police Services |
| DSM-IV-TR | Diagnostic and Statistical Manual of Mental Disorders—Fourth Edition (Text Revision) |
| DTO | Danger(ousness) to others |
| DTR | Dietetic Technician, Registered |
| DTS | Danger(ousness) to self |
| DUE | Drug Utilization Evaluation |
| 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 |
| HCV | Hepatitis C virus |
| HIMD | Health Information Management Department |
| HIV | Human Immunodeficiency Virus |
| HSS | Health Services Specialist |
| IAPS | Integration Assessment: Psychology Section |
| 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 |
| MD | Medicinae Doctor (Doctor of Medicine) |
| MDO | Mentally Disordered Offender |
| MIRC | Mortality Interdisciplinary Review Committee |
| MMSE | Mini Mental Status Examination |
| MNT | Medical Nutrition Training |
| MOD | Medical Officer of the Day |
| MOSES | Monitoring of Side Effects Scale |
| MPPN | Monthly Physician's Progress Note |
| MRC | Medical Report Card |
| MRMC | Medical Risk Management Committee |

| | |
|---|---|
| MRSA | Methicillin-resistant Staphylococcus aureus |
| MS | Master's of Science |
| MSH | Metropolitan State Hospital |
| MSN | Master's of Science in Nursing |
| 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 |
| NEC | Nurse Executive Council |
| NGA | New generation antipsychotic |
| NGRI | Not guilty by reason of insanity |
| NOC | Nocturnal shift |
| NOS | Not otherwise specified |
| NP | Nursing Policy; Nurse Practitioner |
| NPO | Nulla per Os (nothing by mouth) |
| NRT | Narrative Restructuring Therapy |
| NSH | Napa State Hospital |
| NST | Nutritional Status Type |
| OSI | Office of Special Investigations |
| OT | Occupational Therapy/Therapist |
| OTR/L | Occupational Therapist, Registered, Licensed |
| 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 |
| PhD | Philosophiae Doctor (Doctor of Philosophy) |
| PHN | Public health nurse |
| PIO | Public Information Officer |
| PMAB | Prevention and Management of Assaultive Behavior |
| PMHNP | Psychiatric Mental Health Nurse Practitioner |
| PMOD | Psychiatric Medical Officer of the Day |
| POS | Physician Order System |
| POST | Physical, Occupational, and Speech/Language Pathology |
| PPD | Purified Protein Derivative (skin test for tuberculosis) |
| PPN | Physician's Progress Note |
| PRA | Patient Rights Advocate |
| PRC | Program Review Committee |
| PRN | Pro re nata (as needed) |
| PSH | Patton State Hospital |
| PSR | Psychosocial Rehabilitation |
| PSS | Psychology Specialty Services |
| PSSC | Psychology Specialty Services Committee |
| PT | • Physical Therapy/Therapist (in Sections D.4 and F.4)<br>• Psychiatric Technician (in Sections D.3 and F.3) |
| R&R | Rule(s) and Regulation(s) |
| RAN | Reference for Assessment and Notification |
| RBANS | Repeatable Battery for the Assessment of Neuropsychological Status |
| RD | Registered Dietician |
| RIAT | Rehabilitation Integrated Assessment Team |
| RMC | Rehabilitation Management Committee |
| RMS | Record Management System; Recovery Mall Services |
| RN | Registered nurse |
| RNA | Restorative Nursing Assistant |
| R/O | Rule out |
| S&R | Seclusion and Restraint |
| SA | Substance abuse; suicide attempt |

| | |
|---|---|
| SAAT | Substance Abuse Assessment Team |
| SAMHSA | Substance Abuse and Mental Health Services Administration |
| SAR | Substance Abuse Recovery |
| SB-5 | Stanford-Binet Intelligence Scales, Fifth Edition |
| SCD | Standards Compliance Department |
| SI | Suicidal ideation |
| SIB | Self-injurious behavior |
| SLP | Speech Language Pathology/Pathologist |
| SNF | Skilled Nursing Facility |
| SO | Special Order |
| S/P | Status post |
| S/R | Seclusion/restraint |
| SRA | Suicide Risk Assessment |
| SSI | Supervising Special Investigator |
| TB | Tuberculosis |
| TD | Tardive dyskinesia |
| TMET | Therapeutic Milieu Enhancement Team |
| TSI | Therapeutic Strategies and Interventions |
| TST | Tuberculin skin test |
| VRAT | Vocational Rehabilitation Assessment Tool |
| WAIS-III | Wechsler Adult Intelligence Scale, Third Edition |
| WaRMSS | Wellness and Recovery Model Support System |
| WBC | White blood cell [count] |
| WRAP | Wellness and Recovery Action Plan |
| WRP | Wellness and Recovery Plan |
| WRPC | Wellness and Recovery Planning Conference |
| WRPT | Wellness and Recovery Planning Team |

# Introduction

## A. Background Information

The evaluation team, consisting of the Court Monitor (Mohamed El-Sabaawi, MD) and four expert consultants (Victoria Lund, PhD, MSN, ARNP; Ramasamy Manikam, PhD; Elizabeth Chura, MS, RN; and Monica Jackman, OTR/L) visited Patton State Hospital (PSH) from June 8 to 12, 2009 to evaluate the facility's progress regarding compliance with the Enhancement Plan (EP). The evaluators' objective was to develop a detailed assessment of the status of compliance with all action steps of the EP.

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

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

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

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

The EP mandates the findings of compliance, but it does not mandate the means by which the facilities' caregivers and administrators execute their responsibilities to individuals or the processes and tactics by which the facilities achieve compliance with the terms of the EP. As noted 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

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

factors that contribute to changes in facility trends and patterns.

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

a. The utility of the Body Mass Index and weight data is questionable in the judgment of this monitor, given the apparent non-random patterns in the data. While these are important indicators to track, the facility may find more revealing ways to analyze and display the data.
b. The data for waist circumference display an unusual pattern from October 2008 to early 2009 for both males and females.
c. The mild downward trend in the use of three or more inter-class psychotropic medications has continued.
d. The facility reported no repeated falls from September 2008 to April 2009.
e. There has been a mild upward trend in the number of individuals testing positive for street drugs.
f. The graphed data on the number of individuals with fractures displays a repetitive pattern over time appears to be non-random.
g. The use of phenytoin has decreased around 35% in the past six months, and the use of other older anticonvulsants remains low.
h. The trailing twelve-month average number of incidents of restraint has declined from around 20 incidents per month to around 14 incidents per month over the past year.

2. Monitoring, mentoring and self-evaluation

PSH has made further significant progress in self-assessment, data presentation and analysis as well as in mentoring since the previous assessment. The following observations are relevant to this area:

i. PSH has made further refinements of its mentoring program regarding the process of wellness and recovery planning, with significant positive outcomes as verified by the court monitor's on-site observations of the wellness and recovery planning team conferences.
j. With few exceptions, the facility's self-assessment data were internally consistent.
k. 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.

l. PSH presented its self-assessment data and data comparisons as requested above.

m. PSH has utilized all available DMH standardized auditing tools for all applicable sections of the EP and made further progress in improving the sampling methodology during this review period.

n. All facilities are encouraged to ensure that the practice of self-assessment reliably informs performance improvement in the systems of clinical care.

o. The DMH has developed sufficient monitoring tools to ensure meaningful self-assessment of EP implementation. With few exceptions, e.g. the medical emergency response system, there appears to be no need to develop new monitoring tools in this process. However, the existing monitoring tools should be viewed as dynamic instruments that continually respond to realities of clinical practice and updates in current standards of care.

p. 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.

q. The DMH has yet to ensure that the tools and data collection are automated.

3. Implementation of the EP

a. Since the last review, PSH has made significant changes in realigning clinical leadership positions in an effort to accelerate progress towards achieving compliance within the specified timeframes. During this tour, there was evidence that these changes have resulted in positive outcomes in many domains of the EP.

b. The facility's new Medical Director, George Christison, MD, appears to possess the required skills and credentials that can serve this facility and its individuals well both during plan implementation and after the court monitoring process has ended.

c. The effective leadership of the new Medical Director and his Assistant Medical Director (Rebecca Kornbluh, MD) has resulted in significant improvements in the quality of admission and integrated psychiatric assessments and drug utilization evaluation during this review period. However, the facility has yet to make similar progress in other important aspects of psychiatric assessments and services in order to meet compliance within reassessments and services.

d. PSH has maintained compliance with the requirements regarding court assessments (Section D.7) for the past 18 months. According to the terms of the consent judgment, the Court Monitor's evaluation of that section will cease, and it will be up to DMH to provide oversight evaluation and ensure future maintenance of compliance. In this regard, DMH is strongly encouraged to ensure that PSH continues to:
   - Provide ongoing training to WRPTs;
   - Monitor court reports based on a minimum 50% sample and provide data analysis that evaluates any decrease in compliance and identifies corrective actions as indicated;
   - Ensure that symptoms contributing to the offense and persisting during hospitalization are specified regarding their nature, course and setting within which they occur;
   - Ensure that the reports address both psychosocial triggers of dangerousness and symptoms that triggered the instant offense (warning symptoms);
   - Provide needed administrative support to the Chair of the FRP as necessary to facilitate FRP functions; and
   - Provide specific information regarding training provided/facilitated during the reporting period.

e. The DMH has finalized a variety of joint medical and nursing care protocols and other instruments. PSH has begun implementation of these tools. This monitor's interviews with some staff members and reviews of the medical and nursing documentation in the charts found evidence of progress in medical attention to the needs of individuals since the last review. Efforts of the facility's F.7 section leader, Mohamed Hafez, MD have been instrumental in this endeavor. However, the facility has yet to take further measures, most importantly the recruitment of a permanent Chief of Medical Services, to correct some persistent process deficiencies in medical and nursing care. These corrections are required to ensure compliance within the specified timeframes.

f. PSH began the implementation of the new risk management procedure. As mentioned in previous reports, this procedure outlines a system that meets generally accepted standards in this area. Interviews with various WRPTs found that members of the WRPTs were properly oriented to the new system and to their roles within this system. However, the facility has yet to fully implement this system and to ensure that the second level of interventions addresses the needs of all individuals who require this level and produces adequate documentation of reviews and rationale for specific recommendations. These corrections are required to ensure compliance within the specified timeframes.

g. Given that the EP provides the basis for the mental health services delivered in the California DMH State Hospitals, it is the monitor's recommendation that the DMH continue its efforts to standardize across all hospitals the Administrative Directives that impact these services.

h. 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 adequate numbers of facilitation/therapy hours on average during the review period. Progress remains to be made regarding the Mall contributions of disciplines in the long-term

service, psychiatry in general, and nursing.

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

**DMH PSR MALL HOURS REQUIREMENTS**

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

| 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.

ii. **Progress notes**: PSH 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

The table below shows the staffing pattern at PSH as of May 1, 2009:

**Patton State Hospital Vacancy Totals as of May 1, 2009**

| Identified Clinical Positions | Budgeted Positions | Filled Positions | Vacancies | Vacancy Rate |
|---|---|---|---|---|
| Assistant Coordinator of Nursing Services | 5 | 5 | 0 | 0% |
| Assistant Director of Dietetics | 5 | 5 | 0 | 0% |
| Audiologist I | 1 | 1 | 0 | 0% |
| Chief Dentist | 1 | 1 | 0 | 0% |
| Chief Physician & Surgeon | 1 | 1 | 0 | 0% |
| Chief, Central Program Services | 0 | 0 | 0 | 0% |
| Chief Psychologist | 1 | 1 | 0 | 0% |
| Clinical Dietician/Pre-Reg. Clin. Dietician | 11 | 10 | 1 | 9% |
| Clinical Laboratory Technologist | 1 | 1 | 0 | 0% |

| Patton State Hospital Vacancy Totals as of May 1, 2009 | | | | |
|---|---|---|---|---|
| **Identified Clinical Positions** | **Budgeted Positions** | **Filled Positions** | **Vacancies** | **Vacancy Rate** |
| Clinical Social Worker | 103.5 | 93.75 | 9.75 | 9% |
| Coordinator of Nursing Services | 1 | 0 | 1 | 100% |
| Coordinator of Volunteer Services | 1 | 1 | 0 | 0% |
| Dental Assistant | 4 | 4 | 0 | 0% |
| Dentist | 2 | 2 | 0 | 0% |
| Dietetic Technician | 4 | 3 | 1 | 25% |
| E.E.G. Technician | 0 | 0 | 0 | 0% |
| Food Services Technician I and II | 117 | 116 | 1 | 1% |
| Hospital Worker | 0 | 0 | 0 | 0% |
| Health Record Technician I | 10 | 7 | 3 | 30% |
| Health Record Techn II Spec | 3 | 3 | 0 | 0% |
| Health Record Techn II Supv. | 1 | 1 | 0 | 0% |
| Health Record Techn III | 1 | 1 | 0 | 0% |
| Health Services Specialist | 24 | 21 | 3 | 13% |
| Institution Artist Facilitator | 0 | 0 | 0 | 0% |
| Licensed Vocational Nurse | 78 | 74 | 4 | 5% |
| Medical Technical Assistant | 0 | 0 | 0 | 0% |
| Medical Transcriber | 6 | 4 | 2 | 33% |
| Medical Transcriber Sup | 0 | 0 | 0 | 0% |
| Sr Medical Transcriber | 2 | 1 | 1 | 50% |
| Nurse Instructor | 5 | 5 | 0 | 0% |
| Nurse Practitioner | 5 | 5 | 0 | 0% |
| Nurse Coordinator | 12 | 12 | 0 | 0% |

| Patton State Hospital Vacancy Totals as of May 1, 2009 | | | | |
|---|---|---|---|---|
| **Identified Clinical Positions** | **Budgeted Positions** | **Filled Positions** | **Vacancies** | **Vacancy Rate** |
| Office Technician | 29 | 26 | 3 | 10% |
| Pathologist | 0 | 0 | 0 | 0% |
| Pharmacist I | 15 | 15 | 0 | 0% |
| Pharmacist II | 0 | 0 | 0 | 0% |
| Pharmacist Services Manager | 1 | 1 | 0 | 0% |
| Pharmacy Technician | 11 | 11 | 0 | 0% |
| Physician & Surgeon | 23 | 22.75 | 0.25 | 1% |
| Podiatrist | 1 | 1 | 0 | 0% |
| Pre-Licensed Pharmacist | 0 | 0 | 0 | 0% |
| Pre-Licensed Psychiatric Technician | 14 | 14 | 0 | 0% |
| Program Assistant | 8 | 7 | 1 | 13% |
| Program Consultant (RT,PSW) | 1 | 1 | 0 | 0% |
| Program Director | 8 | 7 | 1 | 13% |
| Psychiatric Nursing Education Director | 1 | 1 | 0 | 0% |
| Psychiatric Technician | 714 | 696 | 18 | 3% |
| Psychiatric Technician Trainee | 0 | 0 | 0 | 0% |
| Psychiatric Technician Assistant | 36 | 34 | 2 | 6% |
| Psychiatric Technician Instructor | 1 | 1 | 0 | 0% |
| Psychologist-HF, (Safety) | 80.9 | 74.95 | 5.95 | 7% |
| Public Health Nurse II | 2 | 2 | 0 | 0% |
| Radiological Technologist | 1 | 1 | 0 | 0% |
| Registered Nurse | 385.3 | 379 | 6.3 | 2% |
| Reg. Nurse Pre Registered | 0 | 0 | 0 | 0% |

| Patton State Hospital Vacancy Totals as of May 1, 2009 | | | | |
|---|---|---|---|---|
| **Identified Clinical Positions** | **Budgeted Positions** | **Filled Positions** | **Vacancies** | **Vacancy Rate** |
| Rehabilitation Therapist | 95 | 86.25 | 8.75 | 9% |
| Special Investigator | 2 | 2 | 0 | 0% |
| Special Investigator, Senior | 3 | 3 | 0 | 0% |
| Speech Pathologist I | 1 | 1 | 0 | 0% |
| Sr. Psychiatrist (Spvr) | 23.2 | 10 | 13.2 | 57% |
| Sr. Psychologist (Spvr and Spec) | 15 | 10.25 | 4.75 | 32% |
| Sr. Psych Tech (Safety) | 86 | 86 | 0 | 0% |
| Sr. Radiological Technologist (Specialist) | 1 | 1 | 0 | 0% |
| Sr. Voc. Rehab. Counselor/Voc.Rehab. Counselor 2 | 2 | 2 | 0 | 0% |
| Staff Psychiatrist | 80.2 | 75 | 5.2 | 6% |
| Supervising Psychiatric Social Worker | 0 | 0 | 0 | 0% |
| Supervising Registered Nurse | 3 | 3 | 0 | 0% |
| Supervising Rehabilitation Therapist | 0 | 0 | 0 | 0% |
| Teacher-Adult Educ./Vocational Instructor | 16.5 | 11 | 5.5 | 33% |
| Teaching Assistant | 0 | 0 | 0 | 0% |
| Unit Supervisor | 33 | 32 | 1 | 3% |
| Vocational Services Instructor (Landscp Gardn) (S) | 1 | 1 | 0 | 0% |

Key vacancies again include Senior Psychiatrists and Senior Psychologists. The facility has filled a number of Staff Psychiatrists and Rehabilitation Therapists since the previous review, reducing the vacancy rates for those positions by half or more.

## 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. If any hospital maintains substantial compliance with any Section of the EP for eighteen consecutive months (four reviews), the CM's evaluation of that section will cease, and it will be up to DMH to provide oversight evaluation and ensure future maintenance. Thus, DMH should be prepared to assume this responsibility in terms of trained personnel to provide needed oversight.

F. Next Steps

1. The Court Monitor's team is scheduled to reevaluate Patton State Hospital December 7-11, 2009.
2. The Court Monitor's team is scheduled to tour Napa Hospital July 20-24, 2009 for a follow-up evaluation.
3. All compliance reports should be reviewed and utilized, as applicable, by all facilities to guide implementation efforts regardless of the schedule of facility-specific assessments.

| C. Integrated Therapeutic and Rehabilitation Services Planning | | |
|---|---|---|
| | Each State hospital shall provide coordinated, comprehensive, individualized protections, services, supports, and treatments (collectively "therapeutic and rehabilitation services") for the individuals it serves, consistent with generally accepted professional standards of care. In addition to implementing the therapeutic and rehabilitation planning provisions set forth below, each State hospital shall establish and implement standards, policies, and practices to ensure that therapeutic and rehabilitation service determinations are consistently made by an interdisciplinary team through integrated therapeutic and rehabilitation service planning and embodied in a single, integrated therapeutic and rehabilitation service plan. | **Summary of Progress:**<br>1. PSH has made significant progress in the process of WRPCs during this review period.<br>2. PSH has refined its training and mentoring systems regarding the process of WRP, with positive outcomes, during this review period.<br>3. PSH has fully implemented its new format for the monthly WRPC. This format ensures a meaningful and concise review of the WRPs, provided that individuals' needs are addressed as clinically indicated.<br>4. PSH has made significant recent progress in the structure and content of the interdisciplinary case formulation based on a performance improvement initiative (April 2009).<br>5. PSH has maintained progress in ensuring that WRPs include an enrichment focus, objectives and interventions.<br>6. PSH has maintained progress in the development of learning-based objectives and interventions for individuals with seizure disorders.<br>7. PSH has improved the delineation of individuals' strengths for WRP purposes.<br>8. PSH has improved the timeliness of WRP reviews.<br>9. PSH has developed an adequate corrective action plan to improve the linkages between the case formulations and the foci, objectives and interventions during the next review period.<br>10. PSH has made significant progress in self-monitoring and data gathering, analysis and presentation during this review period.<br>11. Social Work staff has taken strong steps in providing family education and services.<br>12. Mall group organizations, groups offered (including groups for non-adherence) and development of groups for specific cognitive levels have improved during this review period. |

| 1. Interdisciplinary Teams | | |
|---|---|---|
| C.1 | The interdisciplinary team's membership shall be dictated by the particular needs and strengths of the individual in the team's care. At a minimum, each State Hospital shall ensure that the team shall: | **Methodology:**<br><br><u>Interviewed</u>:<br>1. Gari-Lyn Richardson, Director, Standards Compliance<br>2. George Christison, MD, Acting Medical Director<br>3. Jinae Su, MD, Staff Psychiatrist<br>4. Rebecca Kornbluh, MD., Acting Assistant Medical Director<br><br><u>Reviewed</u>:<br>1. PSH WRP Revisions Phase I Outline and Case Formulation Worksheet, April 2009<br>2. PSH WRP Revisions Phase II Outline and examples of foci, objectives and interventions<br>3. DMH WRP Observation Monitoring Form<br>4. DMH WRP Observation Monitoring Form Instructions<br>5. PSH WRP Observation Monitoring summary data (November 2008 – April 2009)<br>6. DMH Clinical Chart Auditing Form<br>7. DMH Clinical Chart Auditing Form Instructions<br>8. PSH Clinical Chart Auditing Form summary data (January 2009 to April 2009)<br>9. DMH WRP Team Facilitator Observation Monitoring Form<br>10. DMH WRP Team Facilitator Observation Monitoring Form Instructions<br>11. PSH WRP Team Facilitator Observation Monitoring Form summary data (December 2008 – April 2009)<br>12. PSH data regarding staffing ratios on admissions and long-term units (November 2008 – April 2009)<br><br><u>Observed</u>:<br>1. WRPC (Program I, unit EB4) for monthly review of JMA<br>2. WRPC (Program IV, unit 36) for quarterly review of LR<br>3. WRPC (Program V, unit N22) for quarterly review of JCM |

| | | |
|---|---|---|
| | | 4. WRPC (Program VI, unit 71) for quarterly review of TAF<br>5. WRPC (Program VI, unit 71) for 7-day review of BLF<br>6. WRPC (Program VI, unit EB10) for monthly review of AB<br>7. WRPC (Program VI, unit EB12) for quarterly review of ACC<br>8. WRPC (Program VI, unit EB12) for 14-day review of LJD<br>9. WRPC (Program VII, unit 77) for quarterly review of DA<br>10. WRPC (Program VIII, unit N20) for annual review of RDT<br>11. WRPC (Program VIII, unit N21) for monthly review of PC<br>12. WRPC (Program VIII, unit N24) for quarterly review of YSL<br>13. WRPC (Program VIII, unit N25) for annual review of DR |
| C.1.a | Have as its primary objective the provision of individualized, integrated therapeutic and rehabilitation services that optimize the individual's recovery and ability to sustain himself/herself in the most integrated, appropriate setting based on the individual's strengths and functional and legal status and support the individual's ability to exercise his/her liberty interests, including the interests of self determination and independence. | **Current findings on previous recommendations:**<br><br>**Recommendation 1, December 2008:**<br>Provide a summary outline of all WRP training and mentoring provided to the WRPTs during the reporting period.<br><br>**Findings:**<br>The following summarizes the facility's actions since the last report:<br><br>1. PSH modified the group mentoring the WRPTs.<br>a. In January 2009, PSH assigned the master trainers, a select group of discipline seniors and peer mentors from high-performing teams to mentor the WRPTs.<br>b. PSH added two new RN master trainers.<br>c. The master trainers, led by Robbin Huff-Musgrove, PhD, facilitated the training of the new mentors.<br>2. The facility designed and implemented a tiered mentoring system.<br>a. Based on audit data and observation, PSH assigned each WRPT to one of three categories:<br>i) Required intensive WRPC mentoring: 34 teams; a WRP Master Trainer was scheduled to mentor all of the WRPCs for each of these teams for a minimum of six weeks. |

| | | |
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| | | ii) Required intermediate mentoring: 18 teams; a peer mentor provided two to four hours of mentoring per week.<br>iii) Required information only: 12 teams; these WRPTs received updates in policy and procedure.<br>b. Mentoring within the tiered system started in February 2009.<br>3. PSH reported that a review of auditing data and observations in mid-March 2009 determined that the quality of the WRPCs improved following implementation of the tiered mentoring system. However, equivalent improvement was not discovered within the WRP documents.<br>4. As a corrective action, the facility designed a two-phase training process to address the identified documentation deficiencies. A summary of Phase I (Case Formulation), implemented in April 2009, follows:<br>a. Eight WRP Master Trainers facilitated these trainings.<br>b. Meeting with two WRPTs at a time, a Master Trainer reviewed the requirements for completing the case formulation, provided the WRPTs the Case Formulation Worksheet and mentored the WRPTs to revise a case formulation.<br>c. Following the training, individual clinicians then revised case formulations for the individuals to whom they provide services.<br>d. The Master Trainers reviewed the case formulations and provided immediate feedback to the clinicians.<br>e. This process occurred for approximately one-half of the WRPs for each team.<br>f. Subsequently, the Master Trainers selected clinicians from each team to continue providing reviews and feedback until all case formulations were revised.<br><br>Additionally, PSH reported that it intends to implement Phase II, which will address the quality and alignment of foci, objectives and interventions in conjunction with structural changes to the Mall and the WaRMSS module during the next review period. |

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| | | **Recommendations 2 and 3, December 2008:**<br>• Ensure that all WRPTs that require training in the MSH modules receive this training.<br>• Provide documentation of results of competency-based training of WRPTs in all WRP training courses. Present the data for each discipline and compare mean rates during the review period with the rates during the previous period.<br><br>**Findings:**<br>PSH reported that it focused all training and mentoring on the activities summarized in C.1.a above and did not provide training on the MSH modules.<br><br>**Recommendation 4, December 2008:**<br>Ensure facility-wide implementation of the format for the focused monthly WRPC.<br><br>**Findings:**<br>PSH reported that it implemented the format for the focused monthly WRPC facility-wide.<br><br>**Recommendation 5, December 2008:**<br>Improve clinical mentoring of the WRPTs to ensure proper attention to important clinical data during the meeting. The mentors must regularly attend the conferences and provide consistent face-to-face feedback to the teams.<br><br>**Findings:**<br>Same as above.<br><br>**Recommendation 6, December 2008:**<br>Provide a summary outline of improvements in practice made as a result of review of internal monitoring data by the Quality Council. |

**Findings:**
Same as above.

**Other findings:**
PSH also used the DMH WRP Clinical Chart Auditing Form (January 2009 to April 2009) to assess compliance with this cell of the EP. The average sample was 11% of the quarterly and annual WRPCs held each month.

This monitoring tool was revised during the review period and PSH implemented the revised tool in January 2009. Specific revisions to the monitoring tool are noted below in applicable cells. The following 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* | 66% |
| 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* | 62% |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 1. | 29% | 66% |
| 2. | 64% | 62% |

| | Previous period | Current period |
|---|---|---|
| Compliance rate in last month of period | | |
| 1. | 45% | 85% |
| 2 | 67% | 69% |

The monitor and his experts attended 13 WRPCs. The meetings were selected from all levels of the facility's tiered training/mentoring system. In general, the meetings showed significant progress in the process of the team's review of the WRPs. The following are examples:

1. All meetings started on time.
2. With few exceptions, all core members attended and participated in the meetings, including psychiatric technicians.
3. The meetings were facilitated by the team psychiatrists in most conferences or the team psychologist in a few conferences. In general, the facilitators demonstrated skill in ensuring meaningful review of the WRPs.
4. Most WRPTs presented an adequate summary of the assessment data and provided adequate review of risk factors prior to the individual's arrival.
5. With few exceptions, the review and update of the present status section of the case formulation was consistent with EP requirements.
6. Almost all WRPTs discussed the key questions to be addressed during the individual's presence based on the review of assessments and risk factors.
7. In all the meetings that included the individuals, the team members were respectful of the individuals and made appropriate efforts to elicit their input.
8. In general, the WRPTs reviewed the diagnosis, objectives and interventions with the individual.
9. With few exceptions, the WRPTs reviewed the individual's progress

| | | |
|---|---|---|
| | | towards discharge and the barriers in discharge planning with the individuals.<br>10. The teams made an effort to review the individual's attendance (and participation) at the assigned groups.<br>11. The teams reviewed By Choice participation and point allocation with the individual.<br>12. In almost all meetings, the individuals were offered the opportunity to ask questions and the teams addressed these questions, as appropriate.<br><br>A few process deficiencies were noted as follows:<br><br>1. The teams did not consistently update the individual's life goals and strengths during the meeting or ensure that the life goals/strengths were properly linked to the objectives and interventions.<br>2. In general, the WRPTs did not review or utilize the information in the Mall progress notes to better assess the individual's progress in Mall groups and to ensure that Mall offerings are properly linked to the WRP objectives.<br>3. The WRPTs did not consistently utilize the WRPC task tracking forms.<br><br>**Compliance:**<br>Partial (but improved compared to last review).<br><br>**Current recommendations**:<br>1. Ensure that the current training and mentoring systems address and correct the process deficiencies outlined by this monitor above.<br>2. Provide a summary outline of all WRP training and mentoring provided to the WRPTs during the reporting period.<br>3. Monitor this requirement using the DMH WRP Clinical Chart Auditing Form based on at least a 20% sample.<br>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. |

<table>
<tr><td></td><td></td><td>5. Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.</td></tr>
<tr><td>C.1.b</td><td>Be led by a clinical professional who is involved in the care of the individual.</td><td>

**Current findings on previous recommendations:**

**Recommendations 1 and 2, December 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:**

Using the DMH WRP Observation Monitoring Form, PSH assessed its compliance based on an average sample of 17% of the quarterly and annual WRPCs held each month during the review period (November 2008 – April 2009):

<table>
<tr><td>1.</td><td>Each team is led by a clinical professional who is involved in the care of the individual:</td><td>100%</td></tr>
</table>

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

The facility also used the DMH WRP Team Facilitator Observation Monitoring Form to assess compliance, based on an average sample of 61% of the required observations (two WRPC observations per team per month) from December 2008 to April 2009. Several items on this auditing form were modified or consolidated during this review to decrease repetition and clarify that any WRPT member can function as a team facilitator. The revised auditing tool was implemented in December 2008. The following table summarizes the data:

</td></tr>
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| | | |
|---|---|---|
| 1. | *The team psychiatrist was present.* | 91% |
| 2. | *The team facilitator encouraged the participation of all disciplines present.* | 86% |
| 3. | *The team facilitator ensured the "Present Status" section in the Case Formulation was meaningfully updated.* | 64% |
| 4. | *The team facilitator ensured that the interventions were linked to the objectives.* | 42% |

Comparative data indicated mixed changes in compliance since the previous review period:

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 1. | 97% | 91% |
| 2. | 92% | 86% |
| 3. | 36% | 64% |
| 4. | 57% | 42% |
| Compliance rate in last month of period | | |
| 2. | 89% | 98% |
| 3 | 28% | 97% |
| 4. | 36% | 67% |

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

**Compliance:**
Partial.

**Current recommendations**:
1. Monitor this requirement using the WRP Observation and WRP Team

<table>
<tr><td></td><td></td><td>Facilitator Observation Monitoring Forms based on samples of 20% and 100%, respectively.<br>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).<br>3. Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.</td></tr>
<tr><td>C.1.c</td><td>Function in an interdisciplinary fashion.</td><td>Current findings on previous recommendations:<br><br>Recommendations 1 and 2, December 2008:<br>• Monitor this requirement using process observation based on at least a 20% sample.<br>• Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).<br><br>Findings:<br>Using the DMH WRP Observation Monitoring Form, PSH assessed its compliance based on an average sample of 17% of the quarterly and annual WRPCs held each month during the review period (November 2008 – April 2009). Two sub-items were re-worded for clarity and one sub-item was deleted due to redundancy during the review period. The following table summarizes the data:<br><br><table><tr><td>2.</td><td>Each team functions in an interdisciplinary fashion.</td><td>91%</td></tr></table><br>Comparative data indicated an improvement in the compliance rate from 19% in the previous review period.<br><br>Compliance:<br>Partial (but improved compared to last review; substantial compliance in this cell is dependent on compliance in C.1.a).</td></tr>
</table>

| | | |
|---|---|---|
| | | **Current recommendations**:<br>1. Monitor this requirement using the DMH WRP Observation Monitoring Form based on at least a 20% sample.<br>2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).<br>3. Provide a summary outline of improvements in practice made as a result of the facility's review 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:**<br><br>**Recommendations 1 and 2, December 2008:**<br>• Monitor this requirement using the Clinical Chart Auditing Form based on at least a 20% sample.<br>• Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).<br><br>**Findings:**<br>Using the DMH WRP Clinical Chart Auditing Form, PSH assessed its compliance based on an average sample of 11% of the quarterly and annual WRPs due from January 2009 to April 2009. This monitoring tool was revised during the review period. PSH implemented the revised tool in January 2009. Specific revisions to the monitoring tool are noted below in applicable cells. The following 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.* | 66% |
| 1.a | *The present status and previous response to treatment sections of the case formulation are* | 58% |

| | | |
|---|---|---|
| | *aligned with the assessments (focused assessment of compliance)* | |
| 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)* | 74% |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 1. | 29% | 66% |
| Compliance rate in last month of period | | |
| 1. | 45% | 85% |
| 1.a | 45% | 75% |
| 1.b | 64% | 94% |

PSH indicated that further data analysis revealed two specific units that contributed negatively to the current compliance rates. Each of these units has a psychiatrist-to-individual ratio of 1:50. The facility identifying the following corrective actions:

1. Implementation of the training and mentoring systems summarized in C.1.a and
2. Recruitment of seventeen staff psychiatrists (two began employment during the current review period and fifteen others are scheduled to begin by August 1, 2009).

**Compliance:**
Partial.

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<td>Current recommendations:<br>1. Monitor this requirement using the Clinical Chart Auditing Form based on at least a 20% sample.<br>2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).<br>3. Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.</td>
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<tr>
<td>C.1.e</td>
<td>Ensure that each member of the team participates appropriately in competently and knowledgeably assessing the individual on an ongoing basis and in developing, monitoring, and, as necessary, revising the therapeutic and rehabilitation services.</td>
<td>Current findings on previous recommendations:<br><br>Recommendations 1 and 2, December 2008:<br>• Monitor this requirement using the DMH WRP Observation Monitoring Form, based on at least a 20% sample.<br>• Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).<br><br>Findings:<br>Using the DMH WRP Observation Monitoring Form, PSH assessed its compliance based on an average sample of 17% of the quarterly and annual WRPCs held each month during the review period (November 2008 – April 2009). One sub-item was deleted to reduce redundancy during the review period. The following table summarizes the data:
<table>
<tr><td>3.</td><td>Each member of the team participates appropriately in competently and knowledgeably assessing the individual on an ongoing basis and in developing, monitoring, and, as necessary revising the therapeutic and rehabilitative services.</td><td>65%</td></tr>
<tr><td>3.a</td><td>Team members present relevant and appropriate content for the discipline-specific assessments.</td><td>62%</td></tr>
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|---|---|---|
| | *The Psychiatric Technician presents global observations of the individual for the WRP review period.* | |
| 3.b | *Team members present their assessments and consultations as listed in the Task Tracking Form.* | 68% |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 3. | 13% | 65% |
| Compliance rate in last month of period | | |
| 3. | 55% | 72% |
| 3.a | 75% | 69% |
| 3.b | 45% | 74% |

PSH reported that further analysis revealed that seven units contributed negatively to the current compliance rates. Four of the seven units were reported to be over the EP's requirement for psychiatrist-to-individual ratio. The facility's corrective actions are summarized in C.1.a and C.1.d.

**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 the facility's review 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 recommendation:**<br><br>**Recommendation, December 2008:**<br>Same as in C.1.a through C.1.e.<br><br>**Findings:**<br>PSH used the DMH Observation Monitoring Form to assess compliance. The mean compliance rate increased to 64% from 11% during the previous review period. The rate for the last month of the period increased to 74% from 51% during the last month of the previous review period.<br><br>**Compliance:**<br>Partial.<br><br>**Current recommendations**:<br>1. Monitor this requirement using the DMH WRP Observation Monitoring Form based on at least a 20% sample.<br>2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).<br>3. Provide a summary outline of improvements in practice made as a result of the facility's review 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:**<br><br>**Recommendations 1 and 2, December 2008:**<br>• Monitor this requirement using the DMH WRP Observation Monitoring Form, based on at least a 20% sample.<br>• Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). |

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**Findings:**
Using the DMH WRP Observation Monitoring Form, PSH assessed its compliance based on an average sample of 17% of the quarterly and annual WRPCs held each month during the review period (November 2008 – April 2009). During this review period, the two sub-items were incorporated into the overall item in an effort to increase efficiency of this tool. The following table summarizes the data:

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<tr>
<td>5.</td>
<td>The WRPT identified someone to be responsible for the scheduling and coordination of assessments and team meetings, the drafting of integrated treatment plans, and the scheduling and coordination of necessary progress reviews.</td>
<td>90%</td>
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Comparative data indicated an improvement in mean compliance from 34% in the previous review period.

**Compliance:**
Substantial.

**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 the facility's review of internal monitoring data.

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<tr>
<td>C.1.h</td>
<td>Consist of a stable core of members, including at least the individual served; the treating psychiatrist, treating psychologist, treating</td>
<td>

**Current findings on previous recommendations:**

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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.

**Recommendations 1, 2 and3, December 2008:**

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

**Findings:**

PSH presented core WRPT member attendance data based on an average sample of 17% of quarterly and annual WRPCs held during the review period (November 2008 – April 2009) The following table is a summary of attendance:

| | Nov 07 – Apr 08 | May 08 – Oct 08 | Nov 08 – Apr 09 |
|---|---|---|---|
| Individual | 86% | 85% | 85% |
| Psychiatrist | 89% | 90% | 87% |
| Psychologist | 62% | 64% | 75% |
| Social Worker | 77% | 76% | 78% |
| Rehabilitation Therapist | 60% | 57% | 70% |
| Registered Nurse | 23% | 82% | 89% |
| Psychiatric Technician | 7% | 48% | 70% |

An increase in attendance was noted for psychologists, rehabilitation therapists, registered nurses and PTs. However, decreases in attendance or maintenance at a low rate were reported for individuals, psychiatrists and social workers.

**Recommendation 4, December 2008:**

Recruit sufficient staff to fill current vacancies in core WRPT members.

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<td>Findings:<br>The facility did not report efforts to fill vacancies, other than for psychiatrists (summarized in C.1.d).<br><br>Compliance:<br>Partial.<br><br>Current recommendations:<br>1. Ensure that vacancies are filled and improve core members' attendance at WRPCs.<br>2. Monitor this requirement using process observation based on at least a 20% sample.<br>3. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</td>
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<td>C.1.i</td>
<td>Not include any core treatment team members with a case load exceeding 1:15 in admission teams (new admissions of 90 days or less) and, on average, 1:25 in all other teams at any point in time.</td>
<td>Current findings on previous recommendations:<br><br>Recommendations 1 and 2, December 2008:<br>• Ensure compliance with the required ratios for Social Workers on the admission units and for psychologists, social workers and rehabilitation therapists on the long-term units.<br>• Provide data regarding staffing case loads on both the admission and long-term units.<br><br>Findings:<br>The facility provided the following data on average case load ratios:
<table>
<tr><td></td><td>Nov 07 – Apr 08</td><td>May 08 – Oct 08</td><td>Nov 08 – Apr 09</td></tr>
<tr><td></td><td colspan="3">Admission Units</td></tr>
<tr><td>MDs</td><td>1:16</td><td>1:15</td><td>1:16</td></tr>
<tr><td>PhDs</td><td>1:20</td><td>1:15</td><td>1:15</td></tr>
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<tr><td></td><td>Nov 07 – Apr 08</td><td>May 08 – Oct 08</td><td>Nov 08 – Apr 09</td></tr>
<tr><td></td><td colspan="3">Admission Units</td></tr>
<tr><td>SWs</td><td>1:16</td><td>1:15</td><td>1:16</td></tr>
<tr><td>RTs</td><td>1:16</td><td>1:16</td><td>1:16</td></tr>
<tr><td>RNs</td><td>1:6</td><td>1:6</td><td>1:6</td></tr>
<tr><td>PTs</td><td>1:3</td><td>1:3</td><td>1:3</td></tr>
<tr><td></td><td colspan="3">Long-Term Units</td></tr>
<tr><td>MDs</td><td>1:28</td><td>1:28</td><td>1:27</td></tr>
<tr><td>PhDs</td><td>1:44</td><td>1:42</td><td>1:31</td></tr>
<tr><td>SWs</td><td>1:23</td><td>1:25</td><td>1:25</td></tr>
<tr><td>RTs</td><td>1:41</td><td>1:39</td><td>1:28</td></tr>
<tr><td>RNs</td><td>1:8</td><td>1:8</td><td>1:8</td></tr>
<tr><td>PTs</td><td>1:3</td><td>1:3</td><td>1:3</td></tr>
</table>
<br>
Compliance:<br>
Partial. The facility achieved substantial compliance with regard to the admission units and approached substantial compliance with regard to the long-term units (sufficient numbers of positions were available to ensure compliance but the current freeze in hiring has delayed recruitment).<br><br>
Current recommendations:<br>
1. Ensure compliance with the required ratios on the admission and long-term units.<br>
2. Provide comparative data from review period to review period regarding case loads on both the admission and long-term units.
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<tr>
<td>C.1.j</td>
<td>Not include staff that is not verifiably competent in the development and implementation of interdisciplinary wellness and recovery plans.</td>
<td>Current findings on previous recommendations:<br><br>Recommendation 1, December 2008:<br>Same as in C.1.a through C.1.f.</td>
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| | | **Findings:**<br>PSH reported that all newly hired WRPT members successfully completed the WRP overview module during New Employee Orientation (by achieving a score of 95% or higher).<br><br>Also same as in C.1.a through C.1.f.<br><br>**Recommendation 2, December 2008:**<br>Ensure accuracy and consistency of training data.<br><br>**Findings:**<br>This recommendation is no longer applicable in view of the current training model (as outlined in C.1.a).<br><br>**Compliance:**<br>Partial (considering overall monitor's findings in C.1. and C.2).<br><br>**Current recommendation**:<br>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:**<br><br><u>Interviewed</u>:<br>1. The following two individuals: BS and CM<br>2. Alejandro Fernandez, Senior Rehabilitation Therapist<br>3. Brian Starck-Riley, Assistant Director of Nutrition Services<br>4. C. Love, PsyD<br>5. Chris Keierleber, Acting Senior Rehabilitation Therapist<br>6. Danielle Helmick, Auditor<br>7. David Glassmire, PhD, Psychology Internship Director<br>8. Diana Tran, Assistant Director of Nutrition Services<br>9. Gari-Lyn Richardson, Director, Standards Compliance<br>10. George Christison, MD, Acting Medical Director<br>11. Grace Ferris, Assistant Director of Nutrition Services<br>12. Greg Siples, Chief of Rehabilitation Therapy Services<br>13. Hope Marriott, LCSW, WRP Master Trainer<br>14. Jacqueline Doss-Haynes, Senior Rehabilitation Therapist<br>15. Jaleh Mohallatee, MHA, Acting Program Director<br>16. Jeanie Kim, Assistant Director of Nutrition Services<br>17. Jinae Su, MD, Staff Psychiatrist<br>18. John Johnston, PhD, Psychologist, PBS Chair<br>19. Jette Warka, PhD, Psychologist, PBS Chair<br>20. Jyun Nam, RT<br>21. Kevin Garland, Assistant Chief, Central Program Services<br>22. Kitchie Miana, Assistant Director of Nutrition Services<br>23. Linda Painter, PT, Auditor<br>24. Mark Camero, Senior Rehabilitation Therapist<br>25. Mark Williams, PhD, Psychologist, PBS Chair<br>26. Melanie Byde, PhD, Mall Director<br>27. Mike Gomes, Senior Rehabilitation Therapist<br>28. Rebecca Kornbluh, MD, Acting Assistant Medical Director<br>29. Renata Geyer, Acting Senior Rehabilitation Therapist |

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| | | 30. Rhodora Reyes, RN, WRP Trainer<br>31. Sean Evans, PhD, Psychologist, PBS Chair<br>32. Stan Hydinger, Senior Rehabilitation Therapist<br>33. Susan Meader, PT, Auditor<br>34. Tai Kim, Director of Nutrition Services<br>35. Willie Harris, MD, Acting Chief of Psychiatry<br><br><u>Reviewed</u>:<br>1. The charts of the following 152 individuals: AAG, AAN, AD, AKA, AKS, AM, AS, ASE, ATM, ATR, AW, BA, BAV, BDT, BG, BJ, BLB, BMC, CH, CJS, CK, CLC, CMR, DB, DBP, DEW, DJS, DJW, DK, DMK, DOR, DR, DRH, DT, DTD, DW, DWM, EAS, ECF, ELF, ELG, EMN, END, EV, FD, FGE, FS, GA, GJW, HLE, HLS, HRB, JAC, JAF, JAM, JC, JCM, JD, JEB, JG, JHB, JJD, JLB, JLF, JM, JMP, JMR, JP, JPL, JPM, JR, JSM, JSN, JTP, JW, KC, KJF, KK, KLS, KMH, KMS, LAJ, LBL, LC, LDH, LEB, LEW, LSB, LTH, LW, MAR, MB, MBE, MBJ, MEB, MED, MLB, MLV, MM, MMR, MRR, MW, NG, NM, NS, NSC, OB, OC, ODM, PC, PF, PH, PLJ, PSC, RA, RAC, RAK, RAR, REA, RF, RH, RL, RLE, RLW, RMM, RP, RTW, RW, RWM, RZ, SAG, SBP, SJW, SPB, SRC, SRF, TAF, TC, TCH, TG THH, TK, TN, TS, VC, VF, VPF, VRH, VT, WCS, YMH and ZB<br>2. DMH WRP Observation Monitoring Form<br>3. DMH WRP Observation Monitoring Form Instructions<br>4. PSH WRP Observation Monitoring summary data (November 2008 to April 2009)<br>5. DMH Clinical Chart Auditing Form<br>6. DMH Clinical Chart Auditing Form Instructions<br>7. PSH Clinical Chart Auditing Form summary data (January 2009 to April 2009)<br>8. DMH Chart Auditing Form<br>9. DMH Chart Auditing Form Instructions<br>10. PSH Chart Auditing Form summary data (November 2008 to April 2009)<br>11. List of all individuals diagnosed with mental retardation<br>12. List of individuals with cognitive disorders |

| | | |
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| | | 13. List of individuals with high Body Mass Index<br>14. List of individuals with Substance Abuse disorders<br>15. Completed Request for New Mall Group/Individual Therapy Forms<br>16. List of new Mall groups<br>17. Mall provider list<br>18. PSH Mall Lesson Plans<br>19. Mall Groups Hours Cancelled Report<br>20. List of scheduled exercise groups<br>21. List of supplemental activities offered<br>22. List of new enrichment activities/groups offered over the last six months<br>23. Credentialing/Privileging for Substance Abuse<br>24. Substance Abuse Facilitator Training List<br>25. List verifying competency for providing substance abuse groups<br>26. PSH Implementation of the Substance Abuse Improvement Plan document<br>27. PSH MAPP data regarding active treatment hours scheduled and attended<br>28. PSH Monthly MAPP Report<br>29. Psychology Specialty Services Committee Minutes<br>30. Psychosocial Enrichment Activity List<br>31. Staff Development Attendance Sheet<br><br><u>Observed</u>:<br>1. WRPC (Program I, unit EB4) for monthly review of JMA<br>2. WRPC (Program IV, unit 36) for quarterly review of LR<br>3. WRPC (Program V, unit N22) for quarterly review of JCM<br>4. WRPC (Program VI, unit 71) for quarterly review of TAF<br>5. WRPC (Program VI, unit 71) for 7-day review of BLF<br>6. WRPC (Program VI, unit EB10) for monthly review of AB<br>7. WRPC (Program VI, unit EB12) for quarterly review of ACC<br>8. WRPC (Program VI, unit EB12) for 14-day review of LJD<br>9. WRPC (Program VII, unit 77) for quarterly review of DA |

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| | | 10. WRPC (Program VIII, unit N20) for annual review of RDT<br>11. WRPC (Program VIII, unit N21) for monthly review of PC<br>12. WRPC (Program VIII, unit N24) for quarterly review of YSL<br>13. WRPC (Program VIII, unit N25) for annual review of DR<br>14. Mall Group: Stress Management Through Creative Arts<br>15. Mall Group: Coping Skills Through Creative Arts<br>16. Mall Group: Enhancing Self Control<br>17. Mall Group: Positive Expression<br>18. Mall Group: Acceptance and Commitment Therapy: Act on Life not Anger |
| C.2.a | Individuals have substantive input into the therapeutic and rehabilitation service planning process, including but not limited to input as to mall groups and therapies appropriate to their WRP. | **Current findings on previous recommendations:**<br><br>**Recommendation 1, December 2008:**<br>Continue current training and mentoring regarding engagement of individuals and present competency-based training data regarding engagement of the individuals.<br><br>**Findings:**<br>The facility's training and mentoring activities are summarized in C.1.a.<br><br>**Recommendations 2 and 3, December 2008:**<br>• Monitor this requirement using process observation based on at least 20% sample.<br>• Provide data analysis that evaluates low compliance and delineates areas of relative improvement (during the reporting period and compared to the last period).<br><br>**Findings:**<br>Using the DMH WRP Observation Monitoring Form, PSH assessed its compliance based on an average sample of 17% of the quarterly and annual WRPCs held each month during the review period (November 2008 – April 2009). The following table summarizes the data: |

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| 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.* | 61% |
| 6.a | *The WRPT asks the individual for his or her input into the evaluation of progress on each objective, as clinically indicated.* | 62% |
| 6.b | *When the individual has achieved an objective, at the current WRPC, the WRPT discusses with the individual the groups available for the next objective. The individual makes a choice from several equivalent options.* | 29% |
| 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.* | 79% |
| 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.* | 73% |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 6. | 13% | 61% |
| Compliance rate in last month of period | | |
| 6. | 35% | 72% |
| 6.a | 65% | 67% |
| 6.b | 17% | 37% |

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| | | 6.c 60% 84%<br>6.d 69% 100%<br><br>PSH reported that further analysis revealed that seven units contributed negatively to the current compliance rates. Four of the seven units were reported to be over the Enhancement Plan's requirement for psychiatrist-to-individual ratios. The facility's corrective actions are summarized in C.1.a and C.1.d.<br><br>**Compliance:**<br>Partial.<br><br>**Current recommendations**:<br>1. Same as in C.1.a.<br>2. Monitor this requirement using the DMH WRP Observation Monitoring Form based on at least a 20% sample.<br>3. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).<br>4. Provide a summary outline of improvements in practice made as a result of the facility's review 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 recommendations:**<br><br>**Recommendations 1 and 2, December 2008:**<br>• Monitor this requirement using WRP Process Observation and Team Leadership Monitoring Forms based on 20% and 100% samples, respectively.<br>• Provide data analysis that delineates and evaluates areas of low |

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| | | compliance and relative improvement (during the reporting period and compared to the last period).<br><br>**Findings:**<br>PSH used the DMH Chart Auditing Form to assess compliance with the requirements in C.2.b.i to C.2.b.iii (November 2008 – April 2009). Based on an average sample of 49% of the A-WRPs, the facility reported a mean compliance rate of 98%, compared to 99% in the previous review period.<br><br>**Other findings:**<br>A review of the charts of 10 individuals admitted during the review period (CLC, DEW, FGE, HLE, JLF, JSM, LSB, MAR, ODM and THH) found substantial compliance in nine charts (CLC, DEW, FGE, HLE, JLF, JSM, MAR, ODM and THH) and noncompliance in one (LSB).<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendation**:<br>Continue to monitor this requirement using the DMH Chart Auditing Form based on at least a 20% sample. |
| C.2.b.ii | master therapeutic and rehabilitation service plans ("Wellness and Recovery Plan" (WRP)) are completed within 7 days of admission; and | **Current findings on previous recommendations:**<br><br>**Recommendations 1 and 2, December 2008:**<br>• Monitor this requirement using chart auditing based on at least 20% sample.<br>• Provide data analysis that evaluates low compliance and delineates areas of relative improvement (during the reporting period and compared to the last period).<br><br>**Findings:**<br>Based on an average sample of 17% of the 7-day WRPs, the facility reported |

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| | | a mean compliance rate of 92%, compared to 98% in the previous review period.<br><br>**Recommendation 3, December 2008:**<br>Ensure that individuals remain on the admission units for 60 or more days prior to inter-unit transfers.<br><br>**Findings:**<br>PSH reported a plan to convert Unit 75 to an admission unit in August 2009, which will facilitate an increase in the length of stay on the admission units.<br><br>**Other findings:**<br>A review of the charts of 10 individuals admitted during the review period (CLC, DEW, FGE, HLE, JLF, JSM, LSB, MAR, ODM and THH) found substantial compliance in all charts.<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendations:**<br>1. Continue to monitor this requirement using the DMH Chart Auditing Form based on at least a 20% sample.<br>2. Ensure that individuals remain on the admission units for 60 or more days prior to inter-unit transfers. |
| 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:**<br><br>**Recommendations 1 and 2, December 2008:**<br>• Monitor this requirement using the DMH Chart Auditing Form based on at least a 20% sample.<br>• Provide data analysis that evaluates low compliance and delineates areas of relative improvement (during the reporting period and compared to the last period), as indicated. |

**Findings:**
The following is a summary of the facility's data:

| WRP Review | Mean sample size | Mean compliance rate |
|---|---|---|
| 14-Day | 19% | 88% |
| Monthly | 19% | 49% |
| Quarterly | 21% | 49% |
| Annual | 26% | 46% |

Comparative data indicated no significant changes in mean compliance since the previous review period:

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 14-Day Review | 90% | 88% |
| Monthly Review | 45% | 49% |
| Quarterly Review | 45% | 49% |
| Annual Review | 43% | 46% |
| Compliance rate in last month of period | | |
| 14-Day Review | 85% | 88% |
| Monthly Review | 44% | 69% |
| Quarterly Review | 50% | 68% |
| Annual Review | 40% | 52% |

PSH reported that it intends to increase oversight, through monitoring by the Clinical Administrator, of scheduling and rescheduling of conferences to ensure compliance with the EP requirements.

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| | | **Other findings:**<br>Chart reviews by this monitor found substantial compliance in all charts reviewed (CLC, DEW, FGE, HLE, JLF, JSM, LSB, MAR, ODM and THH).<br><br>PSH reported that during the current review period, eight long-term units held WRPCs every other month rather than monthly due to the psychiatrist-to-individual ratio (six units at 1:50 and two units at 1:33). The facility indicated that it intends to resume monthly conferences by August 2009 when staffing ratios are anticipated to be 1:25 based on the projected start dates for 17 newly hired psychiatrists.<br><br>**Compliance:**<br>Partial.<br><br>**Current recommendations**:<br>1. Monitor this requirement using the DMH Chart Auditing Form based on at least a 20% sample.<br>2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).<br>3. Provide a summary outline of improvements in practice made as a result of the facility's review 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:**<br><br>**Recommendations 1 and 2, December 2008:**<br>• Monitor this requirement using the Clinical Chart Auditing Form based on at least a 20% sample.<br>• Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). |

**Findings:**
Using the DMH WRP Clinical Chart Auditing Form, PSH assessed its compliance based on an average sample of 11% of the quarterly and annual WRPs due from January 2009 to April 2009. The sub-item that previously referred to mental retardation has been included within sub-time 2.a, cognitive disorders, to eliminate redundancy. 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.* | 62% |
| 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.* | 21% |
| 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.* | 85% |
| 2.c | *When seizure disorder is identified on Axis III, it is written in Focus 6, and has at least one objective with an appropriately linked intervention.* | 79% |

Comparative data indicated little change in mean compliance since the previous review period:

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 2. | 64% | 62% |
| Compliance rate in last month of period | | |
| 2. | 67% | 69% |
| 2.a | N/A | 26% |

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|---|---|---|
| 2.b | 67% | 87% |
| 2.c | N/A | 93% |

**Other findings:**
This monitor reviewed the charts of 11 individuals diagnosed with a variety of cognitive disorders and seven individuals diagnosed with seizure disorders. The reviews found general evidence of continued improvement in the following areas:

1. Documentation of foci, objectives and interventions that addressed the needs of some individuals diagnosed with seizure or cognitive disorders;
2. Decreased use of regular treatment with high-risk medications, including anticholinergic medications and/or benzodiazepines for individuals suffering from dementing illnesses;
3. Consistency between the WRPs and the corresponding psychiatric progress notes regarding the documentation of diagnoses of cognitive impairments;
4. Documentation of the status of some individuals suffering from seizure disorders or dementing illnesses in the present status section of the case formulation; and
5. Development of learning-based objectives and interventions for some individuals suffering from seizure disorders, including recognizing and responding to the experience of an aura, learning about environmental triggers of recurrent seizures and learning ways to decrease the risk of injury during seizure activity (e.g. CH and JJD).

However, the review found some persisting deficiencies that must be corrected to achieve substantial compliance in this area. The following is an outline of the areas of deficiencies:

1. Individuals diagnosed with cognitive impairments (AW, END, HLS, JR, JSN, KLS, MBJ, MW, NSC, RAC and SBP):
   a. The WRPs did not include a focus statement or objectives/

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| | | interventions to address the needs of some individuals diagnosed with Dementia NOS (AW) or Mild Mental Retardation (MBJ, MW and SPB).<br>b. Some WRPs included appropriate foci and objectives related to cognitive impairment in individuals diagnosed with Alcohol-Induced Persisting Dementia (KLS) and Vascular Dementia, Uncomplicated (HLS). However, the interventions were unrelated to the stated objective and did not specify how the objective will be achieved.<br>c. The WRPs included focus statements regarding diagnoses of Dementia NOS (JR) and Vascular Dementia with Depressed Mood (NSC) that did not properly identify the needs of the individuals.<br>d. There was general evidence of limited offerings of cognitive remediation groups to meet the needs of the relatively large number of individuals diagnosed with cognitive impairments in the facility. Only one (RAC) out of 11 individuals reviewed was enrolled in a cognitive remediation group.<br>2. Individuals diagnosed with seizure disorders (AKS, CH, JJD, JM, KMS, MLV and RAR):<br>a. In all the charts reviewed, the WRPs did not specify the morphological diagnosis of the seizure disorder. This information is needed to assess whether the medication regimen is properly matched to the individual's needs.<br>b. Some WRPs included objectives that were not attainable or based on appropriate learning outcomes (e.g. MLV).<br>c. A few WRPs included generic objectives and or interventions that addressed safety (MLV) and compliance with treatment (KMS) without justifying information.<br>d. In all the charts reviewed, the WRPs failed to address the risks of treatment with older anticonvulsant medications, including their impact on the individual's behavior, cognitive status and quality of life. Some individuals were also diagnosed with cognitive impairments, including Dementia (RAR), which increase the risks of this type of treatment. |

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| | | **Compliance:**<br>Partial.<br><br>**Current recommendations:**<br>1. Implement adequate corrective actions to address the deficiencies outlined by this monitor above.<br>2. Monitor this requirement using the DMH WRP Clinical Chart Auditing Form based on at least a 20% sample.<br>3. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).<br>4. Provide a summary outline of improvements in practice made as a result of the facility's review 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:**<br>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:**<br><br>**Recommendation 1, December 2008:**<br>Continue training on the Case Formulation Module for all WRPTs and ensure that the training addresses the deficiencies outlined by this monitor above.<br><br>**Findings:**<br>PSH's training and mentoring activities specific to Case Formulation are summarized in C.1.a. |

**Recommendations 2 and 3, December 2008:**

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

**Findings:**

Using the DMH WRP Clinical Chart Auditing Form, PSH assessed its compliance based on an average sample of 11% of the quarterly and annual WRPs due from January 2009 to April 2009. The sub-items for this indicator were re-worded during this review period to increase clarity. 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.* | 80% |
| 3.a | *Diagnostic and/or treatment planning implications derived from assessments and consultations are incorporated into the case formulation, and* | 68% |
| 3.b | *The case formulation indicates interdisciplinary participation and is not written from the point of view of one discipline.* | 92% |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 3. | 24% | 80% |

| | Previous period | Current period |
|---|---|---|
| Compliance rate in last month of period | | |
| 3. | 18% | 92% |
| 3.a | 50% | 84% |
| 3.b | 40% | 100% |

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

**Other findings:**
This monitor reviewed the charts of 15 individuals (CJS, DBP, DJS, DWM, HLE, JEB, JPL, KJF, KMH, LAJ, LDH, MEB, MED, RL, and VPF) whose case formulations were completed following the facility's performance improvement initiative. This review found general evidence that the WRPTs have made significant progress in improving the structure and content of case formulation. These case formulations provided an adequate review of the individual's status as follows:

1. The pertinent history provided adequate information in the areas of personal, psychiatric and legal history.
2. The predisposing factors section provided adequate information regarding the biomedical, psychosocial and psychoeducational underlying vulnerabilities (relevant to early onset of the psychiatric condition).
3. The precipitating factors section contained adequate information relevant to acute events before first and most recent onset of mental illness and criminal activity.
4. The perpetuating factors section provided an adequate outline of chronic vulnerabilities in relevant biomedical, psychosocial and psychoeducational domains.
5. The previous treatment section adequately addressed previous

| | | |
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| | | medication and psychosocial treatments.<br>6. The present status section of the case formulation contained information in the proper relevant categories: symptoms, interventions and response, risk factors, culture, functional status, barriers to discharge, behavioral guidelines/PBS plan, By Choice status and medication side effects rating data (MOSES).<br><br>To achieve substantial compliance with the requirements of C.2.d, the facility needs to maintain progress in this area and to implement further refinements in practice to ensure the following:<br><br>1. The present status section includes sufficient review and analysis of the use of restrictive interventions (see C.2.g.ii); and<br>2. There is adequate linkage between the case formulation and the individual's objectives and interventions, including proper utilization of the individual's life goals and strengths (see C.2.f).<br><br>**Current recommendations**:<br>1. Continue current training on Case Formulation for all WRPTs and ensure that the training addresses the deficiencies outlined by this monitor above.<br>2. Monitor this requirement using the DMH WRP Clinical Chart Auditing Form based on at least a 20% sample.<br>3. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).<br>4. Provide a summary outline of improvements in practice made as a result of the facility's review 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* — 50% |

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<tr><td></td><td>status.</td><td></td></tr>
<tr><td>4.a</td><td>Clinical outcomes and responses to treatment in the previous three (3) months described in clinical notes are incorporated into the case formulation.</td><td>68%</td></tr>
<tr><td>4.b</td><td>Information recorded in the "interventions and Response" tab in the Present Status for the previous three (3) months (for a quarterly WRP) or for the previous 12 months (for an annual WRP) has been summarized in the Previous Treatment Section of the Case Formulation.</td><td>32%</td></tr>
</table>
<br>
Comparative data indicated improvement in mean compliance since the previous review period. However, PSH did not provide comparative data for the two sub-indicators.
<br><br>
<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>4.</td><td>0%</td><td>50%</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>4.</td><td>0%</td><td>60%</td></tr>
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<tr>
<td>C.2.d.iii</td>
<td>consider biomedical, psychosocial, and psychoeducational factors, as clinically appropriate, for each category in § [III.B.4.b] above;</td>
<td>
During this review period, the sub-items for this indicator were removed and the item was reworded to increase alignment with the EP requirements.
<br><br>
<table>
<tr><td>5.</td><td>The case formulation considers biomedical, psychosocial, and psychoeducational factors, as clinically appropriate.</td><td>86%</td></tr>
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<br>
The mean compliance rate was 86%, compared to 3% during the previous review period. The compliance rate for the last month of this review period was 98% compared to 0% during the last month of the previous review period.
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<tr>
<td>C.2.d.iv</td>
<td>consider such factors as age, gender, culture, treatment adherence, and medication issues that may affect the outcomes of treatment and rehabilitation interventions;</td>
<td>
<table>
<tr><td>6.</td><td>Consider such factors as age, gender, culture, treatment adherence, and medication issues that may affect the outcomes of treatment and rehabilitation interventions</td><td>82%</td></tr>
<tr><td>6.a</td><td>All five factors: age, gender, culture, treatment adherence, and medication issues (are included)</td><td>89%</td></tr>
<tr><td>6.b</td><td>(The formulation) addresses how they affect treatment and rehabilitation outcomes</td><td>74%</td></tr>
</table>
<br>
Comparative data indicated improvement in compliance since the previous review period:
<br>
<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>6.</td><td>22%</td><td>82%</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>6.</td><td>27%</td><td>98%</td></tr>
<tr><td>6.a</td><td>36%</td><td>100%</td></tr>
<tr><td>6.b</td><td>0%</td><td>96%</td></tr>
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<tr>
<td>C.2.d.v</td>
<td>support the diagnosis by diagnostic formulation, differential diagnosis and Diagnostics and Statistical Manual DSM-IV-TR (or the most current edition) checklists; and</td>
<td>
<table>
<tr><td>7.</td><td>Support the diagnosis by diagnostic formulation, differential diagnosis and Diagnostics and Statistical Manual DSM-IV-TR (or the most current edition) checklists</td><td>43%</td></tr>
<tr><td>7.a</td><td>There is a completed DSM IV-TR Checklist that was completed prior to the 7-day WRP, and thereafter</td><td>61%</td></tr>
<tr><td>7.b</td><td>There is a completed DSM IV-TR Checklist completed when there is a change of a psychiatric</td><td>25%</td></tr>
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| | | |
|---|---|---|
| | *diagnosis.* | |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 7. | 71% | 43% |
| Compliance rate in last month of period | | |
| 7. | 90% | 50% |
| 7.a | 90% | 50% |
| 7.b | 90% | 50% |

PSH reported that sample sizes for these items were too small to produce reliable and valid results (e.g., N=2 for April 2009.) The facility reported that it intends to modify its sampling procedure for these items to ensure an adequate sample size.

**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.

During the review period, three sub-items for this indicator were removed as the content was redundant with other audits. Two sub-items were reworded for clarity.

| | | |
|---|---|---|
| 8. | *The case formulation enables the interdisciplinary team to reach sound determinations about each individual's treatment, rehabilitation, enrichment and wellness needs, the type of setting to which the individual should be discharged, and the changes that will be necessary to achieve discharge.* | 68% |
| 8.a | *The present status section addresses the following: Treatment, Rehabilitation and Enrichment* | 59% |

| | | |
|---|---|---|
| | | 8.b — *The case formulation documents the individual's progress as evidenced by symptom reduction, participation in individual therapy and/or mall groups, and achievement of active treatment objectives* — 69%<br>8.c — *The case formulation documents a pathway to the discharge setting* — 92%<br>8.d — *There is proper linkage within different sections of the case formulation when a factor in one section is related to a factor in another section* — 50%<br><br>Comparative data indicated improvement in mean compliance since the previous review period:<br><br>Previous period / Current period<br>Mean compliance rate<br>8. — 0% / 68%<br>Compliance rate in last month of period<br>8. — 0% / 68%<br>8.a — 9% / 75%<br>8.b — 55% / 79%<br>8.c — 73% / 100%<br>8.d — 36% / 18%<br><br>PSH reported that auditing errors contributed to the low compliance rate for 8.d. The facility reported that it intends to retrain auditors during the next review period. |
| C.2.e | The therapeutic and rehabilitation service plan specifies the individual's focus of hospitalization (goals), assessed needs (objectives), and how the | **Current findings on previous recommendations:** |

| | | |
|---|---|---|
| | staff will assist the individual to achieve his or her goals/objectives (interventions); | **Recommendation 1, December 2008:**<br>Same as in C.2.c, C.2.f, C.2.g and C.2.o.<br><br>**Findings:**<br>Same as in C.2.c, C.2.f, C.2.g and C.2.o.<br><br>**Recommendations 2 and 3, December 2008:**<br>• Monitor this requirement using the WRP Chart Auditing Form based on at least a 20% sample.<br>• Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).<br><br>**Findings:**<br>Using the DMH WRP Chart Auditing Form, PSH assessed its compliance based on an average sample of 22% of the quarterly and annual WRPs due each month during the review period (November 2008 – April 2009):<br><br>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).* 62%<br>4.a *There is a focus of hospitalization for each axis I, II, and III diagnosis* 52%<br>4.b *There is a focus for each discharge criteria* 63%<br>4.c *Each focus has an objective and an intervention* 83%<br>4.d *Each intervention includes the name of the staff responsible for implementation, the group name and the group time/day.* 77%<br>4.e *Each objective includes a staff intervention in the therapeutic milieu.* 33% |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 4. | 3% | 62% |
| Compliance rate in last month of period | | |
| 4. | 6% | 69% |
| 4.a | 53% | 52% |
| 4.b | 52% | 74% |
| 4.c | 89% | 86% |
| 4.d | 58% | 86% |
| 4.e | 34% | 45% |

**Other findings:**
A review of the records of 13 individuals receiving Rehabilitation Therapy Services (including Rehabilitation Therapist-facilitated PSR Mall groups and direct Occupational, Speech, and Physical therapy treatment) to assess compliance with the requirements of C.2.e found six records in substantial compliance (DB, FD, JW, NS, PSC and TN), five records in partial compliance (DTD, JAC, JG, LBL and MB) and two records not in compliance (ELF and ZB). Identified areas of deficiency that the facility should focus on in order to improve compliance include:

1. Objectives are not consistently functional, behavioral, observable and measurable.
2. Foci, objectives and interventions are not consistently included in the WRP.

This monitor also reviewed the records of 16 individuals who had IA-RTS assessments and Rehabilitation Therapy focused assessments (Occupational Therapy, Speech Therapy, Physical Therapy, CIPRTA, and Vocational

| | | |
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| | | Rehabilitation) during the review period to assess compliance with the requirements of C.2.e. Three records were in substantial compliance (AKA, RMM and TC), nine records were in partial compliance (BJ, KC, LC, MBE, MM, PC, PLJ, TG and TN) and four records were not in compliance (EMN, JD, JHB and MRR). Identified areas of deficiency that the facility should focus on in order to improve compliance include:<br><br>1. Objectives are not consistently functional, behavioral, observable and measurable.<br>2. Foci, objectives and interventions are not consistently included in the WRP.<br><br>Finally, a review of the records of 15 individuals with completed Nutrition Care assessments to assess compliance with the requirements of C.2.e found three records in substantial compliance (LEW, NG and SRF), 10 records in partial compliance (BDT, ECF, ELG, END, JPM, LSB, LW, PF, RH and TCH) and two records not in compliance (BJ and RTW). Identified areas of deficiency that the facility should focus on in order to improve compliance include:<br><br>1. Objectives are not consistently functional, behavioral, observable and measurable.<br>2. Foci, objectives and interventions are not consistently included in the WRP.<br>3. Interventions are not consistently written according to facility requirements.<br><br>**Compliance:**<br>Partial.<br><br>**Current recommendations**:<br>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).<br>3. Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data. |
| C.2.f | Therapeutic and rehabilitation service planning is driven by individualized needs, is strengths-based (i.e., builds on an individual's current strengths), addresses the individual's motivation for engaging in wellness activities, and leads to improvement in the individual's mental health, health and well being, consistent with generally accepted professional standards of care. Specifically, the interdisciplinary team shall: | Please see sub-cells for compliance findings. |
| C.2.f.i | develop and prioritize reasonable and attainable goals/objectives (e.g., at the level of each individual's functioning) that build on the individual's strengths and address the individual's identified needs and, if any identified needs are not addressed, provide a rationale for not addressing the need; | **Current findings on previous recommendations:**<br><br>**Recommendation 1, December 2008:**<br>Continue training on the Modules regarding Foci/Objectives and Interventions/Mall Integration for all WRPTs and ensure that the training addresses the deficiencies outlined by this monitor above.<br><br>**Findings:**<br>PSH reported that it intends to complete Phase II of its WRP training during the next review period. This training is designed to focus on the development and alignment of Foci, Objectives, and Interventions.<br><br>**Recommendations 2 and 3, December 2008:**<br>• Monitor this requirement based on at least a 20% sample.<br>• Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). |

**Findings:**
Using the DMH WRP Chart Auditing Form, PSH assessed its compliance with the requirements of C.2.f.i through C.2.f.v based on an average sample of 22% of the quarterly and annual WRPs due each month during the review period (November 2008 – April 2009):

| | | |
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| 5. | *The team has developed and prioritized reasonable and attainable goals/objectives (e.g. at the level of each individuals functioning) that builds on the individuals strengths and addresses the individuals identified needs and, if any identified needs are not addressed, provide a rationale for not addressing the need.* | 33% |
| 5.a | *All objectives for Focus 1, 3, and 5 are linked to the individual's stage of change* | 54% |
| 5.b | *The individual's strengths are used in the interventions.* | 22% |
| 5.c | *There is documented rationale in the focus area if any focus of hospitalization does not have an objective or an intervention.* | 22% |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 5. | 7% | 33% |
| Compliance rate in last month of period | | |
| 5. | 10% | 40% |
| 5.a | 48% | 69% |
| 5.b | 22% | 39% |

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<tr><td>5.c</td><td>25%</td><td>12%</td></tr>
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<br>
Other findings:<br>
A review of the charts of six individuals found substantial compliance in four (DB, REA, RWM and WCS) and noncompliance in two (AAG and EAS).<br><br>
Compliance:<br>
Partial.<br><br>
Current recommendations:<br>
1. Ensure that the training and mentoring provided to the WRPTs addresses the deficiencies outlined by this monitor above.<br>
2. Monitor this requirement using the DMH WRP Chart Auditing Form based on at least a 20% sample.<br>
3. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period.<br>
4. Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.
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<td>C.2.f.ii</td>
<td>ensure that the objectives/interventions address treatment (e.g., for a disease or disorder), rehabilitation (e.g., skills/supports, motivation and readiness), and enrichment (e.g., quality of life activities);</td>
<td>
Current findings on previous recommendation:<br><br>
Recommendation, December 2008:<br>
Same as in C.2.f.i.<br><br>
Findings:<br>
Using the DMH WRP Chart Auditing Form, PSH assessed its compliance based on an average sample of 22% of the quarterly and annual WRPs due each month during the review period (November 2008 – April 2009):<br><br>
<table>
<tr><td>6.</td><td>The objectives/interventions address treatment (e.g., for a disease or disorder), rehabilitation (e.g., skills/supports, motivation and readiness), and</td><td>70%</td></tr>
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| | *enrichment (e.g., quality of life activities.)* | |
| 6.a | *There are specific skills training and support groups identified in the interventions that are linked to specific objectives and are provided in the PSR mall.* | 72% |
| 6.b | *There are specific leisure and recreation groups specified in the interventions that are linked to objective derived to focus 10.* | 68% |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 6. | 35% | 70% |
| Compliance rate in last month of period | | |
| 6. | 51% | 86% |
| 6.a | 71% | 89% |
| 6.b | 70% | 83% |

PSH reported that further data analysis revealed one Program that contributes negatively to the compliance rate in this area. The facility indicated that the Program Director and Chief of Rehabilitation Therapy will collaborate on corrective actions for this Program.

**Other findings:**
A review of six charts found substantial compliance in all six (AAG, DB, EAS, REA, RWM and WCS).

**Compliance:**
Partial.

| | | |
|---|---|---|
| | | **Current recommendation**:<br>Same as in C.2.f.i. |
| C.2.f.iii | write the objectives in behavioral, observable, and/or measurable terms; | **Current findings on previous recommendation:**<br><br>**Recommendation, December 2008:**<br>Same as in C.2.f.i.<br><br>**Findings:**<br>The facility reported a mean compliance rate of 26%, compared to 13% during the previous review period. The compliance rate for the last month of this review period was 39% compared to 23% during the last month of the previous review period.<br><br>**Other findings:**<br>Chart reviews found partial compliance in five charts (AAG, DB, REA, RWM and WCS) and noncompliance in one (EAS).<br><br>**Compliance:**<br>Partial.<br><br>**Current recommendation**:<br>Same as in C.2.f.i. |
| C.2.f.iv | include all objectives from the individual's current stage of change or readiness for rehabilitation, to the maintenance stage for each focus of hospitalization, as clinically appropriate; | **Current findings on previous recommendation:**<br><br>**Recommendation, December 2008:**<br>Same as in C.2.f.i.<br><br>**Findings:**<br>The facility reported a mean compliance rate of 68%, compared to 58% during the previous review period. The compliance rate for the last month of this period was 90% compared to 77% during the last month of the |

| | | |
|---|---|---|
| | | previous review period.<br><br>**Other findings:**<br>Chart reviews found substantial compliance in three charts (AAG, DB and RWM), partial compliance in one (WCS) and noncompliance in two (EAS and REA).<br><br>**Compliance:**<br>Partial.<br><br>**Current recommendation**:<br>Same as in C.2.f.i. |
| C.2.f.v | ensure that there are interventions that relate to each objective, specifying who will do what, within what time frame, to assist the individual to meet his/her needs as specified in the objective; | **Current findings on previous recommendation:**<br><br>**Recommendation, December 2008:**<br>Same as in C.2.f.i.<br><br>**Findings:**<br>The facility reported a mean compliance rate of 44%, compared to 27% during the previous review period. The compliance rate for the last month of this period was 58%, compared to 49% during the last month of the previous review period.<br><br>**Other findings:**<br>Chart reviews found substantial compliance in four charts (AAG, REA, RWM and WCS) and partial compliance in two (DB and EAS).<br><br>**Compliance:**<br>Partial.<br><br>**Current recommendation**:<br>Same as in C.2.f.i. |

| | | |
|---|---|---|
| C.2.f.vi | implement interventions appropriately throughout the individual's day, with a minimum of 20 hours of active treatment per week. Individual or group therapy included in the individual's WRP shall be provided as part of the 20 hours of active treatment per week; | **Current findings on previous recommendations:**<br><br>**Recommendations 1-3, December 2008:**<br>• Monitor hours of active treatment (scheduled and attended).<br>• Present data regarding average number of scheduled and attended hours (previous period and last month of previous period compared to current period and last month of current period).<br>• Correct factors related to inadequate scheduling by the WRPTs, inaccurate reporting of hours scheduled on the WRP, discrepancies between WRP and MAPP data and inadequate participation by individuals.<br><br>**Findings:**<br>PSH presented the following data for the review period (November 2008 – April 2009): |

| | Number of individuals by category | |
|---|---|---|
| | Mean scheduled hours | Mean attended hours |
| N | 1525 | 1525 |
| Hours: | | |
| 0-5 | 116 | 271 |
| 6-10 | 204 | 395 |
| 11-15 | 321 | 486 |
| 16-20 | 885 | 375 |

Comparative data indicated an overall decline in attendance since the last review period:

| | Previous period | Current period |
|---|---|---|
| Mean attended hours | | |
| 0-5 | 79 | 271 |
| 6-10 | 227 | 395 |

| | | |
|---|---|---|
| 11-15 | 536 | 486 |
| 16-20+ | 689 | 375 |
| Attended hours in last month of period | | |
| 0-5 | 146 | 529 |
| 6-10 | 353 | 251 |
| 11-15 | 502 | 589 |
| 16-20+ | 547 | 156 |

PSH has taken steps to encourage and motivate individuals who are non-adherent to attend their assigned Mall groups. PSH has offered groups specifically for individuals who meet threshold for Mall group non-adherence. In addition, Enhancement Services staff submits weekly reports on Scheduled vs. Attended Hours to the hospital administration, program management staff and the Standards Compliance Department for management to work with WRPTs to address individuals' Mall attendance.

PSH needs to continue to work on improving the overall attendance of individuals to their assigned Mall groups consistently.

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

| Individual | WRP scheduled hours | MAPP scheduled hours | MAPP attended hours |
|---|---|---|---|
| DJT | 12 | 20 | 2.5 |
| DRH | 9 | 20 | 1 |
| JAM | 8 | 20 | 8 |
| JC | 12 | 20 | 6 |
| JR | 8 | 20 | 5 |

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<table>
<tr><td>RAH</td><td>18</td><td>20</td><td>8</td></tr>
<tr><td>RL</td><td>18</td><td>20</td><td>11</td></tr>
<tr><td>SSM</td><td>9</td><td>10</td><td>6</td></tr>
<tr><td>TCS</td><td>17</td><td>20</td><td>13</td></tr>
<tr><td>TK</td><td>17</td><td>20</td><td>8</td></tr>
</table>
<br>
As the table above shows, there continue to be discrepancies between hours scheduled in the individuals' WRPs and that aggregated in the MaPP schedule. The attended hours are low for the majority of the individuals.<br><br>
Compliance:<br>
Partial.<br><br>
Current recommendations:<br>
1. Monitor hours of active treatment (scheduled and attended).<br>
2. Present data regarding average number of scheduled and attended hours (previous period and last month of previous period compared to current period and last month of current period).<br>
3. Correct factors related to inadequate scheduling by the WRPTs, inaccurate reporting of hours scheduled on the WRP, discrepancies between WRP and MAPP data and inadequate participation by individuals.
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<td>C.2.f.vii</td>
<td>maximize, consistent with the individual's treatment needs and legal status, opportunities for treatment, programming, schooling, and other activities in the most appropriate integrated, non-institutional settings, as clinically appropriate; and</td>
<td>
Current findings on previous recommendations:<br><br>
PSH is legally unable to permit individuals to participate in community treatment opportunities unless accompanied by a CDCR Correctional Officer. This is based on California Welfare and Institutions Code Section 4107(a), which requires that the security of individuals at Patton State Hospital is the responsibility of the Department of Corrections and Rehabilitation. At the present time, PSH has approximately 109 civilly committed individuals who have been determined to exceed the security levels of either Napa State Hospital and/or Metropolitan State Hospital. According to the staff at PSH, these individuals have been identified by
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| | | history to be high risk to the safety and security of the public if they were to elope during community outings. The facility will explore what barriers exist for CDCR to provide/coordinate security supervision to facilitate community treatment opportunities.<br><br>This monitor reviewed eight charts of civilly committed individuals (CS, DR, GB, JK, JL, ML, RA and SC). All eight charts documented individuals' high-risk behaviors including homicidal, aggressive, sexual offending, and suicidal behaviors. |
| C.2.f.viii | ensure that each therapeutic and rehabilitation service plan integrates and coordinates all services, supports, and treatments provided by or through each State hospital for the individual in a manner specifically responsive to the plan's therapeutic and rehabilitation goals. This requirement includes but is not limited to ensuring that individuals are assigned to mall groups that link directly to the objectives in the individual's WRP and needs. | **Current findings on previous recommendations:**<br><br>**Recommendations 1 and 2, December 2008:**<br>• Monitor this requirement using the Mall Alignment Monitoring Form and present data on the main indicator and the two sub-items.<br>• Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).<br><br>**Findings:**<br>Using the DMH Mall Alignment Monitoring Form, PSH assessed its compliance based on a mean sample of 24% of the census each month for the review period (November 2008 – April 2009):<br><br>1. *Integrates and coordinates all services, supports, and treatments provided by or through each state hospital for the individual in a manner specifically responsive to the plan's therapeutic and rehabilitation goals. This requirement includes but is not limited to ensuring that individuals are assigned to mall groups that link directly to the objectives in the individual's WRP and needs.* — 31% |

| | | |
|---|---|---|
| 1.a | *According to the individual's Mall schedule, the individual is assigned to all the Mall courses listed as active treatment in the WRP.* | 34% |
| 1.b | *The reviewed course outlines' content (that) is aligned with the corresponding objectives in the individual's WRP.* | 27% |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 1. | 9% | 31% |
| Compliance rate in last month of period | | |
| 1. | 0% | 48% |

This monitor reviewed nine chart (AM, ATM, CK, DB, DJW, EV, LTH, RA and VF). Six of the individuals (ATM, DB, DJW, EV, LTH and VF) were assigned to Mall groups that were aligned with their needs and linked to the objectives in their WRPs.

**Recommendation 3, December 2008:**
Implement the revised DMH Mall Facilitator Progress Notes and track the completion of these notes and the integration of information into the WRPs.

**Findings:**
A review of the charts of eight individuals found partial compliance in two (EV and VF) and noncompliance in the remaining six (AM, ATM, DB, DJW, LTH and RA).

**Compliance:**
Partial.

| | | |
|---|---|---|
| | | **Current recommendations:**<br>1. Monitor this requirement using the Mall Alignment Monitoring Form and present data on the main indicator and the two sub-items.<br>2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).<br>3. Implement the revised DMH Mall Facilitator Progress Notes and track the completion of these notes and the integration of information into the WRPs. |
| C.2.g | Therapeutic and rehabilitation service plans are revised as appropriate to ensure that planning is based on the individual's progress, or lack thereof, as determined by the scheduled monitoring of identified criteria or target variables, consistent with generally accepted professional standards of care. Specifically, the interdisciplinary team shall: | Please see sub-cells for compliance findings. |
| C.2.g.i | revise the focus of hospitalization, objectives, as needed, to reflect the individual's changing needs and develop new interventions to facilitate attainment of new objectives when old objectives are achieved or when the individual fails to make progress toward achieving these objectives; | **Current findings on previous recommendations:**<br><br>**Recommendations 1, 2 and 3, December 2008:**<br>• Monitor this requirement using Clinical Chart Auditing and the WRP Process Observation Monitoring forms, based on at least a 20% sample.<br>• Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).<br>• Continue implementation of the modified format for the monthly WRPC and ensure timely and appropriate revisions of the WRPs, as clinically indicated.<br><br>**Findings:**<br>See C.2.t, sub-items 11.d and 11.e, for the facility's self-monitoring data. |

| | | |
|---|---|---|
| | | The items that were previously reported in this cell were removed during revisions of the applicable forms due to redundancy with other audit items.<br><br>**Other findings:**<br>A review of the charts of six individuals found substantial compliance in three (AAG, DB and EAS), partial compliance in one (RWM) and noncompliance in two (REA and WCS).<br><br>Additionally, a review of the records of 10 individuals receiving direct Occupational, Speech and Physical Therapy services for evidence that treatment objectives and/or modalities were modified as needed found eight records in substantial compliance (AKA, FD, JAC, JW, PSC, RLE, TN and YMH) and two records not in compliance (DB and PH).<br><br>**Compliance:**<br>Partial.<br><br>**Current recommendation**:<br>Same as in C.2.t. |
| C.2.g.ii | review the focus of hospitalization, needs, objectives, and interventions more frequently if there are changes in the individual's functional status or risk factors (i.e., behavioral, medical, and/or psychiatric risk factors); | **Current findings on previous recommendations:**<br><br>**Recommendation 1, December 2008:**<br>Develop and implement corrective actions to ensure:<br>a. Review by the WRPTs of the circumstances related to the use of restrictive interventions; and<br>b. Timely and appropriate modification of the WRPs in response to the review.<br><br>**Findings:**<br>PSH reported that it intends to implement an enhanced mentoring/ monitoring process in June 2009. The facility indicated that psychiatry seniors will begin reviewing all episodes of seclusion and/or restraint no |

later than the working day following the episode.

**Recommendations 2 and 3, December 2008:**

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

**Findings:**

Using the DMH WRP Clinical Chart Auditing Form, PSH assessed its compliance based on an average sample of 90% of individuals placed in seclusion and/or restraints during March or April 2009. The number of this indicator (but not the content) changed during this review period. The sub-items were revised to increase specificity of monitoring.

| | | |
|---|---|---|
| 12. | *Review the focus of hospitalization, needs, objectives, and interventions more frequently if there are changes in the individual's functional status or risk factors (i.e., behavioral, medical, and/or psychiatric risk factors)* | 37% |
| 12.a | *The Present Status section reviews each use of seclusion and/or restraint, including the circumstances leading to its use, and* | 5% |
| 12.b | *The objectives and interventions have been modified as a result of the use of seclusion and/or restraint, as clinically appropriate.* | 68% |

Comparative data is not available as the revised sub-items were implemented during this review period.

**Other findings:**

This monitor reviewed the charts of five individuals who experienced the

| | | |
|---|---|---|
| | | use of seclusion and/or restraints during this review period (ATR, BMC, JTP, MLB and SPB). The review focused on the documentation (in the Present Status section) of the following:<br><br>1. Circumstances that required the use of restrictive interventions;<br>2. Treatment provided to avert the use of restrictive intervention;<br>3. Modification of ongoing treatment to decrease future risk; and<br>4. Assessment of risk factors in the Present Status section, particularly regarding dangerousness to others.<br><br>The review found partial compliance in four charts (ATR, JTP, MLB and SPB) and noncompliance in one (BMC).<br><br>**Compliance:**<br>Partial.<br><br>**Current recommendations**:<br>1. Improve documentation in the Present Status section of the four items listed in this monitor's review above.<br>2. Monitor this requirement using the revised monitoring tool based on at least a 20% sample.<br>3. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period.<br>4. Provide a summary outline of improvements in practice made as a result of the facility's review 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:**<br><br>**Recommendations 1 and 2, December 2008:**<br>• Monitor this requirement using process observation in this section and DMH Discharge Planning and Community Integration Form in section E.3 based on at least a 20% sample. |

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

**Findings:**
Using the DMH WRP Observation Monitoring Form, PSH assessed its compliance based on an average sample of 17% of the quarterly and annual WRPCs held each month during the review period (November 2008 – April 2009). The number of the indicator (but not the content) changed during this review period due to deletion of other items within the tool. The following table summarizes the data:

| | | |
|---|---|---|
| 7. | *The review process includes an assessment of progress related to discharge to the most integrated setting appropriate to meet the individuals assessed needs, consistent with his/her legal status.* | 63% |
| 7.a | *The team reviews all foci that are barriers to discharge.* | 68% |
| 7.b | *The team reviews the PSR Mall Facilitator's Monthly Notes for all objectives related to discharge.* | 58% |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 7. | 23% | 63% |
| Compliance rate in last month of period | | |
| 7. | 44% | 66% |
| 7.a | 44% | 65% |
| 7.b | 46% | 67% |

| | | |
|---|---|---|
| | | **Recommendation 3, December 2008:**<br>Develop and implement corrective actions to ensure that discharge criteria are individualized and that the WRPTs document their discussion of progress towards discharge criteria.<br><br>**Findings:**<br>The facility's training/mentoring activities are summarized in C.1.a.<br><br>**Other findings:**<br>This monitor assesses the documentation of discharge criteria and the WRPT's discussion of the individual's progress towards discharge (in the Present Status section of the case formulation) in the charts of six individuals. Two individuals (DB and REA) were admitted under PC 1370 and four individuals (RLW, JLB, CMR and DW) were admitted under other categories. The review found substantial compliance in four charts (CMR, DW, JLB and REA) and partial compliance in two (DB and RLW).<br><br>**Compliance:**<br>Partial.<br><br>**Current recommendations**:<br>1. Monitor this requirement using the DMH WRP Observation Monitoring Form in this section and DMH Discharge Planning and Community Integration in section E.3 based on at least a 20% sample.<br>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.<br>3. Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data. |
| C.2.g.iv | base progress reviews and revision recommendations on data collected as | **Current findings on previous recommendations:** |

specified in the therapeutic and rehabilitation service plan.

**Recommendations 1 and 2, December 2008:**

- Same as in C.2.g.i.
- Same as in C.2.f.viii.

**Findings:**

Using the DMH WRP Observation Monitoring Form, PSH assessed its compliance based on an average sample of 17% of the quarterly and annual WRPCs held each month during the review period (November 2008 – April 2009). The number of the indicator (but not the content) changed during this review period due to deletion of other items within the tool. The following table summarizes the data:

| | | |
|---|---|---|
| 8. | *Progress reviews and revision recommendations are based on data collected as specified in the therapeutic and rehabilitation service plan.* | 46% |
| 8.a | *The team reviews the PSR Mall Facilitator's Monthly Progress Notes for all current objectives and interventions for this individual.* | 54% |
| 8.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.* | 37% |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 8. | 13% | 46% |
| Compliance rate in last month of period | | |
| 8. | 37% | 62% |
| 8.a | 39% | 60% |

| | | |
|---|---|---|
| | | 8.b \| 24% \| 64%<br><br>PSH attributed low compliance rates to barriers related to its system for routing Mall notes. The facility reported that implementation of the PSR Mall notes module in the WaRMSS system (scheduled for June 2009) is anticipated to improve compliance.<br><br>**Other findings**:<br>This monitor's chart reviews focused on the presence and content of documentation of the individual's participation and progress in Mall groups (as documented in the Mall Facilitator notes). The review found substantial compliance in one chart (EAS) and noncompliance in five (AAG, DB, REA, RWM and WCS).<br><br>**Compliance:**<br>Partial.<br><br>**Current recommendations**:<br>1. Monitor this requirement using the DMH WRP Observation Form based on at least a 20% sample.<br>2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period.<br>3. Provide a summary outline of improvements in practice made as a result of the facility's review 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 | **Compliance:**<br>Partial. |

| | | |
|---|---|---|
| | professional standards of care, that: | |
| 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:**<br><br>**Recommendation 1, December 2008:**<br>WRPTs should integrate relevant information from discipline-specific assessments and prioritize the individual's assessed needs.<br><br>**Findings:**<br>Using the DMH WRP Mall Alignment Monitoring Form, PSH assessed its compliance based on an average sample of 24% of WRPs due each month during the review period (November 2008 – April 2009): |

| | | |
|---|---|---|
| 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* | 29% |
| 2.a | *All Mall courses listed in the individual's schedule are listed as interventions in the individual's WRP* | 27% |
| 2.b | *The course outlines of all those courses include a rationale for how the Mall course is aimed at improving the individual's independent life functioning* | 31% |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 2. | 20% | 29% |
| Compliance rate in last month of period | | |
| 2. | 12% | 55% |
| 2.a | 12% | 50% |

| | | |
|---|---|---|
| 2.b | 19% | 60% |

A review of the records of six individuals found that all six of the WRPs in the charts had integrated the relevant information from the discipline-specific assessments into the individuals' WRPs (BG, JMB, JR, MG, RC and VV).

A review of the records of nine individuals found that the objectives in seven of the WRPs in the charts were directly linked to a relevant focus of hospitalization (AM, ATM, DB, DJW, EV, LTH and RA); the objectives were not so linked in the remaining two charts (CK and VF).

**Recommendation 2, December 2008:**
Continue to offer groups based on the needs of the individuals in the facility.

**Findings:**
Review of the records of 16 individuals found that groups were based on the individual's needs and matched with the individual's MaPP and Mall group schedules in 11 records (ATM, DB, DH, DJW, DT, EV, LTH, RH, TK, TS and VF). In the remaining five records (JAM, JC, JR, RL and SM), Mall groups did not meet the individual's needs or were not aligned with the individual's MaPP and/or Mall schedules.

**Other findings:**
A review of the records of 13 individuals receiving Rehabilitation Therapy Services (including Rehabilitation Therapist-facilitated PSR Mall groups and direct Occupational, Speech, and Physical therapy treatment) to assess compliance with the requirements of C.2.i.i found all records in substantial compliance. .

**Current recommendations**:
1. WRPTs should integrate relevant information from discipline-specific

<table>
<tr><td></td><td></td><td>assessments and prioritize the individual's assessed needs.<br>2. Continue to offer groups based on the needs of the individuals in the facility.</td></tr>
<tr><td>C.2.i.ii</td><td>Has documented objectives, measurable outcomes, and standardized methodology</td><td>

**Current findings on previous recommendations:**

**Recommendations 1 and 2, December 2008:**
- Ensure that the learning outcomes are stated in measurable terms.
- Ensure that each objective is directly linked to a relevant focus of hospitalization and discharge criteria.

**Findings:**
Using the DMH WRP Chart Auditing Form, PSH assessed its compliance based on an average sample of 22% of the quarterly and annual WRPs due each month during the review period (November 2008 – April 2009):

<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>26%</td></tr>
</table>

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

<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>7.</td><td>13%</td><td>26%</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>7.</td><td>23%</td><td>39%</td></tr>
</table>

See also C.2.f.i.

A review of the records of nine individuals found that six of the WRPs in

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

| | | |
|---|---|---|
| | | the charts contained objectives written in a measurable/observable manner (AM, ATM, DJW, EV, RA and VF) and three did not (CK, DB and LTH). The objectives were directly linked to a relevant focus of hospitalization in seven WRPs (AM, ATM, DB, DJW, EV, LTH and RA) and were not linked in two (CK and VF).<br><br>**Recommendation 3, December 2008:**<br>Ensure that the courses teach to individualized objectives and include evaluation measures for all individuals attending the course.<br><br>**Findings:**<br>Documentation review and interview of the Mall Director found that Mall facilitators utilize objectives in the individual's WRP as part of their Mall group objectives for individuals attending their groups. However, most groups currently do not have appropriate evaluation measures for all individuals attending their Mall courses, as evidenced by the Mall progress note data/information. The Mall Director is working towards this but is facing barriers at many levels including optimal participation of disciplines to serve as Mall facilitators, reluctance to use the lesson plans developed, and failure to write timely monthly Mall progress notes. It appears that for a variety of reasons including expanded tasks and staffing shortage, a high number of staff from many disciplines has been requesting "permanent'" exemptions or reductions in their Mall hours, further reducing the Mall Director's options to manage the Mall groups.<br><br>**Current recommendations:**<br>1. Ensure that the learning outcomes are stated in measurable terms.<br>2. Ensure that each objective is directly linked to a relevant focus of hospitalization and discharge criteria.<br>3. Ensure that the courses teach to individualized objectives and include evaluation measures for all individuals attending the course. |

| | | |
|---|---|---|
| C.2.i.iii | Is aligned with the individual's objectives that are identified in the individual's Wellness and Recovery Plan | **Current findings on previous recommendations:**<br><br>**Recommendation 1, December 2008:**<br>Ensure that WRPTs write objectives in behavioral, observable, and/or measurable terms.<br><br>**Findings:**<br>See Findings, C.2.i.ii.<br><br>**Recommendation 2, December 2008:**<br>Ensure that all therapies and rehabilitation services provided in the Malls are aligned with the assessed needs of the individuals.<br><br>**Findings:**<br>Using the DMH WRP Mall Alignment Monitoring Form, PSH assessed its compliance based on an average sample of 24% of all quarterly and annual WRPs due each month during the review period (November 2008 – April 2009):<br><br>1. *Integrates and coordinates all services, supports and treatments provided by or through each State hospital for the individual in a manner specifically responsive to the plan's therapeutic and rehabilitation goals. This requirement includes, but is not limited to, ensuring that individuals are assigned to mall groups that directly link to the objectives in the individuals WRP and needs.* — 31%<br>1.a *According to the individual's Mall schedule, the individual is assigned to all the Mall courses listed as active treatment in the WRP.* — 34%<br>1.b *The reviewed course outline's content is aligned with the corresponding objectives in the individual's WRP* — 27% |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 1. | 9% | 31% |
| Compliance rate in last month of period | | |
| 1. | 0% | 48% |

A review of WRPs of nine individuals found that the services documented in six of the WRPs were aligned with the individual's assessed needs (ATM, DB, DJW, EV, LTH and VF) and were not aligned in three (AM, CK and RA).

**Recommendation 3, December 2008:**
Ensure that the individual's progress is tracked (using the PSH Mall Facilitator Monthly Progress Note) and that participation at different levels and in different groups is adjusted accordingly.

**Findings:**
A review of eight charts found that only two (EV and VF) contained any notes at all, and the remaining six (AM, ATM, DB, LTH, GJW and RA) did not have any notes. According to the Mall Director, PSH introduced the Mall Progress Note system-wide in April 2009. This monitor's observation and questions of WRPT members found that the teams did not have Mall progress notes to review. A number of the team members reported that there were no Mall notes to review at this time because they are into the new Mall cycle, and it has not been a month to receive the "Monthly" Mall progress notes.

**Current recommendation**:
Ensure that all therapies and rehabilitation services provided in the Malls

<table>
<tr><td></td><td></td><td>are aligned with the assessed needs of the individuals.</td></tr>
<tr><td>C.2.i.iv</td><td>utilizes the individual's strengths, preferences, and interests;</td><td>

**Current findings on previous recommendations:**

**Recommendations 1 and 2, December 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:**

Using the DMH WRP Mall Facilitator Observation Monitoring Form, PSH assessed its compliance based on an average sample of 7% of Mall group facilitators each month during the review period (November 2008 – April 2009):

<table>
<tr><td>15.</td><td>The group facilitator utilizes the individual's strengths, preferences, and interests.</td><td>88%</td></tr>
<tr><td>15.a</td><td>The group provider utilizes one of the individual's strengths, preferences and/or interests.</td><td>88%</td></tr>
<tr><td>15.b</td><td>The group provider correctly identifies at least one of the individual's strengths, preferences and/or interests and the provider can state how and when the last time it was used in the group.</td><td>87%</td></tr>
</table>

Comparative data are not available. PSH used a different auditing tool (the Mall Alignment Monitoring Form) to address this recommendation at the last review, thus, the data are not comparable.

A review of WRPs of nine individuals found that four of the WRPs had specified the strengths of the individual in all active interventions reviewed
</td></tr>
</table>

| | | |
|---|---|---|
| | | (AM, ATM, DB and RA). The remaining five WRPs either failed to include strengths in all the active interventions reviewed, or the stated strength was not in accordance with the DMH WRP Manual (CK, DJW, EV, LTH and VF).<br><br>According to the Mall Director, the WRPTs have identified individuals' strengths relative to treatment interventions within the WRP in preparation for the implementation of the MAPP II program. MAPP II, scheduled for implementation on June 15, 2009, will generate the Mall group rosters and will provide Mall facilitators with the necessary information.<br><br>**Current recommendations**:<br>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.<br>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:**<br><br>**Recommendation 1, December 2008:**<br>Undertake clinical case formulation as a team rather than by assigning the task to a team member or to non-team members.<br><br>**Findings:**<br>This monitor observed three WRPCs (DR, PC and TAF). The team members in all three WRPCs functioned in an interdisciplinary manner. The core team members shared relevant information with the other team members and with the individual. See C.2.d for findings related to case formulation.<br><br>**Recommendations 2 and 3, December 2008:**<br>• Include the individual's vulnerabilities in the case formulation under |

predisposing, precipitating, and perpetuating factors.

- Update the present status to reflect the current status of these vulnerabilities.

**Findings:**
Using the DMH Mall Alignment Monitoring Form, PSH assessed its compliance based an average random sample of 24% of WRPs each month during the review period (November 2008 – April 2009):

| | | |
|---|---|---|
| 3. | *Focuses on the individual's vulnerabilities to mental illness, substance abuse and readmission due to relapse, where appropriate.* | 45% |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 3. | 33% | 45% |
| Compliance rate in last month of period | | |
| 3. | 19% | 75% |

A review of the WRPs of ten individuals found that the individual's vulnerabilities were documented in the case formulation section in eight of the WRPs and where appropriate the vulnerabilities were updated in the subsequent WRPs (AM, ATM, CK, DB, DJW, EV, LTH and VF). This was not the case in the remaining two WRPs (AAN and RZ).

**Other findings:**
Six (AAN, ATM, CK, DJW, EV and LTH) of seven charts reviewed (AAN, ATM, CK, DJW, EV, LTH and VF) reviewed contained documentation that the individual was currently assigned to a WRAP group or has completed a

| | | |
|---|---|---|
| | | WRAP group that focuses on the individual's vulnerabilities to mental illness, substance abuse, and readmission due to relapse, where appropriate.<br><br>**Current recommendations**:<br>1. Include the individual's vulnerabilities in the case formulation under predisposing, precipitating, and perpetuating factors.<br>2. Update the present status to reflect the current status of these vulnerabilities. |
| C.2.i.vi | is provided in a manner consistent with each individual's cognitive strengths and limitations; | **Current findings on previous recommendations:**<br><br>**Recommendation 1, December 2008:**<br>PSR Mall groups should address the assessed cognitive levels of the individuals participating in the group.<br><br>**Findings:**<br>According to the Mall Director, the Unit Psychologists assessed the cognitive levels of all individuals for the PSR Mall Needs Assessment Survey. The resulting data was used to restructure the Mall treatment programming to address cognitive levels. Three levels of support were derived from the data. The Supported Level includes individuals with challenges in self control and learning with high staff-to-individual needs ratios. The Assisted Level includes individuals in need of extra support due to learning/literacy deficits and who would benefits from multi-modal experiential approaches. The Independent Level includes individuals with basic literacy and who need minimal assistance to learn, completing homework on their own or with assistance. The Advanced Level includes literate individuals who are self-directed learners and can complete their homework, and are good peer facilitator candidates.<br><br>Using the DMH Mall Facilitator Observation Monitoring Form, PSH assessed its compliance based on an average sample of 7% of the Mall facilitators for each month of the review period (November 2008 – April 2009): |

| | | |
|---|---|---|
| 16. | *Material is presented in a manner consistent with each individual's cognitive strengths and limitations. The group facilitator can* | 88% |
| 16.a | *Identify a cognitive strength and limitation of a group participant* | 88% |
| 16.b | *Describe how the cognitive strength and limitation was taken into account by the facilitator during the group.* | 87% |

Comparative data is not available. PSH used a different monitoring tool in the previous review.

**Recommendation 2, December 2008:**
Ensure that individuals with cognitive and neurocognitive challenges are evaluated by a DCAT team and assigned to Mall groups that meet their cognitive strengths and limitations.

**Findings:**
Documentation review and interview of the Mall Director found that the DCAT team implemented the Recovery Inspired Skills Enhancement (R.I.S.E.) program specifically designed to provide treatment for individuals who present with severe cognitive needs and challenges. In addition, Neuropsychology developed and implemented a more structured Cognitive Remediation program related to cognitive and neurocognitive rehabilitation. Neuropsychology developed lesson plans and training modules for this group and will maintain oversight of the group.

A review of the records of 12 individuals found that cognitive screening had been conducted as part of the Integrated Assessment: Psychology Section in all 12 of the WRPs (AD, ASE, BAV, BLB, DOR, JAF, LEB, OB, RP, SJW, SRC and VT). Mall catalogues reviewed identified the cognitive levels for which each group is appropriate.

| | | |
|---|---|---|
| | | **Current recommendations**:<br>1. PSR Mall groups should address the assessed cognitive levels of the individuals participating in the group.<br>2. Ensure that individuals with cognitive and neurocognitive challenges are evaluated by a DCAT team and assigned to Mall groups that meet their 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:**<br><br>**Recommendations 1-3, December 2008:**<br>• Ensure that WRPTs receive timely progress notes on individuals' participation in their psychosocial rehabilitation services.<br>• Automate this system.<br>• Use the data from the PSR Mall Facilitator Monthly Progress Notes in the WRP review process.<br><br>**Findings:**<br>To assess its compliance, PSH audited 20% of the individuals in each Program for the last month of the review period. The data indicated that a majority of the Mall facilitators are not completing the required Monthly Mall progress notes or the notes are not timely. The table below showing the number of Progress Notes due for 20% of the individuals in the program (N), the number of Progress Notes available to the WRPTs in each Program (n), and the percentage of compliance (%C) is a summary of the facility's data.: |

| | P1 | P3 | P4 | P5 | P6 | P7 | P8 | Mean |
|---|---|---|---|---|---|---|---|---|
| N | 900 | 800 | 800 | 800 | 1200 | 800 | 800 | |
| n | 485 | 44 | 655 | 108 | 202 | 160 | 72 | |
| %C | 54 | 6 | 82 | 14 | 17 | 20 | 9 | 29 |

PSH's Mall progress notes system is yet to be fully automated. Monthly

| | | |
|---|---|---|
| | | progress notes are being written more consistently, but many of the WRPCs observed did not have Mall progress notes to review. According to the WRPT members, there were no notes at the present time because of the Mall cycle changeover. However, two (EV and VF) of the eight charts reviewed (AM, ATM, DB, EV, GJW, LTH, RA and VF) had some of the required monthly Mall progress notes. None of the information in these notes was incorporated into the Present Status sections of the individuals' WRPs.<br><br>**Other findings:**<br>A review of the records of nine individuals receiving Rehabilitation Therapy Services (including Rehabilitation Therapist-facilitated PSR Mall groups and direct Occupational and Physical therapy treatment) to assess compliance with the requirements of C.2.i.vii found six records in substantial compliance (AKA, DB, DTD, JG, RLE and YMH) and three records in partial compliance (FD, JAC and LBL).<br><br>**Current recommendations**:<br>1. Ensure that WRPTs receive timely progress notes on individuals' participation in their psychosocial rehabilitation services.<br>2. Automate this system.<br>3. Use the data from the PSR Mall Facilitator Monthly Progress Notes in the WRP review process. |
| C.2.i.viii | is provided five days a week, for a minimum of four hours a day (i.e., two hours in the morning and two hours in the afternoon each weekday), for each individual or two hours a day when the individual is in school, except days falling on state holidays; | **Current findings on previous recommendations:**<br><br>**Recommendation 1, December 2008:**<br>Mandate that all staff at PSH, other than those who attend to emergency medical needs of individuals, will provide services at the PSR Mall during scheduled Mall hours. This includes clinical, administrative and support staff. |

**Findings:**
The facility presented the following data regarding Mall group facilitation by discipline:

| Average weekly hours provided by discipline | | |
|---|---|---|
| | Previous review period | Current review period |
| Psychiatry ACUTE (4) | - | 2 |
| Psychiatry L-T (8) | - | 3 |
| Psychology ACUTE (5) | - | 4 |
| Psychology L-T (10) | - | 6 |
| Social Work ACUTE (5) | - | 5 |
| Social Work L-T (10) | - | 9 |
| Rehab Therapy ACUTE (7) | - | 8 |
| Rehab Therapy L-T (15) | - | 11 |
| Nursing (10) | - | Not available |

As shown in the table above, Social Work and Rehabilitation Therapy (acute) are providing or exceeding the required mean hours of service. All other disciplines except for Psychiatry are providing more than half the hours required of them. PSH did not present group facilitation data for Nursing and the Administrative staff. (The Executive Director has directed all off-unit treatment services staff and program management staff to provide a minimum of one hour of treatment mall facilitation each week.)

**Recommendation 2, December 2008:**
All Mall sessions must be 50 minutes in length. Sessions less than that duration do not contribute to an individual's active treatment hours.

**Findings:**
PSH did not present data, but asserted that "The system is automated to only include sessions that are 50 minutes in length."

| | | |
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| | | The Mall groups that this monitor observed all started on time. Generally groups that are less than 50 minutes in length are ones that start late.<br><br>**Recommendation 3, December 2008:**<br>Ensure that individuals participate in their scheduled hours.<br><br>**Findings:**<br>See Findings for Recommendations 1-3, C.2.f.vi.<br><br>**Recommendation 4, December 2008:**<br>Provide groups as needed by the individuals and written in the individuals' WRPs, adding new groups as needs are identified.<br><br>**Findings:**<br>According to the Mall Director, WRPTs continue to use the Group Activity Request Forms when group needs are identified. PSH also has instituted Individual Request Forms with which individuals can request new groups. However, the Mall Director continues to have difficulty meeting the requests for additional groups due to provider shortage. As shown above, most disciplines still do not provide the necessary hours of service to meet group needs.<br><br>**Current recommendations**:<br>1. Ensure that all disciplines facilitate a specified minimum number of hours of Mall groups.<br>2. All Mall sessions must be 50 minutes in length. Sessions less than that duration do not contribute to an individual's active treatment hours.<br>3. Provide groups as needed by the individuals and written in the individuals' WRPs, adding new groups as needs are identified. |
| C.2.i.ix | is provided to individuals in bed-bound status in a manner and for a period that is | **Current findings on previous recommendations:** |

| | | |
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| | commensurate with their medical status; | **Recommendations 1 and 2, December 2008:**<br>• Ensure that bed-bound individuals are included in the planning and implementation of appropriate activities commensurate with their cognitive status and medical, health, and physical limitations.<br>• Ensure that therapy for individuals who are unable to ambulate or be transferred can be provided in any physical location within the hospital as long as the services are structured and consistent with scheduled Mall activities.<br><br>**Findings:**<br>PSH did not have any bed-bound individuals to serve during this review period.<br><br>**Current recommendations**:<br>1. Ensure that bed-bound individuals are included in the planning and implementation of appropriate activities commensurate with their cognitive status and medical, health, and physical limitations.<br>2. Ensure that therapy for individuals who are unable to ambulate or be transferred can be provided in any physical location within the hospital as long as the services are structured and consistent with scheduled Mall activities. |
| C.2.i.x | routinely takes place as scheduled; | **Current findings on previous recommendations:**<br><br>**Recommendations 1 and 2, December 2008:**<br>• Implement a more focused Mall program that is regularly scheduled, implemented, and provided within the individual's cognitive, medical, physical and functional status.<br>• Ensure that Mall groups and individual therapies are cancelled rarely, if ever. |

**Findings:**
Documentation and staff interview found that the PSH has restructured the PSR Mall format to address focus of hospitalization and barriers to discharge, as identified by the WRPTs' completion of the PSR Mall Needs Assessment Spring 2009. Mall facilitators now have access to all Mall lesson plans electronically. PSH has developed and implemented a number of focused Mall groups during this review period, including the Fall Risk Prevention group for units U05, U06 and EB11, the Recovery Inspired Skills Enhancement (R.I.S.E.) group to address individuals presenting with cognitive challenges, and the Cognitive Remediation Program.

PSH presented the following data regarding cancellation of Mall groups:

| | 11/08 | 12/08 | 1/09 | 2/09 | 3/09 | 4/09 | Mean |
|---|---|---|---|---|---|---|---|
| Groups scheduled | 1,590 | 1,595 | 1,718 | 1,734 | 1,742 | 939 | 1,553 |
| Groups cancelled | 338 | 360 | 189 | 171 | 40 | 221 | 220 |
| Cancel-lation rate | 21% | 23% | 11% | 10% | 2% | 24% | 15% |

The mean cancellation rate for this review period was 15%, compared to 11% in the previous review period.

**Recommendation 3, December 2008:**
Ensure that all disciplines facilitate a specified minimum number of hours of Mall groups.

**Findings:**
See Findings for Recommendation 1, C.2.i.viii.

**Current recommendations**:
1. Implement a more focused Mall program that is regularly scheduled,

| | | |
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| | | implemented, and provided within the individual's cognitive, medical, physical and functional status.<br>2. Ensure that Mall groups and individual therapies are cancelled rarely, if ever.<br>3. Ensure that all disciplines facilitate a specified minimum number of hours of Mall groups. |
| C.2.i.xi | includes, in the evenings and weekends, additional activities that enhance the individual's quality of life; and | **Current findings on previous recommendations:**<br><br>**Recommendations 1-3, December 2008:**<br>• Develop a list of all enrichment activities available along with names of staff competent in facilitating the activities in accordance with generally accepted professional standards of care.<br>• 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.<br>• Ensure that there is uniformity in the methodology and process of how the groups are organized and managed.<br><br>**Findings:**<br>PSH has focused its efforts to improve the state of enrichment activities offered at the facility and made strong advances during this review period. In February, 2009, a Supplemental Activities Coordinator was appointed with three Rehabilitation Therapists to make up the Supplemental Activities Team. The new team has conducted numerous activities, including the following:<br><br>• Developed staff training material;<br>• Tested WaRMSS tracking;<br>• Developed Supplemental Activity Organizational Plan;<br>• Conducted hospital-wide interest survey;<br>• Procured incentive supplies, Recreation Center and activity equipment; |

- Launched "Good Morning Patton" Radio Show and "Patton Idol Show";
- Established "Community Information Centers";
- Developed lesson plans; and
- Trained PM shift employees on using rosters for tracking attendance and facilitating activities.

The facility provided the following data regarding enrichment activities:

| | 11/08 | 12/08 | 1/09 | 2/09 | 3/09 | 4/09 | Mean |
|---|---|---|---|---|---|---|---|
| Hours scheduled | 442 | 489 | 359 | 335 | 428 | 434 | 415 |
| Hours offered | 398 | 441 | 324 | 302 | 386 | 392 | 374 |
| Compliance rate | 90% | 90% | 90% | 90% | 90% | 90% | 90% |

Comparative data showed improvement in compliance from 86% in the previous review period.

This monitor's documentation review and interview with individuals found that individuals are informed about the enrichment activities and are encouraged by unit staff to participate in the activities. Documentation review and interview of the Enrichment Activity Coordinator found that the program is receiving the necessary attention to fulfill the needs of individuals, especially in the evening and on weekends. The facility should consider making the coordinator's position a full-time position for consistency and continued growth of the program.

**Current recommendations**:

1. Develop a list of all enrichment activities available along with names of staff competent in facilitating the activities in accordance with generally accepted professional standards of care.
2. Plan and organize these activities such that there is minimal

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<td>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.<br>3. Ensure that there is uniformity in the methodology and process of how the groups are organized and managed.</td>
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<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:<br><br>
Recommendation 1, December 2008:<br>
All WRPs should have therapeutic milieu interventions clearly specified in the intervention sections.<br><br>
Findings:<br>
A review of the charts of seven individuals found that one (AAN) contained milieu interventions that were not aligned with the active interventions, and there were no milieu interventions in the remaining six charts (ATM, LTH, CK, DJW, EV, and VF).<br><br>
Recommendation 2, December 2008:<br>
Ensure that unit staff reinforces individuals appropriately during Mall group activities as well as in the units.<br><br>
Findings:<br>
Using the Therapeutic Milieu Observation Monitoring Form, PSH assessed its compliance based on observations of an average sample of 94% of the units in the facility. The following table summarizes the facility's data:
<table>
<tr><td>1.</td><td>During the 30-min observation, there is more staff in the milieu than in the nursing station.</td><td>83%</td></tr>
<tr><td>2.</td><td>There is some staff interacting (e.g., engaged in conversation or activity) with individuals.</td><td>65%</td></tr>
<tr><td>3.</td><td>There is evidence of a unit recognition program.</td><td>72%</td></tr>
<tr><td>4.</td><td>The posted unit rules reflect recovery language and</td><td>57%</td></tr>
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| | | |
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| | *principles.* | |
| 5. | *The bulletin boards have any postings, literature, or materials that reflect religious or cultural activities.* | 66% |
| 6. | *Staff interacts with individuals, discusses various subjects, and refrains from openly discussing confidential subject matter.* | 96% |
| 7. | *Staff is observed actively engaged with the individuals.* | 74% |
| 8. | *Staff interacts with individuals in a respectful manner.* | 96% |
| 9. | *Situations involving privacy occurred and they were properly handled.* | 99% |
| 10. | *1If during the observation period, there is a situation in which one or more individuals are escalating, and staff reacts calmly.* | 99% |

The facilitators in the Mall groups observed by this monitor reinforced the individuals appropriately. The WRPT members in the WRPCs observed by this monitor also reinforced the individuals appropriately for their participation in their Mall group activities.

**Current recommendations**:
1. All WRPs should have therapeutic milieu interventions clearly specified in the intervention sections.
2. Ensure that unit staff reinforces individuals appropriately during Mall group activities as well as in the units.

| | | |
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| C.2.j | Adequate, individualized group exercise and recreational options are provided, consistent with generally accepted professional standards of care. | **Current findings on previous recommendations:**<br><br>**Recommendations 1-4, December 2008:**<br>• Establish group exercises and recreational activities for all individuals.<br>• Track and review participation of individuals in scheduled group exercise and recreational activities. |

- Provide training to Mall facilitators to conduct the activities appropriately.
- Implement corrective action if participation is low.

**Findings:**
The facility presented the following data:

| Exercise Groups Offered vs. Needed | | | | | | |
|---|---|---|---|---|---|---|
| | Sep | Oct | Nov | Dec | Jan | Feb |
| Number of groups offered | 157 | 157 | 174 | 178 | 178 | 180 |
| Number of groups needed | 65 | 65 | 80 | 80 | 80 | 80 |
| Ratio of offered/needed | 2.4x | 2.4x | 2.2x | 2.2x | 2.2x | 2.3x |

As shown in the table above, PSH offers many opportunities for all individuals to participate in exercise groups. However, as seen in the table below, not all individuals with high BMIs are enrolled in exercise groups. WRPTs should ensure that all individuals with high BMIs are enrolled in one or more exercise groups.

| BMI Level | Individuals in each category | Individuals assigned to exercise groups | Percentage assigned |
|---|---|---|---|
| 25 - 30 | 494 | 338 | 68% |
| 31 - 35 | 278 | 193 | 69% |
| 36 - 40 | 123 | 79 | 64% |
| >40 | 60 | 41 | 68% |

PSH did not present any WRPT and facilitator training plans for the low assignment of individuals with high BMIs.

| | | |
|---|---|---|
| | | **Compliance:**<br>Partial.<br><br>**Current recommendations**:<br>1. Establish group exercises and recreational activities for all individuals.<br>2. Provide training to Mall facilitators to conduct the activities appropriately.<br>3. Track and review participation of individuals in scheduled group exercise and recreational activities.<br>4. 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 recommendation:**<br><br>**Recommendation, December 2008:**<br>Continue to provide family services as needed.<br><br>**Findings:**<br>Social Work staff has been very active over the last six months of this review period. The activities carried out by SW include:<br><br>• Reorganized monthly family psychoeducational workshops to address relationship issues with families and the hospital staff to enhance the recovery process, to help the families learn coping skills with their family members regarding mental illness, and to reduce guilt and shame and improve interactions between family members to create an optimal social environment for recovery after discharge.<br>• Held the second annual "Choices in Recovery" symposium for individuals, family, staff and friends.<br>• In May, SW staff enrolled in the 10-week Family to Family Training provided by Orange County NAMI.<br>• Presented to the California Mental Health Planning Council's Adult System of Care Sub-Committee on "*Knowledge Brings Hope: Family Psychoeducation.*" |

- Developed a webpage in the PSH website on "Families and Friends: An Important Member of the Team."
- Trained Social Workers on resources available to families and WRPTs.
- Trained all social work staff on "Joining with Individuals and Families: A Family Psychoeducation Approach."
- Developed numerous Mall groups: Sharing Stories of Family, Family Film Festival Therapy, Family Dynamics and Addiction, Institutional Parenting and Addiction and Recovery, and Bridging the Parenting Gap between Inpatient Setting and the Community.
- Provided monthly presentations following Patton NAMI meetings November through February.

Using the DMH C2k Family Therapy Auditing Form, PSH assessed its compliance based on an average sample of 100% of individuals with an assessed need for family therapy services and a signed release for family contact:

| | | |
|---|---|---|
| 1. | *Admission: General family education is provided to the family. SW has assessed the family's ability and willingness to be involved, and has identified and documented barriers to family involvement.* | 98% |
| 2. | *Long-Term: Efforts to involve the family, and continuing efforts and outcomes of attempts to decrease barriers to family involvement are documented in the Present Status, and Focus 11 contains an objective that prepares the individual for his or her role within their family system.* | 49% |
| 2.a | *There is documentation in the Present Status section of efforts to involve the family in the individual's WRPC and Recovery.* | 49% |
| 2.b | *In the individual's WRP, Focus 11 contains an objective that prepares the individual for his or her role within their family system, and* | 48% |

| | | |
|---|---|---|
| 2.c | *There is documentation in the Present Status section that the identified barriers have decreased or there is evidence of continuing efforts to decrease the barriers.* | 49% |
| 3. | *Discharge: There is documentation in the Medical Record that family consultation and counseling was provided, the family was provided the individual's Social Work Recommended Continuing Care Plan, and information was provided to the family on community resources.* | 50% |
| 3.a | *Family consultation and counseling was provided in preparation for discharge.* | 50% |
| 3.b | *The family was provided the individual's Social Work Recommended Continuing Care Plan, which includes aftercare plan, and* | 75% |
| 3.c | *Information was provided to the family on community resources.* | 50% |

Comparative data indicated mixed changes in compliance since the previous review period:

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 1. | 78% | 98% |
| 2. | 0% | 49% |
| 3. | 100% | 58% |
| Compliance rate in last month of period | | |
| 2. | 0% | 98% |
| 2.a | 29% | 100% |
| 2.b | 5% | 93% |
| 2.c | 10% | 100% |

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<tr><td>3</td><td>100%</td><td>100%</td></tr>
<tr><td>3.a</td><td>100%</td><td>100%</td></tr>
<tr><td>3.b</td><td>100%</td><td>100%</td></tr>
<tr><td>3.c</td><td>100%</td><td>100%</td></tr>
</table>
<br>
Staff training on item 2 remains to be accomplished. To improve compliance, Social Work intends to track referrals and family contacts and ensure that the information is included in the individual's WRP, and to arrange for notification when an individual is being discharged to ensure that the SW staff is able to provide the individual's family with information.<br><br>
Compliance:<br>
Substantial.<br><br>
Current recommendation:<br>
Continue to provide family services as needed.
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<tr>
<td>C.2.l</td>
<td>Each individual's therapeutic and rehabilitation service plan identifies general medical diagnoses, the treatments to be employed, the related symptoms to be monitored by nursing staff (i.e., registered nurses ["RNs"], licensed vocational nurses ["LVNs"] and psychiatric technicians) and the means and frequency by which such staff shall monitor such symptoms, consistent with generally accepted professional standards of care.</td>
<td>
Current findings on previous recommendations:<br><br>
Recommendation 1, December 2008:<br>
Implement strategies to increase compliance with this requirement.<br><br>
Findings:<br>
Data and findings indicate that current strategies have not been effective to adequately increase compliance with this requirement.<br><br>
Recommendation 2, December 2008:<br>
Increase sample size (20%) for audits regarding items 1-5.<br><br>
Findings:<br>
This recommendation has not yet been addressed; the sample size for this requirement remains low (13%).
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**Recommendation 3, December 2008:**
Continue to monitor this requirement.

**Findings:**
Using the DMH Integration of Medical Conditions in WRP Audit, PSH assessed its compliance based on a 13% mean sample of individuals with at least one Axis III diagnosis who had a WRP due during the review months (November 2008 - April 2009):

| | | |
|---|---|---|
| 1. | *All medical conditions listed on Axis III are included on the Medical Conditions Form.* | 61% |
| 2. | *The WRP includes each medical condition listed on the Medical Conditions Form 42.* | 57% |
| 2.a | *Each medical condition or diagnosis listed on the Medical Conditions form has a focus statement.* | 49% |
| 2.b | *Each medical condition or diagnosis listed on the Medical Conditions form has at least one objective.* | 62% |
| 2.c | *Each medical condition or diagnosis listed on the Medical Conditions form has at least one intervention.* | 61% |
| 3. | *There is an appropriate focus statement for each medical condition or diagnosis.* | 11% |
| 4. | *There is an appropriate objective for each medical condition or diagnosis.* | 41% |
| 4.a | *Each current medical condition or problem has at least one objective.* | 53% |
| 4.b | *The objective is written in observable, measurable and/or behavioral terms as to what the individual will do.* | 15% |
| 4.c | *The objective leads to improvement in the individual's quality of life.* | 56% |
| 5. | *There are appropriate interventions for each objective.* | 25% |

| | | |
|---|---|---|
| 5.a | *Each objective related to current medical problem has at least one intervention.* | 65% |
| 5.b | *The intervention includes the related symptoms to be monitored by nursing staff for each condition.* | 12% |
| 5.c | *The intervention specifies the means by which the staff will monitor these symptoms for each condition.* | 11% |
| 5.d | *The intervention specifies the frequency by which staff will monitor these symptoms for each condition.* | 9% |
| 5.e | *The intervention identifies staff to perform these interventions by title.* | 26% |

Comparative data indicated only modest changes in compliance since the previous review period:

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 1. | 64% | 61% |
| 2. | 56% | 57% |
| 3. | 5% | 11% |
| 4. | 8% | 41% |
| 5. | 21% | 25% |
| Compliance rate in last month of period | | |
| 1. | 61% | 66% |
| 2. | 50% | 59% |
| 2.a | 52% | 50% |
| 2.b | 58% | 63% |
| 2.c | 57% | 63% |
| 3. | 9% | 15% |
| 4. | 8% | 46% |

| | | |
|---|---|---|
| 4.a | 50% | 54% |
| 4.b | 8% | 20% |
| 4.c | 8% | 63% |
| 5. | 0% | 30% |
| 5.a | 59% | 61% |
| 5.b | 8% | 22% |
| 5.c | 5% | 22% |
| 5.d | 5% | 19% |
| 5.e | 17% | 28% |

A review of the WRPs of 40 individuals (AAG, AAN, BJ, BJC, CDP, CMR, CS, DCS, DJ, DSC, EAS, EEG, EJB, EM, ES, EV, GFW, JA, JAO, JJG, JOD, LCB, LM, LMG, MAW, MGM, PMA, RB, RLR, RMM, RP, RWM, SDG, SE, SR, TSS, VFP, VRE, VV and WSB) found that there has been minimal improvement in this area from the last review. Problematic areas continue to include inadequate and inappropriate nursing objectives and interventions. The only improvement noted was related to infectious diseases addressed in the WRPs. In addition, there was little to no evidence in the IDNs that any of the interventions listed in the WRPs were actually being implemented.

PSH also assessed its compliance using the DMH Integration of Medical Conditions in WRP audit, based on an average sample of 28% of individuals scheduled for but refusing to receive medical procedure(s), including laboratory tests, during the review months:

| | | |
|---|---|---|
| 6. | *Each State hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to overcome individual's refusals of medical procedures.* | 34% |
| 6.a | *Refusals are documented in the Present Status section of the Case Formulation in the individual's WRP.* | 24% |
| 6.b | *When a pattern of refusal is evident or there is potential for adverse outcome, there are* | 44% |

| | | |
|---|---|---|
| | *objectives and interventions dealing with the refusal in the individual's WRP.* | |

Comparative data indicated modest changes in compliance since the previous review period.

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 6. | 21% | 34% |
| Compliance rate in last month of period | | |
| 6. | 14% | 22% |
| 6.a | 26% | 17% |
| 6.b | 54% | 26% |

The data for this EP requirement demonstrate that there continue to be significant deficiencies in the adequacy of Focus 6 goals, objectives and interventions as well as in the tracking of and response to treatment refusals. Identified barriers to compliance included the following:

1. Despite trainings, many of the RNs are not comfortable using the WaRMSS system.
2. Only one RN is designated to be immune from floating to other units; thus, it is difficult to ensure consistent documentation.
3. The lack of time for RNs to do the necessary documentation affects the quality of documentation, especially on the day shift.
4. Many of the RNs have limited computer skills.
5. Currently, there is not an adequate system for tracking and responding to treatment refusals.

The plan of action includes a facility-wide project starting in July 2009 to address all individuals' Focus 6 issues while providing direct hands-on

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| | | training in the use of WaRMSS. This project will have three elements intended to facilitate increases in compliance: practical didactic instruction; hands-on use of the WaRMSS system and revising WRPs using mentors/coaches; and distribution of examples of care plan templates for the more common medical problems. In addition, in May, 2009, the acting director of nursing proposed dedicating at least two RNs on chronic units and 3 RNs on acute units to ensure some measure of consistency. Also, the facility is evaluating the option of delegating the updating of Focus 6 nursing care plans to RNs on evening shifts and weekends and increasing the training for computer skills. Regarding refusals, a Refusal of Medical Treatment protocol and policy has been approved by the medical staff and was forwarded on May 27, 2009 to PSH administration. This will be given an expedited review and administrative policies will be formalized and implemented no later than July 2009.<br><br>See also F.9.e for reviewer's findings.<br><br>**Compliance:**<br>Partial.<br><br>**Current recommendations**:<br>1. Increase sample size (20%) for audits regarding items 1-5.<br>2. Implement strategies as noted above to increase compliance with this requirement.<br>3. Continue to monitor this requirement. |
| C.2.m | The children and adolescents it serves receive, consistent with generally accepted professional standards of care: | Not applicable. PSH does not serve children or adolescents. |
| C.2.m.i | Therapy relating to traumatic family and other traumatic experiences, as clinically indicated; and | |

| | | |
|---|---|---|
| C.2.m.ii | reasonable, clinically appropriate opportunities to involve their families in treatment and treatment decisions. | |
| C.2.n | Policies and procedures are developed and implemented consistent with generally accepted professional standards of care to ensure appropriate screening for substance abuse, as clinically indicated. | **Current findings on previous recommendations:**<br><br>**Recommendation 1, December 2008:**<br>Provide summary information regarding specific actions taken as part of the implementation of the improvement plan.<br><br>**Findings:**<br>PSH's initial Substance Abuse screening is carried out via the DMH Admission Psychiatric Assessment in the DMH Integrated Assessment: Psychiatry Section. Those found to be at the contemplative stage or higher in the screening stage are further assessed using the ASI. Documentation review and interview of the SAR Coordinator found that the following actions have been taken as part of the improvement plan:<br><br>• Trained and certified 69 of the 118 SAR providers from November 2008 through April 2009. An additional 29 were trained in May 2009 and the remaining 20 are scheduled to be trained in June 2009. Training was based on the trans-theoretical model of stages of change.<br>• All individuals at PSH with substance-related disorders on Axis I were staged by the Substance Abuse Assessment Team (SAAT) and the results were shared with WRPTs for Mall referral consideration.<br>• Developed Substance Abuse Recovery Mall stratified by stage of change and cognitive functioning.<br><br>**Compliance:**<br>Substantial. |

| | | |
|---|---|---|
| | | **Current recommendation**:<br>Provide summary information regarding specific actions taken as part of the implementation of the improvement plan. |
| C.2.o | Individuals who require treatment for substance abuse are provided appropriate therapeutic and rehabilitation services consistent with generally accepted professional standards of care. | **Current findings on previous recommendations:**<br><br>**Recommendation 1, December 2008:**<br>Provide an outline of the training provided to WRPTs and SAS providers during this reporting period.<br><br>**Findings:**<br>Review of documentation and interview of the SAR coordinator found the following activities regarding the training to SAS providers:<br><br>1. Substance abuse overview involving neurobiology, genetics and epidemiology;<br>2. Specific SA overviews (medical complications of abuse): alcohol, sedative hypnotics, cocaine, methamphetamines, hallucinogens and club drugs, inhalants, nicotine and tobacco, opioids and anabolic steroids;<br>3. Stages of Change;<br>4. Addiction Severity Index (ASI): theory, validity, reliability regarding the screening instrument, scoring and practical sessions;<br>5. Patient Placement Criteria (ASAM PPC 2nd. Edition);<br>6. Motivational Enhancement Therapy: theory, MET practical principles, ME interviewing, ME treatment objective and skills in different stages;<br>7. Matrix Model of treatment;<br>8. Cognitive Behavioral treatment: functional analysis, cognitive restructuring, skill training, relapse prevention<br>9. TSF (Twelve-Step Facilitation);<br>10. Project MATCH;<br>11. Contingency Management (theory and application);<br>12. Modified Therapeutic Community Model: enhancing social development, community integration, discharge planning; |

| | | |
|---|---|---|
| | | 13. Group therapy (theory and process);<br>14. Supportive psychodynamic continuum;<br>15. Drug testing;<br>16. Co-occurring mental illness and substance abuse (dual diagnosis);<br>17. Addiction treatment in a forensic setting;<br>18. Women and addiction;<br>19. HCV/HIV;<br>20. Prescription drug abuse;<br>21. Cultural aspects of addiction treatment; and<br>22. Spiritual aspects of recovery.<br><br>A post-test was used to assess competency and determine Certification eligibility. Training to WRPT members was limited to those who provided SA groups. PSH intends to conduct a complete inventory of the WRPT substance abuse providers who received the training, and to enable them to be trainers for their WRPTs for staging of the SA individuals cared for by their teams. WRPTs without a trained team member will send a representative for training.<br><br>**Recommendation 2, December 2008:**<br>Provide process and clinical outcome data and specify how clinical outcomes were determined if more than one mechanism was used to determine the outcome.<br><br>**Findings:**<br>PSH provided the following data:<br><br><u>Process Outcomes</u><br>1. 1053 individuals identified to have substance-related disorders in PSH were staged by the SAAT. The data were provided to WRPTs for placement of individuals in the SA groups provided in the Mall catalogue. Examples of potential objectives of the different stages of change were distributed to the WRPTs as a guideline for listing at least one |

| | | |
|---|---|---|
| | | objective and one intervention currently linked to their stage of change.<br>2. Ninety-eight SA group providers were trained to competency in the SR curriculum and exhibit an appropriate level of competency.<br>3. One-hundred and eighty-three SA Mall groups were put in place. Sixty-six of these groups had double sessions, and four groups were for four sessions each.<br><br><u>Clinical Outcomes</u><br>'Decisional Balance' - Drug and Alcohol Use is a measure to assess an individual's subjective evaluation of the pros and cons of engaging in the problem behavior versus changing. PSH draws this importance of a decision balance consideration based on a study by Bellack and DiClemente (1999). This concept was a part of the SAR provider training. PSH plans to re-administer the 'Decision Balance' at the end of the Mall group cycle to evaluate the individual's subjective evaluation of change.<br><br>PSH uses the Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES) as the Processes of Change measures. PSH used the SOCRATES to determine the initial staging of 1053 individuals identified to have substance related disorders in PSH.<br><br>Therapists' progress reports at the end of the Mall group cycle will report the pre- and post-group data from the SOCRATES and Decisional Balance instruments. The data will be used in conjunction with the therapist's clinical impressions to arrive at the final outcome of the individual's stage of change. The data is to be reported to the Focus 5 coordinator and advisor and to be used as ongoing evaluation of the clinical treatment process.<br><br>**Recommendations 3 and 4, December 2008:**<br>• Monitor this requirement using the DMH Substance Abuse Auditing Form based on at least a 20% sample.<br>• Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and |

compared to the last period).

**Findings:**
Using the DMH WRP Substance Abuse Auditing form, PSH assessed its compliance based on an average sample of 14% of individuals with a current diagnosis of substance abuse as listed in the WRP, Integrated Assessment: Psychiatric Section or, if admitted before January 2008, the last monthly Psychiatric Progress Note:

| | | |
|---|---|---|
| 1. | *Substance abuse is integrated into the case formulation and discussed in the present status.* | 81% |
| 2. | *There is an appropriate focus statement listed under Focus 5.* | 64% |
| 3. | *There is at least one objective related to the individual's stage of change.* | 54% |
| 4. | *There are interventions that are appropriately linked to the active objective(s).* | 71% |
| 5. | *The active treatment for substance abuse that is specified in the WRP is aligned with the individual's Mall schedule.* | 63% |
| 6. | *The discharge criteria related to substance abuse are individualized and written in behavioral, observable and/or measurable terms.* | 35% |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 1. | 31% | 81% |
| 2. | 42% | 64% |
| 3. | 13% | 54% |

| | | |
|---|---|---|
| | | 4. 25% 71%<br>5. 60% 63%<br>6. 13% 35%<br>Compliance rate in last month of period<br>1. 37% 90%<br>2. 54% 75%<br>3. 17% 66%<br>4. 38% 83%<br>5. 60% 70%<br>6. 20% 52%<br><br>**Compliance:**<br>Partial.<br><br>**Current recommendations:**<br>1. Provide an outline of the training provided to WRPTs and SAS providers during this reporting period.<br>2. Provide process and clinical outcome data and specify how clinical outcomes were determined if more than one mechanism was used to determine the outcome.<br>3. Monitor this requirement using the DMH Substance Abuse Auditing Form based on at least a 20% sample.<br>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). |
| 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 | **Current findings on previous recommendations:**<br><br>**Recommendations 1 and 2, December 2008:**<br>• Monitor the competency of group facilitators and therapists in providing rehabilitation services.<br>• Ensure that providers have education, training and experience appropriate to the scope and complexity of services provided. |

| | | |
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| | individuals' responses to therapy and rehabilitation, and receive regular, competent supervision. | **Findings:**<br>Documentation review and interview of the Mall Director found that the DMH PSR Mall Facilitator Observation audit tool was implemented recently. Training on this tool was conducted by the Medical Director for the Discipline Seniors, Standards Compliance Auditors, and Enhancement Services Focus Coordinators. PSH now audits 20% of the Mall facilitators on monthly basis.<br><br>Using the DMH Mall Facilitator Observation Monitoring Form PSH assessed compliance from observation of a 7% sample of all facilitators during the review months (November 2008 – April 2009): |

| | | |
|---|---|---|
| 1. | *Session starts and ends within five minutes of the designated starting and ending time.* | 69% |
| 2. | *Facilitator greets participants to begin the session.* | 94% |
| 3. | *There is a brief review of work from prior session.* | 69% |
| 4. | *Facilitator introduces the day's topic and goals.* | 90% |
| 5. | *Facilitator shows familiarity with lesson plan either verbally or as demonstrated during the group session.* | 80% |
| 6. | *Facilitator attempts to engage each participant in the session.* | 91% |
| 7. | *Facilitator attempts to keep all participants "on task" during the session.* | 94% |
| 8. | *Facilitator shows a presentation style that keeps some/all participants attentive and interested during the session.* | 95% |
| 9. | *Facilitator attempts to test the participants understanding.* | 86% |
| 10. | *Facilitator presents information in a manner appropriate to the functioning level of the participants.* | 95% |
| 11. | *The facilitator summarizes the work done in the* | 75% |

| | | |
|---|---|---|
| | session. | |
| 12. | *Facilitator/Co-facilitator used at least one of the following: modeling, prompting and coaching, positive reinforcement, shaping, behavioral rehearsal/role play, homework, or multimedia instruction.* | 93% |
| 13. | *The room is arranged in a way that is as conducive to learning as possible.* | 88% |
| 14. | *Lesson plan is available and followed.* | 67% |
| 14.a | *The facilitator has the lesson plan available during the group.* | 66% |
| 14.b | *The lesson plan is followed in the group.* | 68% |

This monitor's observation of Mall groups found the facilitators to be well-prepared, engaging, organized and using multiple presentation methods and teaching strategies. Even the substitute providers were prepared and facilitated the groups as if they were the regular providers. In one group, the co-provider completed the individuals' participation, time in the group, and points at the beginning of the group.

**Compliance:**
Partial.

**Current recommendations**:
1. Monitor the competency of group facilitators and therapists in providing rehabilitation services.
2. Ensure that providers have education, training and experience appropriate to the scope and complexity of services provided.

| | | |
|---|---|---|
| C.2.q | Group facilitators and therapists providing therapeutic and rehabilitation services in the field of substance abuse should be certified substance abuse counselors. | **Current findings on previous recommendations:**<br><br>**Recommendations 1 and 2, December 2008:**<br>• Ensure that all group facilitators complete the substance abuse training curriculum. |

- Ensure that providers serving individuals at the pre-contemplation stage are trained to competency and meet substance abuse counseling competency.

**Findings:**
According to the Substance Abuse Recovery (SAR) Coordinator, group facilitators complete the SA training curriculum. The providers to individuals at the pre-contemplation stage are trained to competency following the facility's curriculum.

PSH presented the following data regarding the certification of Substance Abuse facilitators:

| | |
|---|---|
| Number of SAR providers/co-providers | 118 |
| Number of certified SAR providers/co-providers | 98 |
| Percentage of SAR providers/co-providers who are certified | 83% |

The table below shows the number of SA group facilitators and co-facilitators (N), the number trained and certified (n), and the percent compliance (%C) is a summary of the facility's data:

| Substance Abuse Group Facilitators and Co-Facilitators | | | | | | | |
|---|---|---|---|---|---|---|---|
| | 11/08 | 12/08 | 1/09 | 2/09 | 3/09 | 4/09 | Mean |
| N | 101 | 101 | 93 | 104 | 104 | 118 | 105 |
| n | 12 | 12 | 12 | 12 | 37 | 69 | 41 |
| %C | 12 | 12 | 13 | 13 | 36 | 66 | 39 |

**Compliance:**
Substantial.

**Current recommendations:**
1. Ensure that all group facilitators complete the substance abuse training curriculum.

| | | |
|---|---|---|
| | | 2. Ensure that providers serving individuals at the pre-contemplation stage are trained to competency and meet substance abuse counseling competency. |
| C.2.r | Transportation and staffing issues do not preclude individuals from attending appointments. | **Current findings on previous recommendations:**<br><br>**Recommendations 1 and 2, December 2008:**<br>• Establish an automated system to track cancellation of scheduled appointments.<br>• Ensure that all appointments are completed.<br><br>**Findings:**<br>PSH still is awaiting completion of the WaRMSS scheduler to automate the tracking of cancelled appointments. The facility provided the following data regarding cancellations: |

| Missed Appointments Monitoring – Medical Services | | | |
|---|---|---|---|
| Month | Appointments | | Reasons for Cancellation |
| | Scheduled | Cancelled | |
| Sep 08 | 1366 | 70 | 70 staffing<br>0 transportation<br>0 other |
| Oct 08 | 369 | 7 | 7 staffing<br>0 transportation<br>0 other |
| Nov 08 | 344 | 33 | 33 staffing<br>0 transportation<br>0 other |
| Dec 08 | 271 | 14 | 14 staffing<br>0 transportation<br>0 other |
| Jan 09 | 218 | 14 | 14 staffing<br>0 transportation<br>0 other |

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<tr><td>Feb 09</td><td>323</td><td>14</td><td>13 staffing<br>1 transportation<br>0 other</td></tr>
<tr><td>Total</td><td>2,891</td><td>152</td><td>151 staffing<br>1 transportation</td></tr>
</table>
<br>
As the table above indicates, cancellations were primarily due to staffing issues. Transportation was only an issue for one cancellation. According to the Mall Director, staffing issues for internal appointments mainly arise due to staff not remembering the appointment and to poor planning and scheduling. The facility apparently does not have any such problems for external appointments.<br><br>
Compliance:<br>
Partial.<br><br>
Current recommendations:<br>
1. Establish an automated system to track cancellation of scheduled appointments.<br>
2. Ensure that all appointments are completed.
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<tr>
<td>C.2.s</td>
<td>Adequate oversight to treatment, rehabilitation and enrichment groups is provided to ensure that individuals are assigned to groups that are appropriate to their assessed needs, that groups are provided consistently and with appropriate frequency, and that issues particularly relevant for this population, including the use of psychotropic medications and substance abuse, are appropriately addressed, consistent with generally accepted professional standards of care.</td>
<td>
Current findings on previous recommendations:<br><br>
Recommendation 1, December 2008:<br>
Ensure that individuals' cognitive levels, needs and strengths are utilized when considering group assignments.<br><br>
Findings:<br>
WRPTs have started using the cognitive screening data from the Integrated Assessment: Psychology section, and the Mall course cognitive level indicators to assign individuals to Mall groups. However, not all Mall groups have sessions for each of the three cognitive levels and so in some cases, there is not a cognitively appropriate group to which a WRPT can assign an
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individual. This situation is exacerbated by disciplines not providing Mall services for their required hours.

Using the DMH WRP Clinical Chart Auditing Form, PSH assessed its compliance based on an average sample of 11% of the WRPs due each month during the review period (November 2008 – April 2009):

| | | |
|---|---|---|
| 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.* | 58% |
| 10.a | *The individual's cognitive functioning level, needs, and strengths (as documented in the case formulation) are aligned with the group assignments.* | 71% |
| 10.b | *For each Axis I, II and III diagnoses, the interventions are related to excesses and deficits associated with each diagnosis.* | 45% |

Comparative data indicated mixed changes in compliance since the previous review period:

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 10. | 63% | 58% |
| Compliance rate in last month of period | | |

| | | |
|---|---|---|
| 10. | 64% | 55% |
| 10.a | 64% | 96% |
| 10.b | 90% | 14% |

A review of the WRPs for ten individuals found five individuals were assigned to meaningful groups in line with their diagnoses and cognitive levels (DH, DT, RH, TK and TS). The remaining five individuals (JAM, JC, JR, RL and SM) were not assigned to appropriate groups corresponding to their diagnoses, needs, and/or cognitive levels, or the groups listed in the interventions were not listed in the individuals' Mall schedules.

**Recommendation 2, December 2008:**
Ensure that providers and facilitators are knowledgeable, competent and motivated to translate course content to meet individuals' needs.

**Findings:**
The providers of the Mall groups observed by this monitor had lesson plans for the topics of the day. They were knowledgeable regarding course content and showed enthusiasm and motivation in facilitating the groups. In all cases, the facilitators had appropriate teaching/instructional material, and used a variety of presentation methods and teaching strategies.

**Recommendation 3, December 2008:**
Ensure that progress notes are written in a timely fashion and made available to the individual's WRPT.

**Findings:**
See Findings in C.2.i.vii.

**Compliance:**
Partial.

| | | |
|---|---|---|
| | | **Current recommendations**:<br>1. Ensure that individuals' cognitive levels, needs and strengths are utilized when considering group assignments.<br>2. Ensure that providers and facilitators are knowledgeable, competent and motivated to translate course content to meet individuals' needs. |
| C.2.t | Treatment, rehabilitation and enrichment services are monitored appropriately against rational, operationally defined target variables and revised as appropriate in light of significant developments, and the individual's progress, or lack thereof; | **Current findings on previous recommendations:**<br><br>**Recommendations 1 and 2, December 2008:**<br>• Implement and monitor PSH Mall Facilitator Monthly Progress Notes.<br>• Ensure that WRPTs review PSH Mall Facilitator Monthly Progress Notes, document individual progress or lack thereof, and discuss the findings with the individual.<br><br>**Findings:**<br>PSH has implemented the Monthly Mall progress notes. PSH's monitoring data presented in the previous cell indicated that only about 28% of the Mall progress notes are currently being written and/or being delivered to the WRPTs in a timely manner. The monitor's findings from review of charts are aligned with the facility's data. When Mall notes are available, WRPTs do not consistently review the notes to update the Present Status section and/or modify the individual's objectives and interventions based on the individual's progress (for example, EV and VF).<br><br>Using the DMH WRP Clinical Chart Auditing Form, PSH assessed its compliance based on an average sample of 11% of the WRPs due each month during the review period (November 2008 – April 2009):<br><br>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)* — 49% |

| | | |
|---|---|---|
| 11.a | *Each objective is observable, measurable and behavioral.* | 69% |
| 11.b | *All groups and individual therapies are linked directly to the foci, objective and interventions specified in the individual's WRP.* | 82% |
| 11.c | *There is a DMH PSR Mall Facilitator Monthly Progress Note for each active treatment in the individual's WRP.* | 5% |
| 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.* | 16% |
| 11.e | *If the individual has met the objective, a new objective and related interventions have been developed and implemented.* | 72% |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 11. | 2% | 49% |
| Compliance rate in last month of period | | |
| 11. | 0% | 62% |
| 11.a | 9% | 94% |
| 11.b | 18% | 94% |
| 11.c | 0% | 2% |
| 11.d | 10% | 27% |
| 11.e | 50% | 92% |

| | | |
|---|---|---|
| | | A review of the WRPs for five individuals found that two of the WRPs met the elements of this requirement (JR and VV). Notes were available for two other individuals (JMB and RC) but were not incorporated in the WRPs. There were no notes for review for one individual (MG) and a statement to that effect was documented in the Present Status section of the WRP.<br><br>**Compliance:**<br>Partial.<br><br>**Current recommendations**:<br>1. Implement and monitor PSH Mall Facilitator Monthly Progress Notes.<br>2. Ensure that WRPTs review PSH Mall Facilitator Monthly Progress Notes, document individual progress or lack thereof, and discuss the findings with the individual.<br>3. Ensure that the individual's progress is tracked (using the PSH Mall Facilitator Monthly Progress Note) and that participation at different levels and in different groups is adjusted accordingly. |
| C.2.u | Individuals are educated regarding the purposes of their treatment, rehabilitation and enrichment services. They will be provided a copy of their WRP when appropriate based on clinical judgment. | **Current findings on previous recommendations:**<br><br>**Recommendations 1-3, December 2008:**<br>• Provide data regarding the process of post-testing and the number of individuals who have "tested out" of WRP education during the review period.<br>• Provide data regarding the target population and the number of WRP education groups offered to these individuals. Include the number of groups per term, the hours offered and the number of individuals attending and compare to the last review period.<br>• Provide data to support that individuals are provided a copy of their WRPs based on clinical judgment.<br><br>**Findings:**<br>According to the Compliance Director, newly admitted individuals are |

provided a brief 10-module overview of Wellness and Recovery Planning during the New Admission Orientation, and they are provided with the document "WRP: The Process of Self Empowerment." Individuals no longer are tested out of WRP education.

The table below showing the number of individuals needing WRP education group/number of individuals receiving WRP education group is a summary of the facility's data:

| Number of individuals needing and provided WRP education during the current and previous three Mall terms | | | |
|---|---|---|---|
| Jul-Sep 2008 | Oct-Dec 2008 | Jan-Mar 2009 | April 2009 |
| 1,762/1,762 | 1,588/1,588 | 1,646/1,646 | 65/65 |

PSH did not present data on the number of groups and hours of groups offered.

This monitor observed three WRPCs. In all three conferences, the WRPT members asked the individual if s/he would like a copy of the WRP, and delivered a copy of the WRP if the individual wanted one.

**Compliance:**
Partial.

**Current recommendations**:
1. Provide data regarding the target population and the number of WRP education groups offered to these individuals. Include the number of groups per term, the hours offered and the number of individuals attending and compare to the last review period.
2. Provide data to support that individuals are provided a copy of their WRPs based on clinical judgment.

| | | |
|---|---|---|
| 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:**<br><br>**Recommendation 1, December 2008:**<br>Provide data regarding the process of post-testing and the number of individuals who have "tested out" of medication education during the review period.<br><br>**Findings:**<br>PSH reported that it modified its procedure for determining the need for medication education groups during this review period. WRPTs completed the PSR Mall Needs Assessment Spring 2009 for each individual to determine the need for medication education groups.<br><br>**Recommendation 2, December 2008:**<br>Provide data regarding the target population and the number of medication 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.<br><br>**Findings:**<br>For the April-June 2009 quarter, PSH identified 949 individuals in need of medication education groups. The facility reported that 958 individuals were scheduled for a medication education group during the quarter. PSH offered 78 medication education groups for a total of 146 hours of instruction per week. Groups were offered at both the Supported/Assisted and Independent/Advanced levels of cognitive support. The facility did not provide comparative data.<br><br>**Compliance:**<br>Partial.<br><br>**Current recommendation:**<br>Provide data regarding the number of individuals identified as in need of a |

<table>
<tr><td></td><td></td><td>medication education group, the number of individuals scheduled for a medication education group, the number of groups offered and the number of hours offered. Provide comparative data from the previous to current review period for each data element.</td></tr>
<tr><td>C.2.w</td><td>Interdisciplinary teams review, assess, and develop positive clinical strategies to overcome individuals' barriers to participation in therapeutic and rehabilitation services.</td><td>
Current findings on previous recommendations:<br><br>
Recommendations 1-3, December 2008:<br>
• Assess barriers to individuals' participation in their WRPs and provide strategies to facilitate participation.<br>
• Use systematic methods of behavior change, including Motivational Interviewing, Narrative Restructuring Therapy and other cognitive behavioral interventions, to change individuals' attitudes toward participation in assigned groups and individual therapies.<br>
• Present data regarding the number of individuals who were non-adherent to WRP and improve data reliability.<br><br>
Findings:<br>
The table below showing the mean census for the previous and current review periods (N), and the mean number of individuals meeting the non-adherence criteria is a summary of the facility's data:<br><br>
<table>
<tr><td></td><td>May 2008 - October 2008</td><td>November 2008 – April 2009</td></tr>
<tr><td>N</td><td>1144</td><td>1089</td></tr>
<tr><td>n</td><td>943</td><td>878</td></tr>
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<br>
According to the Mall Director, she and the Chief of Psychology have developed a plan to assess barriers to an individual's participation in treatment and to intervene appropriately based on the reasons for non-adherence indicated in the assessment. The assessment plan put into place is as follows:
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| | | |
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| | | 1. Each month, 80 individuals with the lowest level of participation will be identified by Standards Compliance. The individuals' WRPTs will be alerted.<br>2. Within five working days, one or more members of the individual's WRPT will meet with the individual to assess the reasons for their low participation, and revise the WRP accordingly as follows:<br>a) If the assessed reason for low participation is active psychosis or severe depression or anxiety, the psychiatrist will review, and, as appropriate, revise medications and/or seek consultation. The individual will be placed in groups that help address these issues.<br>b) If the assessed reason is a lack of interest in the groups to which the individual is assigned, the WRPT will perform an interest assessment, speak with the individual about which groups would be preferred, and schedule the individual in one or more groups consistent with those interests/preferences.<br>c) If these preferred groups do not exist, the WRPT will complete an electronic copy of the Group Activity Request Form for consideration of by the Mall Director.<br>d) If the assessed reason is lack of motivation or readiness for change, a member of the WRPT will meet with the individual using Motivational Interviewing (MI) techniques. The individual will also be scheduled into an "Enhancing Motivation" group. This group will use MI techniques, cognitive-behavioral strategies, and seek to support and foster hope and a sense of life purpose/meaning as well as gaining a greater sense of life direction and goals. At least one Enhancing Motivation group will be held in each Mall daily.<br>e) If the assessed reason is misplacement of the individual with regard to level of support needed, the individual will be scheduled into groups with a more appropriate level of support.<br>f) If the assessed reason is language, the WRPT will attempt to schedule the individual into at least one group in the individual's language, consult with the Mall Coordinator about the need for more such groups, and schedule the individual into more groups for which |

| | | |
|---|---|---|
| | | language skills are less essential in order to participate in and obtain benefit.<br>g) If there is another assessed reason for the lack of participation, those reasons will be communicated to the WRPT, who will respond as outlined below.<br>3. Once any barrier to participation has been identified, the WRPT will open a new focus of treatment with appropriate objectives and interventions to address the identified barrier to participation. That focus will remain open until the individual participates in over 80% of groups for at least three months. The WRPT will reassess and make adjustments to the WRPT as needed to address this issue until 80%+ participation is reached.<br>4. As a part of this process, WRPT staff, including psychiatrists, psychologists, social workers, rehabilitation therapists and unit supervisors, will receive additional training in Motivational Interviewing and Cognitive Restructuring techniques as they apply to improving treatment participation.<br><br>The data is being collected and no data is available at this time. MAPP II is not on line as of this review period; PSH expects a more reliable count of non-adherence once MAPP II is online.<br><br>The plan outlined above has merit and can be expected to improve adherence to if the plan is carried out with integrity.<br><br>**Compliance:**<br>Partial.<br><br>**Current recommendations**:<br>1. Assess barriers to individuals' participation in their WRPs and provide strategies to facilitate participation.<br>2. Use systematic methods of behavior change, including Motivational Interviewing, Narrative Restructuring Therapy and other cognitive |

| | | |
|---|---|---|
| | | behavioral interventions, to change individuals' attitudes toward participation in assigned groups and individual therapies.<br>3. Present data regarding the number of individuals who were non-adherent to WRP and improve data reliability. |

| D. Integrated Assessments | | |
|---|---|---|
| D | Each State hospital shall ensure that, consistent with generally accepted professional standards of care, each individual shall receive, promptly after admission to each State hospital, an accurate and comprehensive assessment of the conditions responsible for the individual's admission, to the degree possible given the obtainable information at the time of admission. Thereafter, each individual shall receive an accurate and comprehensive reassessment of the reasons for the individual's continued hospitalization whenever there has been a significant change in the individual's status, or a lack of expected improvement resulting from clinically indicated treatment. The individual's interdisciplinary team shall be responsible for investigating the past and present medical, nursing, psychiatric, and psychosocial factors bearing on the individual's condition, and, when necessary, for revising assessments and therapeutic and rehabilitation plans in accordance with new information that comes to light. Each State hospital shall monitor, and promptly address deficiencies in the quality and timeliness of such assessments. | **Summary of Progress on Psychiatric Assessments and Diagnoses:**<br>1. PSH has made significant progress in the quality of admission psychiatric assessments during this review period and appears to be on the cusp of substantial compliance in this area.<br>2. PSH has made significant progress in the quality of integrated psychiatric assessments during this review period and appears to be on the cusp of substantial compliance in this area.<br>3. PSH has reorganized its medical and psychiatric leadership during this review period. The medical and psychiatric leadership now in place appears to be well-suited to the facility's long-term needs as well as the short-term demands of the EP Performance Improvement process.<br><br>**Summary of Progress on Psychological Assessments:**<br>1. PSH has made significant improvements in all areas relating to Psychological Assessments, including the timeliness and quality of the assessments completed. The Senior Psychologists have established a system to ensure that any deficits are identified and addressed in a timely manner.<br>2. Findings from psychological assessments are now providing useful information to Rehabilitation Services.<br>3. Discipline-specific assessments have been integrated into the individuals' WRPs.<br>4. PSH has established a "Psychology Assessment Center" to centralize all referrals and to track the timeliness of assessments.<br><br>**Summary of Progress on Nursing Assessments:**<br>1. PSH has made extraordinary improvement in the quality of the Nursing Admission and Integrated Assessments, especially in the area of the presenting condition.<br>2. Overall, PSH has made significant improvement in all of the areas |

| | | |
|---|---|---|
| | | regarding Admission and Integrated Assessments and should be able to attain substantial compliance by the next review period.<br><br>**Summary of Progress on Rehabilitation Therapy Assessments:**<br>1. The quality and timeliness of D.4 admission and focused assessments has improved.<br>2. Proactive mentoring has been initiated for therapists who have been identified through the self-assessment auditing process as in need of mentoring and training in specific areas.<br><br>**Summary of Progress on Nutrition Assessments:**<br>The quality of D.5 Nutrition assessments has continued to improve.<br><br>**Summary of Progress on Social History Assessments:**<br>PSH has made significant improvements in most areas in Social History Assessments. The assessments have improved in timeliness and quality (complete, current, and comprehensive).<br><br>**Summary of Progress on Court Assessments:**<br>PSH has maintained substantial compliance with EP requirements regarding PC 1026 and PC 1370 Court Reports for the past 18 months. |

| 1. Psychiatric Assessments and Diagnoses | | |
|---|---|---|
| | Each State hospital shall provide all of the individuals it serves with routine and emergency psychiatric assessments and reassessments consistent with generally accepted professional standards of care; and, | **Methodology:**<br><br><u>Interviewed</u>:<br>1. George Christison, MD, Acting Medical Director<br>2. J. Stephen Maurer, MD, Chief of Medical Staff<br>3. John Thiel, MD, Staff Psychiatrist<br>4. Mohamed Hafez, MD, Physician/Surgeon<br>5. Raafat Girgis, MD, Senior Psychiatrist<br>6. Rebecca Kornbluh, MD., Acting Assistant Medical Director<br>7. Willie Harris, MD, Acting Chief of Psychiatry<br><br><u>Reviewed</u>:<br>1. The charts of the following 51 individuals: AGB, AJV, ATR, AW, BMC, CAZ, CDF, CG, CH, CLC, CRB, DC, DEW, DVL, EG, FGE, GW, HLE, HLW, JLF, JR, JSM, JSN, JTP, KER, LAR, LSB, MAR, MLB, MLV, MW, ODM, PAV, RAC, RG, RRW, RW, SJP, SO, SOG, SPB, SQS, SS, TB, THH, TK, TYH, VAB, VAR, VD and YR<br>2. DMH Admission Psychiatric Assessment Instructions<br>3. DMH Admission Psychiatric Assessment Audit Form<br>4. PSH Admission Psychiatric Assessment summary data (November 2008 to April 2009)<br>5. DMH Integrated Assessment: Psychiatric Section Instructions<br>6. DMH Integrated Assessment: Psychiatric Section Audit Form Instructions<br>7. PSH Integrated Assessment: Psychiatric Section summary data (November 2008 to April 2009)<br>8. DMH Monthly Psychiatric Progress Note, May 2009<br>9. DMH Monthly PPN Audit Form, May 2009<br>10. DMH Monthly PPN Audit Form Instructions, May 2009<br>11. PSH Monthly PPN Audit summary data (November 2008 to April 2009)<br>12. PSH Admission Medical Assessment Auditing summary (November |

| | | |
|---|---|---|
| | | 2008 to April 2009)<br>13. PSH Weekly PPN Auditing summary data (November 2008 to April 2009)<br>14. PSH Physician Transfer Note Auditing summary (November 2008 to April 2009) |
| D.1.a | Each State hospital shall use the diagnostic criteria in the most current Diagnostics and Statistical Manual of Mental Disorders ("DSM") for reaching the most accurate psychiatric diagnoses. | **Current findings on previous recommendations:**<br><br>**Recommendation 1, December 2008:**<br>Ensure full implementation of the DMH revised template for the Admission Psychiatric Assessment.<br><br>**Findings:**<br>PSH reported that the revised template for Admission Psychiatric Assessments has been implemented facility-wide.<br><br>**Recommendations 2 and 3, December 2008:**<br>• Monitor this requirement using the DMH Admission Assessment, Integrated Psychiatric Assessment and Monthly Progress Note auditing forms based on at least a 20% sample.<br>• Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).<br><br>**Findings:**<br>PSH used the DMH Admission and Integrated Psychiatric Assessment Auditing Forms to assess compliance for the review period (November 2008 – April 2009). The average samples were 41% of admission assessments and 36% of integrated assessments. The following tables summarize the data:<br><br>**Admission Assessment**<br>4. *Admission diagnosis is documented* 96% |

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

| **Integrated Assessment** | | |
|---|---|---|
| 2.b | *Statements from the individual are included, if available.* | 92% |
| 2.d | *Includes Diagnosis and medications given at previous facility are included* | 84% |
| 7. | *Includes diagnostic formulation* | 90% |
| 8. | *Includes differential diagnosis* | 75% |
| 9. | *Includes current psychiatric diagnoses* | 97% |

Comparative data indicated mixed changes in compliance since the previous review period:

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 2.b | 87% | 92% |
| 2.d | 74% | 84% |
| 7. | 94% | 90% |
| 8. | 73% | 75% |
| 9. | 89% | 97% |
| Compliance rate in last month of period | | |
| 2.d | 95% | 88% |
| 8. | 74% | 52% |

PSH reported that further data analysis identified three psychiatrists who negatively contributed to compliance in this area. As corrective actions, the facility:

1. Developed and implemented a system of intensive mentoring during this review period. This system paired a Senior Psychiatrist up with a group of Staff Psychiatrists in order to provide ongoing feedback and mentoring; and
2. Filled three vacant Senior Psychiatrist positions, for a total of seven. [Note: The staffing table says there were 10 filled Senior Psychiatrist positions as of May 1, 2009.]

PSH also used the Monthly Physician Progress Note Auditing Form to assess compliance with this requirement. At the request of this Court Monitor, PSH revised the Monthly Physician Progress Note Template and Auditing Form during this review period in an effort to ensure clinical relevance and continue to meet all requirements of the Enhancement Plan. Specific modifications are noted in each cell as applicable.

From November 2008 to March 2009, the average sample size was 20% of the monthly notes for individuals who had been hospitalized for more than 90 days. The following tables summarize the data:

| **Monthly PPN** | | |
|---|---|---|
| 3.b | *Current diagnoses (evidence is present to support changes, if applicable, Includes resolution of NOS, deferred, and rule-out diagnoses, if applicable.)* | 84% |
| 3.b.1 | *The note includes the 5-axis diagnosis and this is consistent with the current presentation and recent developments* | 89% |
| 3.b.2 | *If there is a NOS diagnosis or no diagnosis on Axis I, there is documentation that justifies the diagnosis* | 26% |
| 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* | 16% |

Comparative data indicated mixed changes in compliance since the previous review period:

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 3.b | 83% | 84% |
| Compliance rate in last month of period | | |
| 3.b | 83% | 87% |
| 3.b.1 | 87% | 89% |
| 3.b.2 | 60% | 17% |
| 3.b.3 | 14% | 0% |

PSH implemented the revised PPN Auditing Form in May 2009 and utilized the tool to audit the April 2009 PPNs. This item was revised to clarify the requirement for a discussion of unresolved diagnoses.

For April 2009, the sample size was 10% of the monthly notes for individuals who had been hospitalized for more than 90 days. The following table summarizes the data:

| **Monthly PPN - Revised** | | |
|---|---|---|
| 3. | *Timely and justifiable updates of diagnosis and treatment, as clinically appropriate.* | 90% |
| 3.a | *The PPN includes the 5 Axis Diagnoses.* | 99% |
| 3.c | *The PPN includes a discussion of diagnostic questions that still require resolution including deferred, R/O and NOS diagnoses.* | 75% |

**Compliance:**
Partial.

| | | |
|---|---|---|
| | | **Current recommendations**:<br>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 20% samples.<br>2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period.<br>3. Provide a summary outline of improvements in practice made as a result of review by the facility 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:**<br><br>**Recommendation, December 2008:**<br>Ensure consistent compliance with this requirement.<br><br>**Findings:**<br>The number of board-certified psychiatrists at PSH increased from 43 at the previous review to 51 in April 2009. PSH indicated that only one psychiatrist who provides direct care to individuals is not board-eligible. The facility reported that this psychiatrist is mentored regularly by a Senior Psychiatrist.<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendation**:<br>Continue current practice. |

| | | |
|---|---|---|
| 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:**<br><br>**Recommendation, December 2008:**<br>Utilize data from the physician performance profile in the process of reappointment/reprivileging of physicians.<br><br>**Findings:**<br>PSH reported it currently utilizes the following indicators of performance in the process of reprivileging psychiatrists:<br><br>1. Twenty-four peer review audits of work products (i.e., Admission Assessments, Integrated Assessments, Monthly Progress Notes); the audit is reported to measure timeliness, quality and legibility;<br>2. The quality of psychiatric care as measured by timeliness of discharge summary dictation;<br>3. Clinician-specific psychopharmacologic practice as evidenced by MVRs, ADRs due to prescribing errors, and policy adherence as reviewed by the chair of the Pharmacy and Therapeutics Committee;<br>4. Professionalism as measured by courteous treatment of other staff; and<br>5. Attendance at required Medical Staff Committee meetings as well as department meetings.<br><br>The facility reported that in April 2009, the Medical Executive Committee voted to approve the inclusion of EP-generated audit data in the reprivileging process. PSH indicated that the process of selecting the specific EP audit questions would start during the next review period.<br><br>The facility's current system does not appear to ensure that the reprivileging process at PSH incorporates an objective data-based review of physicians' practice. |

| | | |
|---|---|---|
| | | **Compliance:**<br>Partial.<br><br>**Current recommendation**:<br>Ensure that the process of reprivileging incorporates indicators and operational instructions that provide an objective evaluation of physicians' performance in the areas of: diagnosis/differential diagnosis, admission assessment, integrated assessments, weekly/monthly reassessments, inter-unit transfers, WRPT leadership, and medication management (including high-risk medication uses, ADRs, DUEs and MVRs) as clinically appropriate. |
| D.1.c | Each State hospital shall ensure that: | Please see sub-cells for compliance findings. |
| D.1.c.i | Within 24 hours of an individual's admission to each State hospital, the individual receives an Admission Medical Assessment that includes: | **Current findings on previous recommendations:**<br><br>**Recommendation 1, December 2008:**<br>Finalize and implement the DMH Initial Medical Examination Auditing Form and Instructions for use across facilities.<br><br>**Findings:**<br>This recommendation was not addressed during the review period.<br><br>**Recommendation 2, December 2008:**<br>Ensure consistent implementation of the DMH's newly revised template for the admission medical assessment.<br><br>**Findings:**<br>PSH reported that the DMH template for admission medical assessment was implemented throughout the review period. |

| | | |
|---|---|---|
| | | **Recommendations 3 and 4, December 2008:**<br>• Monitor completeness of the admission medical examination within the specified time frame, based on at least a 20% sample. This monitoring must address follow-up regarding incomplete items on the examination.<br>• Provide data analysis that evaluates and delineates areas of low compliance and relative improvement (during the reporting period and compared to the last period).<br><br>**Findings:**<br>Using the PSH Initial Admission Medical Assessment Monitoring Form, PSH assessed compliance with the requirements of D.1.c.i.1 through D.1.c.i.5 based on an average sample of 100% of admissions each month during the review period (November 2008 – April 2009).<br><br>Mean compliance was 97% for the review period. PSH maintained compliance at or above 90% from the previous review period. The facility did not provide data on follow-up regarding incomplete items on the examination.<br><br>**Other findings:**<br>A review of the charts of 10 individuals admitted during the review period (CLC, DEW, FGE, HLE, JLF, JSM, LSB, MAR, ODM and THH) found substantial compliance in seven (DEW, FGE, HLE, JLF, JSM, LSB and THH) and partial compliance in three (CLC, MAR and ODM). In order to achieve substantial compliance, the facility must ensure that the neurological examinations and the plans of care for identified diagnostic impressions are properly completed in all cases.<br><br>**Compliance:**<br>Partial; improved compared to the last review. |

| | | |
|---|---|---|
| | | **Current recommendations**:<br>1. Finalize and implement the DMH Initial Medical Examination Auditing Form and Instructions for use across facilities.<br>2. Monitor completeness of the admission medical examination within the specified time frame, based on at least a 20% sample. This monitoring must address follow-up regarding incomplete items on the examination.<br>3. Provide data analysis that evaluates and delineates areas of low compliance and relative improvement (during the reporting period and compared to the last period).<br>4. Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data. |
| D.1.c.i.1 | a review of systems; | 97%, compared to 90% in the previous review period. |
| D.1.c.i.2 | medical history; | 95%, compared to 90% in the previous review period. |
| D.1.c.i.3 | physical examination; | 81%, compared to 89%in the previous review period. The compliance rate for the last month of this review period was 93% compared to 87% during the last month of the previous review period. |
| D.1.c.i.4 | diagnostic impressions; and | 92%, compared to 90% in the previous review period. |
| D.1.c.i.5 | management of acute medical conditions | 76%, compared to 90% in the previous review period. The compliance rate for the last month of this review period was 100% compared to 90% during the last month of the previous review period. |
| D.1.c.ii | within 24 hours of an individual's admission to each State hospital, the individual receives an Admission Psychiatric Assessment that includes: | **Current findings on previous recommendations:**<br><br>**Recommendation 1, December 2008:**<br>Ensure full implementation of the DMH revised template for the admission psychiatric assessment. |

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| | | **Findings:**<br>PSH reported that the revised DMH template for admission psychiatric assessment was implemented throughout the review period.<br><br>**Recommendations 2 and 3, December 2008:**<br>• Monitor the Admission Psychiatric Assessment based on at least a 20% sample using the DMH standardized instrument.<br>• Provide data analysis that evaluates and delineates areas of low compliance and relative improvement (during the reporting period and compared with the last period).<br><br>**Findings:**<br>Using the DMH Admission Psychiatric Assessment Audit, PSH assessed its compliance based on an average sample of 41% of admissions each month during the review period (November 2008 – April 2009). Mean compliance increased from 85% in the previous review period to 100% in the current review period.<br><br>The mean compliance rates for the requirements in D.1.c.ii.2 through D.1.c .ii.6 are listed for each corresponding cell below. The comparative data are listed, as appropriate.<br><br>**Other findings:**<br>This monitor reviewed the charts of 10 individuals (CLC, DEW, FGE, HLE, JLF, JSM, LSB, MAR, ODM and THH) who were admitted during this review period. Although only three charts were found to be in substantial compliance (DEW, FGE and HLE) with the rest of the charts in partial compliance, there was clear evidence of overall improvement in the quality of these assessments compared to the last review. In order to achieve substantial compliance with this requirement, the facility needs to address the following process deficiencies that were found during this review: |

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<td>1. The risk assessment for violence and self-injury was not completed in one chart (LSB);<br>2. The mental status examinations of some individuals included reference to active symptoms without necessary specific information, including auditory hallucinations (MAR, ODM and THH) and persecutory delusions (FLF and JSM); and<br>3. In one chart, the diagnosis of Psychotic Disorder NOS was in apparent conflict with the lack of documentation of current (or previous) psychotic symptoms (CLC).<br><br>Compliance:<br>Partial, improved compared to last review.<br><br>Current recommendations:<br>1. Monitor this requirement using the DMH Admission Psychiatric Assessment Auditing Form based on at least a 20% sample.<br>2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period.<br>3. Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.</td>
</tr>
<tr>
<td>D.1.c.ii.1</td>
<td>psychiatric history, including a review of presenting symptoms;</td>
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<table>
<tr><td>2.</td><td>Psychiatric history, including review of presenting symptoms</td><td>98%</td></tr>
<tr><td>2.a</td><td>Identifying data including legal status</td><td>99%</td></tr>
<tr><td>2.b</td><td>Discharge diagnosis and condition</td><td>95%</td></tr>
<tr><td>2.c</td><td>Reason for admission and chief complaint</td><td>99%</td></tr>
<tr><td>2.d</td><td>History of present illness</td><td>100%</td></tr>
<tr><td>2.e</td><td>Psychiatric history</td><td>99%</td></tr>
<tr><td>2.f</td><td>Substance abuse history</td><td>96%</td></tr>
<tr><td>2.g</td><td>Allergies</td><td>98%</td></tr>
<tr><td>2.h</td><td>Current medications</td><td>98%</td></tr>
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| | | |
|---|---|---|
| | | Comparative data indicated improvement in compliance from 73% in the previous review period. |
| D.1.c.ii.2 | complete mental status examination; | 98%, compared to 96% in the previous review period. |
| D.1.c.ii.3 | admission diagnoses; | 96%, compared to 90% in the previous review period. |
| D.1.c.ii.4 | completed AIMS; | 99%, compared to 97% in the previous review period. |
| D.1.c.ii.5 | laboratory tests ordered; | 100%, compared to 98% in the previous review period. |
| D.1.c.ii.6 | consultations ordered; and | 97%, compared to 88% in the previous review period. |
| D.1.c.ii.7 | plan of care. | <table><tr><td>8.</td><td>Plan of care</td><td>96%</td></tr><tr><td>8.a</td><td>Regular psychotropic medications with rationale</td><td>96%</td></tr><tr><td>8.b</td><td>PRN and/or Stat medications as applicable, with specific behavioral indicators</td><td>96%</td></tr><tr><td>8.c</td><td>Special precautions to address risk factors as indicated</td><td>97%</td></tr></table><br>Comparative data indicated improvement in compliance 85% in the previous review period. |
| 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:**<br><br>**Recommendation 1, December 2008:**<br>Ensure full implementation of the integrated psychiatric assessments.<br><br>**Findings:**<br>PSH reported that the integrated psychiatric assessment was implemented throughout the review period. |

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| | | **Recommendation 2, December 2008:**<br>Provide training to WRPTs regarding the proper formulation of individuals' strengths. The training should focus on attributes of the individuals that could be utilized in wellness and recovery planning.<br><br>**Findings:**<br>The facility's training and mentoring activities are summarized in C.1.a.<br><br>**Recommendations 3 and 4, December 2008:**<br>• Continue to monitor the Integrated Psychiatric Assessment using the DMH standardized instrument.<br>• Provide data analysis that evaluates and delineates areas of low compliance and relative improvement (during the reporting period and compared with the last period).<br><br>**Findings:**<br>Using the DMH Integrated Assessment Psychiatry Section Audit, PSH assessed its compliance based on an average sample of 36% of assessments each month during the review period (November 2008 – April 2009). Mean compliance was 97% for the review period. PSH maintained compliance at or above 90% from the previous review period.<br><br>PSH reported that during the current review period, the facility assigned a Senior Psychiatrist to the admission units. The Senior provided focused mentoring for staff psychiatrists with low compliance scores.<br><br>The mean compliance rates for the remaining requirements in D.1.c.iii are listed in each corresponding cell below. Comparative data are listed, as appropriate.<br><br>**Other findings:**<br>This monitor reviewed the charts of 10 individuals (CLC, DEW, FGE, HLE, |

| | | |
|---|---|---|
| | | JLF, JSM, LSB, MAR, ODM and THH) who were admitted during this review period. The review found overall significant improvement compared to the previous review. Substantial compliance was found in seven charts (CLC, JLF, JSM, LSB, MAR, ODM and THH) and partial compliance in three (DEW, FGE and HLE). In order to achieve substantial compliance with this requirement, the facility needs to correct a few process deficiencies that were identified during this review. The following is an outline:<br><br>1. The diagnosis was deferred in one chart due to lack of collateral history, but subsequent notes and WRP reviews did not adequately address the lack of objectives/interventions to address this issue (DEW);<br>2. The documented rationale for not completing the mini-mental status examination was inadequate in one chart (FGE); and<br>3. The mental status examination included generic references to the individual's insight and judgment in one chart (DEW).<br><br>**Compliance:**<br>Partial; improved compared to the last review.<br><br>**Current recommendations**:<br>1. Monitor this requirement using the DMH Integrated Assessment: Psychiatric Section auditing form based on at least a 20% sample.<br>2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period.<br>3. 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.* 90% |

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<table>
<tr><td>2.a</td><td>Identifying data including legal status.</td><td>98%</td></tr>
<tr><td>2.b*</td><td>Statements from the individual are included, if available.</td><td>94%</td></tr>
<tr><td>2.c</td><td>Chief complaint</td><td>98%</td></tr>
<tr><td>2.d</td><td>Diagnosis and medications given at previous facility are included.</td><td>84%</td></tr>
<tr><td>2.e</td><td>Effectiveness of medications from previous facility is included</td><td>79%</td></tr>
<tr><td>2.f</td><td>Past psychiatric history is documented including a review of pertinent physical exam status.</td><td>85%</td></tr>
</table>
*The facility did not provide an explanation for the discrepancy between the compliance rate reported for 2.b (94%) in this cell and the compliance rate reported (92%) in cell D.1.a.<br><br>Comparative data indicated improvement in mean compliance from 62% in the previous review period.
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<tr>
<td>D.1.c.iii.<br>2</td>
<td>psychosocial history;</td>
<td>
<table>
<tr><td>3.</td><td>Psychosocial history is documented.</td><td>90%</td></tr>
<tr><td>3.a</td><td>Developmental history</td><td>85%</td></tr>
<tr><td>3.b</td><td>Family history</td><td>91%</td></tr>
<tr><td>3.c</td><td>Educational history</td><td>92%</td></tr>
<tr><td>3.d</td><td>Religious and cultural influences</td><td>88%</td></tr>
<tr><td>3.e</td><td>Occupational history</td><td>91%</td></tr>
<tr><td>3.f</td><td>Marital status</td><td>90%</td></tr>
<tr><td>3.g</td><td>Sexual history</td><td>87%</td></tr>
<tr><td>3.h</td><td>Legal history</td><td>92%</td></tr>
</table>
Comparative data indicated improvement in mean compliance from 68% in the previous review period.
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<table>
<tr><td>D.1.c.iii.<br>3</td><td>mental status examination;</td><td>
<table>
<tr><td>4.</td><td>Complete mental status examination is documented</td><td>96%</td></tr>
<tr><td>4.a</td><td>Attitude/cooperation</td><td>98%</td></tr>
<tr><td>4.ba</td><td>General appearance</td><td>98%</td></tr>
<tr><td>4.c</td><td>Motor Activity</td><td>97%</td></tr>
<tr><td>4.d</td><td>Speech</td><td>98%</td></tr>
<tr><td>4.e</td><td>Mood/affect</td><td>99%</td></tr>
<tr><td>4.f</td><td>Thought process/content</td><td>98%</td></tr>
<tr><td>4.g</td><td>Perceptual alterations</td><td>99%</td></tr>
<tr><td>4.h</td><td>Fund of general knowledge</td><td>95%</td></tr>
<tr><td>4.i</td><td>Abstraction ability</td><td>92%</td></tr>
<tr><td>4.j</td><td>Judgment</td><td>94%</td></tr>
<tr><td>4.k</td><td>Insight</td><td>97%</td></tr>
<tr><td>4.l</td><td>MMSE</td><td>82%</td></tr>
</table>
Comparative data indicated improvement in mean compliance from 70% in the previous review period.
</td></tr>
<tr><td>D.1.c.iii.<br>4</td><td>strengths;</td><td>92%, compared to 79% in the previous review period.</td></tr>
<tr><td>D.1.c.iii.<br>5</td><td>psychiatric risk factors;</td><td>
<table>
<tr><td>6.</td><td>Psychiatric risk factors are documented</td><td>91%</td></tr>
<tr><td>6.a</td><td>Risk for suicide</td><td>97%</td></tr>
<tr><td>6.b</td><td>Risk for self-injurious behavior</td><td>69%</td></tr>
<tr><td>6.c</td><td>Risk factors for seclusion (medical and emotional)</td><td>94%</td></tr>
<tr><td>6.d</td><td>Risk factors for restraint (medical and emotional)</td><td>95%</td></tr>
<tr><td>6.e</td><td>Risk for aggression</td><td>96%</td></tr>
<tr><td>6.f</td><td>Risk for fire setting</td><td>94%</td></tr>
<tr><td>6.g</td><td>Risk for elopement</td><td>92%</td></tr>
<tr><td>6.h</td><td>Risk for victimization</td><td>91%</td></tr>
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Comparative data indicated improvement in mean compliance from 27% in
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<tr><td></td><td></td><td>the previous review period.</td></tr>
<tr><td>D.1.c.iii.6</td><td>diagnostic formulation;</td><td>90%, compared to 94% in the previous review period.</td></tr>
<tr><td>D.1.c.iii.7</td><td>differential diagnosis;</td><td>75%, compared to 73% during the last review. The rate for the last month of this review period was 52% compared to 74% during the last month of the previous review period.<br><br>PSH reported that further data analysis identified five psychiatrists who contributed negatively to compliance in this area. The facility intends to provide additional mentoring to these psychiatrists during the next review period.</td></tr>
<tr><td>D.1.c.iii.8</td><td>current psychiatric diagnoses;</td><td>97%, compared to 89% in the previous review period.</td></tr>
<tr><td>D.1.c.iii.9</td><td>psychopharmacology treatment plan; and</td><td>
<table>
<tr><td>10.</td><td>Psychopharmacology treatment plan is documented</td><td>83%</td></tr>
<tr><td>10.a</td><td>Current target symptoms</td><td>71%</td></tr>
<tr><td>10.b</td><td>Specific medications to be used</td><td>96%</td></tr>
<tr><td>10.c</td><td>Dosage titration schedules, if indicated</td><td>91%</td></tr>
<tr><td>10.d</td><td>Adverse reactions to monitor for</td><td>77%</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>78%</td></tr>
<tr><td>10.f</td><td>Response to medications since admission, if applicable including PRN and Stat medications.</td><td>73%</td></tr>
<tr><td>10.g</td><td>Medication consent issues were addressed.</td><td>95%</td></tr>
</table>
<br>Comparative data indicated mixed changes in compliance since the previous review period:
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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>45%</td><td>83%</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>10.</td><td>58%</td><td>77%</td></tr>
<tr><td>10.a</td><td>67%</td><td>67%</td></tr>
<tr><td>10.b</td><td>100%</td><td>96%</td></tr>
<tr><td>10.c</td><td>88%</td><td>73%</td></tr>
<tr><td>10.d</td><td>59%</td><td>77%</td></tr>
<tr><td>10.e</td><td>100%</td><td>33%</td></tr>
<tr><td>10.f</td><td>100%</td><td>100%</td></tr>
<tr><td>10.g</td><td>100%</td><td>92%</td></tr>
</table>
PSH reported that the implementation of focused mentoring for low performing psychiatrists is intended to improve compliance for this indicator. Additionally, the facility indicated that it intends to hire a psychopharmacology consultant in July 2009 to assist the psychiatrists in tracking and documenting the use of high-risk medications.
</td></tr>
<tr><td>D.1.c.iii.10</td><td>management of identified risks.</td><td>90%, same as in the previous review period.</td></tr>
<tr><td>D.1.d</td><td>Each State hospital shall ensure that:</td><td>Please see sub-cells for compliance findings.</td></tr>
<tr><td>D.1.d.i</td><td>Clinically justifiable diagnoses are provided for each individual, and all diagnoses that cannot be clinically justified for an individual are discontinued no later than the next review;</td><td>Current findings on previous recommendations:<br><br>Recommendation 1, December 2008:<br>Provide medical education programs to psychiatry staff to improve competency in the area of assessment of cognitive and other neuropsychiatric disorders and provide data regarding number and disciplines of attendees.</td></tr>
</table>

**Findings:**
PSH provided medical education programs on a variety of topics for its staff. The following is a summary of medication education programs specific to assessment of cognitive and other neuropsychiatric disorders:

| Date | Title | Speaker/ affiliations | Attendees |
|---|---|---|---|
| 4-15-09 | Assessment & Rehabilitation of Cognitive Impairment in Schizophrenia | William G. Britt, III; Ph.D., ABN/Patton State Hospital | MD (78), Psychologist (53), SW (28), RT(32), PharmD (11), Other (32) |

**Recommendation 2, December 2008:**
Same as in D.1.a.

**Findings:**
Same as in D.1.a.

**Other findings:**
This monitor reviewed the charts of 14 individuals who have received diagnoses listed as NOS for three or more months during this review period. The review found substantial compliance in three charts (HLW, VAB and YR) and partial compliance in 11 (AW, CH, CRB, JR, JSN, KER, LAR, MLV, RAC, RG and SOG). Based on this review, PSH has made some progress since the last review in the following areas:

1. Finalization and justification of the diagnosis, as indicated; and
2. Ensuring appropriate match between diagnosis and prescribed treatment.

However, the facility has yet to strengthen and ensure consistency of

practice in the above areas and has yet to make progress in the assessment and tracking of the cognitive impairments, as indicated.

The following table outlines the charts reviewed:

| Initials | Diagnosis |
|---|---|
| AW | Dementia NOS |
| CH | Psychotic Disorder NOS |
| CRB | Mental Disorder, NOS |
| HLW | Depressive Disorder NOS (currently Schizoaffective Disorder, Depressive Type) |
| JR | Dementia NOS |
| KER | Cognitive Disorder, NOS |
| LAR | Impulse Control Disorder NOS |
| JSN | Cognitive Disorder, NOS |
| MLV | Psychotic Disorder NOS and Mood Disorder NOS |
| RAC | Cognitive Disorder, NOS |
| RG | Depressive Disorder NOS |
| SOG | Cognitive Disorder, NOS |
| VAB | Mood Disorder NOS |
| YR | Impulse Control Disorder NOS (currently discontinued) |

**Compliance:**
Partial.

**Current recommendations**:
1. Provide documentation of continuing medical education to psychiatry staff to improve competence in the assessment of cognitive and other neuropsychiatric disorders. Provide data regarding the title of each program, the speakers and affiliation and the number and disciplines of attendees.
2. Provide comparative data regarding the average number of individuals

| | | |
|---|---|---|
| | | who have had diagnoses listed as NOS and/or R/O for three or more months during the review period compared with the last period. |
| D.1.d.ii | The documented justification of the diagnoses is in accord with the criteria contained in the most current DSM (as per DSM-IV-TR Checklist); | **Current findings on previous recommendation:**<br><br>**Recommendation, December 2008:**<br>Same as in D.1.d.i.<br><br>**Findings:**<br>Same as in D.1.d.i<br><br>**Compliance:**<br>Partial.<br><br>**Current recommendation**:<br>Same as in D.1.d.i. |
| D.1.d.iii | Differential diagnoses, "deferred," or "rule-out" diagnoses, and diagnoses listed as "NOS" ("Not Otherwise Specified") are timely addressed (i.e., within 60 days), through clinically appropriate assessments, and resolved in a clinically justifiable manner; and | **Current findings on previous recommendation:**<br><br>**Recommendation, December 2008:**<br>Same as in D.1.d.i.<br><br>**Findings:**<br>Same as in D.1.d.i<br><br>**Compliance:**<br>Partial.<br><br>**Current recommendation**:<br>Same as in D.1.d.i. |
| D.1.d.iv | "no diagnosis" is clinically justified and documented. | **Current findings on previous recommendations:** |

| | | |
|---|---|---|
| | | **Recommendation 1, December 2008:**<br>Same as in D.1.d.i.<br><br>**Findings:**<br>Same as in D.1.d.i.<br><br>**Recommendation 2, December 2008:**<br>Review the charts of all individuals who have received "No Diagnosis" on Axis I to determine clinical justification.<br><br>**Findings:**<br>PSH reported that one individual received "No Diagnosis" on Axis I during this review period. The facility reported that the individual was admitted under 1370, remained at PSH for four months, did not display psychiatric symptoms and did not receive psychotropic medication, and that treatment focused on court competency related to the diagnosis of Borderline Intellectual Functioning.<br><br>**Other findings:**<br>Chart reviews by this monitor did not find evidence of "no diagnosis" listed on Axis I.<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendation:**<br>Continue to review the charts of all individuals who have received "No Diagnosis" on Axis I to determine clinical justification. |
| 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 | **Current findings on previous recommendations:**<br><br>**Recommendations 1 and 2, December 2008:**<br>• Monitor this requirement based on a review of at least a 20% sample. |

for the first 60 days on the admissions units and monthly on other units.

- 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 the DMH Weekly Physician Progress Note (PPN) Audit, PSH assessed its compliance based on an average sample of 18% of individuals with length of stay less than 60 days during the review period (November 2008 – April 2009):

| | | |
|---|---|---|
| 1. | *The reassessments are completed weekly for the first 60 days on the admission units:* | 85% |
| 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.* | 42% |
| 1.b.1 | *The note must contain the subjective complaint.* | 92% |
| 1.b.2 | *The note must contain the objective findings.* | 97% |
| 1.b.3 | *The note must contain the assessment.* | 96% |
| 1.b.4 | *The note must contain the plan of care.* | 97% |

Comparative data indicated improvement in compliance since the previous review period with the exception of item 1.a:

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 1. | 39% | 85% |
| Compliance rate in last month of period | | |
| 1. | 60% | 82% |
| 1.a | 62% | 26% |
| 1.b.1 | 87% | 94% |

| | | |
|---|---|---|
| 1.b.2 | 87% | 97% |
| 1.b.3 | 90% | 97% |
| 1.b.4 | 90% | 97% |

PSH also used the DMH Monthly PPN Audit to assess compliance. The average sample was 18% of individuals who had been hospitalized for 90 days or more. The facility reported a mean compliance rate of 85% compared to 81% during the previous review period. The rate for the last month of this review period was 87% compared to 79% during the last month of the previous review period.

The facility reported that psychiatry staffing negatively impacted compliance rates for this indicator. PSH anticipates that recruitment of seventeen staff psychiatrists (two began employment during the current review period and fifteen others are scheduled to begin by August 1 2009) will increase compliance rates.

**Other findings:**
This monitor reviewed the charts of 10 individuals (CLC, DEW, FGE, HLE, JLF, JSM, LSB, MAR, ODM and THH) who were admitted during this reporting period. The review focused on the timeliness of the notes. Regarding the weekly notes for the first 60 days of hospitalization and monthly notes thereafter, the review found compliance in all charts.

**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.<br>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:**<br><br>**Recommendation 1, December 2008:**<br>Streamline the format of psychiatric reassessments and ensure consistent implementation to correct the deficiencies outlined in this monitor's report and in the previous report.<br><br>**Findings:**<br>PSH revised the Monthly Physician Progress Note Template and Auditing Form during this review period. Specific modifications are noted in each cell below as applicable. PSH implemented the revised PPN Auditing Form in May 2009 and utilized the tool to audit the April 2009 PPNs.<br><br>**Recommendations 2 and 3, December 2008:**<br>• Monitor this requirement based on a review of at least a 20% sample.<br>• Provide data analysis that evaluates low compliance and delineates areas of relative improvement (during the reporting period and compared to the last period).<br><br>**Findings:**<br>PSH used the DMH Monthly PPN Audit (from November 2008 to March 2009) to assess compliance, based on an average sample of 20% of individuals who had been hospitalized for 90 days or more. PSH implemented the revised PPN Auditing Form in May 2009 and utilized the tool to audit the April 2009 PPNs with a sample size of 10%. The mean compliance rates for the requirements in D.1.f.i to D.1.f.vii are entered for each corresponding cell below. |

| | | |
|---|---|---|
| | | **Other findings:**<br>Chart reviews by this monitor found general evidence of improved documentation, especially in the notes that utilized the facility's new revised template for the monthly psychiatric notes (AJV, CG, CRB, DC, EG, GW, MW, SO, TK and VD). However, several notes that were hand-written or that utilized a different template (CDF, RW, SJP, SQS, SS and VAR) were inadequate to capture necessary information. Overall, the main barrier to substantial compliance was the lack of adequate documentation to address the following:<br><br>1. Important clinical events under the interval history section; and/or<br>2. Delineation of current side effects, with analysis of risks and benefits and attempts to use safer treatment alternatives.<br><br>In addition, this monitor reviewed the charts of five individuals who experienced the use of seclusion and/or restraint during this review period (ATR, BMC, JTP, MLB and SPB). The review focused on the use of PRN/Stat medications prior to seclusion and/or restraint (as documented in the orders and progress notes). This review is also relevant to the requirements in D.1.f.vi and F.1.b. The review found process deficiencies similar to those identified during the last review. The following are the areas of deficiency:<br><br>1. Timely administration of PRN medications that were appropriately tailored to the symptoms in order to avert the use of seclusion/ restraint;<br>2. Prescription of PRN medications for specified behavioral indications;<br>3. Documentation in the progress notes of the appropriateness and efficacy of the PRN regimen and of timely adjustments of regular treatment following the use of PRN medications (in almost all the charts reviewed);<br>4. Nursing documentation of the circumstances that led to the use of PRN/Stat medications and of the individual's response to these |

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<td>interventions;<br>5. The development and implementation of behavioral guidelines for some individuals who were refractory to current medication trials; and<br>6. The documentation of a face-to-face assessment by the psychiatrists within 24 hours after the administration of Stat medication in a manner that informs future management.<br><br>Compliance:<br>Partial.<br><br>Current recommendations:<br>1. Monitor this requirement using the DMH Psychiatry Monthly PPN Auditing Form based on at least a 20% sample.<br>2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period.<br>3. Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.</td>
</tr>
<tr>
<td>D.1.f.i</td>
<td>significant developments in the individual's clinical status and of appropriate psychiatric follow up;</td>
<td>
<table>
<tr><td>2.</td><td>Progress notes address changes /developments in the individual's clinical status with appropriate psychiatric follow-up including identified target symptoms</td><td>87%</td></tr>
<tr><td>2.a</td><td>Subjective complaints are documented.</td><td>92%</td></tr>
<tr><td>2.b</td><td>Identified target symptoms are documented</td><td>86%</td></tr>
<tr><td>2.c</td><td>Participation in treatment is documented.</td><td>87%</td></tr>
<tr><td>2.d</td><td>Progress towards objectives in the WRP.</td><td>86%</td></tr>
<tr><td>2.e</td><td>The mental status exam is documented</td><td>95%</td></tr>
<tr><td>2.f</td><td>The individual's legal status and any change in legal status, if applicable.</td><td>85%</td></tr>
<tr><td>2.g</td><td>Current status of medical problems and treatment are documented</td><td>86%</td></tr>
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| | | |
|---|---|---|
| 2.h | *Relevant lab data and consults are documented* | 71% |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 2. | 67% | 87% |
| Compliance rate in last month of period | | |
| 2. | 66% | 86% |
| 2.a | 85% | 95% |
| 2.b | 94% | 82% |
| 2.c | 90% | 87% |
| 2.d | 82% | 85% |
| 2.e | 91% | 99% |
| 2.f | 85% | 80% |
| 2.g | 80% | 84% |
| 2.h | 70% | 78% |

PSH implemented the revised PPN Auditing Form in May 2009 and utilized the tool to audit the April 2009 PPNs. The sub-indicators of this item were revised to reorganize the structure of the PPN and further refine the requirements of the assessment of this information. The following table summarizes the data:

| Revised | | |
|---|---|---|
| 2. | *Significant developments in the individual's clinical status and of appropriate psychiatric follow-up reassessments are completed monthly on other (than admission) units.* | 88% |
| 2.a | *Identifying information including current legal* | 91% |

| | | |
|---|---|---|
| | *status.* | |
| 2.b | *Subjective complaints and symptoms are documented or there is documentation substantiating the reason that subjective complaints/concerns are not available.* | 95% |
| 2.c | *Interval history is documented for the past 30 days including a summary of psychiatric progress, a summary of the status of medical problems listed in Foci 6 affecting psychiatric status, a summary of relevant labs, consults and other tests obtained in the past month, and current changes in BMI and waist circumference.* | 85% |
| 2.d | *A list of current medications and dosages including any psychiatric PRNs/stats and any changes which occurred during the past month.* | 94% |
| 2.e | *Current Mini Mental Status Examination* | 67% |
| 2.f | *Current Mental Status Examination* | 98% |
| 2.g | *Current AIMS* | 87% |

PSH reported that it intends to provide training on the Mini Mental Status Examination (MMSE) during the next review period.

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.* | 75% |
| 3.a | *The MMSE is completed and documented in the progress note.* | 66% |
| 3.b | *The current diagnosis includes resolution of NOS, deferred, and rule out diagnoses, if applicable.* | 84% |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 3. | 64% | 75% |
| Compliance rate in last month of period | | |
| 3. | 58% | 77% |
| 3.a | 65% | 67% |
| 3.b | 83% | 87% |

PSH implemented the revised PPN Auditing Form in May 2009 and utilized the tool to audit the April 2009 PPNs. The sub-indicators of this item were revised to emphasize the necessary components for accurate diagnosis and to clarify the requirement for a discussion of unresolved diagnoses. The following table summarizes the data:

| Revised | | |
|---|---|---|
| 3. | *Timely and justifiable updates of diagnoses/ treatment as clinically appropriate.* | 90% |
| 3.a | *The 5 Axis Diagnosis* | 99% |
| 3.b | *The individual's target symptoms are consistent with the diagnosis.* | 96% |
| 3.c | *A discussion of diagnostic questions that still require resolution including deferred, r/o and NOS diagnoses.* | 75% |

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

| | | |
|---|---|---|
| 4. | *Analyses of risks and benefits of chosen treatment interventions* | 81% |
| 4.a | *The risks for the current psychopharmacology plan including anticholinergics, benzodiazepines, and polypharmacy are documented.* | 80% |
| 4.b | *The benefits for the current psychopharmacology* | 82% |

| | | |
|---|---|---|
| | *plan including anticholinergics, benzodiazepines, and polypharmacy are documented.* | |
| 4.c | *Rationale for the current psychopharmacology plan including anticholinergics, benzodiazepines, and polypharmacy are documented* | 80% |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 4. | 67% | 81% |
| Compliance rate in last month of period | | |
| 4. | 63% | 81% |
| 4.a | 77% | 81% |
| 4.b | 79% | 81% |
| 4.c | 70% | 81% |

PSH implemented the revised PPN Auditing Form in May 2009 and utilized the tool to audit the April 2009 PPNs. The number of this item changed and the content was modified to increase the specificity of requirements for analyzing the risks and benefits of pharmacological treatment. The following table summarizes the data:

| Revised | | |
|---|---|---|
| 5. | *Responses to and side effects of prescribed medications, with particular attention to risks associated with the use of benzodiazepines, anticholinergic medications, polypharmacy (use of multiple drugs to address the same condition), and conventional and atypical antipsychotic medications.* | 86% |

| | | | | |
|---|---|---|---|---|
| | | 5.a | *Justify/explain the current regimen considering this month's progress (or lack of progress) and clinical data.* | 92% |
| | | 5.b | *Current regimen is prescribed consistent with DMH Psychotropic guidelines.* | 96% |
| | | 5.c | *Monitored for effectiveness against clearly identified target variables.* | 90% |
| | | 5.d | *Justify/explain the use of medications that pose elevated risks and/or are causing side effects including, if applicable, an analysis of risks and benefits of the following: benzodiazepines, anticholinergics, polypharmacy, conventional and atypical antipsychotics and other psychiatric medications.* | 66% |
| | | The facility's corrective actions are summarized in D.1.c.iii.9. | | |
| 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* | 62% |
| | | 5.a | *There is a description of the current risks specific to this individual and the precautions instituted to minimize those risk.* | 73% |
| | | 5.b | *The monthly note identifies specific risk behaviors including triggers during the interval period.* | 60% |
| | | 5.c | *If applicable, treatment is modified to minimize risk.* | 52% |
| | | Comparative data indicated mixed changes in compliance since the previous review period: | | |

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 5. | 60% | 62% |
| Compliance rate in last month of period | | |
| 5. | 57% | 54% |
| 5.a | 67% | 76% |
| 5.b | 71% | 52% |
| 5.c | 69% | 35% |

PSH implemented the revised PPN Auditing Form in May 2009 and utilized the tool to audit the April 2009 PPNs. The number of this item changed and the content of the sub-items was modified to increase the focus on high-risk behaviors. The following table summarizes the data:

| Revised | | |
|---|---|---|
| 4. | *Assessment of, and attention to, high-risk behaviors (assaults, self-harm, falls) including appropriate and timely monitoring of individuals and interventions to reduce risks* | 83% |
| 4.a | *The individual's high risk behaviors* | 88% |
| 4.b | *The frequency of high risk behaviors during the past month* | 86% |
| 4.c | *Precautions and treatments instituted or planned to minimize those risks* | 78% |
| 4.d | *The effectiveness of precautions taken* | 79% |

The facility's corrective actions are summarized in D.1.c.iii.9.

| | | | |
|---|---|---|---|
| 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* | 84% |

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.* | 78% |
| 6.b | *There is a description of any side effects caused by medications, including sedation and cognitive impairment.* | 81% |
| 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.* | 85% |
| 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* | 90% |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 6. | 62% | 84% |
| Compliance rate in last month of period | | |
| 6. | 60% | 86% |
| 6.a | 72% | 81% |
| 6.b | 83% | 79% |
| 6.c | 81% | 88% |
| 6.d | 86% | 95% |

PSH implemented the revised PPN Auditing Form in May 2009 and

<table>
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<td>utilized the tool to audit the April 2009 PPNs. The number of this item changed and the content was modified to decrease redundancy with other audit tools and increase alignment with the EP requirement. The following table summarizes the data:
<table>
<tr><td colspan="3">Revised</td></tr>
<tr><td>5.d</td><td>Justify/explain the use of medications that pose elevated risks and/or are causing side effects including, if applicable, an analysis of risks and benefits of the following: benzodiazepines, anticholinergics, polypharmacy, conventional and atypical antipsychotics and other psychiatric medications.</td><td>66%</td></tr>
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<tr>
<td>D.1.f.vi</td>
<td>Timely review of the use of “pro re nata” or “as-needed” (“PRN”) and “Stat” (i.e., emergency psychoactive) medications and adjustment of regular treatment, as indicated, based on such use; and</td>
<td>
<table>
<tr><td>7.</td><td>Timely review of the use of "pro re nata" or "as-needed" ("PRN") and "Stat" (i.e., emergency psychoactive) medications and adjustment of regular treatment, as indicated, based on such use</td><td>49%</td></tr>
<tr><td>7.a</td><td>Describes the rationale/specific indications for all PRN orders.</td><td>69%</td></tr>
<tr><td>7.b</td><td>Reviews the PRNs and Stats during the interval period.</td><td>55%</td></tr>
<tr><td>7.c</td><td>Discusses use of PRN/Stat as indicated to reduce the risk of restrictive interventions.</td><td>38%</td></tr>
<tr><td>7.d</td><td>Describes modification of regularly scheduled medication regimen based on the use of PRN/Stat medications.</td><td>34%</td></tr>
</table>
Comparative data indicated modest changes in compliance since the previous review period:
</td>
</tr>
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| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 7. | 48% | 49% |
| Compliance rate in last month of period | | |
| 7. | 42% | 42% |
| 7.a | 51% | 64% |
| 7.b | 45% | 46% |
| 7.c | 26% | 34% |
| 7.d | 15% | 25% |

PSH implemented the revised PPN Auditing Form in May 2009 and utilized the tool to audit the April 2009 PPNs. The number of this item changed and the sub-items were removed to increase focus on the EP requirement. The following table summarizes the data:

| Revised | | |
|---|---|---|
| 6. | *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.* | 74% |

D.1.f.vii

Verification in a clinically justifiable manner, that psychiatric and behavioral treatments are properly integrated. The psychiatrist shall review the positive behavior support plan prior to implementation to ensure consistency with psychiatric formulation, document evidence of regular exchange of data or information with psychologists regarding differentiation of learned behaviors and behaviors targeted for psychopharmacological treatments, and

| | | |
|---|---|---|
| 8. | *Verification in a clinically justifiable manner, that psychiatric and behavioral treatments are properly integrated.* | 64% |
| 8.a | *There is a description in the note of the response to non-pharmacologic treatment.* | 80% |
| 8.b | *If applicable, there is documentation to support that the psychiatrist reviewed the PBS plan prior to implementation to ensure consistency with* | 49% |

document evidence of integration of treatments.

| | | |
|---|---|---|
| | *psychiatric formulation.* | |
| 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.* | 63% |
| 8.d | *There is modification, as clinically appropriate, of diagnosis and/or pharmacological treatment based on above reviews/assessments.* | 64% |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 8. | 59% | 64% |
| Compliance rate in last month of period | | |
| 8. | 57% | 61% |
| 8.a | 73% | 78% |
| 8.b | 44% | 35% |
| 8.c | 56% | 64% |
| 8.d | 52% | 65% |

PSH implemented the revised PPN Auditing Form in May 2009 and utilized the tool to audit the April 2009 PPNs. The number of this item changed and the sub-items were modified to increase the expectation for clinical specificity within the PPN. The following table summarizes the data:

| | | |
|---|---|---|
| | | <table><tr><td>7.</td><td>*Verification in a clinically justifiable manner, that psychiatric and behavioral treatments are properly integrated. The psychiatrist shall review the positive support plans prior to implementation to ensure consistency with psychiatric formulation, document evidence of regular exchange of data or information with psychologists regarding differentiation of learned behaviors and behaviors targeted for psychopharmacological treatments, and document evidence of integration of treatments.*</td><td>83%</td></tr><tr><td>7.a</td><td>*Behavioral guidelines/PBS plans, if applicable including the key strategies being employed.*</td><td>70%</td></tr><tr><td>7.b</td><td>*At least one example of implications of psychiatric status to PSR mall group goals, participation and type of group.*</td><td>81%</td></tr><tr><td>7.c</td><td>*Other therapies such as individual therapy*</td><td>97%</td></tr></table> |
| D.1.g | When individuals are transferred between treatment teams, a psychiatric transfer note shall be completed addressing: review of medical and psychiatric course of hospitalization, including medication trials; current target symptoms; psychiatric risk assessment; current barriers to discharge; and anticipated benefits of transfer. | **Current findings on previous recommendations:**<br><br>**Recommendation 1, December 2008:**<br>Implement a tracking system to ensure adequate design and implementation of behavioral guidelines/PBS plans prior to transfers of individuals who present severe management problems. Provide specific information regarding implementation of this system.<br><br>**Findings:**<br>PSH reported that in non-emergent circumstances, the transfers of individuals who present severe management problems are considered by the ETRC, which includes the Chief of Psychiatry, the Medical Director and the PBS chair. Consideration is given to the individual remaining on the current unit with increased behavioral interventions. The facility reported that its current practice is to avoid abrupt transfer. Rather, |

PBS personnel provide training to the receiving unit prior to the transfer. PSH also reported that the Quality Council intends to initiate a Corrective Action Team to develop an oversight system to ensure that this requirement is being met.

**Recommendations 2 and 3, December 2008:**

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

**Findings:**

PSH used the DMH Physician Inter-Unit Transfer Note Audit to assess compliance. The average sample was 16% of the individuals who experienced inter-unit transfer per month during the review period (November 2008 – April 2009):

| | | |
|---|---|---|
| 1. | *Psychiatric course of hospitalization,* | 51% |
| 2. | *Medical course of hospitalization,* | 61% |
| 3. | *Current target symptoms,* | 70% |
| 4. | *Psychiatric risk assessment,* | 58% |
| 5. | *Current barriers to discharge,* | 40% |
| 6. | *Anticipated benefits of transfer.* | 67% |

Comparative data indicated improvements in mean compliance (with the exception of item 5) since the previous review period:

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 1. | 21% | 51% |
| 2. | 27% | 61% |
| 3. | 56% | 70% |

| | | |
|---|---|---|
| 4. | 21% | 58% |
| 5. | 44% | 40% |
| 6. | 29% | 67% |
| Compliance rate in last month of period | | |
| 1. | 18% | 49% |
| 2. | 25% | 54% |
| 3. | 50% | 75% |
| 4. | 17% | 54% |
| 5. | 73% | 67% |
| 6. | 17% | 82% |

PSH reported that it intends to ensure implementation of a standardized transfer note template to increase compliance with this requirement.

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

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

**Other findings:**
This monitor reviewed the charts of seven individuals who experienced inter-unit transfers during the review period. The following is an outline of the reviews:

| Initials | Date of transfer |
|---|---|
| AGB | 03/24/09 |
| CAZ | 03/16/09 |
| DVL | 05/01/09 |
| PAV | 03/02/09 |

| | | |
|---|---|---|
| RRW | 04/02/09 |
| TB | 04/24/09 |
| TYH | 04/01/09 |

The reviews found substantial compliance in one chart (TYH) and partial compliance in six (AGB, CAZ, DVL, PAV, RRW and TB). The main barrier to compliance was the lack of adequate information in the following areas:

1. The anticipated benefits of the transfer were either not mentioned or stated in generic terms in all cases.
2. The course of hospitalization (psychiatric and medical), psychiatric risk assessment and discharge barriers were generally incomplete and inadequate to ensure continuity of care at the receiving unit.

**Compliance:**
Partial.

**Current recommendations**:
1. Provide ongoing feedback and mentoring to correct the deficiencies outlined by this monitor with respect to transfer psychiatric assessments.
2. Monitor this requirement using the DMH Physician Inter-Unit Transfer Note 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.
5. Provide information regarding the frequency of inter-unit transfers of individuals who present severe management problems and have not received behavioral interventions in accord with PBS principles.

| 2. Psychological Assessments | | |
|---|---|---|
| | | **Methodology:**<br><br><u>Interviewed</u>:<br>1. Allison Pate, PhD, Senior Supervising Psychologist<br>2. David Haimson, PhD, Chief of Psychology<br>3. Susan Velasquez, PhD, PSSC Coordinator<br>4. Dominique Kinney, PhD, Senior Psychologist Specialist<br>5. Helga Thordarson, PhD, Senior Supervising Psychologist<br>6. Steven Berman, PhD, Psychologist, By Choice Coordinator<br><br><u>Reviewed</u>:<br>1. Chart review of the following 50 individuals: AAA, AKR, AM, BG, BM, BRC, BTC, CAL, CCR, CDP, CK, CRG, CS, DC, DDL, EC, EJB, GT, HG, JE, JEB, JJG, JMB, JME, JOS, JP, JTM, LEW, LP, MD, MJB, MO, MRC, MZ, PLN, PR, RA, RB, RC, REA, RLP, RP, RVB, TB, TCK TMM, TT, WR, YG, and YT<br>2. List of individuals tested in their primary/preferred languages<br>3. List of school-age/other individuals needing cognitive and academic assessments within 30 days of admission<br>4. Standard Assessment Protocols<br>5. Cognitive/Academic Assessments<br>6. Psychological Focused Assessments<br>7. Structural/Functional Assessments<br>8. List showing verifiable competence in assessment<br>9. List showing Senior Psychologists' observations of Psychological Assessments<br>10. Standard Assessment Protocols<br>11. Integrated Assessments completed on individuals admitted prior to the effective date<br>12. Integrated Psychological Assessments |

| | | |
|---|---|---|
| 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 recommendations:**<br><br>**Recommendation 1, December 2008:**<br>Ensure that revised documents or manuals, where applicable, are aligned across DMH hospitals.<br><br>**Findings:**<br>Documentation review found that the DMH Psychology, PBS and By Choice manuals have been completed and aligned across DMH hospitals.<br><br>**Recommendation 2, December 2008:**<br>Ensure that there are sufficient numbers of psychologists to fulfill all requirements of the EP.<br><br>**Findings:**<br>See findings for Recommendation 1, D.2.c.<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendation**:<br>Continue current practice. |
| D.2.b | Each State hospital shall require the completion of cognitive and academic assessments within 30 days of admission of all school-age and other individuals, as required by law, unless comparable testing has been performed within one year of admission and is available to the interdisciplinary team. | **Current findings on previous recommendation:**<br><br>**Recommendation, December 2008:**<br>Continue current practice.<br><br>**Findings:**<br>Documentation review found that PSH had admitted 30 individuals age 22 and younger during this review period. Eleven of the 30 met criteria for cognitive and intellectual assessments. However, all but one refused to participate and declined services. Using the DMH Psychology Assessment |

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<td>Monitoring Form, PSH assessed its compliance based on an average sample of 100% of all individuals below 23 years of age during this review period (November 2008 – April 2009):
<table>
<tr><td>1.</td><td>Each State hospital shall require the completion of cognitive and academic assessments within 30 days of admission of all school-age and other individuals (i.e., 22 years or younger), as required by law, unless comparable testing has been performed within one year of admission and is available to the interdisciplinary team.</td><td>100%</td></tr>
</table>
This monitor's findings from review of completed assessments are in agreement with the facility's findings.<br><br>
Compliance:<br>
Substantial.<br><br>
Current recommendation:<br>
Continue current practice.</td>
</tr>
<tr>
<td>D.2.c</td>
<td>Each State hospital shall ensure that all clinicians responsible for performing or reviewing psychological assessments and evaluations are verifiably competent in the methodology required to conduct the assessment.</td>
<td>Current findings on previous recommendations:<br><br>
Recommendation 1, December 2008:<br>
Fill all vacant psychology positions.<br><br>
Findings:<br>
Documentation review and staff interviews found that PSH employed 89 psychologists during this review period. Eighty-seven of them are active filled positions and two are not full FTEs. Six psychologists left employment at PSH during this review period and the facility was able to hire three new staff, with six others targeted for hire soon. The staffing strength stands at 90%. However, a number of psychologists</td>
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| | | hold other positions (Clinical Administrator, Mall Director, Mall Coordinator, and Standards Compliance). Thus, the number needed for clinical work is much lower than the number of "filled" positions.<br><br>Sixty-four psychologists are licensed. Thirty-eight have full medical staffing privileges, and 26 have provisional privileges. The remaining 25 are privileged through the Psychology Department and function under supervision from the licensed Psychologists.<br><br>The PSH staffing table shown in the Introduction indicates that there were 95.9 positions budgeted for psychologists and senior psychologists, and that 85.2 positions were filled as of May 1, 2009.<br><br>**Recommendation 2, December 2008:**<br>Ensure that senior psychologists have the necessary time to properly mentor and supervise psychology staff.<br><br>**Findings:**<br>According to the Chief of Psychology and the Senior Psychologists, supervision has been the Senior Psychologists' priority during this review period. Senior Psychologists have been supervising By Choice, behavioral interventions, risk management, psychological assessments and resolution of diagnostic uncertainties. Apparently, the Senior Psychologists' roles had expanded with their participation in the hospital-wide efforts to improve EP compliance. Three lead psychologists dedicate twelve hours per week to the WRP Mentoring Project. One admission lead psychologist had been dedicated to full-time supervision of WRPTs as part of the facility's "6Ps Clean-Up Project." The Senior Psychologists also have used the "EP News" feature in the Psychology newsletter as a supplement to direct supervision.<br><br>**Recommendation 3, December 2008:**<br>Ensure that staff is trained on the Psychology Focused Assessment and |

fully implemented when the instrument receives DMH approval.

**Findings:**
According to the Chief of Psychology the focused assessment template is fully implemented. Documentation showed that staff was trained on the template.

Senior Psychologists review all Focused Psychology Assessments and provide corrective feedback prior to finalization of the reports. Staff education and training on the Psychology Focused Assessments is integrated into the Psychology Department training program and new hire orientation.

**Other findings:**
PSH establishes competence of psychologists by ensuring that the psychologists have the necessary professional credentials and training relevant to the EP and their scope of practice, and by observing their conduct of assessments. The following table shows the number of staff involved in performing evaluations, the number of staff meeting the facility's credentialing and privileging requirements, and the number of staff observed and found to be competent:

| | | |
|---|---|---|
| 1.a | *Number of psychologists who are responsible for performing or reviewing psychological assessments and evaluations* | 89 |
| 1.b | *Number of psychologists who meet the hospital's credentialing and privileging requirements* | 89 |
| 2.a | *Number of psychologists observed while undertaking psychological assessments* | 14 |
| 2.b | *Number observed to be verifiably competent in assessment procedures* | 14 |

| | | |
|---|---|---|
| | | **Compliance:**<br>Substantial.<br><br>**Current recommendations**:<br>1. Ensure that there are sufficient numbers of psychologists to fulfill all requirements of the EP.<br>2. Ensure that senior psychologists have the necessary time to properly mentor and supervise psychology staff. |
| D.2.d | Each State hospital shall ensure that all psychological assessments, consistent with generally accepted professional standards of care, shall: | **Compliance:**<br>Substantial. |
| D.2.d.i | expressly state the clinical question(s) for the assessment; | **Current findings on previous recommendation:**<br><br>**Recommendation, December 2008:**<br>Continue current practice.<br><br>**Findings:**<br>Using the DMH Psychology Assessment Monitoring form, PSH assessed its compliance based on an average sample of 84% of the Focused Psychological Assessments due each month for the review period (November 2008 – April 2009):<br><br>3. *Expressly state the clinical question(s) for the assessment.* 100%<br><br>Comparative data indicated maintenance of a compliance rate of or greater than 90% from the previous review period.<br><br>A review of the Focused Psychology Assessments for six individuals (BG, BM, LP, PR, RC and TMM) found that all six contained clear and concise |

<table>
<tr><td></td><td></td><td>statements with a rationale for the referral.<br><br>Current recommendation:<br>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:<br><br>Recommendation, December 2008:<br>Continue with the current practice of including findings specifically addressing the clinical question(s), but not limited to diagnoses and treatment recommendations.<br><br>Findings:<br>Using the DMH Psychology Assessment Monitoring form, PSH assessed its compliance based on an average sample of 84% of the Focused Psychological Assessments due each month for the review period (November 2008 – April 2009):<br><br>
<table>
<tr><td>4.</td><td>Include findings specifically addressing the clinical question(s), but not limited to diagnoses and treatment recommendations.</td><td>100%</td></tr>
</table>
<br>Comparative data indicated maintenance of a compliance rate of or greater than 90% from the previous review period.<br><br>A review of the Focused Psychology Assessments for the above-identified six individuals found that all six addressed the clinical question and the findings included sufficient information to inform the psychiatric diagnosis, identified the individual’s treatment and rehabilitation needs, and suggested interventions for inclusion in the individual’s WRP.<br><br>Current recommendation:<br>Continue current practice.</td></tr>
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<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>
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**Current findings on previous recommendation:**

**Recommendation, December 2008:**
Ensure that all psychological assessments include findings and recommendations pertaining to the individual's participation in therapeutic services.

**Findings:**
Using the DMH Psychology Assessment Monitoring form, PSH assessed its compliance based on an average sample of 84% of the Focused Psychological Assessments due each month for the review period (November 2008 – April 2009):

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<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>96%</td>
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Comparative data indicated maintenance of a compliance rate of or greater than 90% from the previous review period.

A review of the Focused Psychology Assessments for the above-identified six individuals found that all six indicated if the individual would benefit from individual and/or group therapy.

**Current recommendation**:
Continue current practice.

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<tr>
<td>D.2.d.iv</td>
<td>be based on current, accurate, and complete data;</td>
<td>

**Current findings on previous recommendation:**

**Recommendation, December 2008:**
Continue and improve on current practice.

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**Findings:**
Using the DMH Psychology Assessment Monitoring form, PSH assessed its compliance based on an average sample of 84% of the Focused Psychological Assessments due each month for the review period (November 2008 – April 2009):

<table>
<tr><td></td><td>Be based on current, accurate, and complete data.</td><td></td></tr>
<tr><td>6.a</td><td>The identification information is stated (including but not limited to the name of individual, ID#, age/date of birth, marital status, gender, level of education, ethnicity and/or cultural identity, preferred language, religion/spiritual preferences, legal status, date of report) per Section I of the DMH Focused Psychological Assessment:</td><td>99%</td></tr>
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Comparative data indicated maintenance of a compliance rate of or greater than 90% from the previous review period.

A review of the Focused Psychology Assessments for 14 individuals (AKR, BG, BM, CS, JMB, JME, LP, PR, RC, RLP, TMM, TT, WR and YG) found that all 14 included the identification information, listed the sources of information and documented direct observation information, including the individual's cooperation and motivation during the evaluation.

**Current recommendation**:
Continue current practice.

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<td>D.2.d.v</td>
<td>determine whether behavioral supports or interventions (e.g., behavior guidelines or mini behavior plans) are warranted or whether a full positive behavior support plan is required;</td>
<td>

**Current findings on previous recommendation:**

**Recommendation, December 2008:**
Ensure that all psychological assessments of individuals with maladaptive behavior meet this requirement.

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**Findings:**
Using the DMH Psychology Assessment Monitoring form, PSH assessed its compliance based on an average sample of 84% of the Focused Psychological Assessments due each month for the review period (November 2008 – April 2009):

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<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>99%</td>
</tr>
</table>

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

A review of the Focused Psychology Assessments for six individuals (BG, BM, LP, PR, RC and TMM) found that all six indicated whether the individual would benefit from behavioral guidelines or required Positive Behavioral Support.

**Current recommendation:**
Continue current practice.

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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, December 2008:**
Continue current practice.

**Findings:**
Using the DMH Psychology Assessment Monitoring form, PSH assessed its compliance based on an average sample of 84% of the Focused Psychological Assessments due each month for the review period (November 2008 – April 2009):

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<tr><td>8.</td><td>Include the implications of the findings for interventions</td><td>100%</td></tr>
</table>
<br>
Comparative data indicated maintenance of a compliance rate of or greater than 90% from the previous review period.<br><br>
A review of the Focused Psychology Assessments for the above-identified six individuals found that all six contained documentation of the implications of the findings for PSR and other interventions.<br><br>
Current recommendation:<br>
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:<br><br>
Recommendation 1, December 2008:<br>
Ensure that all psychological assessments meet this requirement.<br><br>
Findings:<br>
Using the DMH Psychology Assessment Monitoring form, PSH assessed its compliance based on an average sample of 84% of the Focused Psychological Assessments due each month for the review period (November 2008 – April 2009):<br><br>
<table>
<tr><td>9.</td><td>Identify any unresolved issues encompassed by the assessment and, where appropriate, specify further observations, records review, interviews, or re-evaluations that should be performed or considered to resolve such issues.</td><td>98%</td></tr>
</table>
<br>
Comparative data indicated maintenance of a compliance rate of or greater than 90% from the previous review period.
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| | | |
|---|---|---|
| | | A review of the Focused Psychology Assessments for the above-identified six individuals found that all six contained statements on unresolved issues encompassed by the assessment, avenues to resolve the inconsistencies and a timeline for doing so. In all cases, the information and recommendations were included in the individual's WRP. Additional workups requested were not completed yet, but were within the 60-day timeline.<br><br>**Recommendation 2, December 2008:**<br>Ensure that WRPTs review and include appropriate recommendations in the individual's WRP.<br><br>**Findings:**<br>In an interview, the Chief of Psychology said that in April 2009, PSH conducted a "6P Clean-Up Project" to address EP matters system-wide. As part of this review and training, teams reviewed psychological assessments and ensured that findings and recommendations were incorporated into the individuals' WRPs. According to the Chief of Psychology, six senior supervising psychologists now attend weekly Trigger meetings (PRC and combined PSSC/ETRC meetings).<br><br>**Recommendation 3, December 2008:**<br>Ensure that additional workups are completed as requested.<br><br>**Findings:**<br>According to the Chief of Psychology, the Psychology Assessment Center now operates as a facility-wide referral system. Additional workups identified in tests are tracked. Resources are made available to facilitate specialized or urgent workups, and critical assessments are "fast-tracked" or referred for expert consultation. |

<table>
<tr><td></td><td></td><td>Current recommendation:<br>Continue current practice.</td></tr>
<tr><td>D.2.d.<br>viii</td><td>Use assessment tools and techniques appropriate for the individuals assessed and in accordance with the American Psychological Association Ethical Standards and Guidelines for testing.</td><td>Current findings on previous recommendation:<br><br>Recommendation, December 2008:<br>Ensure that the American Psychological Association Ethical Standards and Guidelines for Testing are followed.<br><br>Findings:<br>Using the DMH Psychology Assessment Monitoring form, PSH assessed its compliance based on an average sample of 84% of the Focused Psychological Assessments due each month for the review period (November 2008 – April 2009):<br><br>
<table>
<tr><td>10.</td><td>Use assessment tools and techniques appropriate for the individuals assessed and in accordance with the American Psychological Association Ethical Standards and Guidelines for testing</td><td>99%</td></tr>
</table>
<br>Comparative data indicated maintenance of a compliance rate of or greater than 90% from the previous review period.<br><br>A review of the Focused Psychology Assessments for ten individuals (AKR, BG, BM, JME, LP, PR, RC, TMM, TT and WR) found that all ten assessments were conducting using assessment tools that were appropriate to address the referral questions and for the individuals assessed in accordance with the American Psychological Association Ethical Standards and Guidelines for Testing. The assessments included statements of confidentiality and validity of the testing, used instruments from the facility's Clinical Indicator List of approved instruments and the instruments used for the testing were appropriate to answer the referral questions.</td></tr>
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| | | **Current recommendation**:<br>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 recommendations:**<br><br>**Recommendations 1-3, December 2008:**<br>• Ensure that psychological tests are completed in a timely manner, as specified in the EP.<br>• Ensure that reports meet acceptable quality.<br>• Review all psychological assessments of all individuals residing at PSH who were admitted prior to June 1, 2006, and complete further assessments as required by the EP.<br><br>**Findings:**<br>Documentation review and interview of the Chief of Psychology confirmed that PSH has completed all reviews and retesting of individuals admitted before June 1, 2006.<br><br>At the end of the last review period, PSH had 52 assessments to be completed. A review of the charts of six individuals admitted before June 1, 2006 (AAA, EC, JEB, MJB, RA and RB) found that all six contained the revised Integrated Assessments: Psychology Section. The assessments were complete and comprehensive. The assessment for EC was not available in the chart for review; however a Psychology progress note was in the chart with the assessment date and data.<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendation:**<br>None. |

| | | |
|---|---|---|
| D.2.f | Each State hospital shall ensure that all appropriate psychological assessments shall be provided in a timely manner whenever clinically indicated, consistent with generally accepted professional standards of care, including whenever there has been a significant change in condition, a lack of expected improvement resulting from treatment, or an individual's behavior poses a significant barrier to treatment, therapeutic programming, safety to self or others, or school programming, and, in particular: | **Compliance:**<br>Substantial. |
| D.2.f.i | before an individual's therapeutic and rehabilitation service plan is developed, a psychological assessment of the individual shall be performed that will: | **Current findings on previous recommendation:**<br><br>**Recommendation, December 2008:**<br>Ensure that integrated psychological assessments are conducted in a timely manner as required.<br><br>**Findings:**<br>Using the DMH Psychology Assessment Monitoring form, PSH assessed its compliance based on an average sample of 95% of the Integrated Assessments: Psychology Section (IAPs) due each month for the review period (November 2008 – April 2009):<br><br>12. *Before an individual's therapeutic and rehabilitation service plan is developed, a psychological assessment of the individual shall be performed.* 94%<br><br>Comparative data indicated improvement in compliance from 68% in the previous review period.<br><br>A review of the IAPs for 13 individuals (BTC, CAL, CCR, DDL, GT, HG, JTM, MRC, MZ, REA, RP, RVB and TB) found that all 13 were conducted in |

<table>
<tr><td></td><td></td><td>a timely manner.<br><br>Current recommendation:<br>Ensure that integrated psychological assessments are conducted in a timely manner as required.</td></tr>
<tr><td>D.2.f.i.1</td><td>address the nature of the individual's impairments to inform the psychiatric diagnosis; and</td><td>Current findings on previous recommendation:<br><br>Recommendation, December 2008:<br>Ensure that integrated psychological assessments address the nature of the individual's impairments that inform the psychiatric diagnosis.<br><br>Findings:<br>Using the DMH Psychology Assessment Monitoring form, PSH assessed its compliance based on an average sample of 100% of the Integrated Assessments: Psychology Section (IAPs) completed each month for the review period (November 2008 – April 2009):<br><br>
<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>
<br>Comparative data indicated maintenance of a compliance rate of or greater than 90% from the previous review period.<br><br>A review of the IAPs for the above-identified 13 individuals found that 12 documented the nature of the individual's psychological impairments and provided adequate information to inform the psychiatric diagnosis (BTC, CAL, DDL, GT, HG, JTM, MRC, MZ, REA, RP, RVB and TB). The remaining one (CCR) did not fully address the nature of the individual's impairments and/or translate the assessment data into practical terms so the individual's WRPT could determine the nature, direction, and sequence of interventions needed for the individual's rehabilitation.</td></tr>
</table>

<table>
<tr><td></td><td></td><td>Current recommendation:<br>Ensure that integrated psychological assessments address the nature of the individual's impairments that 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:<br><br>Recommendation, December 2008:<br>Ensure accurate and complete evaluation of an individual's psychological functioning that informs the WRPTs of the individual's rehabilitation service needs.<br><br>Findings:<br>Using the DMH Psychology Assessment Monitoring form, PSH assessed its compliance based on an average sample of 100% of the Integrated Assessments: Psychology Section (IAPs) due each month for the review period (November 2008 – April 2009):<br><br>
<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>
<br>Comparative data indicated maintenance of a compliance rate of or greater than 90% from the previous review period.<br><br>A review of the IAPs for the above-identified 13 individuals found that 12 provided an accurate and valid evaluation of the individual's psychological functioning, and the assessment data were interpreted to assist the WRPTs in determining the interventions needed for the individual's rehabilitation (BTC, CAL, DDL, GT, HG, JTM, MRC, MZ, REA, RP, RVB and TB). The remaining one (CCR) did not include data for the explanation given.</td></tr>
</table>

| | | |
|---|---|---|
| | | **Current recommendation**:<br>Ensure accurate and complete evaluation of an individual's psychological functioning that informs the WRPTs 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:**<br><br>**Recommendation, December 2008:**<br>Ensure that PBS referrals get timely attention to assist unit staff to manage individuals with significant learned maladaptive behaviors.<br><br>**Findings:**<br>A review of documentation found that PBS teams conduct structural and functional assessments for all PBS referrals prior to developing and implementing PBS plans. Data also showed that all PBS referrals are attended to within a 72-hour period.<br><br>**Current recommendation**:<br>Continue current practice. |
| D.2.f.iii | additional psychological assessments shall be performed, as appropriate, where clinical information is otherwise insufficient, and to address unresolved clinical or diagnostic questions, including differential diagnosis, "rule-out," "deferred," "no-diagnosis" and "NOS" diagnoses. | **Current findings on previous recommendations:**<br><br>**Recommendations 1-3, December 2008:**<br>• Ensure that additional psychological assessments are performed as required.<br>• Ensure that the facility's monitoring instrument that addresses "no diagnosis" is aligned with the key requirement, i.e. that "no diagnosis" is backed up by clinical data, especially in individuals with forensic issues.<br>• Ensure that supporting documents are recorded and referenced when using previous assessment results to address diagnosis-related matters. |

**Findings:**
According to the Chief of Psychology, PSH established a tracking and prompting system to support unit psychologists in meeting follow-up assessment deadlines. This was conducted through identification of assessments with diagnostic uncertainties and followed up with information to unit psychologists. Further notification to unit psychologists was provided when the due date for completion of the assessment approached. PSH had encountered difficulty in completing follow-up assessments in a timely manner when the individuals were transferred to long-term units before the 60-day mark. PSH now follows up the issue of testing with the WRPT psychologists for resolution of the diagnostic uncertainty. The efforts seemed to pay off, as compliance greater than 90% was noted during follow-up review in March and April 2009.

According to the Chief of Psychology and the Senior Psychologists, Psychologists are informed on the requirement to have supporting documents referenced when using previous assessments to address diagnosis-related matters.

Using the DMH Psychology Assessment Monitoring Form, PSH assessed its compliance based on an average sample of 78% of the Integrated Assessments: Psychology Section (IAPs) due each month during the review period (November 2008 – April 2009). The following table showing the diagnoses and the corresponding compliance rate of assessments that resolved the diagnostic uncertainties is a summary of the facility's data:

| | | |
|---|---|---|
| 16. | *Differential diagnosis* | 75% |
| 17. | *Rule-out* | 73% |
| 18. | *Deferred* | 72% |
| 19. | *No diagnosis* | 98% |
| 20. | *NOS diagnosis* | 81% |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 16. *Differential diagnosis* | 56% | 75% |
| 17. *Rule-out* | 30% | 73% |
| 18. *Deferred* | 45% | 72% |
| 19. *No diagnosis* | 95% | 98% |
| 20. *NOS diagnosis* | 25% | 81% |

PSH's item for "no diagnosis" in the monitoring instrument is aligned with the key requirement that a case of "no diagnosis" is accompanied with clinical data. PSH utilizes the DSM-IV-TR Checklist for this purpose. The psychologists use the DSM-IV-TR as part of their IAP assessment.

This monitor reviewed the charts of 11 individuals whose diagnoses needed clarification due to insufficient information to form a firm diagnosis. The review found documentation in 10 charts indicating that additional psychological assessments were requested or conducted (BRC, CDP, JE, JME, JOS, LEW, MD, RA, RLP and TCK). The remaining one (EJB) did not request and/or conduct additional assessments to clarify the diagnostic uncertainties. All the reviewed assessments conducted the necessary assessments and none used previous assessments for the purpose of the diagnostic clarification.

**Current recommendations**:

1. Ensure that additional psychological assessments are performed as required.
2. Ensure that the facility's monitoring instrument that addresses "no diagnosis" is aligned with the key requirement, i.e. that "no diagnosis" is backed up by clinical data, especially in individuals with forensic

<table>
<tr><td></td><td></td><td>issues.<br>3. Ensure that supporting documents are recorded and referenced when using previous assessment results to address diagnosis-related matters.</td></tr>
<tr><td>D.2.g</td><td>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.</td><td>Current findings on previous recommendation:<br><br>Recommendation, December 2008:<br>Ensure that assessments conducted meet the requirement of this cell.<br><br>Findings:<br>Using the DMH Psychology Assessment Monitoring Form, PSH assessed its compliance based on an average sample of 100% of the Integrated Assessments: Psychology Section (IAPs) due each month during the review period (November 2008 – April 2009):<br><br>
<table>
<tr><td>21.a</td><td>Number of individuals who needed assessment during the evaluation period whose primary language was not English</td><td>17</td></tr>
<tr><td>21.b</td><td>Of those in 21.a, number of individuals who were assessed in their primary language</td><td>16</td></tr>
<tr><td>22.a</td><td>Of those in 21.a, number of individuals who could not be assessed</td><td>1</td></tr>
<tr><td>22.b</td><td>Of those in 22.a, number of individuals who had plans developed to meet their assessment needs</td><td>1</td></tr>
<tr><td>23.</td><td>Of those in 22.b, number of individuals whose plans for assessment were implemented</td><td>1</td></tr>
</table>
<br>A review of the charts of nine individuals found that all nine (AM, CK, CRG, DC, JJG, JP, MO, PLN and YT) were assessed in their primary or preferred language. Eight of the individuals in this group were Spanish-</td></tr>
</table>

| | | |
|---|---|---|
| | | speaking, and assessments were conducted by Spanish-speaking psychologists or with the use of interpreters. One Korean speaking individual (CK) wanted to be tested in English; however, psychology staff recognized that CK had difficulty with the language and used a Korean-speaking staff to complete the assessment. CK also was moved to a unit with a Korean-speaking MD.<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendation**:<br>Continue current practice. |

| 3. Nursing Assessments | | |
|---|---|---|
| | | **Methodology:**<br><br>Interviewed:<br>1. Cathy Rhinehart, RN, Nursing Coordinator Program VIII<br>2. Charles Allen, RN, Nursing Coordinator Program VI<br>3. Darold Dahse, RN, Nursing Coordinator Program III<br>4. Diane White, Nursing Coordinator Program I<br>5. Don Clutter, Nursing Coordinator Program VII<br>6. James Birks, RN, Nursing Coordinator Program V<br>7. Kathy Wood, Nursing Coordinator Program VI<br>8. Lidia Lau, RN, Assistant Coordinator of Nursing Services<br>9. Regina Olender, Supervising RN<br>10. Sandra Doerner, Acting Nurse Administrator<br>11. Susan King, Psychiatric Technician, Acting Nursing Coordinator Program IV, Unit Supervisor Program V<br><br>Reviewed:<br>1. PSH's progress report<br>2. Revised DMH Admission and Integrated Nursing Assessment forms<br>3. DMH Admission and Integrated Nursing Assessment Instructions<br>4. PSH Training Rosters for Nursing Assessments<br>5. DMH Registered Nurse Progress Note for Assessment and Evaluation Policy (4/09)<br>6. DMH RN Progress Note for Assessment and Evaluation forms<br>7. Admission and Integrated Assessments for the following 40 individuals: AAG, AAN, BJ, BJC, CDP, CMR, CS, DCS, DJ, DSC, EAS, EEG, EJB, EM, ES, EV, GFW, JA, JAO, JJG, JOD, LCB, LM, LMG, MAW, MGM, PMA, RB, RLR, RMM, RP, RWM, SDG, SE, SR, TSS, VFP, VRE, VV and WSB<br><br>Observed:<br>1. WRPC for LR on Program IV, Unit 36 |

| | | |
|---|---|---|
| | | 2. WRPC for ACC on Program IV, Unit EB-12<br>3. WRPC for RDT on Program VIII, Unit N-20 |
| D.3.a | Each State hospital shall develop standard nursing assessment protocols, consistent with generally accepted professional standards of care. These protocols shall address, at a minimum: | **Compliance:**<br>Partial. |
| D.3.a.i | a description of presenting conditions; | **Current findings on previous recommendations:**<br><br>**Recommendation 1, December 2008:**<br>Ensure compliance scores accurately reflect items being reviewed.<br><br>**Findings:**<br>No response was provided by PSH regarding this recommendation.<br><br>**Recommendation 2, December 2008:**<br>Include the clinical relevance of questions contained in the admission and integrated assessments in RN training.<br><br>**Findings:**<br>No response was provided by PSH regarding this recommendation.<br><br>**Recommendation 3, December 2008:**<br>Continue to monitor this requirement.<br><br>**Findings:**<br>Using the DMH Nursing Admission Assessment Monitoring Audit, PSH assessed its compliance based on a 99% mean sample of admissions each month during the review period (November 2008 - April 2009):<br><br>1. *A description of presenting conditions* 83%<br>1.a *Each section of the Psychiatric and Psychological* 86% |

| | | |
|---|---|---|
| | *section of the Nursing Assessment is complete.* | |
| 1.b | *Each box checked is elaborated on in the narrative description in the summary of presenting observations.* | 79% |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 1. | 6% | 83% |
| Compliance rate in last month of period | | |
| 1. | 16% | 93% |
| 1.a | 48% | 96% |
| 1.b | 30% | 89% |

Since April 2009, the Admission and Integrated Nursing Assessments have been streamlined to reflect the clinical flow of the assessments. Although PSH has made significant progress in this item, a barrier to compliance continues to be when an admission assessment is completed by a float RN on the Admission Suite. The plan of correction includes having Program Management select from a group of RNs based on clinical nursing skills and admission assessment competency from monitoring findings to float to the Admission Suite for coverage. An RN Registry Assessment coach and the Admission Suite RNs provide assistance to the unit RNs focusing on the clinical relevance of the assessment questions.

A review of Admission Nursing Assessments for 40 individuals (AAG, AAN, BJ, BJC, CDP, CMR, CS, DCS, DJ, DSC, EAS, EEG, EJB, EM, ES, EV, GFW, JA, JAO, JJG, JOD, LCB, LM, LMG, MAW, MGM, PMA, RB, RLR, RMM, RP, RWM, SDG, SE, SR, TSS, VFP, VRE, VV and WSB) found that PSH has made significant progress, especially in the area of the

presenting condition on the Admission Nursing Assessments. The narratives for this section contained individual-specific information that reflected clinical data observed by the nurse conducting the assessment. There was also improvement in a number of the goals included in the assessments that were aligned with the information contained in the assessment. With the improvement in these areas, the quality of the admission assessments has also significantly improved. However, the area regarding discharge and barriers to discharge was basically identical in all assessments reviewed and needs to be individualized. The use of a generic template for this section has resulted in the template not being modified to include individual-specific information and in some cases, leaving "he/she" in the section. The other elements of the admission assessments either showed significant improvement or were found to have been appropriately maintained.

Using the DMH Integrated Nursing Assessment Monitoring Audit, PSH assessed its compliance based on a 96% mean sample of admissions each month during the review period (November 2008 - April 2009):

| | | |
|---|---|---|
| 1. | *The present status of the Integrated assessment: Nursing section is complete, or there is documentation that the individual is non-adherent with the interview.* | 88% |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 1. | 61% | 88% |

A review of Integrated Nursing Assessments for 40 individuals (AAG, AAN, BJ, BJC, CDP, CMR, CS, DCS, DJ, DSC, EAS, EEG, EJB, EM, ES, EV,

<table>
<tr><td></td><td></td><td>GFW, JA, JAO, JJG, JOD, LCB, LM, LMG, MAW, MGM, PMA, RB, RLR, RMM, RP, RWM, SDG, SE, SR, TSS, VFP, VRE, VV and WSB) found that PSH has made significant progress regarding the present status documentation contained in the integrated assessments. Similar to what was noted above with regard to the admission assessments, the quality of the content showed significant improvement in all integrated assessments reviewed.<br><br>Other findings:<br>If PSH continues to focus on quality and the few areas in need of further improvement in the Integrated Assessments, the facility should be able to attain substantial compliance by the next review.<br><br>Current recommendation:<br>Continue to monitor this requirement.</td></tr>
<tr><td>D.3.a.ii</td><td>current prescribed medications;</td><td><u>Admission Assessments</u><br><br>
<table>
<tr><td>2</td><td>On the Admission Nursing Assessment, all currently prescribed medications are documented to include the last time taken, dose, side effects if any, the individual's understanding of the medication and reasons for treatment OR there is documentation that medication records are not available and the individual is unable to provide any information about past medication history.</td><td>94%</td></tr>
</table>
<br>Comparative data indicated significant improvement in compliance from 49% in the previous review period.</td></tr>
</table>

<table>
<tr><td></td><td></td><td>Integrated Assessments<br><br><table><tr><td>2.</td><td>On the Integrated Nursing Assessment, all sections of the medication management section are complete, or there is documentation that the individual is non-adherent with the interview, or the "no medication" box is checked.</td><td>98%</td></tr></table><br>Comparative data indicated that PSH maintained a compliance rate of 90% or greater from the previous review period.</td></tr>
<tr><td>D.3.a.iii</td><td>vital signs;</td><td>Admission Assessments<br><br><table><tr><td>3.</td><td>Vital signs</td><td>99%</td></tr></table><br>Comparative data indicated that PSH maintained a compliance rate of 90% or greater from the previous review period.<br><br>Integrated Assessments<br><br><table><tr><td>3.</td><td>Vital signs</td><td>95%</td></tr></table><br>Comparative data indicated improvement in compliance from 84% in the previous review period.</td></tr>
<tr><td>D.3.a.iv</td><td>allergies;</td><td>Admission Assessments<br><br><table><tr><td>4.</td><td>Allergies</td><td>99%</td></tr></table><br>Comparative data indicated significant improvement in compliance from 71% in the previous review period.</td></tr>
</table>

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

<u>Integrated Assessments</u>

| | | |
|---|---|---|
| 4. | *Allergies* | 98% |

Comparative data indicated improvement in compliance from 89% in the previous review period.

</td></tr>
<tr><td>D.3.a.v</td><td>pain;</td><td>

<u>Admission Assessments</u>

| | | |
|---|---|---|
| 5. | *Pain* | 98% |

Comparative data indicated significant improvement in compliance from 68% in the previous review period.

<u>Integrated Assessments</u>

| | | |
|---|---|---|
| 5. | *Pain* | 87% |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 5. | 62% | 87% |
| Compliance rate in last month of period | | |
| 5. | 72% | 97% |

PSH reported that the current plan of action has been effective in improving compliance and no additional action is required.

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

<table>
<tr>
<td>D.3.a.vi</td>
<td>use of assistive devices;</td>
<td>
<u>Admission Assessments</u>
<table>
<tr><td>6.</td><td>Use of assistive devices: The functional assessment and assistive devices section is complete, or the "no concerns", "no condition" or "none" boxes is checked.</td><td>93%</td></tr>
</table>
Comparative data indicated significant improvement in compliance from 54% in the previous review period.<br><br>
<u>Integrated Assessments</u>
<table>
<tr><td>6.</td><td>The update assistive devices use or need section is complete, or the "no problems noted" box is checked.</td><td>97%</td></tr>
</table>
Comparative data indicated improvement in compliance from 86% in the previous review period.
</td>
</tr>
<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>100%</td></tr>
</table>
Comparative data indicated improvement in compliance from 88% in the previous review period.<br><br>
<u>Integrated Assessments</u>
<table>
<tr><td>7.</td><td>Activities of daily living</td><td>80%</td></tr>
</table>
Comparative data indicated improvement in compliance since the previous review period:
</td>
</tr>
</table>

<table>
<tr>
<td></td>
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<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>7.</td><td>46%</td><td>80%</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>7.</td><td>51%</td><td>100%</td></tr>
</table>
<br>PSH reported that the current plan of action has been effective in improving compliance and no additional action is required.
</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>The Risks/Alerts Requiring immediate nursing interventions section is completed or the "none known" box is checked.</td><td>99%</td></tr>
</table>
<br>Comparative data indicated improvement in compliance from 89% in the previous review period.
<br><br><u>Integrated Assessments</u>
<table>
<tr><td>8.</td><td>The Risks/Alerts Requiring immediate nursing interventions section is completed or the "none known" box is checked.</td><td>98%</td></tr>
</table>
<br>Comparative data indicated maintenance of a compliance rate of 90% or greater from the previous review period.
</td>
</tr>
<tr>
<td>D.3.a.ix</td>
<td>conditions needing immediate nursing interventions.</td>
<td>
<u>Admission Assessments</u>
<table>
<tr><td>9.</td><td>Conditions needing immediate nursing interventions</td><td>93%</td></tr>
</table>
</td>
</tr>
</table>

<table>
<tr>
<td></td>
<td></td>
<td>Comparative data indicated significant improvement in compliance from 9% in the previous review period.<br><br><u>Integrated Assessments</u><br><br>
<table>
<tr><td>9.</td><td>Conditions needing immediate nursing interventions</td><td>87%</td></tr>
</table>
<br>Comparative data indicated significant improvement in compliance since the previous review period.<br><br>
<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>9.</td><td>20%</td><td>87%</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>9.</td><td>10%</td><td>99%</td></tr>
</table>
<br>PSH reported that the current plan of action has been effective in increasing compliance and no additional action is required.</td>
</tr>
<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 recommendation:<br><br>Recommendation, December 2008:<br>Continue current practice.<br><br>Findings:<br>PSH's Nursing Department Policy and Procedures and assessment tools verify that they are consistently using the Wellness and Recovery Model for Nursing.<br><br>Compliance:<br>Substantial.</td>
</tr>
</table>

| | | |
|---|---|---|
| | | **Current recommendation**:<br>Continue current practice. |
| D.3.c | Each State hospital shall ensure that all nurses responsible for performing or reviewing nursing assessments are verifiably competent in performing the assessments for which they are responsible. All nurses who are employed at Patton 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 recommendation:**<br><br>**Recommendation, December 2008:**<br>Continue current practice.<br><br>**Findings:**<br>PSH's training rosters verified that all 52 RNs who were required to complete competency-based training for Nursing Assessments completed and passed the training.<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendation**:<br>Continue current practice. |
| D.3.d | Each State hospital shall ensure that nursing assessments are undertaken on a timely basis, and in particular, that: | **Compliance:**<br>Partial. |
| D.3.d.i | Initial nursing assessments are completed within 24 hours of the individual's admission; | **Current findings on previous recommendations:**<br><br>**Recommendation 1, December 2008:**<br>Ensure that the "Sections Completed" area is appropriately completed.<br><br>**Findings:**<br>Review of 40 Nursing Admission Assessments found that this section was completed for all assessments. |

<table>
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<td></td>
<td></td>
<td>
Recommendation 2, December 2008:<br>
Continue to monitor this requirement.<br><br>
Findings:<br>
Using the DMH Nursing Admission Assessment Monitoring Audit, PSH assessed its compliance based on a 99% mean sample of admissions each month during the review period (November 2008 - April 2009):<br><br>
<table>
<tr><td>10.</td><td>Initial nursing assessments are completed within 24 hours of the individual's admission.</td><td>99%</td></tr>
</table>
<br>
Comparative data indicated that PSH maintained a compliance rate of 90% or greater from the previous review period.<br><br>
A review of Nursing Admission Assessments for 40 individuals (AAG, AAN, BJ, BJC, CDP, CMR, CS, DCS, DJ, DSC, EAS, EEG, EJB, EM, ES, EV, GFW, JA, JAO, JJG, JOD, LCB, LM, LMG, MAW, MGM, PMA, RB, RLR, RMM, RP, RWM, SDG, SE, SR, TSS, VFP, VRE, VV and WSB) found that all were timely completed.<br><br>
Compliance:<br>
Substantial.<br><br>
Current recommendation:<br>
Continue current practice.
</td>
</tr>
<tr>
<td>D.3.d.ii</td>
<td>Further nursing assessments are completed and integrated into the individual's therapeutic and rehabilitation service plan within seven days of admission; and</td>
<td>
Current findings on previous recommendation:<br><br>
Recommendation, December 2008:<br>
Continue to monitor this requirement.<br><br>
Findings:<br>
Using the DMH Nursing Integrated Assessment Monitoring Audit, PSH
</td>
</tr>
</table>

assessed its compliance based on a 96% mean sample of admissions each month during the review period (November 2008 - April 2009):

| | | |
|---|---|---|
| 10. | *Further nursing assessments are completed and integrated into the individual's therapeutic and rehabilitation service plan within seven days of admission.* | 75% |
| 10.a | *The Integrated Nursing Assessment is completed prior to the 7 day WRP, and* | 69% |
| 10.b | *An RN was present and signed the 7 day WRP.* | 81% |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 10. | 29% | 75% |
| Compliance rate in last month of period | | |
| 10. | 45% | 91% |
| 10.a | NA | 93% |
| 10.b | 45% | 88% |

PSH indicated that in March 2009, five specific RNs were not timely in completing the Integrated Assessments. The plan of correction included providing this information to Program Management for supervision and follow-up. No barriers or plan of correction were provided regarding RN attendance at the WRPTs.

A review of Integrated Nursing Assessments for 40 individuals (AAG, AAN, BJ, BJC, CDP, CMR, CS, DCS, DJ, DSC, EAS, EEG, EJB, EM, ES, EV, GFW, JA, JAO, JJG, JOD, LCB, LM, LMG, MAW, MGM, PMA, RB, RLR, RMM, RP, RWM, SDG, SE, SR, TSS, VFP, VRE, VV and WSB) found that

<table>
<tr><td></td><td></td><td>39 were timely completed and 34 had an RN present at the WRPT.<br><br>Compliance:<br>Partial.<br><br>Current recommendations:<br>1. Provide barriers and plan of correction for required items.<br>2. Continue to monitor this requirement.</td></tr>
<tr><td>D.3.d.iii</td><td>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.</td><td>Current findings on previous recommendation:<br><br>Recommendation, December 2008:<br>Continue to monitor this requirement.<br><br>Findings:<br>Using the DMH Observation Monitoring Audit, PSH assessed its compliance based on a mean sample of 36% of quarterly and annual WRPCs observed each month during the review period (November 2008 - April 2009):<br><br>
<table>
<tr><td>3.</td><td>Each member of the team participates appropriately, competently and knowledgeably assessing the individual on an ongoing basis and in developing, monitoring, and as necessary, revising the therapeutic and rehabilitation services.</td><td>59%</td></tr>
</table>
<br>Comparative data indicated improvement in compliance since the previous review period:<br><br>
<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td>Mean compliance rate</td><td></td><td></td></tr>
<tr><td>3.</td><td>13%</td><td>59%</td></tr>
</table>
</td></tr>
</table>

| Compliance rate in last month of period | | |
|---|---|---|
| 3. | 55% | 66% |

PSH's analysis indicated that the average of the last quarter's (Feb-April) performance regarding this item demonstrated that seven out of 32 units consistently contributed to the low compliance rates. Of these seven units, four have not been fully staff psychiatrically, possibly contributing to the low compliance. The plan of action includes having all units fully staffed by August 1, 2009.

From observations of three WRPCs (Program IV, Units 36 and EB-12 and Program VIII, Unit N-20), full teams were present at two of the WRPCs and two teams appeared well-prepared and presented clinically relevant information regarding the individual and health and mental health WRP objectives. One of the teams seemed to be unprepared and the information provided at the conference indicated that they did not know the individual well after having worked with him for a year. In addition, there was no psychologist in attendance at this WRPC.

**Other findings:**
PSH's data for this requirement combines participation by all members of the WRPTs, not just nursing (RN and PT), which may skew the data depending on lack of participation from other disciplines. The facility may want to consider breaking out the data for RNs and PTs to more accurately reflect these disciplines' participation.

**Compliance**:
Partial.

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

| 4. Rehabilitation Therapy Assessments | | |
|---|---|---|
| | | **Methodology:**<br><br>Interviewed:<br>1. Alejandro Fernandez, Senior Rehabilitation Therapist<br>2. Billy Mange, Senior Vocational Rehabilitation Counselor<br>3. Chris Keierleber, Acting Senior Rehabilitation Therapist<br>4. Colleen O'Neill, Vocational Services Rehabilitation Therapist<br>5. Cynthia Siples, Vocational Services Rehabilitation Therapist<br>6. Greg Siples, Chief of Rehabilitation Therapy Services<br>7. Jack Baum, Senior Vocational Rehabilitation Counselor<br>8. Jacqueline Doss-Haynes, Senior Rehabilitation Therapist<br>9. Jay Gehrke, Industrial Therapist<br>10. Mark Camero, Senior Rehabilitation Therapist<br>11. Mike Gomes, Senior Rehabilitation Therapist<br>12. Renata Geyer, Acting Senior Rehabilitation Therapist<br>13. Stan Hydinger, Senior Rehabilitation Therapist<br><br>Reviewed:<br>1. DMH Rehabilitation Therapy IA-RTS audit data for November 2008-April 2009<br>2. Focused assessment audit data for November 2008-April 2009 for Vocational Rehabilitation, Occupational Therapy, Speech Therapy and Physical Therapy<br>3. List of individuals who had IA-RTS assessments from November 2008-April 2009<br>4. Records for the following 14 individuals who had IA-RTS assessments from November 2008-April 2009: ANT, DIB, DLR, JW, KC, LC, MBE, MM, NMJ, PLJ, RLR, TG, TS and WDJ<br>5. List of individuals who had Vocational Rehabilitation assessments from November 2008-April 2009<br>6. Records for the following eight individuals who had Vocational Rehabilitation Assessments from November 2008-April 2009: ADT, |

| | | |
|---|---|---|
| | | EMN, JCH, JD, LRS, MRS, RMM and VEB<br>7. List of individuals who had Physical Therapy assessments from November 2008-April 2009<br>8. Records for the following five individuals who had Physical Therapy assessments from November 2008-April 2009: AEJ, BJ, BZ, RF and TN<br>9. List of individuals who had Occupational Therapy assessments from November 2008-April 2009<br>10. Records for the following five individuals who had Occupational Therapy assessments from November 2008-April 2009: AFF, FD, LBP, MRR and PC<br>11. List of individuals who had Speech Therapy assessments from November 2008-April 2009<br>12. Records for the following five individuals who had Speech Therapy assessments from November 2008-April 2009: AB, AKA, JHB, LM and PH<br>13. List of individuals with CIPRTA assessments from November 2008-April 2009<br>14. Records for the following five individuals who had CIPRTA assessments from November 2008-April 2009: NM, RE, REB, RRR and TC<br>15. List of individuals who had type D.4.d assessments from November 2008-April 2009<br>16. Records of the following seven individuals who had type D.4.d assessments from November 2008-April 2009: CMTR, DVS, GB, JHC, KED, LM and RDK<br>17. O*Net Interest Profile Assessment |
| 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 | **Current findings on previous recommendations:**<br><br>**Recommendation 1, December 2008:**<br>Implement the Department of Mental Health Rehabilitation Therapy Service Manual draft and revise as needed based on changes, new |

| | | |
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| | therapy assessment. | 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.<br><br>**Findings:**<br>The Rehabilitation Therapy Service Manual was approved and implemented on 1/13/09.<br><br>**Recommendation 2, December 2008:**<br>Utilize standardized assessments (e.g. Careerscope) when available as part of the vocational rehabilitation focused assessments as clinically indicated.<br><br>**Findings:**<br>The Vocational Services staff is now using different supplemental standardized assessments based on the assessment need for each individual. Supplemental Focused assessments currently in use are the CASAS, implemented 8/28/08, and the O*Net Interest Profiler. Use of the Careerscope has been delayed due to limited access to the computer lab.<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendation**:<br>Continue current practice. |
| D.4.b | Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care: | **Current findings on previous recommendation:**<br><br>**Recommendation, December 2008:**<br>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.

**Findings:**
Using the DMH Integrated Assessment Rehabilitation Therapy Section Monitoring Tool, PSH assessed its compliance with timeliness based on an average sample of 100% of Integrated Rehabilitation Therapy Assessments due each month for the review period November 2008 - April 2009 (total of 509):

| | | |
|---|---|---|
| 1. | *Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:* | 99% |

Comparative data indicated that PSH maintained a compliance rate of 90% or greater from the previous review period.

A review of the records of 14 individuals to assess compliance of IA-RTS Assessments with timeliness found 13 records in compliance (ANT, DIB, JW, KC, LC, MBE, MM, NMJ, PLJ, RLR, TG, TS and WDJ) and one record not in compliance (DLR).

Using the DMH Occupational Therapy Focused Assessment Monitoring Tool, PSH assessed its compliance with timeliness based on an average sample of 100% of Occupational Therapy Focused Assessments due each month for the review period November 2008 - April 2009 (total of 35):

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

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

A review of the records of four individuals to assess compliance of Occupational Therapy Focused Assessments with timeliness found three records in compliance (FD, LBP and MRR) and one record not in compliance (PC).

Using the DMH Physical Therapy Focused Assessment Monitoring Tool, PSH assessed its compliance with timeliness based on an average sample of 100% of Physical Therapy Focused Assessments due each month for the review period November 2008 - April 2009 (total of 84):

| | | |
|---|---|---|
| 1. | *Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:* | 13% |
| 1.a | *The assessment was completed within 14 days of referral, and* | 11% |
| 1.b | *Filed in the medical record.* | 15% |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 1. | 5% | 13% |
| Compliance rate in last month of period | | |
| 1.a | 0% | n/a |
| 1.b | 0% | n/a |

The facility reviewed the data and determined that low compliance with

| | | |
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| | | item 1 is due to inadequate staffing to complete assessments in a timely manner. Currently, there is only one Physical Therapist employed, and the Physical Therapy Assistant's contract was terminated in March 2009. This resulted in an increased workload for the current PT, who is now responsible for all direct treatment sessions in addition to completion of assessments. The facility plans to improve compliance by prioritizing referrals based on acuity and by actively recruiting additional Physical Therapy staff during the upcoming fiscal year.<br><br>A review of the records of five individuals to assess compliance of Physical Therapy Focused Assessments with timeliness found one record not in compliance (BJ); the remaining four records did not contain referrals so it was not possible to determine timeliness with assessment based on record review.<br><br>Using the DMH Speech Therapy Focused Assessment Monitoring Tool, PSH assessed its compliance with timeliness based on an average sample of 100% of Speech Therapy Focused Assessments due each month for the review period November 2008 - April 2009 (total of 30):<br><br>1. *Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:* 98%<br><br>Comparative data indicated that PSH maintained a compliance rate of 90% or greater from the previous review period.<br><br>A review of the records of five individuals to assess compliance of Speech Therapy Focused Assessments with timeliness found all records in compliance.<br><br>Using the DMH Vocational Rehabilitation Focused Assessment Monitoring |

Tool, PSH assessed its compliance with timeliness based on an average sample of 100% of Vocational Rehabilitation Focused Assessments due each month for the review period November 2008 - April 2009 (total of 44):

| | | |
|---|---|---|
| 1. | *Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:* | 98% |

Comparative data indicated improvement in compliance from 30% in the previous review period.

A review of the records of eight individuals to assess compliance of Vocational Rehabilitation Focused Assessments with timeliness found seven records in compliance (ADT, EMN, JD, LRS, MRS, RMM and VEB) and one record not in compliance (JCH).

Using the DMH Comprehensive Physical Rehabilitation Therapy Focused Assessment Monitoring Tool, PSH assessed its compliance with timeliness based on an average sample of 100% of Comprehensive Physical Rehabilitation Therapy Focused Assessments due each month for the review period November 2008 - April 2009 (total of 12):

| | | |
|---|---|---|
| 1. | *Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:* | 79% |
| 1.a | *The assessment was completed within 14 days of referral, and* | 58% |
| 1.b | *Filed in the medical record.* | 100% |

Comparative data indicated a modest decline in compliance since the

<table>
<tr>
<td></td>
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<td>previous review period:<br><br>
<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>1.</td><td>86%</td><td>79%</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>1.a</td><td>67%</td><td>100%</td></tr>
<tr><td>1.b</td><td>100%</td><td>100%</td></tr>
</table>
<br>
The facility attributed less than substantial compliance with timeliness to the Physical therapy staff shortage.<br><br>
A review of the records of three individuals to assess compliance of Comprehensive Physical Rehabilitation Therapy Focused Assessments with timeliness found two records in compliance (RR and TC) and one record not in compliance (REB).<br><br>
Compliance:<br>
Partial.<br><br>
Current recommendation:<br>
Continue current efforts to achieve compliance.</td>
</tr>
<tr>
<td>D.4.b.i</td>
<td>Is accurate and comprehensive as to the individual's functional abilities;</td>
<td>Current findings on previous recommendations:<br><br>
Recommendations 1 and 2, December 2008:<br>
• Ensure that all Rehabilitation Services admission and focused assessments are accurate and comprehensive as to the individual's functional abilities.<br>
• Implement plans of correction based on review of audit data to improve compliance with D.4.b.i criteria.</td>
</tr>
</table>

**Findings:**
Using the DMH Integrated Assessment Rehabilitation Therapy Section Monitoring Tool, PSH assessed its compliance with D.4.b.i based on an average sample of 100% of Integrated Rehabilitation Therapy Assessments due each month for the review period November 2008 - April 2009 (total of 509):

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

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

A review of the records of 14 individuals to assess compliance of IA-RTS assessments with D.4.b.i found all records in substantial compliance.

Using the DMH Occupational Therapy Focused Assessment Monitoring Tool, PSH assessed its compliance with D.4.b.i based on an average sample of 100% of Occupational Therapy Focused Assessments due each month for the review period November 2008 - April 2009 (total of 35):

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

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

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

Using the DMH Physical Therapy Focused Assessment Monitoring Tool, PSH assessed its compliance with D.4.b.i based on an average sample of

15% of Physical Therapy Focused Assessments due each month for the review period November 2008 - April 2009 (total of 13 out of 84):

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

Comparative data indicated improvement in compliance from 70% in the previous review period.

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

Using the DMH Speech Therapy Focused Assessment Monitoring Tool, PSH assessed its compliance with D.4.b.i based on an average sample of 100% of Speech Therapy Focused Assessments due each month for the review period November 2008 - April 2009 (total of 30):

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

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

A review of the records of five individuals to assess compliance of Speech Therapy Focused Assessments with D.4.b.i found four records in substantial compliance (AKA, JHB, LM and PH) and one record in partial compliance (AB).

Using the DMH Vocational Rehabilitation Focused Assessment Monitoring Tool, PSH assessed its compliance with D.4.b.i based on an average sample of 100% of Vocational Rehabilitation Focused Assessments due each month for the review period November 2008 - April 2009 (total of 44):

| | | |
|---|---|---|
| 2. | *Is accurate and comprehensive as to the individuals functional abilities;* | 98% |

Comparative data indicated improvement in compliance from 37% in the previous review period.

A review of the records of eight individuals to assess compliance of Vocational Rehabilitation Focused Assessments with D.4.b.i found three records in substantial compliance (ADT, MRS and RMM) and five records in partial compliance (EMN, JCH, JD, LRS and VEB).

Using the DMH Comprehensive Physical Rehabilitation Therapy Focused Assessment Monitoring Tool, PSH assessed its compliance with D.4.b.i based on an average sample of 100% of Comprehensive Physical Rehabilitation Therapy Focused Assessments due each month for the review period November 2008 - April 2009 (total of 12):

| | | |
|---|---|---|
| 2. | *Is accurate and comprehensive as to the individuals functional abilities;* | 97% |

Comparative data indicated improvement in compliance from 43% in the previous review period.

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

**Compliance:**
Substantial.

**Current recommendation:**
Continue current practice.

| | | |
|---|---|---|
| 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 recommendations:**<br><br>**Recommendation 1, December 2008:**<br>Ensure that all Rehabilitation Services admission and focused assessments identify the individual's current functional status and the skills and supports needed to facilitate transfer to the next level of care.<br><br>**Findings:**<br>Using the DMH Integrated Assessment Rehabilitation Therapy Section Monitoring Tool, PSH assessed its compliance with D.4.b.ii based on an average sample of 100% of Integrated Rehabilitation Therapy Assessments due each month for the review period November 2008 - April 2009 (total of 509):<br><br>3. *Identifies the individual's current functional status, and* — 98%<br>4. *The skills and supports needed to facilitate transfer to the next level of care* — 99%<br><br>Comparative data indicated that PSH maintained compliance rates greater than 90% from the previous review period.<br><br>A review of the records of 14 individuals to assess compliance of IA-RTS Assessments with D.4.b.ii found all records in substantial compliance.<br><br>Using the DMH Occupational Therapy Focused Assessment Monitoring Tool, PSH assessed its compliance with D.4.b.ii based on an average sample of 100% of Occupational Therapy Focused Assessments due each month for the review period November 2008 - April 2009 (total of 35):<br><br>3. *Identifies the individual's current functional status, and* — 100%<br>4. *The skills and supports needed to facilitate transfer* — 100% |

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

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

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

Using the DMH Physical Therapy Focused Assessment Monitoring Tool, PSH assessed its compliance with D.4.b.ii based on an average sample of 15% of Physical Therapy Focused Assessments due each month for the review period November 2008 - April 2009 (total of 13 out of 84):

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

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

A review of the records of five individuals to assess compliance of Physical Therapy Focused Assessments with D.4.b.ii found three records in substantial compliance (AEJ, BZ and TN) and two records in partial compliance (BJ and RF).

Using the DMH Speech Therapy Focused Assessment Monitoring Tool, PSH assessed its compliance with D.4.b.ii based on an average sample of 100% of Speech Therapy Focused Assessments due each month for the review period November 2008 - April 2009 (total of 30):

| | | |
|---|---|---|
| 3. | *Identifies the individual's current functional status,* | 100% |

| | | |
|---|---|---|
| | *and* | |
| 4. | *The skills and supports needed to facilitate transfer to the next level of care* | 100% |

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

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

Using the DMH Vocational Rehabilitation Focused Assessment Monitoring Tool, PSH assessed its compliance with D.4.b.ii based on an average sample of 100% of Vocational Rehabilitation Focused Assessments due each month for the review period November 2008 - April 2009 (total of 44):

| | | |
|---|---|---|
| 3. | *Identifies the individual's current functional status, and* | 91% |
| 4. | *The skills and supports needed to facilitate transfer to the next level of care* | 95% |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 3. | 32% | 91% |
| 4. | 37% | 95% |

A review of the records of eight individuals to assess compliance of Vocational Rehabilitation Focused Assessments with D.4.b.ii found one

<table>
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<td>record in substantial compliance (RMM) and seven records in partial compliance (ADT, EMN, JCH, JD, LRS, MRS and VEB).<br><br>Using the DMH Comprehensive Physical Rehabilitation Therapy Focused Assessment Monitoring Tool, PSH assessed its compliance with D.4.b.ii based on an average sample of 100% of Comprehensive Physical Rehabilitation Therapy Focused Assessments due each month for the review period November 2008 - April 2009 (total of 12):<br><br>
<table>
<tr><td>3.</td><td>Identifies the individual's current functional status, and</td><td>100%</td></tr>
<tr><td>4.</td><td>The skills and supports needed to facilitate transfer to the next level of care</td><td>100%</td></tr>
</table>
<br>Comparative data indicated that PSH maintained compliance rates greater than 90% from the previous review period.<br><br>A review of the records of three individuals to assess compliance of Comprehensive Physical Rehabilitation Therapy Focused Assessments with D.4.b.ii found all records in substantial compliance.<br><br>Compliance:<br>Partial.<br><br>Current recommendation:<br>Continue current efforts to achieve compliance.</td>
</tr>
<tr>
<td>D.4.b.iii</td>
<td>Identifies the individual's life goals, strengths, and motivation for engaging in wellness activities.</td>
<td>Current findings on previous recommendations:<br><br>Recommendations 1 and 2, December 2008:<br>• Ensure that all Rehabilitation Services admission and focused assessments identify the individual's life goals, strengths, and motivation for engaging in wellness activities.</td>
</tr>
</table>

- Implement plans of correction based on review of audit data to improve compliance with D.4.b.iii criteria.

**Findings:**
Using the DMH Integrated Assessment Rehabilitation Therapy Section Monitoring Tool, PSH assessed its compliance with D.4.b.iii based on an average sample of 100% of Integrated Rehabilitation Therapy Assessments due each month for the review period November 2008 - April 2009 (total of 509):

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

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

A review of the records of 14 individuals to assess compliance of IA-RTS Assessments with D.4.b.iii found all records in substantial compliance.

Using the DMH Occupational Therapy Focused Assessment Monitoring Tool, PSH assessed its compliance with D.4.b.iii based on an average sample of 100% of Occupational Therapy Focused Assessments due each month for the review period November 2008 - April 2009 (total of 35):

| | | |
|---|---|---|
| 5. | *Identifies the individual's life goals,* | 98% |
| 6. | *Strengths, and:* | 100% |
| 7. | *Motivation for engaging in wellness activities* | 97% |

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

A review of the records of five individuals to assess compliance of

Occupational Therapy Focused Assessments with D.4.b.iii found all records in substantial compliance.

Using the DMH Physical Therapy Focused Assessment Monitoring Tool, PSH assessed its compliance with D.4.b.iii based on an average sample of 15% of Physical Therapy Focused Assessments due each month for the review period November 2008 - April 2009 (total of 13 out of 84):

| | | |
|---|---|---|
| 5. | *Identifies the individual's life goals,* | 96% |
| 6. | *Strengths, and:* | 92% |
| 7. | *Motivation for engaging in wellness activities* | 100% |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 5. | 70% | 96% |
| 6. | 20% | 92% |
| 7. | 60% | 100% |

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

Using the DMH Speech Therapy Focused Assessment Monitoring Tool, PSH assessed its compliance with D.4.b.iii based on an average sample of 100% of Speech Therapy Focused Assessments due each month for the review period November 2008 - April 2009 (total of 30):

| | | |
|---|---|---|
| 5. | *Identifies the individual's life goals,* | 100% |
| 6. | *Strengths, and:* | 98% |

| | | |
|---|---|---|
| 7. | *Motivation for engaging in wellness activities* | 95% |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 6. | 53% | 98% |
| 7. | 47% | 95% |

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

Using the DMH Vocational Rehabilitation Focused Assessment Monitoring Tool, PSH assessed its compliance with D.4.b.iii based on an average sample of 100% of Vocational Rehabilitation Focused Assessments due each month for the review period November 2008 - April 2009 (total of44):

| | | |
|---|---|---|
| 5. | *Identifies the individual's life goals,* | 99% |
| 6. | *Strengths, and:* | 98% |
| 7. | *Motivation for engaging in wellness activities* | 90% |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 6. | 47% | 98% |
| 7. | 16% | 90% |

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

Using the DMH Comprehensive Physical Rehabilitation Therapy Focused Assessment Monitoring Tool, PSH assessed its compliance with D.4.b.iii based on an average sample of 100% of Comprehensive Physical Rehabilitation Therapy Focused Assessments due each month for the review period November 2008 - April 2009 (total of 12):

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

Comparative data indicated maintenance of compliance rates greater than 90% from the previous review period for items 5 and 7, and improvement in compliance for item 6 from 71% in the previous review period.

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

**Compliance:**
Substantial.

| | | |
|---|---|---|
| | | **Current recommendation:**<br>Continue current practice. |
| D.4.c | Each State hospital shall ensure that all clinicians responsible for performing or reviewing rehabilitation therapy assessments are verifiably competent in performing the assessments for which they are responsible | **Current findings on previous recommendations:**<br><br>**Recommendation 1, December 2008:**<br>Ensure that all clinicians responsible for performing or reviewing rehabilitation therapy assessments are verifiably competent in performing the assessments for which they are responsible.<br><br>**Findings:**<br>Nineteen out of 19 Rehabilitation Therapists were trained on completing the IA-RTS and were trained to competency on training materials. Training was held on 11/4/08, 12/3/08, and 4/10/09; this was verified by review of training rosters and post-tests.<br><br>**Recommendation 2, December 2008:**<br>Develop and implement a system to recommend training CEU courses based on findings of audit data, and track CEU courses attended by Rehabilitation Therapy staff.<br><br>**Findings:**<br>Therapy Services staff continues to be trained based on audit results in both group and individual format.<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendation:**<br>Ensure that all clinicians responsible for performing or reviewing rehabilitation therapy assessments are verifiably competent in performing the assessments for which they are responsible. |

| | | |
|---|---|---|
| D.4.d | Each State hospital shall ensure that all rehabilitation therapy assessments of all individuals who were admitted to each State hospital before the Effective Date hereof shall be reviewed by qualified clinicians and, as indicated, revised to meet the criteria in D.4.b and sub-cells above. | **Current findings on previous recommendation:**<br><br>**Recommendation, December 2008:**<br>Ensure that all individuals admitted to PSH prior to June 1, 2006 receive an Integrated Assessment-Rehabilitation Therapy Section Assessment within the next six months.<br><br>**Findings:**<br>According to facility report, 270 out of 270 type D.4.d assessments were completed during the review period. At this time, the facility reports that all conversion assessments have been completed.<br><br>**Other findings:**<br>A review of records of seven individuals with type D.4.d assessments found that all records contained evidence that the assessments were completed as reported.<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendation:**<br>None. |

| 5. Nutrition Assessments | | |
|---|---|---|
| D.5 | Each State hospital shall provide nutrition assessments, reassessments, and interventions consistent with generally accepted professional standards of care. A comprehensive nutrition assessment will include the following: | **Methodology:**<br><br>Interviewed:<br>1. Brian Starck-Riley, Assistant Director of Nutrition Services<br>2. Diana Tran, Assistant Director of Nutrition Services<br>3. Grace Ferris, Assistant Director of Nutrition Services<br>4. Jeanie Kim, Assistant Director of Nutrition Services<br>5. Kitchie Miana, Assistant Director of Nutrition Services<br>6. Tai Kim, Director of Nutrition Services<br><br>Reviewed:<br>1. Nutrition Care Monitoring audit data for November 2008-April 2009 for each assessment type<br>2. List of individuals with Nutrition Care Assessments due from November 2008-April 2009 for each assessment type<br>3. Record for the following individual with type D.5.a assessment from November 2008-April 2009: JR<br>4. Records for the following six individuals with type D.5.d assessments from November 2008-April 2009: EZW, LSB, NG, RH, RTE and WG<br>5. Records for the following four individuals with type D.5.e assessments from November 2008-April 2009: BJ, DMH, MSMC and RCR<br>6. Records for the following five individuals with type D.5.f assessments from November 2008-April 2009: EAL, EV, LEW, RME and WSB<br>7. Records for the following nine individuals with type D.5.g assessments from November 2008-April 2009: ADC, BDT, DM, GAF, JD, JJF, MES, RLL and TJM<br>8. Records for the following 12 individuals with type D.5.i assessments from November 2008-April 2009: ALM, BQ, DE, END, HLP, JPM, LES, LW, PF, RTW, SRF and WCS<br>9. Records for the following nine individuals with type D.5.j.i assessments from November 2008-April 2009: AMO, CMJ, ES, GRA, |

| | | |
|---|---|---|
| | | JAC, JB, JEP, MSB and TCH<br>10. Records for the following eight individuals with type D.5.j.ii assessments from November 2008-April 2009: ECF, ELG, HP, JCT, JLH, KJ, ME and MP |
| 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:**<br><br>**Recommendation, December 2008:**<br>Continue current efforts to achieve compliance.<br><br>**Findings:**<br>Using the DMH Nutrition Care Monitoring Tool, PSH assessed its compliance based on an average sample of 100% of Nutrition Type D.5.a Assessments due each month for the review period November 2008 - April 2009 (total of one): |

| | | |
|---|---|---|
| 1. | *Assessment is completed on time per policy* | 0% |
| 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* | 0% |
| 12. | *NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment* | 100% |
| 13. | *Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present* | 100% |
| 14. | *Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support* | N/A |
| 15. | *Assessment utilizes approved abbreviations* | 100% |
| 16. | *Assessment is concise* | 100% |
| 17. | *Assessment is legible* | 100% |
| 18. | *Each page of the assessment is signed* | 100% |

Comparative data indicated maintenance of compliance rates of 90% or greater from the previous review period for items 2, 5-8, 10, 12, and 15-18, and mixed changes in compliance for the remaining items:

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 1. | 100% | 0% |
| 3. | 50% | 100% |
| 4. | 50% | 100% |
| 9. | N/A | N/A |
| 11. | 100% | 0% |
| 13. | N/A | 100% |
| 14. | N/A | N/A |
| Compliance rate in last month of period | | |
| 1. | 100% | 0% |
| 11. | 100% | 0% |

The facility attributed lack of compliance with item 1 (timeliness) to the RD not being notified about the high-risk referral within 24 hours.

| | | |
|---|---|---|
| | | A review of the record of one individual to assess compliance with Nutrition type D.5.a criteria found the record in partial compliance.<br><br>**Compliance:**<br>Unable to determine based on sample size.<br><br>**Current recommendation:**<br>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. | Not applicable. PSH does not have a medical-surgical unit. |
| D.5.c | For new admissions directly into the skilled nursing facility unit, a comprehensive Admission Nutrition Assessment will be completed within 7 days of admission. | Not applicable. PSH does not have a skilled nursing facility unit. |
| D.5.d | For new admissions with identified nutritional triggers from Nursing Admission Assessment or physician's consult (e.g., for severe food allergies, tube feeding, extensive dental problems or dental surgery, NPO/clear liquid diet for more than three days, uncontrolled diarrhea/vomiting more than 24hrs, and MAOI, as clinically indicated), a comprehensive Admission Nutrition Assessment will be completed within 7 days of admission. | **Current findings on previous recommendation:**<br><br>**Recommendation, December 2008:**<br>Continue current efforts to achieve compliance.<br><br>**Findings:**<br>Using the DMH Nutrition Care Monitoring Tool, PSH assessed its compliance based on an average sample of 100% of Nutrition Type D.5.d Assessments due each month for the review period November 2008 - April 2009 (total of 40):<br><br>1. *Assessment is completed on time per policy* 98%<br>2. *All required subjective concerns are addressed* 98% |

| | | |
|---|---|---|
| 3. | *All pertinent objective nutrition information is accurately addressed* | 90% |
| 4. | *Estimated daily needs for nutrients specified are appropriate* | 98% |
| 5. | *Assessment utilizes findings from subjective and objective data* | 93% |
| 6. | *Nutrition diagnosis is correctly formulated, prioritized and validated* | 93% |
| 7. | *Nutrition education is documented* | 97% |
| 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* | 97% |
| 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* | 98% |
| 18. | *Each page of the assessment is signed* | 100% |

Comparative data indicated maintenance of compliance rates of 90% or greater from the previous review period for items 2, 5-8, 10, 12, 13 and 15-18, and improvement in compliance for the remaining items:

<table>
<tr>
<td></td>
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<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>1.</td><td>76%</td><td>98%</td></tr>
<tr><td>3.</td><td>87%</td><td>90%</td></tr>
<tr><td>4.</td><td>88%</td><td>98%</td></tr>
<tr><td>9.</td><td>100%</td><td>N/A</td></tr>
<tr><td>11.</td><td>89%</td><td>97%</td></tr>
<tr><td>14.</td><td>N/A</td><td>N/A</td></tr>
</table>
<br>
A review of the records of six individuals to assess compliance with Nutrition type D.5.d criteria found five records in substantial compliance (EZW, NG, RH, RTE and WG) and one record in partial compliance (LSB).<br><br>
Compliance:<br>
Substantial.<br><br>
Current recommendation:<br>
Continue current practice.
</td>
</tr>
<tr>
<td>D.5.e</td>
<td>For new admissions with therapeutic diet orders for medical reasons, a comprehensive Admission Nutrition Assessment will be completed within 7 days of admission.</td>
<td>
Current findings on previous recommendation:<br><br>
Recommendation, December 2008:<br>
Continue current efforts to achieve compliance.<br><br>
Findings:<br>
Using the DMH Nutrition Care Monitoring Tool, PSH assessed its compliance based on an average sample of 100% of Nutrition Type D.5.e Assessments due each month for the review period November 2008 - April 2009 (total of 26):<br><br>
<table>
<tr><td>1.</td><td>Assessment is completed on time per policy</td><td>65%</td></tr>
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</table>

| | | |
|---|---|---|
| 2. | *All required subjective concerns are addressed* | 100% |
| 3. | *All pertinent objective nutrition information is accurately addressed* | 96% |
| 4. | *Estimated daily needs for nutrients specified are appropriate* | 96% |
| 5. | *Assessment utilizes findings from subjective and objective data* | 96% |
| 6. | *Nutrition diagnosis is correctly formulated, prioritized and validated* | 92% |
| 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* | 95% |
| 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* | 0% |
| 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* | 96% |

Comparative data indicated maintenance of compliance rates of 90% or greater from the previous review period for items 2, 4, 5, 7, 8, 10-12 and 15-18, and mixed changes in compliance for the remaining items:

<table>
<tr>
<td></td>
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<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>1.</td><td>85%</td><td>65%</td></tr>
<tr><td>3.</td><td>85%</td><td>96%</td></tr>
<tr><td>6.</td><td>88%</td><td>92%</td></tr>
<tr><td>9.</td><td>100%</td><td>N/A</td></tr>
<tr><td>13.</td><td>100%</td><td>0%</td></tr>
<tr><td>14.</td><td>n/a</td><td>N/A</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>1.</td><td>100%</td><td>56%</td></tr>
<tr><td>13.</td><td>100%</td><td>0%</td></tr>
</table>
<br>
The facility reviewed the data and attributed low compliance with item 1 (timeliness) to late notification of therapeutic diets.<br><br>
A review of the records of four individuals to assess compliance with Nutrition type D.5.e criteria found three records in substantial compliance (BJ, DMH and RCR) and one record in partial compliance (MSMC).<br><br>
**Compliance:**<br>
Partial.<br><br>
**Current recommendation:**<br>
Continue current efforts to achieve compliance.
</td>
</tr>
<tr>
<td>D.5.f</td>
<td>For individuals with therapeutic diet orders for medical reason after admission, a comprehensive 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:**<br><br>**Recommendation, December 2008:**<br>Continue current efforts to achieve compliance.</td>
</tr>
</table>

**Findings:**
Using the DMH Nutrition Care Monitoring Tool, PSH assessed its compliance based on an average sample of 100% of Nutrition Type D.5.f Assessments due each month for the review period November 2008 - April 2009 (total of 44):

| | | |
|---|---|---|
| 1. | *Assessment is completed on time per policy* | 64% |
| 2. | *All required subjective concerns are addressed* | 88% |
| 3. | *All pertinent objective nutrition information is accurately addressed* | 81% |
| 4. | *Estimated daily needs for nutrients specified are appropriate* | 93% |
| 5. | *Assessment utilizes findings from subjective and objective data* | 100% |
| 6. | *Nutrition diagnosis is correctly formulated, prioritized and validated* | 93% |
| 7. | *Nutrition education is documented* | 98% |
| 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* | 95% |
| 11. | *Recommendations are appropriate and complete* | 68% |
| 12. | *NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment* | 100% |
| 13. | *Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present* | 100% |
| 14. | *Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support* | N/A |
| 15. | *Assessment utilizes approved abbreviations* | 100% |
| 16. | *Assessment is concise* | 100% |

| | | |
|---|---|---|
| 17. | *Assessment is legible* | 100% |
| 18. | *Each page of the assessment is signed* | 98% |

Comparative data indicated maintenance of compliance rates of 90% or greater from the previous review period for items 4-8, 10, 12, 13 and 15-18 and declines in compliance for the remaining items:

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 1. | 86% | 64% |
| 2. | 97% | 88% |
| 3. | 88% | 81% |
| 9. | 100% | N/A |
| 11. | 96% | 68% |
| 14. | N/A | N/A |
| Compliance rate in last month of period | | |
| 1. | 88% | 57% |
| 2. | 100% | 100% |
| 3. | 88% | 86% |
| 11. | 100% | 86% |

The facility reviewed the data and attributed low compliance with item 1 (timeliness) to late notification of therapeutic diets.

A review of the records of five individuals to assess compliance with Nutrition type D.5.f criteria found two records in substantial compliance (LEW and WSB) and three records in partial compliance (EAL, EV and RME). Identified areas of deficiency that the facility should focus on in order to improve compliance with Nutrition type D.5.f criteria include:

1. Assessments are not consistently completed in a timely manner.

<table>
<tr>
<td></td>
<td></td>
<td>2. Nutrition recommendations are not consistently appropriate, complete, and aligned with nutrition diagnosis and objectives.<br><br>Compliance:<br>Partial.<br><br>Current recommendation:<br>Continue current efforts to achieve compliance.</td>
</tr>
<tr>
<td>D.5.g</td>
<td>For all other individuals, a comprehensive Admission Nutrition Assessment will be completed within 30 days of admission.</td>
<td>Current findings on previous recommendation:<br><br>Recommendation, December 2008:<br>Continue current efforts to achieve compliance.<br><br>Findings:<br>Using the DMH Nutrition Care Monitoring Tool, PSH assessed its compliance based on an average sample of 21% of Nutrition Type D.5.g Assessments due each month for the review period November 2008 - April 2009 (total of 83 out of 388):<br><br>
<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>96%</td></tr>
<tr><td>3.</td><td>All pertinent objective nutrition information is accurately addressed</td><td>89%</td></tr>
<tr><td>4.</td><td>Estimated daily needs for nutrients specified are appropriate</td><td>98%</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>89%</td></tr>
<tr><td>7.</td><td>Nutrition education is documented</td><td>99%</td></tr>
<tr><td>8.</td><td>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers</td><td>100%</td></tr>
</table>
</td>
</tr>
</table>

| | | |
|---|---|---|
| | *identified* | |
| 9. | *Progress is monitored, measured, and evaluated* | N/A |
| 10. | *Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable* | 96% |
| 11. | *Recommendations are appropriate and complete* | 92% |
| 12. | *NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment* | 99% |
| 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* | 99% |
| 18. | *Each page of the assessment is signed* | 100% |

Comparative data indicated maintenance of compliance rates of 90% or greater from the previous review period for items 1, 2, 4, 5, 7, 8, 10-12 and 15-18 and modest declines in compliance for the remaining items:

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 3. | 97% | 89% |
| 6. | 97% | 89% |
| 9. | N/A | N/A |
| 13. | N/A | N/A |
| 14. | N/A | N/A |
| Compliance rate in last month of period | | |
| 3. | 100% | 100% |
| 6. | 100% | 93% |

| | | |
|---|---|---|
| | | A review of the records of nine individuals to assess compliance with Nutrition type D.5.g criteria found all records in substantial compliance.<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendation:**<br>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:**<br><br>**Recommendation, December 2008:**<br>Continue current practice.<br><br>**Findings:**<br>Using the DMH Nutrition Care Monitoring Tool, PSH assessed its compliance based on an average sample of 25% of Nutrition Assessments (all types) due each month of the review period November 2008 - April 2009 (568 out of 2305). The facility reports that a weighted mean of 97% of Nutrition admission assessments had evidence of a correctly assigned NST level.<br><br>Comparative data indicated that PSH maintained a compliance rate greater than 90% from the previous review period.<br><br>A review of the records of 54 individuals found that 100% had evidence of a correctly assigned Nutritional Status Type and were in compliance with D.5.h.<br><br>**Compliance:**<br>Substantial. |

<table>
<tr><td></td><td></td><td>Current recommendation:<br>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:<br><br>Recommendation, December 2008:<br>Continue current efforts to achieve compliance.<br><br>Findings:<br>Using the DMH Nutrition Care Monitoring Tool, PSH assessed its compliance based on an average sample of 21% of Nutrition Type D.5.i Assessments due each month for the review period November 2008 - April 2009 (total of 221 out of 1075):
<table>
<tr><td>1.</td><td>Assessment is completed on time per policy</td><td>31%</td></tr>
<tr><td>2.</td><td>All required subjective concerns are addressed</td><td>93%</td></tr>
<tr><td>3.</td><td>All pertinent objective nutrition information is accurately addressed</td><td>71%</td></tr>
<tr><td>4.</td><td>Estimated daily needs for nutrients specified are appropriate</td><td>92%</td></tr>
<tr><td>5.</td><td>Assessment utilizes findings from subjective and objective data</td><td>90%</td></tr>
<tr><td>6.</td><td>Nutrition diagnosis is correctly formulated, prioritized and validated</td><td>84%</td></tr>
<tr><td>7.</td><td>Nutrition education is documented</td><td>84%</td></tr>
<tr><td>8.</td><td>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</td><td>93%</td></tr>
<tr><td>9.</td><td>Progress is monitored, measured, and evaluated</td><td>96%</td></tr>
<tr><td>10.</td><td>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</td><td>92%</td></tr>
<tr><td>11.</td><td>Recommendations are appropriate and complete</td><td>92%</td></tr>
<tr><td>12.</td><td>NST is correctly assigned to reflect acuity level and</td><td>96%</td></tr>
</table></td></tr>
</table>

| | | |
|---|---|---|
| | *date of next review. Include NST in comment* | |
| 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* | 97% |

Comparative data indicated maintenance of compliance rates of 90% or greater from the previous review period for items 2, 5, 8-13 and 15-18 and mixed changes in compliance for the remaining items:

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 1. | 35% | 31% |
| 3. | 86% | 71% |
| 4. | 87% | 92% |
| 6. | 97% | 84% |
| 7. | 91% | 84% |
| 14. | N/A | N/A |
| Compliance rate in last month of period | | |
| 1. | 61% | 23% |
| 3. | 86% | 100% |
| 6. | 96% | 100% |
| 7. | 95% | 100% |

The facility attributed low compliance with item 1 (timeliness) to RD vacancies and large caseloads, which result in prioritizing higher-acuity assessments.

<table>
<tr><td></td><td></td><td>A review of the records of 12 individuals to assess compliance with Nutrition type D.5.i criteria found 11 records in substantial compliance (ALM, BQ, DE, END, HLP, JPM, LES, LW, PF, RTW and WCS) and one record in partial compliance (SRF).<br><br>Compliance:<br>Partial.<br><br>Current recommendation:<br>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 recommendation:<br><br>Recommendation, December 2008:<br>Continue current efforts to achieve compliance.<br><br>Findings:<br>Using the DMH Nutrition Care Monitoring Tool, PSH assessed its compliance based on an average sample of 22% of Nutrition Type D.5.j.i Assessments due each month for the review period November 2008 - April 2009 (total of 45 out of 208):<br><br>
<table>
<tr><td>1.</td><td>Assessment is completed on time per policy</td><td>93%</td></tr>
<tr><td>2.</td><td>All required subjective concerns are addressed</td><td>98%</td></tr>
<tr><td>3.</td><td>All pertinent objective nutrition information is accurately addressed</td><td>82%</td></tr>
<tr><td>4.</td><td>Estimated daily needs for nutrients specified are appropriate</td><td>93%</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>93%</td></tr>
</table></td></tr>
</table>

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

Comparative data indicated maintenance of compliance rates of 90% or greater from the previous review period for items 2, 5-10, 12, 13 and 15-18 and improvement in compliance for the remaining items:

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 1. | 78% | 93% |
| 3. | 77% | 82% |
| 4. | 85% | 93% |
| 11. | 80% | 100% |
| 14. | N/A | N/A |

<table>
<tr><td></td><td></td><td>
<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>3.</td><td>30%</td><td>100%</td></tr>
</table>
<br>
A review of the records of nine individuals to assess compliance with Nutrition type D.5.j.i criteria found six records in substantial compliance (AMO, ES, GRA, JEP, MSB and TCH) and three records in partial compliance (CMJ, JAC and JB).<br><br>
Compliance:<br>
Partial.<br><br>
Current recommendation:<br>
Continue current efforts to achieve compliance.
</td></tr>
<tr><td>D.5.j.ii</td><td>Every individual will be assessed annually.</td><td>
Current findings on previous recommendation:<br><br>
Recommendation, December 2008:<br>
Continue current efforts to achieve compliance.<br><br>
Findings:<br>
Using the DMH Nutrition Care Monitoring Tool, PSH assessed its compliance based on an average sample of 21% of Nutrition Type D.5.j.ii Assessments due each month for the review period November 2008 - April 2009 (total of 108 out of 523):<br><br>
<table>
<tr><td>1.</td><td>Assessment is completed on time per policy</td><td>34%</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>79%</td></tr>
<tr><td>4.</td><td>Estimated daily needs for nutrients specified are</td><td>93%</td></tr>
</table>
</td></tr>
</table>

| | | |
|---|---|---|
| | *appropriate* | |
| 5. | *Assessment utilizes findings from subjective and objective data* | 98% |
| 6. | *Nutrition diagnosis is correctly formulated, prioritized and validated* | 91% |
| 7. | *Nutrition education is documented* | 95% |
| 8. | *Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified* | 100% |
| 9. | *Progress is monitored, measured, and evaluated* | 97% |
| 10. | *Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable* | 98% |
| 11. | *Recommendations are appropriate and complete* | 90% |
| 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* | 100% |
| 14. | *Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support* | N/A |
| 15. | *Assessment utilizes approved abbreviations* | 98% |
| 16. | *Assessment is concise* | 100% |
| 17. | *Assessment is legible* | 100% |
| 18. | *Each page of the assessment is signed* | 100% |

Comparative data indicated maintenance of compliance rates of 90% or greater from the previous review period for items 2, 4-11 and 15-18 and mixed changes in compliance for the remaining items:

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 1. | 32% | 34% |

| | | |
|---|---|---|
| 3. | 89% | 79% |
| 12. | 89% | 93% |
| 13. | 80% | 100% |
| 14. | N/A | N/A |
| Compliance rate in last month of period | | |
| 1. | 62% | 39% |
| 3. | 100% | 80% |

The facility attributed low compliance with item 1 (timeliness) to RD vacancies and large caseloads, which result in prioritizing higher-acuity assessments.

A review of the records of eight individuals to assess compliance with Nutrition type D.5.j.ii criteria found three records in substantial compliance (ECF, JLH and MP) and five records in partial compliance (ELG, HP, JCT, KJ and ME).

**Compliance:**
Partial.

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

| 6. Social History Assessments | | |
|---|---|---|
| | Each State hospital shall ensure that each individual has a social history evaluation that, consistent with generally accepted professional standards of care: | **Methodology:**<br><br>Interviewed:<br>1. Hope Marriott, LCSW<br>2. Rachel Strydom, LCSW(A), Supervising Social Worker<br>3. Tiffany Rector, LCSW (A), Supervising Social Worker, D.6 Section Leader<br>4. Veronica Kaufman, LCSW, Chief of Social Work<br><br>Reviewed:<br>1. The charts of the following 21 individuals: CAL, CJS, CMR, DLR, EAS, EDM, GE, HH, JDB, JE, JEG, JFH, JWF, MED, MW, RAR, RB, REA, RR, SJW and VF<br>2. DMH Integrated Assessments: Social Work Section<br>3. DMH 30-Day Psychosocial Assessments<br>4. PSH Progress Report Data<br>5. Family Education Assessments |
| D.6.a | Is, to the extent reasonably possible, accurate, current and comprehensive; | **Current findings on previous recommendation:**<br><br>**Recommendation, December 2008:**<br>Ensure that the five-day and 30-day Social History Assessments are timely, accurate, and comprehensive.<br><br>**Findings:**<br>Using the DMH Social History Assessment Monitoring Form, PSH assessed its compliance based on an average sample of 94% of the Integrated Assessments: Social Work sections due each month during the review period (November 2008 – April 2009):<br><br>1. *Is, to the extent reasonably possible, accurate* 93%<br>2. *Current, and* 94% |

| | | |
|---|---|---|
| 3. | *Comprehensive: All sections are completed with at least the minimum information required in the instructions as applicable or indicate why the information is not available.* | 93% |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 1. | 85% | 93% |
| 2. | 79% | 94% |
| 3. | 88% | 93% |

This monitor reviewed the charts of 16 individuals to evaluate the Integrated Assessments: Social Work Section. All 16 assessments were current and comprehensive (CAL, CJS, CMR, DLR, EAS, EDM, HH, JDB, JE, JFH, MW, RAR, RB, REA, RR and SJW).

Again using the DMH Social History Assessment Monitoring Form, PSH also assessed its compliance based on an average sample of 23% of the 30-Day Social Work Assessments due each month during the review period (November 2008 – April 2009):

| | | |
|---|---|---|
| 1. | *Is, to the extent reasonably possible, accurate* | 98% |
| 2. | *Current, and* | 98% |
| 3. | *Comprehensive: All sections are completed with at least the minimum information required in the instructions as applicable or indicate why the information is not available.* | 97% |

Comparative data indicated improvement in compliance since the previous

<table>
<tr>
<td></td>
<td></td>
<td>review period:<br><br>
<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>1.</td><td>85%</td><td>98%</td></tr>
<tr><td>2.</td><td>79%</td><td>97%</td></tr>
<tr><td>3.</td><td>88%</td><td>98%</td></tr>
</table>
<br>
This monitor reviewed the charts of 20 individuals to evaluate the 30-Day Social Work Assessments. Five of them (CAL, CJS, JE, JFH and RB) did not have the 30-day assessments. Eleven assessments were current and comprehensive (EAS, EDM, GE, HH, JDB, JEG, JWF, MW, RAR, SJW and VF) and four were not current and/or comprehensive (CMR, DLR, MED and REA).<br><br>
Compliance:<br>
Partial.<br><br>
Current recommendation:<br>
Ensure that the five-day and 30-day Social History Assessments are timely, accurate, 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 recommendations:<br><br>
Recommendations 1-3, December 2008:<br>
• Ensure that Social History assessments contain all relevant information.<br>
• Ensure that social workers identify and address the inconsistencies in current assessments.<br>
• Monitor factual inconsistencies in social histories and revise to correct the inconsistencies.</td>
</tr>
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**Findings:**
Using the DMH Social History Assessments Monitoring Form, PSH assessed its compliance based on an average sample of 23 % of WRPs due each month during the review period (November 2008 – April 2009):

| | | |
|---|---|---|
| 4. | *Expressly identifies factual inconsistencies among sources.* | 98% |
| 5. | *Resolves or attempts to resolve inconsistencies.* | 98% |
| 6. | *Explains the rationale for the resolution offered.* | 96% |

Comparative data indicated maintenance of a compliance rate of or greater than 90% for item 4 and improvement in compliance since the previous review period for items 5 and 6:

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 5. | 88% | 98% |
| 6. | 86% | 96% |

This monitor reviewed the charts of 10 individuals to evaluate the 30-Day Social Work Assessments for documentation of factual inconsistencies. All 10 assessments identified and resolved factual inconsistencies (CMR, EAS, EDM, GE, JEG, JWF, RAR, REA, SJW and VF).

**Compliance:**
Substantial.

**Current recommendations**:
1. Ensure that Social History assessments contain all relevant information.
2. Ensure that social workers identify and address the inconsistencies in current assessments.

| | | |
|---|---|---|
| | | 3. Monitor factual inconsistencies in social histories and revise to correct the inconsistencies. |
| D.6.c | Is included in the 7-day integrated assessment and fully documented by the 30th day of an individual's admission; and | **Current findings on previous recommendations:**<br><br>**Recommendation 1, December 2008:**<br>Ensure that all social history integrated assessments are completed in a timely fashion and made available to the individual's WRPT before the seven-day WRPC.<br><br>**Findings:**<br>Using the DMH Social History Assessments Monitoring Form, PSH assessed its compliance based on an average sample of 94 % of Integrated Assessments: Social Work Sections due each month during the review period (November 2008 – April 2009):<br><br>7. *Is included in the 7-day integrated assessment* 91%<br><br>Comparative data indicated improvement in compliance from 74% in the previous review period.<br><br>This monitor reviewed 16 charts to evaluate timeliness of the Social Work Integrated Assessments. Twelve assessments were timely (CJS, CMR, DLR, EAS, EDM, HH, JDB, MW, RAR, REA, RR and SJW) and four were untimely (CAL, JE, JFH and RB).<br><br>**Recommendation 2, December 2008:**<br>Ensure that all 30-day social histories are completed and available to the individual's WRPT by the 30th day of admission.<br><br>**Findings:**<br>Using the DMH Social History Assessments Monitoring Form, PSH assessed its compliance based on an average sample of 23 % of 30-Day |

Psychosocial Assessments due each month during the review period:

| | | |
|---|---|---|
| 8. | *Fully documented by the 30th day of the individual's admission.* | 87% |
| 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* | 79% |
| 8.b | *Filed in the medical record.* | 94% |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 8. | 63% | 87% |
| Compliance rate in last month of period | | |
| 8. | 45% | 73% |
| 8.a | 45% | 63% |
| 8.b | 54% | 83% |

This monitor reviewed 19 charts to evaluate timeliness of the 30-day Social Work Assessments. Fifteen assessments were timely (CAL, CJS, EAS, EDM, GE, HH, JDB, JE, JEG, JFH, JWF, RAR, RB, SJW and VF) and four were untimely (CMR, DLR, MED and REA).

During the review period, PSH found that e-mail reminders to staff conducting integrated assessments were productive and will implement the same for the 30-Day assessments. PSH also intends to continue with the disciplinary counseling for those social workers whose assessments are untimely. In addition, PSH is working to improve coverage for SW staff on leave.

| | | |
|---|---|---|
| | | **Compliance:**<br>Partial.<br><br>**Current recommendations**:<br>1. Ensure that all social history integrated assessments are completed in a timely fashion and made available to the individual's WRPT before the seven-day WRPC.<br>2. Ensure that all 30-day social histories are completed and available to the individual's WRPT 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:**<br><br>**Recommendation, December 2008:**<br>Ensure that social history assessments contain sufficient information on the individual's social factors and educational status to reliably inform the individual's WRPT.<br><br>**Findings:**<br>Using the DMH Social History Assessments Monitoring Form, PSH assessed its compliance based on an average sample of 23 % of the Integrated Assessments: Social Work Sections, and 94% of the 30-Day Social Work Assessments due each month during the review period:<br><br>9. *Social factors* 95%<br>10. *Educational status* 98%<br><br>Comparative data indicated maintenance of compliance rates of 90% or greater from the previous review period.<br><br>This monitor reviewed 20 charts to evaluate documentation of the individual's social factors and educational status in the 30-day Social Work Assessment. All 20 assessments included information on the individual's social factors and educational status (CAL, CJS, CMR, DLR, |

| | | |
|---|---|---|
| | | EAS, EDM, GE, HH, JDB, JE, JEG, JFH, JWF, MED, RAR, RB, REA, RR, SJW and VF).<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendation**:<br>Ensure that social history assessments contain sufficient information on the individual's social factors and educational status to reliably inform the individual's WRPT. |

| 7. Court Assessments | | |
|---|---|---|
| | | **Methodology:**<br><br>Interviewed:<br>Ai-Li Arias, MD, Chair, Forensic Review Panel (FRP)<br><br>Reviewed:<br>1. Charts of six individuals who were admitted under PC 1026 (AM, BEH, CM, JHM, PS and RR)<br>2. Charts of six individuals who were admitted under PC 1370 (HLW, JDP, MAA, MGW, MSB and RP)<br>3. Minutes of the FRP (November 2008 to April 2009)<br>4. A sample of e-mails containing feedback from FRP to WRPTs (November 2008 to April 2009)<br>5. Court Report PC 1026 Audit Tool<br>6. Court Report PC 1026 summary data (November 2008 to April 2009)<br>7. Court Report PC 1370 Audit Tool<br>8. Court Report PC 1370 summary data (November 2008 to April 2009) |
| D.7.a | Each State hospital shall develop and implement policies and procedures to ensure an interdisciplinary approach to the development of court submissions for individuals adjudicated "not guilty by reason of insanity" ("NGI") pursuant to Penal Code Section 1026, based on accurate information, and individualized risk assessments. The forensic reports should include the following, as clinically indicated: | **Compliance:**<br>Substantial. |
| D.7.a.i | clinical progress and achievement of stabilization of signs and symptoms of mental illness that were the cause, or contributing | **Current findings on previous recommendations:** |

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| | factor in the commission of the crime (i.e., instant offense); | **Recommendation 1, December 2008:**<br>Ensure that all reports include a specific description of the nature of the individual's symptoms, their course and the setting within which they occur.<br><br>**Findings:**<br>PSH used the DMH Court Report PC 1026 Monitoring Form to assess compliance. The facility reviewed 100% of the court reports completed from November 2008 to February 2009 and 50% of the court reports completed in March and April 2009. The mean compliance rate was 99%, compared to 98% in the previous review period.<br><br>The mean compliance rates for the requirements in D.7.a.ii through D.7.a.xi are reported for each corresponding cell below. The indicators are listed if they represented sub-criteria of the requirement. Comparative data are listed as appropriate.<br><br>**Recommendation 2, December 2008:**<br>Continue current practice and ensure ongoing training of WRPTs regarding compliance with EP requirements.<br><br>**Findings:**<br>PSH has maintained its practice and provided further training on PC 1026 report writing to the WRPTs on April 1, 2009.<br><br>**Recommendation 3, December 2008:**<br>Continue to monitor this requirement based on a 50% sample.<br><br>**Findings:**<br>See Findings for Recommendation 1 above.<br><br>**Other findings:**<br>A review of the charts of six individuals admitted under PC 1026 found |

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| | | substantial compliance in all charts (AM, BEH, CM, JHM, PS and RR).<br><br>**Current recommendation**:<br>Continue current practice. |
| D.7.a.ii | acts of both verbal and physical aggression and property destruction during the past year of hospitalization and, if relevant, past acts of aggression and dangerous criminal behavior; | **Current findings on previous recommendations:**<br><br>**Recommendations 1 and 2, December 2008:**<br>• Continue current practice and ensure ongoing training of WRPTs regarding compliance with EP requirements.<br>• Continue to monitor this requirement based on a 50% sample.<br><br>**Findings:**<br>Same as above. The facility reported a mean compliance rate of 97% with this requirement, compared to 98% in the previous review period.<br><br>**Other findings:**<br>This monitor found substantial compliance in all charts reviewed (AM, BEH, CM, JHM, PS and RR).<br><br>**Current recommendation**:<br>Continue current practice. |
| D.7.a.iii | understanding of potential for danger and precursors of dangerous/criminal behavior, including instant offense; | **Current findings on previous recommendations:**<br><br>**Recommendation 1, December 2008:**<br>Ensure that the report addresses both psychosocial triggers of dangerousness and symptoms that triggered the instant offense.<br><br>**Findings:**<br>The facility's data (same as Findings for Recommendation 3 below) indicated that PSH has maintained compliance at a rate above 90% from the previous review period. Reviews by this monitor (see other |

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| | | findings below) found improved compliance compared to the last review.<br><br>**Recommendations 2 and 3, December 2008:**<br>• Continue current practice and ensure ongoing training of WRPTs regarding compliance with EP requirements.<br>• Continue to monitor this requirement based on a 50% sample.<br><br>**Findings:**<br>PSH has implemented this recommendation. The facility reported a mean compliance rate of 100%, compared to 96% in the previous review period.<br><br>**Other findings:**<br>This monitor found substantial compliance in five charts (AM, BEH, CM, PS and RR) and partial compliance in one (JHM).<br><br>**Current recommendation:**<br>Continue current practice. |
| D.7.a.iv | acceptance of mental illness and understanding of the need for treatment, both psychosocial and biological, and the need to adhere to treatment; | **Current findings on previous recommendation2:**<br><br>**Recommendations 1 and 2, December 2008:**<br>• Continue current practice and ensure ongoing training of WRPTs regarding compliance with EP requirements.<br>• Continue to monitor this requirement based on a 50% sample.<br><br>**Findings:**<br>PSH has continued its practice and training activities. The facility reported the following compliance data:<br><br>14. *Individual's acceptance of mental illness* 99%<br>15. *Individual's understanding of the need for treatment* 100%<br>16. *Individual's adherence to treatment* 99% |

| | | |
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| | | Comparative data indicated that PSH maintained compliance rates of 90% or greater since the previous review period for all three indicators.<br><br>**Other findings:**<br>This monitor found substantial compliance in all charts reviewed (AM, BEH, CM, JHM, PS and RR).<br><br>**Current recommendation**:<br>Continue current practice. |
| D.7.a.v | development of relapse prevention plan (i.e., Personal Wellness Recovery Plan or Wellness Recovery Action Plan) for mental illness symptoms, including the individual's recognition of precursors and warning signs and symptoms and precursors for dangerous acts; | **Current findings on previous recommendations:**<br><br>**Recommendations 1-3 December 2008:**<br>• Ensure that relapse prevention plans include specifics of the plan in all cases.<br>• Continue current practice and ensure ongoing training of WRPTs regarding compliance with EP requirements.<br>• Continue to monitor this requirement based on a 50% sample.<br><br>**Findings:**<br>PSH has implemented these recommendations. The facility reported the following data:<br><br>17. *Individual's development of relapse prevention plan for mental illness symptoms* — 100%<br>18. *Individual's recognition of precursors and warning signs and symptoms (that may mediate) future dangerous acts* — 100%<br><br>Comparative data indicated that PSH maintained compliance rates of 90% or greater since the previous review period for both indicators. |

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| | | **Other findings:**<br>This monitor found substantial compliance in all charts reviewed (AM, BEH, CM, JHM, PS and RR).<br><br>**Current recommendation:**<br>Continue current practice. |
| D.7.a.vi | willingness to achieve understanding of substance abuse issues and to develop an effective relapse prevention plan (as defined above); | **Current findings on previous recommendation:**<br><br>**Recommendation, December 2008:**<br>Same as above.<br><br>**Findings:**<br>The facility reported a mean compliance rate of 99%, compared to 100% for the last review period.<br><br>**Other findings:**<br>This monitor found substantial compliance in all five charts to which the requirement was applicable (AM, BEH, CM, JHM and RR).<br><br>**Current recommendation:**<br>Continue current practice. |
| D.7.a.vii | previous community releases, if the individual has had previous CONREP revocations; | **Current findings on previous recommendations:**<br><br>**Recommendations 1 and 2, December 2008:**<br>• Continue current practice and ensure ongoing training of WRPTs regarding compliance with EP requirements.<br>• Continue to monitor this requirement based on a 50% sample.<br><br>**Findings:**<br>PSH has implemented these recommendations. The facility reported a |

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| | | mean compliance rate of 100%, compared to 93% during the previous review period.<br><br>**Other findings:**<br>This monitor found substantial compliance in all three charts to which the requirement was applicable (CM, JHM and PS).<br><br>**Current recommendation**:<br>Continue current practice. |
| D.7.a. viii | social support, financial resources, family conflicts, cultural marginalization, and history of sexual and emotional abuse, if applicable; and | **Current findings on previous recommendation:**<br><br>**Recommendation, December 2008:**<br>Same as above.<br><br>**Findings:**<br>The facility reported a mean compliance rate of 97%, compared to 93% in the previous review period.<br><br>**Other findings:**<br>This monitor found substantial compliance in all six charts reviewed (AM, BEH, CM, JHM, PS and RR).<br><br>**Current recommendation**:<br>Continue current practice. |
| D.7.a.ix | relevant medical issues, all self-harm behaviors, risks for self harm and risk of harm to others, to inform the courts and the facility where the individual will be housed after discharge. | **Current findings on previous recommendation:**<br><br>**Recommendation, December 2008:**<br>Same as above.<br><br>**Findings:**<br>The facility reported a mean compliance rate of 96%, compared to 95% |

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| | | in the previous review period.<br><br>**Other findings:**<br>This monitor found substantial compliance in five charts (AM, BEH, CM, JHM and RR) and partial compliance in one (PS).<br><br>**Current recommendation**:<br>Continue current practice. |
| D.7.b | Each State hospital shall develop and implement policies and procedures to ensure an interdisciplinary approach to the development of court submissions for individuals admitted to the hospital pursuant to Penal Code Section 1370, "incompetent to stand trial" ("IST"), based on accurate information and individualized risk assessments. Consistent with the right of an individual accused of a crime to a speedy trial, the focus of the IST hospitalization shall be the stabilization of the symptoms of mental illness so as to enable the individual to understand the legal proceedings and to assist his or her attorney in the preparation of the defense. The forensic reports should include the following: | **Compliance:**<br>Substantial. |
| D.7.b.i | relevant clinical description of initial presentation, if available, which caused the individual to be deemed incompetent to stand trial by the court; | **Current findings on previous recommendations:**<br><br>**Recommendation 1, December 2008:**<br>Continue current practice and ensure ongoing training of WRPTs regarding compliance with EP requirements.<br><br>**Findings:**<br>PSH has maintained its practice and provided further training on PC |

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| | | 1370 report writing to the WRPTs on April 8, 2009.<br><br>**Recommendation 2, December 2008:**<br>Continue to monitor this requirement.<br><br>**Findings:**<br>PSH used the DMH Court Report PC 1370 Monitoring Form to assess compliance. The facility reviewed 100% of the court reports completed from November 2008 to February 2009 and 50% of the court reports completed in March and April 2009. The mean compliance rate for this requirement was 100%, the same as reported for the previous review period.<br><br>The mean compliance rates for the requirements in D.7.b.ii through D.7.b.iv are reported for each corresponding cell below. The indicators are listed if they represented sub-criteria of the requirement. Comparative data are listed as appropriate.<br><br>**Other findings:**<br>A review of the charts of six individuals admitted under PC 1370 found substantial compliance in all charts (HLW, JDP, MAA, MGW, MSB and RP).<br><br>**Current recommendation**:<br>Continue current practice. |
| D.7.b.ii | clinical description of the individual at the time of admission to the hospital; | **Current findings on previous recommendation:**<br><br>**Recommendation, December 2008:**<br>Same as above.<br><br>**Findings:**<br>The facility reported a mean compliance rate of 100%, compared to |

<table>
<tr><td></td><td></td><td>99% in the previous review period.<br><br>Other findings:<br>This monitor found substantial compliance in all six charts reviewed (HLW, JDP, MAA, MGW, MSB and RP).<br><br>Current recommendation:<br>Continue current practice.</td></tr>
<tr><td>D.7.b.iii</td><td>course of hospital stay, describing any progress or lack of progress, response to treatment, current relevant mental status, and reasoning to support the recommendation; and</td><td>Current findings on previous recommendation:<br><br>Recommendation, December 2008:<br>Same as above.<br><br>Findings:<br>The facility reported the following data:
<table>
<tr><td>14.</td><td>Description of any progress or lack of progress</td><td>100%</td></tr>
<tr><td>15.</td><td>Individual's response to treatment</td><td>100%</td></tr>
<tr><td>16.</td><td>Current relevant mental status</td><td>100%</td></tr>
<tr><td>17.</td><td>Reasoning to support the recommendation: a) stability of the symptom and capacity to cooperate rationally with counsel in the conduct of a defense; b) individual's understanding of the charge and legal procedures</td><td>100%</td></tr>
</table>
Comparative data indicated that PSH maintained compliance rates of 90% or greater since the previous review period for all four indicators.<br><br>Other findings:<br>This monitor found substantial compliance in five charts (HLW, JDP, MAA, MGW and RP) and partial compliance in one (MSB).</td></tr>
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| | | **Current recommendation**:<br>Continue current practice. |
| D.7.b.iv | all self-harm behaviors and relevant medical issues, to inform the courts and the facility where the individual will be housed after discharge. | **Current findings on previous recommendation:**<br><br>**Recommendation, December 2008:**<br>Same as above.<br><br>**Findings:**<br>The facility reported a mean compliance rate of 97%, the same as reported for the previous review period.<br><br>**Other findings:**<br>This monitor found substantial compliance in all six charts reviewed (HLW, JDP, MAA, MGW, MSB and RP).<br><br>**Current recommendation**:<br>Continue current practice. |
| D.7.c | Each State hospital shall establish a Forensic Review Panel (FRP) to serve as the internal body that reviews and provides oversight of facility practices and procedures regarding the forensic status of all individuals admitted pursuant to Penal Code 1026 and 1370. The FRP shall review and approve all forensic court submissions by the Wellness and Recovery Teams and ensure that individuals receive timely and adequate assessments by the teams to evaluate changes in their psychiatric condition, behavior and/or risk factors that may warrant modifications in their forensic status and/or level of restriction | **Current findings on previous recommendation:**<br><br>**Recommendation, December 2008:**<br>Ensure that the FRP is able to perform its current duties regarding the review of reports, providing corrective feedback to practitioners and keeping adequate minutes of the FRP meetings.<br><br>**Findings:**<br>Review of the minutes of the FRP, a sample of e-mails containing its feedback to WRPTs, random samples of PC 1026 and PC 1370 reports (see corresponding cells above) and the facility's self-assessment data found that the facility has maintained adequate practice since the last review. The facility has yet to provide the Chair of the FRP with administrative support. |

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| | | **Compliance:**<br>Substantial.<br><br>**Current recommendation**:<br>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:**<br><br>**Recommendation, December 2008:**<br>Continue current practice.<br><br>**Findings:**<br>Review of minutes of the FRP meetings during this review period found that PSH has maintained its current practice.<br><br>**Other findings:**<br>PSH reported that all FRP members who review court reports have received ongoing training on both group and individual bases. During this review period, all FRP members who review court reports have received a series of mandatory didactic trainings provided by the Chair of the FRP that covered the following topics:<br><br>1. The legal basis of the Penal Code commitments, including landmark cases (Dusky, Wilson, Godinez v. Moran, Indiana v. Edwards, Frendak, in re Hernandez, Sell v. U.S., Galindo, etc);<br>2. A review of the DMH manual and an item-by-item discussion of each Enhancement Plan requirement;<br>3. The hospital's role in the treatment of individuals admitted under PC 1026 and PC 1370 and how the recovery model applies to their care;<br>4. The importance of appropriate documentation to support the opinions in the court reports; |

| | | |
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| | | 5. The importance of malingering assessments in PC1370 cases;<br>6. The importance of PC 1026 extensions and PC 2972 renewals, including the differences in the specific language required for each statute and the double jeopardy clause;<br>7. The role and function of the Conditional Release Program and the importance of collaboration with the CONREP care providers; and<br>8. The dual roles of evaluators and treatment providers and how to resolve conflicts that may arise between them<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendation**:<br>Continue current practice. |

| E. Discharge Planning and Community Integration | | |
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| | | **Summary of Progress:**<br>1. PSH has made significant improvement in discharge-related matters, including working with CONREP to improve communication and cooperation to reduce delay in discharge, keeping ongoing contact to ensure that both parties are apprised of the individual's discharge status.<br>2. PSH has produced a number of educational materials (both printed and audio/video) for use with individuals and Mall facilitators.<br>3. Focus 11 is opened more consistently for individuals.<br>4. A number of groups have been opened to give individuals the opportunity to learn about and prepare for discharge. |
| E | Taking into account the limitations of court-imposed confinement, the State shall pursue actively the appropriate discharge of individuals under the State's care at each State hospital and, subject to legal limitations on the state's control of the placement process, provide services in the most integrated, appropriate setting in which they reasonably can be accommodated, as clinically appropriate, that is consistent with each individual's needs. | **Methodology:**<br><br><u>Interviewed</u>:<br>1. The following two individuals: BS and CM<br>5. Hope Marriott, LCSW<br>6. Rachel Strydom, LCSW, (A) Supervising Social Worker<br>7. Veronica Kaufman, LCSW, Chief of Social Work<br><br><u>Reviewed</u>:<br>1. The charts of the following 52 individuals: AAN, AD, ASE, ASM, ATM, AV, BAV, BC, BLB, BP, CK, DH, DJ, DJW, DOR, DT, EF, EV, GT, JAF, JAM, JC, JMR, JR, KF, LAJ, LDH, LEB, LTH, MED, MMR, MS, OB, PC, PS, RA, RAK, RB, REA, RH, RL, RP, SAG, SDG, SH, SJW, SM, SRC, TB, TK, VF, and VT<br>2. List of individuals referred for discharge but still hospitalized<br>3. List of individuals assessed to need family therapy<br><br><u>Observed</u>:<br>1. PSSC/ETRC Meeting (June 10, 2009) |

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| | | 2. Mall Group: Stress Management through Creative Arts<br>3. Mall Group: Coping Skills through Creative Arts<br>4. Mall Group: Enhancing Self Control<br>5. Mall Group: Positive Expression<br>6. Mall Group: Acceptance and Commitment Therapy: Act on Life, Not Anger<br>7. WRPC (Program VI, unit 71) for quarterly review of TAF<br>8. WRPC (Program VIII, unit N25) for annual review of DR<br>9. WRPC (Program VIII, unit N21) for monthly review of PC |
| 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: | Please see sub-cells for compliance findings. |
| E.1.a | those factors that likely would foster successful discharge, including the individual's strengths, preferences, and personal life goals; | **Current findings on previous recommendations:**<br><br>**Recommendations 1-3, December 2008:**<br>• Ensure that the individual's strengths and preferences are utilized to achieve discharge goals. These should be linked to the interventions that impact the individual's discharge criteria.<br>• The individual's life goals should be linked to one or more focus/foci of hospitalization, with associated objectives and interventions.<br>• Ensure that the individual's current WRP satisfies the necessary conditions to successfully meet discharge criteria<br><br>**Findings:**<br>Using the DMH Discharge Planning and Community Integration Auditing Form, PSH assessed its compliance based on an average sample of 16% of quarterly and annual WRPs due each month during the review period (November 2008 – April 2009): |

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| 1. | *Those factors that likely would foster successful discharge, including the individual's strengths, preferences, and personal life goals.* | 23% |
| 1.a | *There is at least one objective that is aligned with the individual's personal life goals that are stated on the first page of the WRP; and* | 29% |
| 1.b | *The interventions will use the individual's strengths and preferences to achieve the respective objective.* | 16% |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 1. | 6% | 23% |
| Compliance rate in last month of period | | |
| 1. | 5% | 44% |
| 1.a | 19% | 52% |
| 1.b | 5% | 35% |

A review of the records of 29 individuals found that 15 of the WRPs in the charts had utilized the individual's strengths, preferences, and life goals and that these were aligned with the intervention(s) that impacted the individual's discharge goals (ASE, ASM, AV, BAV, BLB, BP, DJW, DOR, EF, OB, PS, RB, SH, TB and VF). The individual's strengths, preferences, and life goals had not been appropriately utilized in the remaining 14 (AAN, AD, ATM, BC, CK, EV, JAF, LEB, LTH, MS, RP, SJW, SRC and VT).

The facility reported that a barrier to compliance has been WRPTs' difficulty in understanding the linkage between Life Goal and a Focus of

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| | | Hospitalization. Didactic training has been provided, but actual application and revisions to the WRP were not done consistently. Improvement began when unit social workers took responsibility for doing the linkage.<br><br>To improve compliance, the WRP Clean-Up Phase II will focus on this issue. The Mentorship Program will reinforce Life Goal linkage and the inclusion of strengths/preferences with WRPTs. Senior social workers will provide supervision to ensure that unit social workers are following up and linking Life Goals to Focus of Hospitalization and including Strengths, in cases where the WRPT has not done so.<br><br>**Compliance:**<br>Partial.<br><br>**Current recommendations**:<br>1. Ensure that the individual's strengths and preferences are utilized to achieve discharge goals. These should be linked to the interventions that impact the individual's discharge criteria.<br>2. The individual's life goals should be linked to one or more focus/foci of hospitalization, with associated objectives and interventions.<br>3. Ensure that the individual's current WRP satisfies the necessary conditions to successfully meet discharge criteria. |
| E.1.b | the individual's level of psychosocial functioning; | **Current findings on previous recommendations:**<br><br>**Recommendation 1, December 2008:**<br>Ensure that the level of psychosocial functioning (functional status) is included in the individual's present status section of the case formulation section of the WRP.<br><br>**Findings:**<br>Using the DMH Discharge Planning and Community Integration Auditing |

Form, PSH assessed its compliance based on an average sample of 16% of the quarterly and annual WRPs due each month during the review period (November 2008 – April 2009):

| | | |
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| 2. | *The individual's level of psychosocial functioning* | 78% |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 2. | 25% | 78% |
| Compliance rate in last month of period | | |
| 2. | 36% | 97% |

A review of the records of 31 individuals found that 28 of the WRPs in the charts included the individual's psychosocial functioning in the Present Status section (AAN, ASE, ASM, ATM, AV, BAV, BC, BLB, BP, CK, DOR, EF, EV, GT, JAF, LEB, LTH, MS, OB, PS, RA, RB, SH, SJW, SRC, TB, VF and VT). The remaining three (AD, DJW and RP) did not include the information or the information was not comprehensive.

**Recommendation 2, December 2008:**
Ensure that team members are aware of and trained in elements to consider in updating GAF scores.

**Findings:**
According to the Chief of Social Work, WRPT members have been trained on and are aware of and addressing GAF scores. WRPTs are composed of at least three disciplines which, by virtue of their education and training as psychiatrists, clinical social workers and psychologists, should be familiar with GAF methodology. The WRPTs observed by this

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| | | monitor discussed and addressed the individuals' GAF scores. A review of five records found that all five WRPs (JMR, PC, RAK, SAG and TK) had changed the GAF scores from the previous score, and the information in the Present Status sections evidenced changes in the individuals' functioning from the previous WRPs.<br><br>**Compliance:**<br>Partial.<br><br>**Current recommendation**:<br>Ensure that the level of psychosocial functioning (functional status) is included in the individual's present status section of the case formulation section of the WRP. |
| E.1.c | any barriers preventing the individual from transitioning to a more integrated environment, especially difficulties raised in previously unsuccessful placements; and | **Current findings on previous recommendations:**<br><br>**Recommendation 1, December 2008:**<br>Ensure that discharge barriers, especially difficulties in previously unsuccessful placements, are discussed with the individual at scheduled WRPCs.<br><br>**Findings:**<br>According to the Chief of Social Work, Section E leaders have distributed clinical samples on "Barriers to Discharge" and "Focus 11" to all social workers and WRP mentors. WRP mentors provided training to WRPTs. This issue was addressed with WRPTs during the WRP Clean-Up Phase I (April 2009) and Phase II (May 2009). According to the Chief of Social Work, CONREP is participating in 7-day WRPCs through teleconference and providing written input via form MH-7021 for re-hospitalized individuals, at which time information regarding the circumstances of prior unsuccessful placements of these individuals is discussed and integrated into the individuals' WRPs. |

Using the DMH Discharge Planning and Community Integration Auditing Form, PSH assessed its compliance based on an average sample of 16 % of the quarterly and annual WRPs due each month during the review period (November 2008 – April 2009):

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| 3. | *Any barriers preventing the individual from transitioning to more integrated environment, especially difficulties raised in previously unsuccessful placements.* | 58% |
| 3.a | *The individual's barriers to discharge, including difficulties encountered in previous placements are mentioned in the Present Status Section of the WRP.* | 58% |
| 3.b | *These barriers are listed in Focus 11, with appropriate objectives and interventions.* | 58% |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 3. | 7% | 58% |
| Compliance rate in last month of period | | |
| 3. | 16% | 79% |
| 3.a | 46% | 72% |
| 3.b | 26% | 85% |

A review of the records of 31 individuals found that 26 of the WRPs in the charts contained documentation that discharge barriers were discussed with the individual (AAN, ASE, ASM, ATM, AV, BAV, BC, BLB, BP, CK, DOR, EF, EV, JAF, LEB, LTH, MS, OB, PS, RA, RB, SH, SJW, SRC, TB and VF). The remaining five (AD, GT, LEB, RP and VT) did not.

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| | | **Recommendation 2, December 2008:**<br>Include all skills training and supports in the WRP so that the individual can overcome barriers and meet discharge criteria.<br><br>**Findings:**<br>See E.1.d.<br><br>**Compliance:**<br>Partial.<br><br>**Current recommendation:**<br>Ensure that discharge barriers, especially difficulties in previously unsuccessful placements, are discussed with the individual at scheduled WRPCs. |
| E.1.d | the skills and supports necessary to live in the setting in which the individual will be placed. | **Current findings on previous recommendations:**<br><br>**Recommendations 1-3, December 2008:**<br>• Assess the skills and supports that will be needed by the individual for a successful transition to the identified setting.<br>• Include these skills and supports in the individual's WRP and use this information to guide appropriate services for the individual.<br>• Ensure that WRPT members focus on this requirement and update the individual's WRP as necessary.<br><br>**Findings:**<br>Since the last review, SW staff has successfully accomplished a number of projects and activities with regards to the skills and supports individuals would benefit from having upon discharge. PSH has implemented the "Discharge Planning Group" and WRP Sponsorship groups were made available for all individuals in the facility. Lesson Plans for Focus 11 Groups were distributed. The California ID and Birth |

Certificate- Location for DMV processing was established and negotiations with the DMV are ongoing. The facility is collaborating with CONREP to create a database of county-specific program information. A DVD including presentations by and interviews with CONREP Program Directors was produced and distributed for staff training and for use in the PSR Mall Groups with individuals. Aspects of Barriers to Discharge, and interventions were addressed during the facility's WRP Clean-Up Phase I (April 2009) and Phase II (May 2009). Senior SW staff assisted mentors on each assigned unit in Phase I to make sure Barriers to Discharge in the WRP included anticipated discharge placement.

Using the DMH Discharge Planning and Community Integration Auditing Form, PSH assessed its compliance based on an average sample of 16% of the quarterly and annual WRPs due each month during the review period (November 2008 – April 2009):

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| 4. | *The skills and supports necessary to live in the setting in which the individual will be placed.* | 81% |
| 4.a | *The Present Status section of the individual's WRP includes the anticipated discharge placement* | 85% |
| 4.b | *The scheduled PSR groups listed in the interventions include skills and supports the individual will need in the anticipated placement.* | 77% |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 4. | 23% | 81% |
| Compliance rate in last month of period | | |
| 4. | 49% | 85% |

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| 4.a | 59% | 90% |
| 4.b | 67% | 79% |

A review of the records of 25 individuals found that 23 of the WRPs in the charts documented the skills training and supports the individual needed to overcome barriers to discharge and successfully transition to the identified setting (AAN, ASE, ATM, AV, BAV, BC, BP, CK, DOR, EF, EV, JAF, LEB, LTH, OB, PS, RA, RB, SH, SJW, SRC, TB and VF). The remaining three (ASM, BLB and MS) did not. However, many of the groups in which the individuals are enrolled do not pertain directly to the acquisition of the skills and supports individuals will need upon discharge in their respective placements.

The facility identified WRPTs' frequent inattention to incorporating the interventions in the WRP in a timely manner as a barrier to compliance. To improve compliance, Senior Social Work staff will supervise unit SW staff in addressing the WRP requirements. SW is proposing a full-time position to ensure that community resources are arranged for all individuals.

**Compliance:**
Partial.

**Current recommendations**:
1. Assess the skills and supports that will be needed by the individual for a successful transition to the identified setting.
2. Include these skills and supports in the individual's WRP and use this information to guide appropriate services for the individual.
3. Ensure that WRPT members focus on this requirement and update the individual's WRP as necessary.

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| E.2 | Each State hospital shall ensure that, beginning at the time of admission and continuously throughout | **Current findings on previous recommendations:** |

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| | 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. | **Recommendations 1 and 3, December 2008:**<br>• Ensure that the individual is an active participant in the discharge planning process.<br>• Ensure that the individual understands all of the discharge requirements before leaving the WRPC.<br><br>**Findings:**<br>PSH has established a team of mentors including 1) master trainers, 2) discipline seniors who have demonstrated good mentoring skills, and 3) peer mentors from WRPTs known to be holding excellent conferences. Additional training was provided to this smaller group of mentors. SW staff categorized WRPTs by mentoring needs (intensive, intermediate, informational) and assigned mentors to work with the WRPTs in real time to address discharge matters and related information and documentation.<br><br>Using the DMH Discharge Planning and Community Integration Auditing Form, PSH assessed its compliance based on an average sample of 32 % of the quarterly and annual WRPs due each month during the review period (November 2008 – April 2009):<br><br>9. *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.* — 57%<br><br>Comparative data indicated improvement in compliance since the previous review period: |

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 9. | 33% | 57% |
| Compliance rate in last month of period | | |
| 9. | 40% | 74% |

A review of the records of 14 individuals found that one WRPs contained documentation indicating that the individual was an active participant in the discharge process (TK); two WRPs contained documentation suggesting the individuals had cognitive deficits that may present an obstacle to engagement with the team (JAM and RL); and one individual did not attend the conference (SM). The remaining ten WRPs did not contain documentation indicating that the individual was an active participant in the discussion on barriers to discharge (DH, DT, JC, JMR, JR, MMR, PC, RAK, RH and SAG). The significant discrepancy between the chart documentation and observation of WRPC data (see below) suggests that the manner of documentation does not fully reflect what happens during the WRPCs. Most charts merely rewrite the discharge criteria and indicate the status of the individual with regards to the discharge criteria. There is no discussion about the barriers or who said/did what, especially the individual.

This monitor observed three WRPCs (DR, PC and TAF). In all three WRPCs, the teams involved the individual in discussing the discharge barriers, though in some cases the discussion was brief. Only one of the WRPCs had the individual read the discharge criteria from the screen and evaluated whether or not the individual understood the criteria.

**Recommendation 2, December 2008:**
Prioritize objectives and interventions related to the discharge process.

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| | | **Findings:**<br>A review of the records of eight individuals found that seven of the WRPs in the charts prioritized objectives and interventions related to the discharge processes with appropriate foci, objectives, and relevant PSR Mall services (DJ, KF, LAJ, MED, REA, SDG and VF). The remaining one (HE) did not.<br><br>According to the Chief of Social Work, WRPTs sometimes fail to focus on the discharge criteria aspects of the WRP, especially when individuals are not nearing discharge. To improve compliance, PSH will continue with the mentoring program and SW staff will initiate inclusion of the individual in discussion of the discharge planning process on a quarterly basis.<br><br>**Compliance:**<br>Partial.<br><br>**Current recommendations**:<br>1. Ensure that the individual is an active participant in the discharge planning process.<br>2. Prioritize objectives and interventions related to the discharge process.<br>3. Ensure that the individual understands all of the discharge requirements before leaving the WRPC. |
| E.3 | Each State hospital shall ensure that, consistent with generally accepted professional standards of care, each individual has a professionally developed discharge plan that is integrated within the individual's therapeutic and rehabilitation service plan, that addresses his or her particular discharge considerations, and that includes: | Please see sub-cells for compliance findings. |

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| E.3.a | measurable interventions regarding these discharge considerations; | **Current findings on previous recommendation:**<br><br>**Recommendation, December 2008:**<br>Write all interventions, including those dealing with discharge criteria, in behavioral and measurable terms as outlined in the DMH WRP Manual.<br><br>**Findings:**<br>Using the DMH Discharge Planning and Community Integration Auditing Form, PSH assessed its compliance based on an average sample of 16 % of the quarterly and annual WRPs due each month during the review period (November 2008 – April 2009): |

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| | *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* | 29% |

Comparative data indicated mixed changes in compliance since the previous review period:

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 6. | 17% | 29% |
| Compliance rate in last month of period | | |
| 6. | 39% | 24% |

A review of the WRPs of 22 individuals found that the objectives and

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| | | discharge criteria were written in behavioral and/or measurable terms in 10 of the WRPs (AD, ASM, AV, DOR, EF, GT, LEB, SH, SRC and VT). The objectives and/or discharge criteria were not written in behavioral and/or measurable terms in the remaining 12 WRPs (ASE, BAV, BLB, BP, JAF, LDH, MS, OB, PS, RB, RP and SJW).<br><br>**Compliance:**<br>Partial.<br><br>**Current recommendation**:<br>Write all interventions, including those dealing with discharge criteria, in behavioral and measurable terms as outlined in the DMH WRP Manual. |
| E.3.b | the staff responsible for implement the interventions; and | **Current findings on previous recommendations:**<br><br>**Recommendation 1, December 2008:**<br>Confirm that the staff to be listed in the WRP is actually involved in facilitating the activity, group, or intervention.<br><br>**Findings:**<br>Using the DMH Discharge Planning and Community Integration Auditing Form, PSH assessed its compliance based on an average sample of 16 % of all Quarterly and Annual WRPs due each month during the review period (November 2008 – April 2009):<br><br>7. *The interventions specify the name(s) of specific staff responsible for implementing each one* 98%<br><br>Comparative data indicated improvement in the compliance rate from 65% in the previous review period.<br><br>A review of the records of 27 individuals found that 22 of the WRPs in the charts identified the staff member responsible for the interventions |

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| | | (AAN, ASE, ASM, ATM, AV, BAV, BC, BLB, BP, CK, DOR, EF, EV, JAF, LEB, MS, OB, RA, RB, SH, SRC and VF). The remaining five (LDH, PS, RP, SJW and TB) did not do so for one or more interventions.<br><br>**Recommendation 2, December 2008:**<br>Ensure that all elements required for fulfilling the intervention section of the WRP are completed.<br><br>**Findings:**<br>A review of eight WRPs found that interventions in four fulfilled the required elements (JMR, MMR, RAK and SAG), and the remaining four (JR, PC, RL and TK) did not include one or more of the required elements, especially strengths and appropriate milieu interventions.<br><br>**Compliance:**<br>Partial.<br><br>**Current recommendations**:<br>1. Confirm that the staff to be listed in the WRP is actually involved in facilitating the activity, group, or intervention.<br>2. Ensure that all elements required for fulfilling the intervention section of the WRP are completed. |
| E.3.c | The time frames for completion of the interventions. | **Current findings on previous recommendation:**<br><br>**Recommendation, December 2008:**<br>Ensure that the review date for each objective is the same as the individual's next scheduled WRPC.<br><br>**Findings:**<br>Using the DMH Discharge Planning and Community Integration Auditing Form, PSH assessed its compliance based on an average sample of 16 % of quarterly and annual WRPs due each month during the review period |

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<td>(November 2008 – April 2009):
<table>
<tr><td></td><td>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:</td><td></td></tr>
<tr><td>8.</td><td>The time frames for completion of interventions</td><td>97%</td></tr>
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Comparative data indicated improvement in the compliance rate from 69% in the previous review period.<br><br>
A review of the records of 21 individuals found that 17 of the WRPs in the charts clearly stated the time frame for the next scheduled review for each intervention in the Mall or for individual therapy (AD, ASE, ASM, AV, BP, DOR, EF, GT, JAF, LEB, MS, OB, RA, RB, SJV, SRC and VT). The remaining four (BAV, BLB, RP and SH) did not specify a time frame or the stated time frame was not aligned with the next WRPC schedule.<br><br>
Compliance:<br>
Partial.<br><br>
Current recommendation:<br>
Ensure that the review date for each objective is the same as the individual's next scheduled WRPC.</td>
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<td>E.4</td>
<td>Each State hospital shall provide transition supports and services consistent with generally accepted professional standards of care. In particular, each State hospital shall ensure that:</td>
<td>Compliance:<br>
Partial.</td>
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| E.4.a | individuals who have met discharge criteria are discharged expeditiously, subject to the availability of suitable placements; and | **Current findings on previous recommendation:**<br><br>**Recommendation, December 2008:**<br>Use objective data for all discharge criteria and planning.<br><br>**Findings:**<br>Since the last review, Section E Leaders developed the "Discharge Planning Status" log. The log, which tracks availability of and current efforts to find suitable placement, is used for monthly documentation of information such as discharge status and external/internal barriers to discharge for individuals who have met discharge criteria. A CONREP Referral Process Flowchart had been drafted to define the current process for a Community Outpatient Referral.<br><br>A review of the records of nine individuals found that five of the WRPs in the charts contained discharge criteria written in behavioral terms (ASM, JMR, RAK, SAG and TK). The remaining four (JR, MMR, PC and RL) contained one or more discharge criteria written in non-behavioral/measurable terms.<br><br>According to PSH's data, 35 individuals remain in the facility after meeting all discharge criteria. Twenty-six of these individuals (74%) remain hospitalized due to external factors, such as the need for court hearings to determine placement status or waiting for CONREP to initiate final placement in the community. Five of these individuals (14%) remain hospitalized due to internal factors, such as unusual placement difficulties (i.e. LPS placement, history of sex offense), the need for further assessment, or timeliness of court report and review. Three of these individuals (9%) have recently received recommendations for discharge and community placement and the placement status of one individual (3%) was not identified, although this individual had received a CONREP recommendation. Ten individuals (31%) have been hospitalized for more than six months after meeting discharge criteria, all of these |

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| | | due to external factors.<br><br>Further analysis of the CONREP Referral Process Flowchart will determine steps in the process that can be improved and become more efficient to expedite discharge.<br><br>**Current recommendation**:<br>Use objective data for all discharge criteria and planning. |
| E.4.b | Individuals receive adequate assistance in transitioning to the new setting. | **Current findings on previous recommendations:**<br><br>**Recommendations 1 and 2, December 2008:**<br>• Document specific assistance provided to the individual when transitioned to a new setting.<br>• Ensure that early in the discharge process, support and assistance that an individual may need to transition to the new setting is discussed with the individual, and documented in the individual's WRP.<br><br>**Findings:**<br>Using the DMH Discharge Planning and Community Integration Auditing Form, PSH assessed its compliance based on an average sample of 100% of the quarterly and annual WRPs due each month during the review period (November 2008 – April 2009): |

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| | *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. (E4b)* | 21% |
| 10.a | *The Present Status section of the individual's WRP describes the assistance needed to transition to t he discharge setting; and* | 24% |

| | | |
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| 10.b | *Identifies the persons (i.e. agency staff) responsible for providing transitional assistance.* | 18% |

Comparative data indicated mixed changes in compliance since the previous review period:

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 10. | 6% | 21% |
| Compliance rate in last month of period | | |
| 10. | 33% | 16% |
| 10.a | 67% | 16% |
| 10.b | 33% | 16% |

A review of the records of 12 individuals found that 10 of the WRPs in the charts contained documentation of the assistance needed by the individual in the new setting (ASE, ASM, BLB, BP, LDH, OB, RA, RB, SH and TB). The remaining 2 (ASM and SH) did not.

PSH provided didactic training to unit social workers during the interval. Further training in practical terms will be provided to define who has met discharge criteria (hospital-wide) to enable unit SW staff to include appropriate discharge status information in the WRP.

PSH has also implemented a monthly monitoring tool to collect accurate data on the number of discharge-ready individuals. Individuals meeting discharge criteria as determined by their WRPTs will be followed up on. Section E Leaders and Senior SWs will ensure that WRPT SW staff will document the individual's discharge status in Present Status: Barriers to Discharge section of WRPs.

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| | | **Current recommendations**:<br>1. Document specific assistance provided to the individual when transitioned to a new setting.<br>2. Ensure that early in the discharge process, support and assistance that an individual may need to transition to the new setting is discussed with the individual, and documented in the individual's WRP. |
| E.5 | For all children and adolescents it serves, each State hospital shall: | The requirements of Section E.5 are not applicable to PSH 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 | |
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| | **Summary of Progress on Psychiatric Services:**<br>1. The DMH's Psychopharmacology Advisory Committee, led by PSH's psychopharmacology consultant, has made appropriate revisions, updates and additions to the DMH Psychotropic Medication Policy.<br>2. PSH has decreased the unjustified use of anticholinergic medications for individuals over age 60 and with cognitive impairments of any type.<br>3. PSH has decreased the unjustified use of benzodiazepines for individuals with cognitive impairments of any type.<br>4. PSH has increased reporting of Adverse Drug Reactions (ADRs) and conducted appropriate intensive case analysis of ADRs as indicated.<br>5. PSH has conducted appropriate Drug Utilization Reviews (DUEs).<br>6. PSH has improved the laboratory monitoring of individuals receiving new generation antipsychotic agents (NGAs) regarding the risk of pancreatic dysfunction.<br>7. PSH has implemented the standardized DMH monitoring tool for individuals receiving NGAs.<br><br>**Summary of Progress on Psychological Services:**<br>1. The Psychology Specialty Services Committee (PSSC) procedures and documentation have significantly improved.<br>2. The PSSC tracks and monitors all referred triggers; the Committee's activity showed good reviews and follow-up of individuals referred to them.<br>3. The PSSC/ETRC meetings are effective in triaging cases and in providing support to the PSSC.<br>4. The By Choice system and operation has improved. The By Choice Coordinator has produced many valuable tools and handouts to help increase staff awareness and support the individuals in their participation in the incentive system. |

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| | **Summary of Progress on Nursing Services:**<br>1. PSH's Standards Compliance Department has made great efforts to revise the Medication Variance Report tracking system to ensure accurate data.<br>2. PSH has made significant progress regarding the shift change process.<br>3. PSH has made significant progress by using mentors to demonstrate procedures regarding medication administration and providing information and education to individuals during this time.<br><br>**Summary of Progress on Rehabilitation Therapy Services:**<br>1. Improvement is noted in the quality of focus statements, objectives and interventions written for individuals receiving Rehabilitation Therapy services.<br>2. WRP integration for individuals receiving Rehabilitation Therapy services has improved since the previous review.<br>3. The Vocational Services program has continued to develop, and the number of Vocational Services-related PSR Mall groups has increased from nine to 28.<br><br>**Summary of Progress on Nutrition Services:**<br>1. Nutrition PSR Mall group hours provided by Dietitians have increased and lesson plans appear to meet generally accepted standards of practice.<br>2. Improvement is noted in the quality of focus statements, objectives and interventions written for individuals receiving Nutrition services.<br>3. The Interdisciplinary Weight Management PSR Mall group has been implemented and an outcomes study was performed on the pilot group. The outcomes study found an improvement in weight and weight-related risk factors for individuals participating in the group.<br><br>**Summary of Progress on Pharmacy Services:**<br>PSH has achieved substantial compliance with EP requirements in this |

| | |
|---|---|
| | section.<br><br>**Summary of Progress on General Medical Services:**<br>1. The DMH has finalized joint nursing and medical protocols and other guidelines. If properly implemented, these tools have the potential to correct the process deficiencies regarding nursing assessments, physician-nurse communications and some aspects of medical care.<br>2. PSH has improved the documentation of some of the evaluations conducted by physicians upon the return of individuals from outside hospitalization.<br>3. PSH has developed a procedure (draft) that outlines appropriate interdisciplinary processes to address refusals by some individuals of medical examinations and care.<br><br>**Summary of Progress on Infection Control:**<br>1. The Infection Control Department has added two full-time PPD/Immunization nurses to administer PPDs, read PPD results and administer immunizations throughout the hospital.<br>2. The Department has been working aggressively with unit staff regarding the WRPs, which has already produced positive results.<br>3. The Infection Control Department has maintained substantial compliance in a number of areas. With continued implementation of Infection Control's strategies, the facility should be able to attain substantial compliance with all EP requirements by the next review period.<br><br>**Summary of Progress on Dental Services**<br>1. PSH's Dental Department has implemented the EagleSoft dental software.<br>2. In spite of workload and staffing issues, the Dental Department has maintained substantial compliance in a number of areas.<br>3. PSH is developing a system by which WRPTs will address dental refusals that should increase compliance in this area. |

| 1. Psychiatric Services | | |
|---|---|---|
| | | **Methodology:**<br><br>Interviewed:<br>1. George Christison, MD, Acting Medical Director<br>2. J. Stephen Maurer, MD, Chief of Medical Staff<br>3. Jana Christ, RN<br>4. John Thiel, MD, Staff Psychiatrist<br>5. Raafat Girgis, MD, Senior Psychiatrist<br>6. Rebecca Kornbluh, MD, Acting Assistant Medical Director<br>7. Washington Ubillus, Jr., Acting Pharmacist II<br>8. Willie Harris, MD, Acting Chief of Psychiatry<br><br>Reviewed:<br>1. The charts of the following 34 individuals: BRA, CDF, CF, CLS, CTH, DG, DLW, DRL, HG, HMG, HN, JAM, JBW, JEB, JEL, JHB, JLC, JO, JRT, JS, LDS, LZ, MC, OVM, RAP, RW, RWT, SJP, SO, SQS, SS, SWK, VAR and VGC<br>2. Revised Special Order 105.11, DMH Psychotropic Medication Policy, February 11, 2009<br>3. DMH Admission Psychiatric Assessment Auditing Form<br>4. DMH Admission Psychiatric Assessment Auditing Form Instructions<br>5. PSH Admission Psychiatric Assessment Auditing summary data (November 2008 to April 2009)<br>6. DMH Integrated Assessment: Psychiatry Section Auditing Form<br>7. DMH Integrated Assessment: Psychiatry Section Auditing Form Instructions<br>8. PSH Integrated Assessment: Psychiatry Section Auditing summary data (November 2008 to April 2009)<br>9. DMH Monthly Psychiatric Progress Note, May 2009<br>10. DMH Monthly PPN Audit Form, May 2009<br>11. DMH Monthly PPN Audit Form Instructions, May 2009<br>12. PSH Monthly PPN Audit summary data (November 2008 to April |

| | | |
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| | | 2009)<br>13. PSH PRN and Stat monitoring summary data (November 2008 to April 2009)<br>14. DMH Benzodiazepine Auditing Form<br>15. DMH Benzodiazepine Auditing Form Instructions<br>16. PSH Benzodiazepine Auditing Form summary data (November 2008 to April 2009)<br>17. DMH Anticholinergics Auditing Form<br>18. DMH Anticholinergics Auditing Form Instructions<br>19. PSH Anticholinergics Auditing Form summary data (November 2008 to April 2009)<br>20. DMH Polypharmacy Auditing Form<br>21. DMH Polypharmacy Auditing Form Instructions<br>22. PSH Polypharmacy Auditing Form summary data (November 2008 to April 2009)<br>23. DMH New Generation Antipsychotic Medications Monitoring Form<br>24. DMH New Generation Antipsychotic Medications Monitoring Form Instructions<br>25. PSH New Generation Antipsychotic Medications Monitoring summary data (November 2008 to April 2009)<br>26. DMH Tardive Dyskinesia (TD) Monitoring Form<br>27. DMH TD Monitoring Form Instructions<br>28. PSH TD Monitoring summary data (November 2008 to April 2009)<br>29. Last ten ADRs for this reporting period<br>30. PSH data regarding medication variances (November 2008 to April 2009)<br>31. Last ten MVRs for this reporting period<br>32. Pharmacy and Therapeutics Committee meeting minutes during this review period |
| F.1.a | Each State hospital shall develop and implement policies and procedures to ensure system-wide monitoring of the safety, efficacy, and | **Current findings on previous recommendations:** |

| | | |
|---|---|---|
| | 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: | **Recommendations 1 and 2, December 2008:**<br>• Finalize individualized guidelines for all psychotropic and anticonvulsant medications listed in the formulary.<br>• Ensure that the individualized medication guidelines are continually revised, as appropriate, to reflect current literature, relevant clinical experience and professional practice guidelines. Provide a summary outline of the revisions made during the review period.<br><br>**Findings:**<br>During this review period, the DMH's Psychopharmacology Advisory Committee, led by PSH's psychopharmacology consultant, has made significant revisions, updates and additions to the DMH Psychotropic Medication Policy. This monitor reviewed the changes and found that they comported with current literature and generally accepted standards. The following is an outline of these changes:<br><br>1. A new guideline regarding the use of iloperidone, a new generation antipsychotic medication (NGA), was added.<br>2. The current guidelines regarding the use of NGAs (with the exception of aripiprazole) were updated by adding a notation regarding the relationship between the risk of hyperprolactinemia and the plasma concentrations of the drugs.<br>3. Information regarding the occurrence of hyperprolactinemia in the context of various psychotropic drug treatments was added.<br>4. A new indication was added to the current aripiprazole guideline to address the newly recognized benefits of this medication in the treatment of certain affective disorders (major depressive and bipolar disorders).<br>5. A new guideline regarding the metabolic syndrome (risk factors, screening, diagnosis and management) was added.<br>6. New guidelines regarding the use of lithium and non-serotonin specific reuptake inhibitor (non-SSRI) antidepressants were added.<br>7. The current guideline regarding the use of SSRIs was updated to |

| | | |
|---|---|---|
| | | address the risks of gestational hypertension and eclampsia.<br>8. The current guideline regarding the use of valproic acid/divalproex was updated to clarify the different forms of treatment and to address the risks of osteoporosis and osteopenia.<br>9. The current guideline regarding the use of PRN and Stat medications was updated, providing further information on medications in common use.<br>10. The current information regarding the use of medications for elderly individuals was updated to address the cardiovascular risks associated with NGAs and the risks of osteoporosis and osteopenia associated with SSRIs.<br>11. The current information regarding the maximum daily doses of medications was updated (doses of paroxetine and duloxetine were increased to 60 mg and 120 mg, respectively).<br>12. A new guideline regarding tardive dyskinesia, including diagnosis/ differential diagnosis and management, was added.<br>13. A new guideline regarding neuroleptic malignant syndrome, including diagnosis/differential diagnosis, laboratory evaluation and treatment, was added.<br>14. The Drug Utilization Evaluation (DUE) instruments were edited to maintain congruence with the respective guideline/information in the policy.<br><br>**Recommendations 3 and 4, December 2008:**<br>• Monitor these requirements using the standardized DMH tools based on at least a 20% sample.<br>• Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period).<br><br>**Findings:**<br>PSH used the DMH Admission Psychiatric Assessment and Integrated Assessment: Psychiatry Section and Monthly PPN Auditing Forms to |

| | | |
|---|---|---|
| | | assess compliance during the review period (November 2008 – April 2009), based on average samples of 41% and 36%, respectively.<br><br>PSH also used the Monthly Psychiatric Progress Note Auditing Form to assess compliance with this requirement. PSH revised the Monthly Physician Progress Note Template and Auditing Form during this review period in efforts to ensure clinical relevance and continue to meet all requirements of the Enhancement Plan. Specific modifications are noted in each cell as applicable. From November 2008 to March 2009, the average sample size was 20% and for April 2009 the sample size was 10% of the monthly notes for individuals who had been hospitalized for more than 90 days.<br><br>Compliance data with corresponding indicators and sub-indicators and comparative data are summarized in each cell below.<br><br>**Compliance:**<br>Partial (improved compared to the last review).<br><br>**Current recommendations**:<br>1. Ensure that the individualized medication guidelines are continually revised, as appropriate, to reflect current literature, relevant clinical experience and professional practice guidelines. Provide a summary outline of the revisions made during the review period.<br>2. Monitor this requirement using the DMH Admission Psychiatric Assessment, DMH Integrated Assessment: Psychiatric Section and Monthly PPN Auditing Forms based on at least a 20% sample.<br>3. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period.<br>4. Provide a summary outline of improvements in practice made as a result of the facility's review 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:* | 96% |
| 8.a | *Regular psychotropic medications, with rationale.* | 96% |
| 8.b | *PRN and/or Stat medication as applicable, with specific behavioral indications* | 96% |
| 8.c | *Special precautions to address risk factors, as indicated.* | 97% |

The facility reported an improvement in the mean compliance rate from 85% during the previous review period.

| **Integrated Psychiatric Assessment** | | |
|---|---|---|
| 7. | *Diagnostic formulation is documented* | 90% |

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

The facility reported data for Item 10 from the Integrated Psychiatric Assessment; however the data was not consistent with data for this item reported in cell D.1.c.iii.9, did not appear valid and is not summarized here.

| **Monthly PPN** | | |
|---|---|---|
| 2.b | *The current target symptoms which are the focus of treatment are identified in the progress note.* | 86% |
| 6.a.1 | *The risks, benefits and rationale for the current psychopharmacology plan including anticholinergics, benzodiazepines, and polypharmacy are documented.* | 78% |
| 6.a.2 | *There is a clear description of the reasoning for continuing the current medication regiment and the proposed future plans, such as augmentation, dose tapering, change in medication, etc.* | 78% |

Comparative data indicated modest changes in mean compliance since the previous review period:

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 2.b | 87% | 86% |
| 6.a.1 | 76% | 78% |
| 6.a.2 | 76% | 78% |
| Compliance rate in last month of period | | |
| 2.b | 94% | 82% |
| 6.a.1 | 72% | 81% |
| 6.a.2 | 72% | 78% |

PSH implemented the revised PPN Auditing Form in May 2009 and utilized the tool to audit the April 2009 PPNs. These items numbers were changed and these items were revised to more closely align with the EP requirement.

| **Monthly PPN Revised** | | |
|---|---|---|
| 2.b | *Subjective complaints and symptoms are documented or there is documentation substantiating the reason that subjective complaints/concerns are not available.* | 95% |
| 3. | *Timely and justifiable updates of diagnosis and treatment, as clinically indicated.* | 90% |
| 3.a | *The 5 Axis Diagnosis* | 99% |
| 3.b | *The individual's target symptoms are consistent with the diagnosis.* | 96% |
| 3.c | *A discussion of diagnostic questions that still require resolution including deferred, r/o and NOS diagnoses.* | 75% |

<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><td colspan="3">Monthly PPN</td></tr>
<tr><td>2.h.2</td><td>Current psychotropic medication dosage/laboratory monitoring/diagnostic testing and consultation protocols are followed as indicated (as per DMH psychotropic guidelines.)</td><td>77%</td></tr>
</table>
<br>
Comparative data indicated no significant changes in compliance since the previous review period:
<br>
<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>2.h.2</td><td>75%</td><td>77%</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>2.h.2</td><td>76%</td><td>80%</td></tr>
</table>
<br>
PSH implemented the revised PPN Auditing Form in May 2009 and utilized the tool to audit the April 2009 PPNs. The item number changed and this item was revised to simplify wording to reduce confusion.
<br>
<table>
<tr><td colspan="3">Monthly PPN Revised</td></tr>
<tr><td>5.b</td><td>Current regimen is prescribed consistent with DMH psychotropic guidelines.</td><td>96%</td></tr>
</table>
</td>
</tr>
<tr>
<td>F.1.a.iii</td>
<td>tailored to each individual's symptoms;</td>
<td>
<table>
<tr><td colspan="3">Monthly PPN Revised</td></tr>
<tr><td>5.a</td><td>Justify/explain the current regimen considering this month's progress (or lack of progress) and clinical data.</td><td>92%</td></tr>
</table>
</td>
</tr>
</table>

F.1.a.iv

monitored for effectiveness against clearly identified target variables and time frames;

| **Monthly PPN** | | |
|---|---|---|
| 2.b | *Identified target symptoms are documented.* | 86% |
| 2.c | *Participation in treatment is documented.* | 87% |
| 2.d | *Progress towards objective in the Wellness and Recovery Plan (is documented).* | 86% |

Comparative data indicated modest changes in mean compliance since the previous review period:

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 2.b | 87% | 86% |
| 2.c | 87% | 87% |
| 2.d | 81% | 86% |
| Compliance rate in last month of period | | |
| 2.b | 94% | 82% |
| 2.c | 90% | 87% |
| 2.d | 82% | 85% |

PSH implemented the revised PPN Auditing Form in May 2009 and utilized the tool to audit the April 2009 PPNs. This item number changed and this item was revised to facilitate the discussion of target symptoms within the context of treatment.

| **Monthly PPN Revised** | | |
|---|---|---|
| 5.c | *Monitored for effectiveness against clearly identified target variables* | 90% |

| F.1.a.v | monitored appropriately for side effects; |
|---|---|

| **Monthly PPN** | | |
|---|---|---|
| 6.b | *Monitoring of side effects (is documented.)* | 81% |
| 6.c | *AIMS is completed.* | 85% |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 6.b | 78% | 81% |
| 6.c | 84% | 85% |
| Compliance rate in last month of period | | |
| 6.b | 83% | 79% |
| 6.c | 81% | 88% |

PSH implemented the revised PPN Auditing Form in May 2009 and utilized the tool to audit the April 2009 PPNs. This item number changed and this item was revised for clarity.

| **Monthly PPN Revised** | | |
|---|---|---|
| 2.g | *Current AIMS* | 87% |
| 5.d | *Justify/explain the use of medications that pose elevated risks and/or are causing side effects including, if applicable, an analysis of risks and benefits of the following: benzodiazepines, anticholinergics, polypharmacy, conventional and atypical antipsychotics and other psychiatric medications.* | 66% |

F.1.a.vi modified based on clinical rationales;

| **Monthly PPN** | | |
|---|---|---|
| 6.a.1 | *The risks, benefits and rationale for the current psychopharmacology plan including anticholinergics, benzodiazepines, and polypharmacy are documented.* | 78% |
| 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% |

Comparative data indicated modest changes in mean compliance since the previous review period:

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 6.a.1 | 76% | 78% |
| 6.a.2 | 76% | 78% |
| Compliance rate in last month of period | | |
| 6.a.1 | 72% | 81% |
| 6.a.2 | 72% | 81% |

PSH implemented the revised PPN Auditing Form in May 2009 and utilized the tool to audit the April 2009 PPNs. These items numbers were changed and these items were revised for clarity.

| **Monthly PPN Revised** | | |
|---|---|---|
| 5.a | *Justify/explain the current regimen considering this month's progress (or lack of progress) and clinical data* | 92% |
| 5.d | *Justify/explain the use of medications that pose elevated risks and/or are causing side effects* | 66% |

| | | |
|---|---|---|
| | | *including, if applicable, an analysis of risks and benefits of the following: benzodiazepines, anticholinergics, polypharmacy, conventional and atypical antipsychotics and other psychiatric medications.* |
| F.1.a.vii | are not inhibiting individuals from meaningfully participating in treatment, rehabilitation, or enrichment and educational services as a result of excessive sedation; and | |

| **Monthly PPN** | | |
|---|---|---|
| 2.c | *Participation in treatment is documented.* | 87% |
| 6.b | *Monitoring of side effects (is documented.)* | 81% |
| 6.c | *AIMS is completed.* | 85% |

Comparative data indicated modest changes in mean compliance since the previous review period:

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 2.c | 87% | 87% |
| 6.b | 78% | 81% |
| 6.c | 84% | 85% |
| Compliance rate in last month of period | | |
| 2.c | 90% | 87% |
| 6.b | 83% | 79% |
| 6.c | 81% | 88% |

PSH implemented the revised PPN Auditing Form in May 2009 and utilized the tool to audit the April 2009 PPNs. This item number was changed and these items were consolidated to reduce redundancy.

| **Monthly PPN Revised** | | |
|---|---|---|
| 5.d | *Justify/explain the use of medications that pose* | 66% |

| | | |
|---|---|---|
| | | *elevated risks and/or are causing side effects including, if applicable, an analysis of risks and benefits of the following: benzodiazepines, anticholinergics, polypharmacy, conventional and atypical antipsychotics and other psychiatric medications.* |
| F.1.a.viii | Properly documented. | Admission Psychiatric Assessment: 8.a, 8.b and 8.c — 96%<br>Integrated Assessment (Psychiatry): 7 and 10 — *<br>Monthly PPN: 2.b, 2.c, 2.d, 2.h.2, 6.a.1, 6.a.2, 6.b and 6.c — 91%<br>*Not reported due to data discrepancies summarized in F.1.a.i.<br><br>PSH did not report comparative data between the previous and current review period. |
| 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:**<br><br>**Recommendation 1, December 2008:**<br>Update the facility's procedures regarding PRN and Stat medications to ensure physician's review and documentation of the circumstances leading to the use of these medications, adjustment of regular treatment as needed based on PRN and/or Stat medication use and face-to-face evaluation of the individuals within 24 hours of Stat medication use.<br><br>**Findings:**<br>PSH reported that AD 15.14 was approved in January 2009. The facility indicated that this policy includes provisions for a face-to-face assessment by a psychiatrist with 24 hours following the administration of a Stat medication. The assessment is to contain reason for administration, response to administration and adjustments to current |

treatment and/or diagnosis as applicable.

**Recommendations 2 and 3, December 2008:**

- Monitor the use of PRN and Stat medications based on at least a 20% sample.
- Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period).

**Findings:**

PSH used the DMH Monthly PPN Auditing Form to assess compliance with this requirement. From November 2008 to March 2009, the average sample size was 20% of the monthly notes for individuals who had been hospitalized for more than 90 days. The following tables summarize 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 treatment, as indicated, based on such use:* | 49% |
| 7.a | *Describes the rationale/specific indications for all PRN orders.* | 69% |
| 7.b | *Reviews the PRNs and Stats during the interval period.* | 55% |
| 7.c | *Discusses use of PRN/Stat as indicated to reduce the risk of restrictive interventions.* | 38% |
| 7.d | *Describes modification of regularly scheduled medication regimen based on the use of PRN/Stat medications.* | 34% |

Comparative data indicated no significant changes in compliance since the previous review period:

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 7. | 48% | 49% |
| Compliance rate in last month of period | | |
| 7. | 42% | 42% |
| 7.a | 51% | 64% |
| 7.b | 45% | 46% |
| 7.c | 26% | 34% |
| 7.d | 15% | 25% |

PSH implemented the revised PPN Auditing Form in May 2009 and utilized the tool to audit the April 2009 PPNs. The number of this item was revised and the sub-items removed to more closely align it with the EP requirement. For April 2009, the sample size was 10% of the monthly notes for individuals who had been hospitalized for more than 90 days. The following table summarizes the data:

| **Monthly PPN Revised** | | |
|---|---|---|
| 6. | *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.* | 74% |

The facility also used the DMH Nursing Services Monitoring Forms for PRN and Stat medication uses, based on average samples of 16% and 23% of PRN and Stat medications given per month, respectively. The following tables summarize the data:

| **Nursing Services PRN** | | |
|---|---|---|
| 1. | *Safe administration of PRN medication.* | 94% |

| | | |
|---|---|---|
| 2. | *Documentation of the circumstances requiring PRN medication.* | 62% |
| 3. | *Documentation of the individual's response to PRN medication.* | 44% |

Comparative data indicated mixed changes in compliance since the previous review period:

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 1. | 94% | 94% |
| 2. | 79% | 62% |
| 3. | 15% | 44% |
| Compliance rate in last month of period | | |
| 2. | 76% | 71% |
| 3. | 20% | 54% |

| **Nursing Services Stat** | | |
|---|---|---|
| 1. | *Safe administration of Stat medication.* | 95% |
| 2. | *Documentation of the circumstances requiring Stat medication.* | 80% |
| 3. | *Documentation of the individual's response to Stat medication.* | 52% |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 1. | 89% | 95% |

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<table>
<tr><td>2.</td><td>63%</td><td>80%</td></tr>
<tr><td>3.</td><td>12%</td><td>52%</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>2.</td><td>59%</td><td>86%</td></tr>
<tr><td>3.</td><td>23%</td><td>68%</td></tr>
</table>
<br>
Compliance:<br>
Partial.<br><br>
Current recommendations:<br>
1. Monitor this requirement using the DMH Monthly Physician Progress Note auditing form and the DMH Nursing Services Monitoring Forms for PRN and Stat medication uses based on at least a 20% sample.<br>
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.<br>
3. Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.
</td>
</tr>
<tr>
<td>F.1.c</td>
<td>Each State hospital shall monitor the psychiatric use of benzodiazepines, anticholinergics, and polypharmacy to ensure clinical justification and attention to associated risks.</td>
<td>
Current findings on previous recommendations:<br><br>
Recommendations 1 and 2, December 2008:<br>
• Monitor this requirement using the DMH standardized tools based on at least a 20% sample.<br>
• Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period).<br><br>
Findings:<br>
PSH used the DMH Benzodiazepine, Anticholinergics and Polypharmacy Audit Forms to assess compliance (November 2008 to April 2009). The following is a summary of the monitoring indicators, corresponding mean compliance rates and comparative data, as applicable:
</td>
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| | | |
|---|---|---|
| **Benzodiazepines** (Average sample has varied depending on the indicator, ranging from 16% to 18% of all individuals receiving regularly scheduled benzodiazepines) | | |
| 1. | *Indication for regularly scheduled use of benzodiazepine clearly documented in medical record* | 72% |
| 2. | *Benzodiazepine used for individuals with alcohol / drug use problems justified in PPN* | 41% |
| 3. | *Benzodiazepine used for individuals with cognitive disorders justified in PPN* | 53% |
| | *Routine Benzodiazepine use for more than 2 months, PPN clearly documents the risks of:* | |
| 4. | *Drug dependence* | 34% |
| 5. | *Cognitive decline* | 36% |
| 6. | *Sedation* | 43% |
| 7. | *Gait unsteadiness / falls if indicated* | 27% |
| 8. | *Respiratory depression (for those with underlying respiratory problems e.g. COPD)* | 17% |
| 9. | *Toxicity if used in individuals with liver impairment (if using long acting agents)* | 30% |
| 10. | *Treatment modified in an appropriate and timely manner to ensure proper indications and to minimize risk.* | 75% |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 1. | 35% | 72% |
| 2. | 32% | 41% |

| | | |
|---|---|---|
| 3. | 14% | 53% |
| 4. | 18% | 34% |
| 5. | 10% | 36% |
| 6. | 24% | 43% |
| 7. | 12% | 27% |
| 8. | 8% | 17% |
| 9. | 29% | 30% |
| 10. | 34% | 75% |
| Compliance rate in last month of period | | |
| 1. | 38% | 76% |
| 2. | 44% | 33% |
| 3. | 0% | 50% |
| 4. | 25% | 53% |
| 5. | 24% | 39% |
| 6. | 24% | 28% |
| 7. | 18% | 20% |
| 8. | 20% | 0% |
| 9. | 50% | 0% |
| 10. | 62% | 56% |

| **Anticholinergics** (Average sample has varied depending on the indicator, ranging from 16% to 19% of all individuals receiving regularly scheduled anticholinergic medications) | | |
|---|---|---|
| 1. | *Indication for use of anticholinergic clearly documented in PPN (N = All individuals on any of the four anticholinergics)* | 50% |
| | *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* | 39% |
| 3. | *Sedation* | 39% |

| | | |
|---|---|---|
| 4. | *Gait unsteadiness/falls* | 31% |
| 5. | *Blurred vision, constipation, urinary retention* | 32% |
| 6. | *Worsening narrow angle glaucoma* | 0% |
| | *Regularly scheduled anticholinergics 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* | 25% |
| 8. | *Sedation (as indicated)* | 32% |
| 9. | *Gait unsteadiness / falls (as indicated)* | 24% |
| 10. | *Blurred vision, constipation, urinary retention* | 27% |
| 11. | *Worsening narrow angle glaucoma, if present* | 38% |
| 12. | *Substance abuse/dependence if listed on Axis I* | 21% |
| 13. | *Worsening TD if present* | 39% |
| 14. | *Dosage is within DMH psychotropic medication policy (unless TRC/MRC consult was obtained. N= all individuals on the four anticholinergics for 14.* | 96% |
| 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.* | 84% |

Comparative data indicated mixed changes in compliance since the previous review period:

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 1. | 38% | 50% |
| 2. | 19% | 39% |
| 3. | 44% | 39% |

| | | |
|---|---|---|
| 4. | 20% | 31% |
| 5. | 19% | 32% |
| 6. | 67% | 0% |
| 7. | 11% | 25% |
| 8. | 20% | 32% |
| 9. | 13% | 24% |
| 10. | 8% | 27% |
| 11. | 8% | 38% |
| 12. | 16% | 21% |
| 13. | 23% | 39% |
| 14. | 89% | 96% |
| 15. | 41% | 84% |
| Compliance rate in last month of period | | |
| 1. | 19% | 50% |
| 2. | 0% | 50% |
| 3. | 0% | 50% |
| 4. | 0% | 33% |
| 5. | 0% | 17% |
| 6. | n/a% | 0% |
| 7. | 23% | 23% |
| 8. | 7% | 24% |
| 9. | 14% | 24% |
| 10. | 7% | 26% |
| 11. | 0% | 0% |
| 12. | 13% | 20% |
| 13. | 0% | n/a |
| 14. | 100% | 100% |
| 15. | 60% | 100% |

**Polypharmacy** (Average sample has varied depending on the indicator, ranging from 10% to 15% of all individuals receiving regularly scheduled inter or intra-class polypharmacy)

| | | |
|---|---|---|
| 1. | *Target symptoms were clearly identified.* | 90% |
| 2. | *Documentation in PPN justifies the need for inter-class polypharmacy.* | 58% |
| 3. | *Documentation in PPN justifies the need for intra-class for polypharmacy.* | 66% |
| 4.a | *The PPN documents the risks of the polypharmacy including drug-to-drug interactions* | 30% |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 1. | 71% | 90% |
| 2. | 35% | 58% |
| 3. | 34% | 66% |
| 4. | 16% | 30% |
| Compliance rate in last month of period | | |
| 1. | 71% | 100% |
| 2. | 48% | 72% |
| 3. | 36% | 64% |
| 4. | 15% | 31% |

**Recommendation 3, December 2008:**
Provide ongoing feedback and mentoring by Senior Psychiatrists to ensure correction of the deficiencies noted by this monitor.

**Findings:**
The facility's mentoring system is described in D.1.a, and PSH reported that the Senior Psychiatrists will specifically mentor the practice of psychiatrists who prescribe high-risk medications.

| | | |
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| | | **Recommendation 4, December 2008:**<br>Identify patterns and trends regarding high-risk medication uses and implement corrective and educational actions.<br><br>**Findings:**<br>PSH reported that there was a steady decrease in the number of individuals diagnosed with borderline intellectual functioning, mental retardation, cognitive disorder NOS, or dementia who were prescribed benzodiazepines.<br><br>PSH also reported that the number of prescriptions of anticholinergics decreased by 10%. With regard to individuals over the age of 60 with cognitive impairments, PSH reported a decrease in anticholinergic use of 50%. Additionally, PSH reported a 19% decrease in the number of individuals who have received anticholinergics for more than two months.<br><br>**Other findings:**<br>This monitor reviewed the facility's databases regarding individuals receiving long-term treatment with the following types of medication uses:<br><br>1. Benzodiazepines in presence of diagnoses of substance use disorders and/or cognitive disorders;<br>2. Anticholinergic medications for individuals diagnosed with cognitive disorders and/or elderly individuals; and<br>3. Various forms of polypharmacy.<br><br>This monitor also reviewed the charts of 18 individuals receiving the above types of medication regimens. The reviews confirmed the facility's data regarding the overall decrease in the long-term use of benzodiazepines and/or anticholinergic medications for individuals at risk. However, for individuals currently receiving these modalities as well as |

individuals currently receiving polypharmacy, a persistent pattern was noted regarding inadequate documentation of the justification of treatment and/or assessment of the individuals for the risks associated with this practice.

**Benzodiazepine use**

| Individual | Medication(s) | Diagnosis |
|---|---|---|
| CDF | Lorazepam | Polysubstance Dependence and Borderline Intellectual Functioning |
| HG | Alprazolam | Polysubstance Dependence |
| JBW | Lorazepam | Polysubstance Dependence |
| JEL | Lorazepam | Polysubstance Dependence |
| JO | Clonazepam | Polysubstance Dependence |
| LZ | Lorazepam | Polysubstance Dependence |
| OVM | Clonazepam | Dementia and Polysubstance Dependence |
| RAP | Lorazepam | Polysubstance Dependence |

**Anticholinergic use**

| Individual | Medication(s) | Diagnosis |
|---|---|---|
| DLW | Benztropine | Borderline Intellectual Functioning and Tardive Dyskinesia |
| RWT | Benztropine | Borderline Intellectual Functioning |
| SO | Benztropine | Dementia Due to General medical Condition |

**Polypharmacy use**

| Individual | Medication(s) | Diagnosis |
|---|---|---|
| BRA | Clozapine, haloperidol, lorazepam and levetiracetam | Polysubstance Dependence |
| CF | Clozapine, risperidone, lorazepam and divalproex | Borderline Intellectual Functioning |
| CLS | Ziprasidone, mirtazapine, carbamazepine, lamotrigine, lithium, buspirone and escitalopram. | |
| HMG | Olanzapine, alprazolam, bupropion and escitalopram | Polysubstance Dependence |
| HN | Risperidone, loxapine, sertraline, lamotrigine, trazodone, gabapentin and clonazepam | |
| JLC | Clozapine, haloperidol, olanzapine, lamotrigine, zolpidem, bupropion and clonazepam | Alcohol Dependence |
| JRT | Olanzapine, quetiapine, paroxetine, clonazepam, divalproex and levetiracetam | |

**Compliance:**
Partial.

**Current recommendations**:
1. Monitor this requirement using the current DMH tool based on at least a 20% sample.
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.<br>4. Identify patterns and trends regarding high-risk medication uses and implement corrective and educational actions. |
| F.1.d | Each State hospital shall ensure the monitoring of the metabolic and endocrine risks associated with the use of new generation antipsychotic medications. | **Current findings on previous recommendations:**<br><br>**Recommendations 1 and 2, December 2008:**<br>• Monitor this requirement using the DMH standardized tools based on at least a 20% sample.<br>• Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period).<br><br>**Findings:**<br>Using the DMH New Generation Antipsychotic Medications Auditing Form, PSH assessed its compliance based on an average sample of 10% of individuals receiving these medications during the review period (November 2008 – April 2009): |

| | | |
|---|---|---|
| 1. | *Indications for use are documented in the PPN* | 92% |
| 2. | *Absolute contraindications are absent* | 97% |
| 3. | *Relative contraindications are absent unless benefits outweigh risks* | 95% |
| 4. | *Family and personal risk factors are addressed in the PPN (if medication started within last 90 days)* | 28% |
| | *Justification for use is documented in the PPN for individuals with a diagnosis of:* | |
| 5. | *Dyslipidemia* | 53% |
| 6. | *Diabetes Mellitus* | 65% |
| 7. | *Obesity* | 52% |
| 8. | *Justification for use is documented in the PPN for* | 33% |

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|---|---|---|---|---|
| | | | *individuals on risperidone with hyperprolactinemia* | |
| | | 9. | *Dose initiation meets requirements* | 93% |
| | | 10. | *Dose titration meets requirements* | 93% |
| | | 11. | *Appropriate monitoring for postural hypotension for individuals with BP <90/60* | 79% |
| | | 12. | *EKG within previous 12 months for ziprasidone* | 76% |
| | | 13. | *Semi-annual EKG for individuals on ziprasidone* | 64% |
| | | 14. | *If given a concurrent medication that prolongs the QTC, a semiannual EKG was done* | 56% |
| | | 15. | *Monitoring of vital signs* | 82% |
| | | | *There is appropriate baseline and regular monitoring of:* | |
| | | 16. | *Body Mass Index* | 69% |
| | | 17. | *Waist Circumference* | 66% |
| | | 18. | *Fasting Blood Sugar (FBS) initially* | 79% |
| | | 19. | *FBS monthly for the first six months (clozapine and olanzapine only)* | 43% |
| | | 20. | *FBS quarterly (including olanzapine and clozapine after first 6 months)* | 65% |
| | | 21. | *Triglycerides* | 86% |
| | | 22. | *Cholesterol* | 86% |
| | | 23. | *HgbA1C if FBS high* | 75% |
| | | 24. | *Prolactin level (annually, and initially for risperidone and paliperidone only)* | 49% |
| | | 25. | *Breast exam* | 58% |
| | | 26. | *AIMS exam* | 88% |
| | | 27. | *Serum amylase/lipase* | 42% |
| | | 28. | *If an unstable seizure disorder present, a neurology consultation was ordered.* | 63% |
| | | 29. | *There is documentation of potential and actual risk for each medication used* | 55% |
| | | 30. | *Treatment was modified in an appropriate and timely* | 86% |

| | | |
|---|---|---|
| | *manner to address identified risks* | |
| 31. | *For clozapine only, the DMH Psychotropic Guidelines were followed for changes in WBC/ANC* | 96% |

The facility did not provide comparative data.

PSH reported that it gained access (through the facility's laboratory vendor) to electronic real-time lab results in February 2009. This facilitates the Pharmacy Department's efforts to provide psychiatrists with monitoring reminders.

**Recommendation 3, December 2008:**
Provide ongoing feedback and mentoring by Senior Psychiatrists to ensure correction of the deficiencies noted by this monitor.

**Findings:**
PSH reported that it intends to complete the following as corrective actions:

1. Train clinicians and auditors on documenting and auditing refusals of medication monitoring;
2. Conduct a DUE on prolactin levels and risperidone; and
3. Hold a case conference on hyperprolactinemia.

**Recommendation 4, December 2008:**
Identify patterns and trends regarding high-risk medication uses and implement corrective and educational actions.

**Findings:**
The facility did not report information relevant to this recommendation.

**Other findings:**
This monitor reviewed the charts of 12 individuals who were receiving

new generation antipsychotic agents and suffering from a variety of metabolic disorders. The following table outlines the initials of the individuals, the medication(s) used and the metabolic disorder(s):

| Individual | Medication(s) | Diagnosis |
|---|---|---|
| BRA | Clozapine | Diabetes Mellitus |
| CTH | Olanzapine | Unspecified Hyperlipidemia and Obesity |
| DG | Clozapine | Diabetes Mellitus |
| DRL | Clozapine | Diabetes Mellitus and Pure Hypertriglyceridemia |
| LDS | Risperidone | Diabetes Mellitus, Obesity and Dyslipidemia |
| MC | Risperidone | Diabetes Mellitus, Obesity and Hyperlipidemia |
| RW | Olanzapine | Diabetes Mellitus |
| SJP | Risperidone | Obesity and Hyperlipidemia |
| SQS | Olanzapine | Diabetes Mellitus |
| SS | Risperidone | Hyperprolactinemia (not documented) |
| SWK | Olanzapine | Obesity |
| VAR | Olanzapine | Metabolic Syndrome |

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 made further progress in the laboratory monitoring of individuals to address various metabolic risks, including the risks of endocrine and pancreatic dysfunction. This monitor found fewer process deficiencies compared to the last review. The following are examples of the noted deficiencies:

1. There was evidence of inadequate laboratory testing for serum lipids

| | | |
|---|---|---|
| | | in an individual with diagnosis of Diabetes Mellitus and history of elevated triglycerides. The individual was receiving high-risk treatment with clozapine (BRA).<br>2. The psychiatric progress note and corresponding WRP did not address a diagnosis of Diabetes Mellitus that was recently established by the physician and surgeon in an individual with history of metabolic syndrome and receiving high-risk treatment with olanzapine (VAR).<br>3. The psychiatric progress note and corresponding WRP did not address significant elevation of triglycerides in an individual diagnosed with Diabetes Mellitus and receiving high-risk treatment with olanzapine (SQS).<br>4. The psychiatric progress notes did not address the clinical or laboratory status of a female individual who was receiving high-risk treatment with risperidone and developed significant elevation of serum prolactin despite documentation, in the same note, of the possible risk of hyperprolactinemia (SS).<br>5. The psychiatric progress note documented significant elevation of serum prolactin in a female individual receiving high-risk treatment with risperidone, but did not include any measures for further assessment of associated risks (SJP).<br>6. The WRP did not address the weight status of an individual diagnosed with obesity and receiving high-risk treatment with olanzapine. However, the corresponding psychiatric progress note included documentation of proper monitoring of the weight status (CTH).<br><br>**Compliance:**<br>Partial.<br><br>**Current recommendations**:<br>1. Monitor this requirement using the DMH New Generation Antipsychotic Medications Auditing Form based on at least a 20% sample. |

| | | |
|---|---|---|
| | | 2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period.<br>3. Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.<br>4. Identify patterns and trends regarding high-risk medication uses and implement corrective and educational actions. |
| F.1.e | Each State hospital shall ensure regular monitoring, using a validated rating instrument (such as AIMS or DISCUS), of tardive dyskinesia (TD); a baseline assessment shall be performed for each individual at admission with subsequent monitoring of the individual every 12 months while he/she is receiving antipsychotic medication, and every 3 months if the test is positive, TD is present, or the individual has a history of TD. | **Current findings on previous recommendations:**<br><br>**Recommendations 1 and 2, December 2008:**<br>• Monitor this requirement using the DMH standardized tool based on at least a 20% sample and ensure accuracy of data.<br>• Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period).<br><br>**Findings:**<br>Using the DMH TD Auditing Form, PSH assessed its compliance based on average samples ranging from 13% to 97% of individuals relevant to each indicator during the review period (November 2008 – April 2009): |

| | | |
|---|---|---|
| 1. | *A baseline assessment shall be performed for each individual at admission.* | 97% |
| 2. | *Subsequent monitoring of the individual every 12 months while he/she is receiving antipsychotic medication.* | 57% |
| 3. | *Monitoring of the individual is conducted every 3 months if the test (AIMS or DISCUS) is positive, TD is present, or the individual has a history of TD.* | 41% |
| 4. | *If an older generation antipsychotic is used there is evidence in monthly physician progress note of justification of using the older generation medication.* | 60% |

| | | |
|---|---|---|
| 5. | *A neurology consultation / TD Clinic evaluation was completed as indicated.* | 55% |
| 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.* | 77% |
| 7. | *Diagnosis of TD is listed on Axis I and/or III (for current diagnosis).* | 48% |
| 8. | *Tardive Dyskinesia is included in Focus 6 of the WRP.* | 56% |
| 9. | *The WRP reflect objectives and interventions for Tardive Dyskinesia.* | 55% |

Comparative data are not presented in this report as the facility acknowledged during the previous review that its data collection at that time was unreliable regarding this audit.

**Recommendations 3 and 4, December 2008:**

- Develop and implement a policy and procedure to ensure that:
  - The diagnoses listed on the WRP are aligned with those listed in psychiatric documentation, including TD;
  - TD is recognized as one of the foci of hospitalization and appropriate objectives and interventions are identified for treatment and/or rehabilitation;
  - The individuals receive appropriate periodic screening; and
  - The individuals receive care at a specialized TD clinic.
- Update the staff psychiatrist manual to include the standards outlined in the policy/procedure.

**Findings:**

During this review period, the DMH has updated SO 105.11, DMH Psychotropic Medication Policy. As mentioned in F.1.a, the revised policy includes a new guideline regarding the diagnosis/differential diagnosis and management of TD. This guideline comports with current generally

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| | | accepted standards. In addition, PSH reported that the Pharmacy and Therapeutic Manual and Policies 1.08 and 1.09 outline the timeline for appropriate screening and intervention for Tardive Dyskinesia. The facility indicated that the policies include guidelines for how to address the risk of Tardive Dyskinesia in the WRP. Additionally, PSH's manual indicates that all individuals with TD receive a neurology consultation.<br><br>**Other findings:**<br>The facility's database identified 89 individuals as meeting one or more of the following three criteria: current diagnosis of TD, history of TD or current abnormal AIMS score. During the previous review, the database identified 181 individuals in these categories. The facility attributed this decrease to improvements in its data collection system. During the review period, nurse auditors supervised by the Standards Compliance Department began oversight of this task. These auditors completed three trainings (defining history of TD, defining positive AIMS and documentation of TD in the chart).<br><br>This monitor reviewed the charts of six individuals currently diagnosed with tardive dyskinesia (DLW, JAM, JEB, JHB, JS and VGC). The review found that PSH has made some progress as follows:<br><br>1. Admission AIMS tests were completed on all individuals who were admitted during the past year.<br>2. The WRPs included diagnosis, focus and corresponding objectives and interventions related to tardive dyskinesia in most of the charts reviewed (DLW, JAM, JHB, JS and VGC).<br>3. The psychiatric progress notes contained adequate tracking of the status of TD in most charts (DLW, JAM, JHB, JS and VGC).<br>4. The objectives related to TD utilized appropriate learning outcomes for a few individuals (e.g. JAM).<br>5. A few charts documented attempts to use safer treatment alternatives for these individuals (e.g. JAM). |

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|---|---|---|
| | | However, the review showed a pattern of deficiencies as follows:<br><br>1. The psychiatric progress notes did not provide timely tracking of the status of involuntary movements in one individual (JS).<br>2. Some WRPs included objectives and interventions that were not properly formulated or matched to the individual's needs (DLW, JHB and VGC).<br>3. The WRP did not include focus, objectives or interventions to address the individual's condition in a few charts (e.g. JEB).<br>4. Some individuals diagnosed with TD received unnecessary long-term treatment with anticholinergic agents during this review period (JEB and VGC).<br>5. The AIMS tests were not completed quarterly as required in most of the charts reviewed.<br><br>**Compliance:**<br>Partial.<br><br>**Current recommendations**:<br>1. Monitor this requirement using the DMH Tardive Dyskinesia Monitoring Form based on a 100% sample.<br>2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period.<br>3. Provide a summary outline of 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:**<br><br>**Recommendations 1 and 2, December 2008:**<br>• Increase reporting of ADRs.<br>• Continue review and analysis of ADRs and present summary of |

aggregated data to address the following:

- The number of ADRs reported each month during the review period compared with number reported during the previous period;
- Classification of probability and severity of ADRs;
- Any negative outcomes for individuals who were involved in serious reactions;
- Data analysis regarding patterns and trends of ADRs, including recommendations for corrective actions; and
- Any Intensive Case Analysis done, including review of circumstances of the events, contributing factors, conclusions regarding preventability and any possible process deficiencies; and specific recommendations for corrective actions (full report).

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

| | Previous period | Current period |
|---|---|---|
| Total ADRs | 55 | 107 |
| Classification of Probability of ADRs | | |
| Doubtful | 7 | 28 |
| Possible | 26 | 42 |
| Probable | 21 | 31 |
| Definite | 0 | 6 |
| Classification of Severity of ADRS | | |
| Mild | 20 | 63 |
| Moderate | 32 | 41 |
| Severe | 0 | 3 |

[With regard to the previous review period, the numbers in each classification category do not sum to 55.]

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|---|---|---|
| | | Of the three severe ADRs during the current review period, none resulted in permanent sequelae to the individual involved.<br><br>The intensive case analyses involved the following ADRs:<br><br>1. WBC of 4,200 and ANC of 800 secondary to peginterferon alfa-2a resulting in discontinuation of that medication;<br>2. An increase of CK to 956 u/l, rhabdomyolysis secondary to simvastatin resulting in discontinuation of that medication;<br>3. Ziprasidone-induced priapism resulting in treatment in the emergency room and discontinuation of that medication; and<br>4. Clozapine toxicity following smoking cessation resulting in a decrease in that medication and monitoring of drug levels.<br><br>**Other findings:**<br>Review by this monitor found that the facility's ICAs employed appropriate methodologies and comported with generally accepted standards in this process.<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendations**:<br>1. Increase reporting of ADRs.<br>2. Continue review and analysis of ADRs and present summary of aggregated data to address the following:<br>a. The number of ADRs reported each month during the review period compared with number reported during the previous period;<br>b. Classification of probability and severity of ADRs;<br>c. Any negative outcomes for individuals who were involved in serious reactions;<br>d. Data analysis regarding patterns and trends of ADRs, including |

| | | |
|---|---|---|
| | | recommendations for corrective actions; and<br>e. Any Intensive Case Analysis done, including review of circumstances of the events, contributing factors, conclusions regarding preventability and any possible process deficiencies; and specific recommendations for corrective actions (full report).<br>3. Provide analysis of patterns and trends, with corrective/educational actions related to ADRs. |
| F.1.g | Each State hospital shall ensure drug utilization evaluation ("DUE") occurs in accord with established, up-to-date medication guidelines that shall specify indications, contraindications, and screening and monitoring requirements for all psychotropic medications; the guidelines shall be in accord with current professional literature.<br><br>A verifiably competent psychopharmacology consultant shall approve the guidelines and ensure adherence to the guidelines. | **Current findings on previous recommendations:**<br><br>**Recommendation 1, December 2008:**<br>Conduct further DUEs based on a specified calendar and ensure that all DUEs include review of use; analysis of trends/patterns; conclusions regarding findings; and recommendations for corrective actions/ educational activities based on the review.<br><br>**Findings:**<br>PSH reported that it completed DUEs on monitoring required by the use of lithium; the use of SSRIs concurrent with anticoagulating agents; and the use of SSRIs for individuals at risk of fracture due to age.<br><br>Review by this monitor found that the facility's DUEs employed appropriate methodologies and comported with generally accepted standards in this process.<br><br>**Recommendation 2, December 2008:**<br>Provide a summary outline of corrective actions to address recommendations of the four DUEs completed during [the previous] reporting period.<br><br>**Findings:**<br>PSH reported that it followed up on its DUEs on divalproex monitoring |

| | | |
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| | | and BMI change following Medical Risk Factor groups.<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendation:**<br>Conduct further DUEs based on a specified calendar and ensure that all DUEs include review of use; analysis of trends/patterns; conclusions regarding findings; and recommendations for corrective actions/ educational activities based on the review. |
| F.1.h | Each State hospital shall ensure documentation, reporting, data analyses, and follow-up remedial action regarding actual and potential medication variances ("MVR") consistent with generally accepted professional standards of care. | **Current findings on previous recommendation:**<br><br>**Recommendation, December 2008:**<br>Report, review and analyze medication variances based on the current written instructions and present summary of aggregated data to address the following:<br>a. Total number of variances reported each month during the review period compared with numbers reported during the previous period;<br>b. Classification of variances by category (e.g. prescription, administration, documentation, etc) and by potential vs. actual;<br>c. Any negative outcomes for individuals who were involved in serious reactions;<br>d. Data analysis regarding patterns and trends of variances, including recommendations for corrective actions; and<br>e. Any Intensive Case Analysis done, including review of circumstances of the events, contributing factors, conclusions regarding preventability and any possible process deficiencies; and specific recommendations for corrective actions (full report).<br><br>**Findings:**<br>The facility presented data as requested relative to this recommendation. However, this monitor's review of the data found that |

| | | |
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| | | the facility did not employ appropriate methodology in the calculation of the total types (categories) of variance vs. the number of critical breakdown points in the chain of events involved in complex variances. The facility updated the total number of variances after recalculation; however, the data did not appear to be internally consistent and is not presented here.<br><br>Of the reported variances, none reached Category E or above. The facility conducted two intensive case analyses (ICAs) for variances that reached Category D. The ICAs utilized appropriate methodology and included adequate corrective actions.<br><br>**Compliance:**<br>Partial.<br><br>**Current recommendations**:<br>1. Present and ensure validity of data to address the following:<br>a. Total number of variances and total number of critical breakdown points during the review period compared with numbers reported during the previous review period;<br>b. Total number of actual and potential variances during the review period compared with numbers reported during the previous period;<br>c. Number of variances by category (e.g. prescription, administration, documentation, etc.);<br>d. Number of variances by outcome;<br>e. Clinical information regarding each variance (category E or above) and the outcome to the individual involved;<br>f. Information regarding any intensive case analysis done for each reaction that was classified as Category E or above; and<br>g. Outline of ICAs, including description of variance, recommendations and actions taken.<br>2. Provide analysis of patterns and trends, with corrective/educational |

| | | |
|---|---|---|
| | | actions related to MVRs. |
| F.1.i | Each State hospital shall ensure tracking of individual and group practitioner trends, including data derived from monitoring of the use of PRNs, Stat medications, benzodiazepines, anticholinergics, and polypharmacy, and of ADRs, DUE, and MVR consistent with generally accepted professional standards of care. | **Current findings on previous recommendation:**<br><br>**Recommendation, December 2008:**<br>Same as in F.1.a through F.1.h.<br><br>**Findings:**<br>Same as in F.1.a through F.1.h.<br><br>**Compliance:**<br>Partial.<br><br>**Current recommendations**:<br>Same as in F.1.a through F.1.h. |
| F.1.j | Each State hospital shall ensure feedback to the practitioner and educational/corrective actions in response to identified trends consistent with generally accepted professional standards of care. | **Current findings on previous recommendation:**<br><br>**Recommendation, December 2008:**<br>Same as in F.1.a through F.1.h.<br><br>**Findings:**<br>Same as in F.1.a through F.1.h.<br><br>**Compliance:**<br>Partial.<br><br>**Current recommendations**:<br>Same as in F.1.a through F.1.h. |
| F.1.k | Each State hospital shall ensure integration of information derived from ADRs, DUE, MVR, and the Pharmacy & Therapeutics, Therapeutics | **Current findings on previous recommendation:** |

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| | Review, and Mortality and Morbidity Committees consistent with generally accepted professional standards of care. | **Recommendation, December 2008:**<br>Same as in F.1.a through F.1.h.<br><br>**Findings:**<br>Same as in F.1.a through F.1.h.<br><br>**Compliance:**<br>Partial.<br><br>**Current recommendations**:<br>Same as in F.1.a through F.1.h. |
| F.1.l | Each State hospital shall ensure that all physicians and clinicians are verifiably competent, consistent with generally accepted professional standards of care, in appropriate medication management, interdisciplinary team functioning, and the integration of behavioral and pharmacological treatments. | **Current findings on previous recommendation:**<br><br>**Recommendation, December 2008:**<br>Same as in D.1.b, D.1.c, D.1.f.viii and F.1.a through F.1.h.<br><br>**Findings:**<br>Same as in D.1.b, D.1.c, D.1.f.viii and F.1.a through F.1.h.<br><br>**Compliance:**<br>Partial.<br><br>**Current recommendations**:<br>Same as in D.1.b, D.1.c, D.1.f.viii and F.1.a through F.1.h. |
| F.1.m | Each State hospital shall review and ensure the appropriateness and safety of the medication treatment, consistent with generally accepted professional standards of care, for: | **Compliance:**<br>Partial. |
| F.1.m.i | all individuals prescribed continuous anticholinergic treatment for more than two | **Current findings on previous recommendation:** |

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

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| | impairments, regardless of duration of treatment; and | **Recommendation, December 2008:**<br>Same as above.<br><br>**Findings:**<br>Same as above.<br><br>**Current recommendation**:<br>Same as above. |
| F.1.m.v | all individuals with a diagnosis or evidencing symptoms of tardive dyskinesia. | **Current findings on previous recommendation:**<br><br>**Recommendation, December 2008:**<br>Same as F.1.e.<br><br>**Findings:**<br>Same as F.1.e.<br><br>**Current recommendation**:<br>Same as F.1.e. |
| F.1.m.vi | all individuals diagnosed with dyslipidemia, and/or obesity, and/or diabetes mellitus who are prescribed new generation antipsychotic medications | **Current findings on previous recommendation:**<br><br>**Recommendation, December 2008:**<br>Same as in F.1.d. and F.1.g.<br><br>**Findings:**<br>Same as in F.1.d. and F.1.g.<br><br>**Current recommendations**:<br>Same as in F.1.d. and F.1.g. |
| F.1.n | Each State hospital shall ensure that the medication management of individuals with | **Current findings on previous recommendation:** |

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| | substance abuse disorders is provided consistent with generally accepted professional standards of care. | **Recommendation, December 2008:**<br>Same as in C.2.o and F.1.c.<br><br>**Findings:**<br>Same as in C.2.o and F.1.c.<br><br>**Compliance:**<br>Partial.<br><br>**Current recommendations**:<br>Same as in C.2.o and F.1.c. |
| F.1.o | Metropolitan State Hospital shall provide a minimum of 16 hours per year of instruction, through conferences, seminars, lectures and /or videotapes concerning psychopharmacology. Such instruction may be provided either onsite or through attendance at conferences elsewhere. | This requirement applies only to Metropolitan State Hospital. |

| 2. Psychological Services | | |
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| | Each State hospital shall provide adequate and appropriate psychological supports and services that are derived from evidence-based practice or practice-based evidence and are consistent with generally accepted professional standards of care, to individuals who require such services; and: | **Methodology:**<br><br><u>Interviewed</u>:<br>1. The following two individuals: BS and CM<br>2. C. Love, PsyD<br>3. Danielle Helmick, Auditor<br>4. David Glassmire, PhD, Psychology Internship Director<br>5. Gari-Lyn Richardson, Director, Standards Compliance<br>6. George Christison, MD, Acting Medical Director<br>7. Hope Marriott, LCSW, WRP Master Trainer<br>8. Jaleh Mohallatee, MHA, Acting Program Director<br>9. John Johnston, PhD, Psychologist, PBS Chair<br>10. Jette Warka, PhD, Psychologist, PBS Chair<br>11. Jyun Nam, RT<br>12. Kevin Garland, Assistant Chief, Central Program Services<br>13. Linda Painter, PT, Auditor<br>14. Mark Williams, PhD, Psychologist, PBS Chair<br>15. Melanie Byde, PhD, Psychologist, Mall Director<br>16. Rhodora Reyes, RN, WRP Trainer<br>17. Sean Evans, PhD, Psychologist, PBS Chair<br>18. Steven Berman, PhD, Senior Supervising Psychologist, By Choice Coordinator<br>19. Susan Meader, PT, Auditor<br>20. Susan Velasquez, PhD, Senior Supervising Psychologist, Coordinator of Psychology Services<br>21. Willie Harris, MD, Acting Chief of Psychiatrist<br><br><u>Reviewed</u>:<br>1. The charts of the following 43 individuals: AAN, AM, AS, ATM, BA, BG, CK, DJW, DK, DMK, DR, DRH, DT, EV, FS, GA, HRB, JAM, JC, JCM, JMP, JMR, JP, JR, KK, LTH, MLB, MMR, NM, OC, PC, RAK, RF, |

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| | | RL, RW, SAG, TAF, TG, TK, TS, VC, VRH, and VF<br>2. By Choice Items Catalog<br>3. Completed By Choice audits<br>4. By Choice Implementation Monitoring Form<br>5. By Choice Incentive Store Policies and Guidelines<br>6. By Choice Calorie Activity Guide<br>7. By Choice Training Documents<br>8. List of individuals with PBS plans<br>9. List of individuals receiving DCAT services<br>10. Cognitive Remediation Plan<br>11. PSSC meeting schedules and attendance logs<br>12. PSSC reports<br>13. List of individuals who have utilized higher than threshold levels of seclusion, restraint, and psychiatric PRN or Stat medication for maladaptive behaviors in the last six months<br>14. Neuropsychological assessments completed in the last six months<br>15. Structural and functional assessments completed in the last six months<br>16. Behavioral guidelines developed and implemented in the last six months<br>17. List of individuals reviewed by the Psychology Specialized Services Committee<br>18. List of individuals identified as needing neuropsychological services<br><br><u>Observed</u>:<br>1. PSSC/ETRC Meeting (June 10, 2009)<br>2. WRPC (Program VI, unit 71) for quarterly review of TAF<br>3. WRPC (Program VIII, unit N25) for annual review of DR<br>4. WRPC (Program VIII, unit N21) for monthly review of PC |
| 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 | **Findings:**<br>PSH has four PBS teams, which is one team short of the number of teams required to meet the 1:300 ratio. The current PBS teams lack a Data |

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| | 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: | Analyst. Shortage of PBS teams has affected the activities and tasks for which PBS team members are responsible. For example, fidelity checks are not consistent, staff training across settings is delayed, and interdisciplinary collaboration is inconsistent. The PSSC is now reviewing and addressing all triggers, and this has increased the number of behavior plans to be developed and implemented.<br><br>**Compliance:**<br>Partial.<br><br>**Current recommendation**:<br>Ensure the required number of PBS teams to meet the 1:300 ratio. |
| 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 recommendation:**<br><br>**Recommendation, December 2008:**<br>Continue to train all relevant staff on all aspects of PBS training.<br><br>**Findings:**<br>PSH has continued to provide ongoing training to its PBS team members on aspects of applied behavior analysis, behavioral interventions, PBS plan development, fidelity of plan implementation, outcome tracking and analysis, staff training, and plan revision and termination. Besides peer teaching and training, Dr. Nirbhay Singh, the DMH CRIPA consultant, provided a more formal training to the PBS staff.<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendation**:<br>Continue to train all relevant staff on all aspects of PBS training. |

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| F.2.a.ii | the development and implementation of a facility-wide behavioral incentive system, referred to as "By CHOICE" that encompasses self-determination and choice by the individuals served. | **Current findings on previous recommendations:**<br><br>**Recommendation 1, December 2008:**<br>Report By Choice point allocation in the Present Status section of the individual's case formulation and update at every scheduled WRPC.<br><br>**Findings:**<br>Using the DMH Psychology Service Monitoring Form, PSH assessed its compliance based on an average sample of 10% of the WRPs due each month during the review period (November 2008 – April 2009):<br><br>16. *The By Choice point allocation is updated monthly in the individual's Wellness and Recovery Plan.* 69%<br>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.* 61%<br>16.b *There is documentation that the individual determines the point allocation.* 76%<br><br>Comparative data indicated improvement in compliance since the previous review period:<br><br>Previous period / Current period<br>Mean compliance rate<br>16. 26% 69%<br>Compliance rate in last month of period<br>16. 21% 94%<br>16.a - 91%<br>16.b - 96%<br><br>A review of the records of seven individuals found that five of the WRPs |

in the charts reported the By Choice point allocation in the Present Status section of the individual's case formulation and updated the information in the subsequent WRPs (ATM, CK, DJW, EV and VF). In the remaining two WRPs (AAN and LTH), the By Choice point allocation was not properly documented or was not updated (in many cases, the documentation was duplicated across WRPs).

**Recommendation 2, December 2008:**
Ensure that the program receives adequate resources.

**Findings:**
PSH has issued layoff notices to three of the seven By Choice staff (the staff members remained in the employ of the state as of August 2009). According to the Mall Director, the layoffs stem from the State's budget constraints. These positions need to be filled for the By Choice program to function fully and effectively.

**Recommendation 3, December 2008:**
Train all staff in correctly implementing the By Choice program.

**Findings:**
The following table summarizes staff training on By Choice during the past eight months:

| | Sep 08 - Apr 09 |
|---|---|
| Number of staff eligible for training | 2092 |
| Number of staff trained | 1987 |
| Percent of eligible staff trained | 95% |

At the table above indicates, 95% of the staff that needed to be trained was trained during this review period.

Using the Fidelity of Implementation By Choice Direct Care Staff

Competency and Fidelity Monitoring Form, PSH assessed its compliance based on a mean sample of 5% of the Nursing staff:

| | | |
|---|---|---|
| 1. | *Staff understands the goal of the By Choice system.* | 89% |
| 2. | *Staff can state the current point cycle.* | 96% |
| 3. | *Staff can state the procedure for assigning participation points on an individual's point card.* | 97% |
| 4. | *Staff can state the behavioral criteria, as it appears in the By Choice manual, for determining and assigning individual FP, MP, and NP for the current cycle.* | 93% |
| 5. | *Staff correctly assigns an appropriate participation level and marks and individuals By Choice.* | 96% |
| 6. | *Staff can locate the current By Choice Manual on their worksite or can correctly identify the location where the By Choice manual can be found.* | 83% |
| 7. | *Staff can correctly state the difference between a Baseline point card and a Reallocation point card.* | 85% |
| 8. | *Staff can state when and how By Choice points are reallocated and where the review and reallocation documentation can be found in an individual's WRP.* | 84% |
| 9. | *Staff can indicate that there is a system for orienting new individuals to the By Choice system.* | 93% |
| 10. | *Staff is able to state their unit or programs Incentive Store hours of operation.* | 96% |
| 11 | *Staff can correctly state what the By Choice levels indicate and how they can achieve higher levels.* | 82% |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 1. | - | 89% |
| 2. | 69% | 96% |
| 3. | 86% | 97% |
| 4. | 94% | 93% |
| 5. | 87% | 96% |
| 6. | 97% | 83% |
| 7. | 66% | 85% |
| 8. | 78% | 84% |
| 9. | 77% | 93% |
| 10. | 83% | 96% |
| 11. | - | 82% |
| Compliance rate in last month of period | | |
| 1. | - | 92% |
| 6. | 96% | 100% |
| 7. | 59% | 95% |
| 8. | 90% | 95% |
| 11. | - | 100% |

**Recommendation 4, December 2008:**
Ensure that individuals know their performance requirements to earn full points.

**Findings:**
Using the DMH By Choice Competency and Fidelity Survey – Individual Form, PSH assessed fidelity of By Choice implementation based on a mean sample of 5% of individuals in the facility:

| | | |
|---|---|---|
| 1 | *The individual understands the goal of the By Choice* | 75% |

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| | *system.* | |
| 2. | *Individual is holding his/her own Point Card or if not, indicates which staff member is holding it for them.* | 92% |
| 3. | *The individual can state, to the best of his/her ability how they earn points throughout the day.* | 93% |
| 4. | *The individual can state how they spend their By Choice points and what types of items they can purchase with their points.* | 91% |
| 5. | *The individual can state the behavioral criteria for earning an FP, MP, or NP for the current cycle.* | 75% |
| 6. | *Individual can indicate how many points he or she may earn each day.* | 78% |
| 7. | *Individual can correctly state the difference between a Baseline Point card and a Reallocated Point Card.* | 52% |
| 8. | *Individual can correctly state the procedure for reallocating their By Choice points.* | 58% |
| 9 | *The individual is able to state their unit or program's incentive store hours of operation.* | 88% |
| 10 | *Individual is able to state what the By Choice levels indicate and how they can achieve higher levels.* | 31% |

Comparative data indicated maintenance of compliance rates of 90% or greater since the previous review period for items 2-4 and mixed changes in compliance for other items:

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 1. | - | 75% |
| 5. | 90% | 75% |
| 6. | 83% | 78% |
| 7. | - | 52% |

| | | |
|---|---|---|
| 8. | 49% | 58% |
| 9. | 90% | 88% |
| 10. | - | 31% |
| Compliance rate in last month of period | | |
| 1. | | |
| 5. | 93% | 75% |
| 6. | 80% | 80% |
| 7. | - | 61% |
| 8. | 28% | 57% |
| 9. | 95% | 87% |
| 10. | - | 0% |

Using the By Choice Monitoring Form: Satisfaction Check, PSH surveyed a mean sample of 22% of the individuals in the facility to evaluate their satisfaction with the By Choice Incentive program:

| | | Previous period | Current period |
|---|---|---|---|
| 1. | *Is the point system helpful to you?* | 81% | 89% |
| 2. | *Do staff explain how you earn an "FP", "MP", or "NP' for all your activities?* | 73% | 84% |
| 3. | *Do staff tell you if you earned an "FP", "MP", or "NP' for all your activities?* | 60% | 68% |
| 4. | *Are you satisfied with the numbers of points you can earn for each cycle or group?* | 69% | 77% |
| 5. | *Do you like what is offered in the incentive store?* | 77% | 84% |
| 6. | *Do you hold on to your point card during the day?* | 80% | 92% |
| 7. | *Do you discuss how you want your points allocated when you meet with your team* | 80% | 61% |

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| | *during your conferences?* | | |

This monitor interviewed two individuals (BS and CM) and both indicated that they knew what they should be doing to earn full points for certain groups but did not in others.

A review of the records of 14 individuals found that 12 of the WRPs in the charts contained documentation that the individual was a participant in his/her By Choice point allocation (DRH, DT, JAM, JC, JR, MMR, PC, RAK, RL, SAG, TS and VRH). The remaining two (JMR and TK) did not.

This monitor observed three WRPCs (DR, PC and TAF). All three WRPTs engaged the individuals in the By Choice point allocation process.

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

| | | |
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| 1. | *The incentive store has regular hours of operation and they are posted in the incentive store(s) and on the units and Malls.* | 76% |
| 2. | *The incentive store includes a delivery system that ensures that all individuals have access to incentive items.* | 100% |
| 3. | *The incentive store is well stocked with appropriate items from the incentive list.* | 80% |
| 4. | *The incentive store has an inventory control system.* | 98% |
| 5. | *The incentive store has a system to track and remove outdated food items.* | 90% |
| 6. | *There is a By Choice Manual located in the incentive store.* | 95% |
| 7. | *The incentive store staff has completed incentive* | 96% |

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| | *store training.* | |
| 8. | *The individuals bring their point cards to the store to make a purchase.* | 100% |
| 9. | *There is a By Choice Calorie Activity Guide located in the incentive store.* | 33% |
| 10. | *There is an Alert list in the incentive store for staff reference.* | 23% |

Comparative data indicated mixed changes in compliance since the previous review period:

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 1. | 58% | 76% |
| 2. | 100% | 100% |
| 3. | 94% | 80% |
| 4. | 81% | 98% |
| 5. | - | 90% |
| 6. | 85% | 95% |
| 7. | 92% | 96% |
| 8. | 100% | 100% |
| 9. | 55% | 33% |
| 10. | 51% | 23% |
| 11. | 75% | 41% |
| Compliance rate in last month of period | | |
| 1. | 0% | 80% |
| 2. | | 100% |
| 3. | 100% | 100% |
| 9. | 13% | 36% |
| 10. | 25% | 25% |
| 11. | 25% | 42% |

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| | | PSH added/changed items in the various monitoring/survey instruments. It is important that a number of important elements be addressed as soon as possible, for example having the Alert List in the incentive store for staff reference to ensure that individuals are not presented with items not suitable for them (23%, item 10 in the table above).<br><br>The facility stated that PSH was not able to conduct Individual Surveys on a monthly basis and that to improve compliance, staff members need a better understanding of and additional training on their By Choice responsibilities, individuals need further information about the By Choice program and incentive stores should have calorie guides, handouts on healthy eating tips and Alert Lists. The facility intends to address these items during the coming review period.<br><br>**Compliance:**<br>Partial.<br><br>**Current recommendations**:<br>1. Report By Choice point allocation in the Present Status section of the individual's case formation and update at every scheduled WRPC.<br>2. Ensure that the program receives adequate resources.<br>3. Train all staff in correctly implementing the By Choice program.<br>4. Ensure that individuals know their performance requirements to earn full points. |
| 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:**<br><br>**Recommendation, December 2008:**<br>Continue current practice.<br><br>**Findings:**<br>The Chief of Psychology continues to have all clinical and administrative |

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| | | authority for the PBS teams and the By Choice incentive program. However, the Chief of Psychology has chosen to share some of the responsibility with the Coordinator of Psychology Specialty Services.<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendation**:<br>Continue current practice. |
| F.2.c | Each State Hospital shall ensure that: | **Compliance:**<br>Partial. |
| F.2.c.i | behavioral assessments include structural and functional assessments and, as necessary, functional analysis; | **Current findings on previous recommendation:**<br><br>**Recommendation, December 2008:**<br>Continue current practice of staff training on PBS principles and practices.<br><br>**Findings:**<br>See findings for Recommendation 1, F.2.a.i.<br><br>**Other findings:**<br>Using the DMH Behavior Guidelines and Positive Behavior Support Plan Monitoring Form, PSH assessed its compliance based on a 100% sample of the PBS plans and Behavior Guidelines developed and implemented during the review period (November 2008 – April 2009):<br><br>1. *The individual's WRPT and the PSST (i.e., PBS, DCAT, By Choice, Neuropsychology Services) are involved in the assessment process during the development of the BG or PBS plan* — 91%<br>2. *The WRPT and the PSST determined the goals of the* — 96% |

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| | *intervention* | |
| 3. | *At least one specific behavior of concern was defined in clear, observable and measurable terms.* | 100% |
| 4. | *Baseline of the maladaptive behavior was established in terms of objective measures (e.g., rate, frequency, duration, intensity, severity);* | 100% |
| 5. | *Pertinent records of the individual's challenging behavior were reviewed for antecedents, triggering events, and consequences* | 100% |
| 6. | *A functional assessment interview was completed for the structural assessment* | 95% |
| 7. | *Direct observations of the challenging behavior were undertaken, as applicable.* | 100% |
| 8. | *Additional structural assessments (e.g., ecological. sleep, medication effects, Mall attendance) were completed.* | 100% |
| 9. | *A functional assessment rating scale was completed.* | 100% |
| 10. | *Additional functional assessment interviews were conducted with people (e.g., individual, level of care staff, clinical staff and mall staff) who often interact with the individual in different settings and activities.* | 44% |
| 11. | *Patterns of the challenging behavior were recognized based on the structural and functional assessments* | 77% |

PSH used a new monitoring tool with a number of new items to address this recommendation during this review period. The data is not comparable with data from the previously used monitoring tool. However, overall compliance was high.

Inter-rater reliability needs to be established for the new items. Additionally, PSH plans to train authors of PBS plans and Behavior Guideless on the new items so that they understand what is being monitored going forward.

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| | | The monitor's findings from reviews of nine PBS plans (DK, FS, JP, KK, MLB, OC, RF, TG and VC) are in agreement with the facility's findings. All nine PBS plans had been developed and implemented based on data derived from structural and functional assessments.<br><br>**Current recommendation**:<br>Ensure that behavioral assessments include structural and functional assessments and, as necessary, functional analysis. |
| F.2.c.ii | hypotheses of the maladaptive behavior are based on structural and functional assessments; | **Current findings on previous recommendation2:**<br><br>**Recommendations 1 and 2, December 2008:**<br>• Ensure that proper assessments are conducted prior to developing and implementing intervention plans.<br>• Ensure that hypotheses of the maladaptive behaviors are based on structural and functional assessments and clearly stated in the PBS documentation.<br><br>**Findings:**<br>Using the DMH Behavior Guidelines and Positive Behavior Support Plan Monitoring Form, PSH assessed its compliance based on a 100% sample of PBS plans and Behavior Guidelines developed and implemented during the review period (November 2008 – April 2009):<br><br>12. *Testable data-based hypotheses of the challenging behavior were developed* — 100%<br><br>PSH used the new monitoring tool and the item numbers for this review period were different. However, comparative data indicated that PSH maintained a compliance rate of 90% or greater from the previous review period. |

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| | | A review of four PBS plans (DK, HB, TG and VC) found that the hypotheses in all four plans were based on structural and functional assessments and aligned with findings from the structural/functional assessments. Structural and functional assessments do not consistently identify setting events, antecedents, establishing operations, and precursors to the challenging behaviors. PBS team members and unit psychologists need to collect and analyze data to identify these elements to be used for preventive and reactive strategies. PBS team members are not documenting behavior chains, behavior classes, and developing Competing Pathway models for alternate and replacement behaviors.<br><br>**Current recommendations**:<br>1. Ensure that proper assessments are conducted prior to developing and implementing intervention plans.<br>2. Ensure that hypotheses of the maladaptive behaviors are based on structural and functional assessments and clearly stated in the PBS documentation. |
| F.2.c.iii | There is documentation of previous behavioral interventions and their effects; | **Current findings on previous recommendation:**<br><br>**Recommendation, December 2008:**<br>Continue current practice.<br><br>**Findings:**<br>Using the DMH Behavior Guidelines and Positive Behavior Support Plan Monitoring Form, PSH assessed its compliance based on a 100% sample of PBS plans developed during the review period (November 2008 – April 2009):<br><br>7. *There is documentation of previous behavioral interventions and their effects* — 100%<br><br>Comparative data indicated that PSH maintained compliance at or greater |

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| | | than 90% since the previous review period.<br><br>A review of nine PBS plans found that six contained documentation of previous behavioral interventions and their effects (JP, KK, MLB, OC, RF and VC) and three (DK, FS and TG) did not.<br><br>**Current recommendation**:<br>Ensure documentation of 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:**<br><br>**Recommendation, December 2008:**<br>Ensure that all behavioral interventions are based on a PBS model without any use of aversive or punishment contingencies.<br><br>**Findings:**<br>Using the DMH Behavior Guidelines and Positive Behavior Support Plan Monitoring Form, PSH assessed its compliance based on a 100% sample of PBS plans and Behavior Guidelines developed and implemented during the review period (November 2008 – April 2009):<br><br>17. *Reactive strategies, excluding any use of aversive or punishment contingencies, for the staff to use when the challenging behavior occurs; and* — 68%<br>17.a *If the Intervention section of the BG and PBS plan does not include any aversive or punishment contingencies, and* — 100%<br>17.b *Includes positive intervention and de-escalation strategies to handle the challenging behaviors when they occur* — 36%<br><br>PSH used a new monitoring tool with newly added items so data is not |

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| | | directly comparable to data from the previous review period. PSH also presented combined Positive Behavior Plans and Behavior Guidelines data.<br><br>A review of ten PBS plans (DK, FS, HB, JP, KK, MLB, OC, RF, TG and VC) found that all ten plans were based on a positive behavioral supports model without any use of aversive or punishment contingencies. The findings are also in agreement with the facility's data on the lack of appropriate reactive and de-escalation techniques to be applied when staff encounter challenging behaviors. Most of the plans, especially the behavior guidelines, presented prevention strategies but were short on active treatment strategies. A review of five Behavior Guidelines (AS, GA, NM, RW and SAG) found that many of them incorporated the individuals' PRN and crisis plans into the behavioral intervention plans. All Behavior Guidelines should be based on a positive model of service for all sections of interventions, including prevention and reactive strategies.<br><br>**Current recommendation**:<br>Ensure that all behavioral interventions are based on a PBS model without any use of aversive or punishment contingencies. |
| F.2.c.v | behavioral interventions are consistently implemented across all settings, including school settings; | **Current findings on previous recommendations:**<br><br>**Recommendations 1 and 2, December 2008:**<br>• Conduct training across settings so that staff in those settings has the knowledge and skill to implement interventions for individuals who are on such plans.<br>• Monitor the implementation of PBS plans to ensure that all behavioral interventions are consistently implemented across all settings, including the PSR Mall and vocational and education settings.<br><br>**Findings:**<br>Using the DMH Behavior Guidelines and Positive Behavior Support Plan Monitoring Form, PSH assessed its compliance based on a 100% sample of |

PBS plans and behavior guidelines developed and implemented during the review period (November 2008 – April 2009):

| | | |
|---|---|---|
| 22. | *The PSSC ensures that the BG and PBS plan, as applicable, are monitored to ensure that the interventions are used consistently across all settings.* | 73% |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 22. | 70% | 73% |
| Compliance rate in last month of period | | |
| 22. | 68% | 100% |

This monitor's findings from review of nine PBS plans (DK, FS, JP, KK, MLB, OC, RF, TG and VC) are in agreement with the facility's data. Fidelity data were not collected consistently and across settings. Staff report indicated that staffing shortage and expanded roles interfered with their ability to fulfill all required PBS activities. Fidelity data is a crucial element in evaluating outcomes and decision-making as to plan revision, especially when there are indications that plans are not being implemented with high integrity or data collection is poor (for example, behavior guideline for AM, JC and PC).

**Current recommendations**:

1. Conduct training across settings so that staff in those settings has the knowledge and skill to implement interventions for individuals who are on such plans.
2. Monitor the implementation of PBS plans to ensure that all behavioral interventions are consistently implemented across all settings,

| | | |
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| | | including the PSR Mall and 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:**<br><br>**Recommendation, December 2008:**<br>Ensure and document that individuals who trigger are referred for assessment and where appropriate, behavioral intervention(s).<br><br>**Findings:**<br>The table below showing the types of triggers, the number of individuals who triggered during this review period (N), the number of triggers reviewed by the PSSC (n), and the compliance rate (%C) is a summary of the facility's data: |

| **Triggers** | **N** | **n** | **%C** |
|---|---|---|---|
| Restraint | 222 | 222 | 100% |
| Seclusion | 9 | 9 | 100% |
| 1:1 | 686 | 686 | 100% |
| Aggression to others with major injury | 214 | 214 | 100% |
| Aggression to self with major injury | 39 | 39 | 100% |

As the table above shows, the PSSC has been tracking and monitoring all triggers during this review period. According to the PSSC Coordinator, the PSSC meets three times a week. The PSSC reviews all referrals for PBS and DCAT services, discusses each referral and makes a determination if the referral is suitable for behavioral services. Cases determined to be appropriate for behavioral services are referred to the PBS/DCAT teams for assessments and intervention plans. According to the PSSC Coordinator, during this review period, PSSC received referrals for 1170 individuals who met trigger thresholds. Three hundred and five were reviewed, and 126 resulted in further assessments and/or behavioral interventions.

| | | |
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| | | **Current recommendation**:<br>Continue current practice. |
| 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:**<br><br>**Recommendation, December 2008:**<br>Ensure that treatment modalities are integrated to better serve individuals, as indicated.<br><br>**Findings:**<br>Using the DMH Behavior Guidelines and Positive Behavior Support Plan Monitoring Form, PSH assessed its compliance based on a 100% sample of PBS plans developed during the review period (November 2008 – April 2009): |

| | | |
|---|---|---|
| | *Positive Behavior Support teams and team psychologists integrate their therapies with other treatment modalities, including drug therapy.* | 29% |
| a | *There is documentation in the Psychology Progress Notes of discussions between the psychiatrist, the team psychologist and the PBS psychologist specifying why the specific medications and PBS interventions were chosen and how the two treatment modalities will assist the individual to recover from psychiatric illness and manage maladaptive behavior.* | 57% |
| b | *There is documentation in the Psychology Progress Notes specifying how the information gathered for the PBS plan can be used by various disciplines to enhance the effectiveness of other treatment modalities (e.g., how information from reinforcer preferences can be used across settings and interventions.* | 0% |

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| | | PSH used a new monitoring tool with new items added to the tool. The data in the table above showing 29% reflects progress in compliance since the previous review period. Items "a" and "b" are new items.<br><br>This monitor reviewed nine PBS plans (DK, FS, JP, KK, MLB, OC, RF, TG and VC). Six of the plans contained documentation (progress notes) indicating that the PBS team members consulted with members of other disciplines to get a better understanding of the influence of other modalities in the individual's challenging behaviors (JP, KK, MLB, OC, RF and VC). However, the discussion was not ongoing to address changes in medication and/or symptoms. Three of the plans did not have any interdisciplinary consultation notes. (DK, FS and TG).<br><br>According to the Chief of Psychology and the PBS team members, PBS team members were not able to conduct fidelity checks and interdisciplinary consultations as often as required due to staffing shortage and the expanded role of psychologists resulting in an increased workload. The addition of a fifth PBS team and full team staffing with data analysts is expected to increase compliance.<br><br>**Current recommendation**:<br>Ensure that treatment modalities are integrated to better serve individuals, as indicated. |
| 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:**<br><br>**Recommendation, December 2008:**<br>Specify PBS plans in the objectives and interventions sections of the individual's WRP, as outlined in the DMH WRP Manual.<br><br>**Findings:**<br>Using the DMH Behavior Guideline and Positive Behavior Support Plan |

Monitoring Form, PSH assessed its compliance based on a 100% sample of PBS plans and Behavior Guidelines developed and implemented during the review period (November 2008 – April 2009):

| | | |
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| 19. | *The BG or PBS plan, as applicable, is specified in the Present Status Section in the individual's WRP and in the Objective and Interventions sections* | 45% |
| 19.a | *The Present Status of the WRP includes the inclusion of a statement that a BG or PBS plan is being implemented* | 64% |
| 19.b | *The Objective section of the WRP states what the individuals will learn to do regarding his maladaptive behavior,* | 36% |
| 19.c | *The Intervention section of the WRP will state that the staff will implement the BG or PBS as written* | 34% |

PSH's monitoring tool and items in the tool has changed. The main item audits the same indicator as in the previous review period; comparative data indicated improvement in compliance for this item from 0% in the previous review period.

A review of the records of five individuals with PBS plans or PBS assessments found that three (DMK, FS and JMP) had proper documentation in the individuals' WRPs, and there was no documentation or the documentation was not comprehensive in the remaining two (DMK and HRB).

**Current recommendation**:
Specify PBS plans in the objectives and interventions sections of the individual's WRP, as outlined in the DMH WRP Manual.

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| F.2.c.ix | all positive behavior support plans are updated as indicated by outcome data and reported at least quarterly in the Present Status section of the case formulation in the individual's Wellness and Recovery Plan | **Current findings on previous recommendations:**<br><br>**Recommendations 1 and 2, December 2008:**<br>• Collect objective information to evaluate the effectiveness of the PBS plans and behavior guidelines, including change in behaviors, stability of behavior change, changes in co-varying behaviors, achievement of broader goals and durability of behavior change.<br>• Continue to track and monitor that PBS plans and behavior guidelines are updated using outcome data in the individual's present status section of the WRP<br><br>**Findings:**<br>Using the DMH Behavior Guideline and Positive Behavior Support Plan Monitoring Form, PSH assessed its compliance based on a 100% sample of PBS plans and behavior guidelines developed and implemented during the review period (November 2008 – April 2009):<br><br>24. *The WRPT Psychologist discusses the individual's monthly outcome data during the WRPC* — 57%<br><br>PSH used a different modality, tool, and item to audit this recommendation. The data was derived from WRPC observation instead of chart reviews.<br><br>This monitor's review of PBS plans, outcome data, and WRPs of four individuals (DMK, FS, HRB and JMP) found that PBS teams reviewed and revised all four PBS plans based on data trends. In general, plans did not track and monitor replacement behaviors. Replacement behaviors, when identified, were not graphed to show trends and/or co-variations with other targeted behaviors.<br><br>**Current recommendations**:<br>1. Collect objective information to evaluate the effectiveness of the |

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| | | PBS plans and behavior guidelines, including change in behaviors, stability of behavior change, changes in co-varying behaviors, achievement of broader goals and durability of behavior change.<br>2. Continue to track and monitor that PBS plans and behavior guidelines are updated using outcome data in the individual's present status section of the WRP. |
| F.2.c.x | all staff has received competency-based training on implementing the specific behavioral interventions for which they are responsible, and performance improvement measures are in place for monitoring the implementation of such interventions. | **Current findings on previous recommendations:**<br><br>**Recommendations 1 and 2, December 2008:**<br>• Provide competency-based PBS training to all staff.<br>• Ensure that PBS plans are fully implemented once the plans are "tested" in the unit by the PBS team and the unit staff is trained<br><br>**Findings:**<br>Using the DMH Behavior Guideline and Positive Behavior Support Plan Monitoring Form, PSH assessed its compliance based on a 100% sample of PBS plans and Behavior Guidelines developed and implemented during the review period (November 2008 – April 2009):<br><br>[illegible] *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.*<br>20. *WRPT Psychologist ensures that the individual's enduring staff (e.g., unit, and mall) is trained on the BG* 66%<br>21. *The PSST ensures that the individual's enduring staff (e.g., unit and Mall) is trained on the PBS plan* 100%<br><br>PSH used a new monitoring tool with new items and thus directly comparable data is not available. In the new tool, PSH separated the |

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| | | data by Behavior Guidelines (for which WRPT Psychologists are responsible for staff training) and PBS plans (for which PBS/PSST members are responsible for staff training). As the table above shows, compliance is low for Behavior Guidelines and very high for PBS plans.<br><br>A review of nine PBS plans and related assessment and staff training data (DK, FS, JP, KK, MLB, OC, RF, TG and VC) found that the staff responsible for implementing the PBS plans had been trained to competency in eight of them. The plan for RF is on the shelf waiting to be implemented.<br><br>**Current recommendations**:<br>1. Provide competency-based training on behavioral interventions to all staff.<br>2. Ensure that behavioral interventions are fully implemented once the plans are "tested" in the unit and the unit staff is trained. |
| 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:**<br><br>**Recommendation, December 2008:**<br>Ensure the required number of PBS teams to meet the 1:300 ratio.<br><br>**Findings:**<br>See F.2.a.<br><br>**Other findings:**<br>PBS team members informed this monitor that there is no conflict or barrier to their primary roles to provide PBS/behavioral intervention services. When they had to work overtime, they were assigned to their usual PBS duties.<br><br>15.a.i — *All PBS team members are primarily responsible for the provision of behavioral interventions* — 15/15 |

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<tr><td>15.a.ii</td><td>All PBS team members facilitate one PSR Mall group weekly during their assigned work hours</td><td>15/15</td></tr>
<tr><td>15.b</td><td>If PBS team members are required to do mandatory overtime on state holidays, they are assigned to their usual PBS duties</td><td>15/15</td></tr>
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Current recommendation:<br>
Continue current practice.
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<td>F.2.c.xii</td>
<td>the By CHOICE point allocation is updated monthly in the individual's Wellness and Recovery Plan.</td>
<td>
Current findings on previous recommendations:<br><br>
Recommendation 1, December 2008:<br>
Ensure that By Choice point allocation is updated monthly in the individual's WRP.<br><br>
Findings:<br>
Using item 16 from the DMH Psychology Service Monitoring Form, PSH assessed its compliance based on an average sample of 10% of the WRPs due for the month (November 2008 – April 2009). The table below is a summary of the data:<br><br>
<table>
<tr><td>16.</td><td>The By Choice point allocation is updated monthly in the individual's Wellness and Recovery Plan.</td><td>69%</td></tr>
<tr><td>16.a</td><td>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.</td><td>61%</td></tr>
<tr><td>16.b</td><td>There is documentation that the individual determines the point allocation.</td><td>76%</td></tr>
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Comparative data indicated improvement in compliance since the previous review period:
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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>16.</td><td>26%</td><td>69%</td></tr>
<tr><td>16.a</td><td>-</td><td>61%</td></tr>
<tr><td>16.b</td><td>-</td><td>76%</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>16.</td><td>21%</td><td>94%</td></tr>
<tr><td>16.a</td><td>-</td><td>91%</td></tr>
<tr><td>16.b</td><td>-</td><td>96%</td></tr>
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<br>
A review of the records of eight individuals found that six of the WRPs in the charts contained documentation of the individual's By Choice point allocation in the Present Status section (JR, MMR, PC, RAK, RL and SAG). Documentation in the remaining two WRPs (JMR and TK) was missing or not comprehensive.<br><br>
**Current recommendation**:<br>
Ensure that By Choice point allocation is updated monthly in the individual's WRP.
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<td>F.2.d</td>
<td>Each State hospital shall ensure that it has at least one developmental and cognitive abilities team (DCAT; consisting of 1 clinical psychologist, 1 registered nurse, 1 social worker, 1 psychiatric technician, and 1 data analyst (who may be a behavior specialist) who have a demonstrated competence, consistent with generally accepted professional standards of care, in assessing individuals with cognitive disorders/challenges; developing therapeutic interventions (including positive behavior supports); advising therapy and rehabilitation providers on the implementation of</td>
<td>
**Current findings on previous recommendations:**<br><br>
**Recommendations 1-5, December 2008:**<br>
• Develop and implement a full DCAT, consisting of a clinical psychologist, registered nurse, social worker, psychiatric technician, and data analyst.<br>
• Ensure that all individuals with cognitive challenges are assessed by the DCAT.<br>
• Ensure that all DCAT members are available for consultation to other staff to assist with planning therapeutic activities at the individual's cognitive functioning level.<br>
• Ensure that DCAT members' primary responsibility is consistent with
</td>
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| | 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. | the EP.<br>• Ensure that DCAT members receive appropriate training.<br><br>**Findings:**<br>PSH has one DCAT team, but the team is not yet fully deployed. According to the Chief of Psychology, PSH has hired a number of DCAT members representing several disciplines. Most of these positions were filled in November 2008, and many of the team members were under training during much of this review period. The DCAT still lacks a Nurse and a Data Analyst. PSH plans to hire a RN once budgetary constraints are lifted. Nevertheless, the current DCAT members have provided services for 34 individuals including include behavioral assessments, PBS plans, team consultations, creation of a cognitive rehabilitation program, and liaison with the Regional Center. When fully manned, the DCAT will increase services to individuals in the facility.<br><br>**Compliance:**<br>Partial.<br><br>**Current recommendations**:<br>1. Develop and implement a full DCAT, consisting of a clinical psychologist, registered nurse, social worker, psychiatric technician, and data analyst.<br>2. Ensure that all individuals with cognitive challenges are assessed by the DCAT.<br>3. Ensure that all DCAT members are available for consultation to other staff to assist with planning therapeutic activities at the individual's cognitive functioning level.<br>4. Ensure that DCAT members' primary responsibility is consistent with the EP.<br>5. Ensure that DCAT members receive appropriate training. |

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| F.2.e | Each State Hospital shall develop and implement a Behavioral Consultation Committee (BCC), chaired by the Chief of Psychology, and co-chaired by the Chief of Psychiatry, to review the Wellness and Recovery Plan and maladaptive behavior(s) of the individuals who have not made timely progress on positive behavior support plans. The Chief of Psychology is responsible for the functions of this committee, together with members of the positive behavior support team (in functions of the committee that relate to individuals under the care of those team members). The committee membership shall include all clinical discipline heads, including the medical director, as well as the clinical administrator of the facility. | **Current findings on previous recommendation:**<br><br>**Recommendation, December 2008:**<br>Schedule regular meetings and ensure that all standing members of the PSSC attend the meetings regularly.<br><br>**Findings:**<br>This monitor reviewed 54 PSSC meeting schedules and reports (November through April, 2009), and found that PSSC meetings were regularly held. Attendance at these meetings was high, especially that of the standing team members (a mean attendance of over 90%). The PSSC now reviews all triggers, including seclusion, restraint, 1:1, and aggression with and without injury to self and others. During the review period, the PSSC reviewed 305 individuals who met a trigger threshold with a learned function, resulting in 126 cases being opened for assessment and interventions. PSSC referrals that meet criteria are triaged for PBS, DCAT, and neuropsychology services. Documentation of reviews and reports showing factors considered, decisions made, rationale for the decisions, and actions taken were found in the reports.<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendation**:<br>Schedule regular meetings and ensure that all standing members of the PSSC attend the meetings regularly. |
| F.2.f | Each State Hospital shall ensure that it has sufficient neuropsychological services for the provision of adequate neuropsychological assessment of individuals with persistent mental illness. | **Current findings on previous recommendations:**<br><br>**Recommendation 1, December 2008:**<br>Ensure that WRPT members, especially psychiatrists and psychologists, make referrals, when appropriate, for neuropsychological assessments. |

**Findings:**
Documentation review found that the total number of referrals for neuropsychological assessments has increased from 81 in the previous review period to 94 during the current review period. A neuropsychologist has been included as a standing member in the Rehabilitation Management Committee (RMC). Referrals now are also coming directly from the Risk Management System.

The Neuropsychology staff conducted training for clinical staff on referral criteria and procedures (four training sessions from March through June, 2009) and feels that unit psychologists and psychiatrists would benefit from further knowledge and awareness of Neuropsychology assessments. The Neuropsychology staff plans to provide additional training to psychologists and psychiatrists, and work with the Senior Psychologists to increase awareness among WRPTs. In a number of cases, the PSSC had initiated referrals for Neuropsychology assessments; this is further evidence for the need of training and awareness by WRPTs regarding appropriate referrals.

Using the DMH Psychology Services Monitoring Form, PSH assessed its compliance based on a 100% sample of referrals received each month during the review period (November 2008 – April 2009):

| | | Nov | Dec | Jan | Feb | Mar | Apr | Mean |
|---|---|---|---|---|---|---|---|---|
| 18.a.i | *Number of neuro-psychological assessments due for completion in the review month* | 10 | 11 | 16 | 10 | 13 | 17 | 12.8 |
| 18.a.ii | *Of those in 18.a.i, number completed* | 2 | 2 | 1 | 5 | 6 | 4 | 3.3 |
| 18.a.iii | *Average time taken from referral to completion for all neuropsychological assessments during the* | | | | | | | 91 days |

| | | |
|---|---|---|
| | *current evaluation period* | |

**Recommendation 2, December 2008:**
Increase the number of neuropsychologists to meet the anticipated demand for neuropsychological services.

**Findings:**
The number of neuropsychologists on staff is stable at 3.5 since the last review. According to the Chief of Psychology, a plan is underway to hire two additional Neuropsychologists from within the system. At this time, the Chief of Psychology is addressing some of the personnel deficiencies through reallocation of recourses.

**Recommendation 3, December 2008:**
Ensure that retesting and follow-up neuropsychological evaluations are conducted in a timely fashion.

**Findings:**
Documentation review and interview of the Neuropsychology staff and the Chief of Psychology found that 54 assessments were completed during this review period, compared to 59 during the previous review period. Twenty-eight referrals are on the waiting list as of April 2009. The mean number of days to complete referrals during this review period was 91 days, compared to 83.5 days during the previous review period. However, it only took 30 days to complete the assessments once the referral was assigned to the psychologist. It is clear that with sufficient resources, the assessments can be completed in a timely manner.

**Compliance:**
Partial.

**Current recommendations:**
1. Ensure that WRPT members, especially psychiatrists and

| | | |
|---|---|---|
| | | psychologists, make referrals, when appropriate, for neuropsychological assessments.<br>2. Increase the number of neuropsychologists to meet the anticipated demand for neuropsychological services.<br>3. Ensure that retesting and follow-up neuropsychological evaluations are conducted in a timely fashion. |
| F.2.g | All clinical psychologists with privileges at any State Hospital shall have the authority to write orders for the implementation of positive behavior support plans, consultation for educational or other testing, and positive behavior support plan updates. | **Current findings on previous recommendation:**<br><br>**Recommendation, December 2008:**<br>Continue current practice.<br><br>**Findings:**<br>The authority has been approved for psychologists at PSH to write orders for the implementation of positive behavior support plans, positive behavior support plan updates and consultation for educational or other testing. The PSSC Coordinator met with Nursing Services to establish a process for psychologists to write orders, and the Medical Executive Committee has approved the process. The form to be used for this process is under revision. It appears that this process has been very slow. PSH should complete all remaining related activities so that the work can be carried out by the psychologists.<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendation**:<br>Continue current practice. |

| 3. Nursing Services | | |
|---|---|---|
| | Each State hospital shall provide adequate and appropriate nursing care and services consistent with generally accepted professional standards of care to individuals who require such services. | Methodology:<br><br><u>Interviewed</u>:<br>1. Cathy Rhinehart, RN, Nursing Coordinator Program VIII<br>2. Charles Allen, RN, Nursing Coordinator Program VI<br>3. Darold Dahse, RN, Nursing Coordinator Program III<br>4. Diane White, Nursing Coordinator Program I<br>5. Don Clutter, Nursing Coordinator Program VII<br>6. James Birks, RN, Nursing Coordinator Program V<br>7. Kathy Wood, Nursing Coordinator Program VI<br>8. Lidia Lau, RN, Assistant Coordinator of Nursing Services<br>9. Regina Olender, Supervising RN<br>10. Sandra Doerner, Acting Nurse Administrator<br>11. Susan King, Psychiatric Technician, Acting Nursing Coordinator Program IV, Unit Supervisor Program V<br><br><u>Reviewed</u>:<br>1. PSH's progress report and data<br>2. MedSelect training outline and schedule<br>3. MedSelect Operations Manual<br>4. PRN/Stat Medication Note form<br>5. Nursing Policy and Procedure 538, PRN and Stat Medication (May 2009); 400, Change of Physical/Behavioral Condition/Status (April 2008); 514, 24 Hours Night Shift Medication and Treatment Audit<br>6. PSH Plan of Action for Medication Variance Report Data Entry<br>7. DMH Kardex form<br>8. AD 10.52, Provision of Medical Care to Individuals (February 17, 2009); AD 10.53, RN and Physician Communication About Physical Status Change (February 17, 2009); AD 10.54, Transfer to and Return from Another Facility For Evaluation and/or Medical or Surgical Treatment (February 17, 2009); AD 20.02, Kardex Usage (February 17, 2009); AD 20.03, Nursing Staff Assignment (February |

| | | |
|---|---|---|
| | | 17, 2009); AD 20.04, Nursing Weekly Progress Note (February 17, 2009); AD 20.05, Registered Nurse Progress Note for Assessment and Evaluation (February 17, 2009)<br>9. Revised Controlled Drug Count/Key Transfer Signature Record<br>10. PSH's training rosters<br>11. Current MTRs and Controlled Sheets for Program I, Unit 74; Program VI, Unit 75; and Program VII, Unit 77<br>12. Medical records for the following 90 individuals: AAG, AAN, BJ, BJC, BLW, CC, CDP, CG, CMR, CS, DB, DCS, DFN, DJ, DJW, DL, DLR, DSC, EAS, EEG, EJB, EKG, EM, EMH, ES, EV, EV, FGC, FMD, GFW, GNC, HDM, JA, JAH, JAO, JJG, JOD, JP, JPK, JRA, JS, JT, JW, JWP, KAF, KAM, LC, LCB, LM, LMG, LML, LST, LTH, MAW, MGM, MLD, MMM, MT, MW, PAS, PMA, PMC, RAE, RB, RBK, RBS, RCK, RJL, RK, RL, RLR, RMM, RP, RWM, SB, SDG, SE, SJP, SR, SS, TD, TSS, VDM, VFP, VRE, VV, WMM, WOL, WSB and ZHO<br><br><u>Observed</u>:<br>1. WRPCs on Program IV, Unit 36; Program VI, Unit EB-12; and Program VIII, Unit N20<br>2. Shift report on Unit 36<br>3. 8 a.m. medication administration on Program VI, Unit 02 |
| F.3.a | Each State hospital shall develop and implement policies and protocols regarding the administration of medication, including pro re nata ("PRN") and "Stat" medication (i.e., emergency use of psychoactive medication), consistent with generally accepted professional standards of care, to ensure: | **Compliance:**<br>Partial. |
| F.3.a.i | safe administration of PRN medications and Stat medications; | **Current findings on previous recommendations:** |

**Recommendation 1, December 2008:**
Ensure accuracy of documentation regarding medication administration and the MedSelect system.

**Findings:**
PSH noted that some of the Unit staff had difficulty using the MedSelect System. Additional training was provided by the Pharmacist and/or the Staff Development Center. In addition, a MedSelect Prompt Sheet was developed by Pharmacy to assist staff. PSH has provided the MedSelect Training Part II to 94% of the required staff as of May 2009.

**Recommendation 2, December 2008:**
Continue to monitor this requirement.

**Findings:**
Using the DMH Nursing Services Monitoring PRN Audit, PSH assessed its compliance based on a 16% mean sample of PRNs administered each month during the review period (November 2008 - April 2009):

| | | |
|---|---|---|
| 1. | *Safe administration of PRN medications* | 94% |

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

Using the DMH Nursing Services Monitoring Stat Audit, PSH assessed its compliance based on a 23% mean sample of Stat medications administered each month during the review period (November 2008 - April 2009):

| | | |
|---|---|---|
| 1. | *Safe administration of Stat medications* | 95% |

Comparative data indicated improvement in compliance from 89% in the

| | | |
|---|---|---|
| | | previous review period.<br><br>A review of 84 PRN orders and 31 Stat orders for 38 individuals (BLW, CC, CG, DB, DFN, DJW, DL, DLR, EKG, EMH, EV, FMD, HDM, JPK, JRA, JS, JW, JWP, LC, LML, LST, LTH, MLD, MMM, MT, MW, PAS, PMC, RAE, RBS, RJL, SB, SJP, SS, TD, VDM, WMM and WOL) found that 98 orders included specific individual behaviors. In addition, 44 of the new PRN/Stat/Emergency Medication notes were reviewed. Although the medications, dosages and routes (issues that had been problematic in the past) were consistently documented on these forms, there were a number of other issues found:<br><br>1. Dates and times were missing from several entries.<br>2. The site for injections is documented using a numeric code; however, no key explaining this code is provided.<br>3. Documentation regarding effectiveness continues to be non-specific and lacks objective observations of the individual.<br>4. There is inconsistent documentation of "PRN" or "Stat."<br>5. There is inconsistent documentation of indicators per physician order.<br>6. The times included on the forms were not consistently appropriately documented<br><br>**Current recommendations**:<br>1. Increase sample size for PRN data to 20%.<br>2. Address problematic issues noted above in the PRN/Stat/Emergency Medication notes.<br>3. 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:**<br><br>**Recommendation 1, December 2008:**<br>Implement strategies to increase compliance with this requirement. |

**Findings:**
PSH appointed a member of the Nurse Executive Council (NEC) as the Team Leader for oversight of the PRN and Stat medication process. PSH initiated the "PRN/Stat IDN form in May 2009. As noted above in F.3.a.i, a number of these forms were reviewed and noted to have made some improvement in the documentation process. However, other problematic issues were found as listed above.

**Recommendation 2, December 2008:**
Continue to monitor this requirement.

**Findings:**
Using the DMH Nursing Services Monitoring PRN Audit, PSH assessed its compliance based on a 16% mean sample of PRNs administered each month during the review period (November 2008 - April 2009):

| | | |
|---|---|---|
| 3. | *There is documentation in the Interdisciplinary Note of the individual prior to the PRN medication administration, which includes the circumstances/behavior requiring the medication.* | 62% |

Comparative data indicated no change in mean compliance from the previous review period.

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 3. | 62% | 62% |
| Compliance rate in last month of period | | |
| 3. | 53% | 71% |

A review of 84 incidents of PRN medications for 38 individuals (BLW, CC,

CG, DB, DFN, DJW, DL, DLR, EKG, EMH, EV, FMD, HDM, JPK, JRA, JS, JW, JWP, LC, LML, LST, LTH, MLD, MMM, MT, MW, PAS, PMC, RAE, RBS, RJL, SB, SJP, SS, TD, VDM, WMM and WOL) found adequate documentation of the circumstances requiring the PRN in the IDNs in 44 incidents.

Using the DMH Nursing Services Monitoring Stat Audit, PSH assessed its compliance based on a 23% mean sample of Stat medications administered each month during the review period (November 2008 - April 2009):

| | | |
|---|---|---|
| 4. | *There is documentation in the Interdisciplinary Note of the individual prior to the Stat medication administration, which includes the circumstances/behavior requiring the medication.* | 80% |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 4. | 63% | 80% |
| Compliance rate in last month of period | | |
| 4. | 59% | 86% |

A review of 31 incidents of Stat medications for 23 individuals (CG, DB, DFN, DJW, DLR, EKG, EV, FMD, HDM, JCH, JS, JW, LC, LST, MLD, MMM, PAS, RAE, RBS, SJP, SS, TD and WOL) found adequate documentation of the circumstances requiring the Stat medication in the IDNs in 26 incidents.

A barrier to compliance for both PRN and Stat documentation data is the

<table>
<tr><td></td><td></td><td>lack of nursing accountability regarding documentation. PSH has initiated a review system as of May 2009 to monitor the PRN/Stat documentation and then review the data with the unit supervisors.<br><br>Current recommendation:<br>See F.3.a.i.</td></tr>
<tr><td>F.3.a.iii</td><td>documentation of the individual's response to PRN and Stat medication.</td><td>Current findings on previous recommendation:<br><br>Recommendation, December 2008:<br>Continue to monitor this requirement.<br><br>Findings:<br>Using the DMH Nursing Services Monitoring PRN Audit, PSH assessed its compliance based on a 16% mean sample of PRNs administered each month during the review period (November 2008 - April 2009):<br><br>
<table>
<tr><td>5.</td><td>There is documentation in the Interdisciplinary Note of the individual's response to the PRN medication within one hour of administration.</td><td>44%</td></tr>
</table>
<br>Comparative data indicated improvement in compliance since the previous review period.<br><br>
<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>5.</td><td>15%</td><td>44%</td></tr>
</table>
<br>A review of 84 incidents of PRN medications for 38 individuals (BLW, CC, CG, DB, DFN, DJW, DL, DLR, EKG, EMH, EV, FMD, HDM, JPK, JRA, JS, JW, JWP, LC, LML, LST, LTH, MLD, MMM, MT, MW, PAS, PMC, RAE, RBS, RJL, SB, SJP, SS, TD, VDM, WMM and WOL) found a</td></tr>
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<td></td>
<td>comprehensive assessment of the individual's response in the IDNs in 39 incidents.<br><br>Using the DMH Nursing Services Monitoring Stat Audit, PSH assessed its compliance based on a 23% mean sample of Stat medications administered each month during the review period (November 2008 - April 2009):<br><br>
<table>
<tr><td>6.</td><td>There is documentation in the Interdisciplinary Note of the individual's response to the Stat medication within one hour of administration.</td><td>52%</td></tr>
</table>
<br>Comparative data indicated improvement in compliance since the previous review period.<br><br>
<table>
<tr><th></th><th>Previous period</th><th>Current period</th></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>6.</td><td>12%</td><td>52%</td></tr>
</table>
<br>A review of 31 incidents of Stat medications for 23 individuals (CG, DB, DFN, DJW, DLR, EKG, EV, FMD, HDM, JCH, JS, JW, LC, LST, MLD, MMM, PAS, RAE, RBS, SJP, SS, TD and WOL found a comprehensive assessment of the individual's response in the IDNs in 24 incidents.<br><br>See F.3.a.ii for barriers and plan of correction.<br><br>Current recommendation:<br>See F.3.a.i.</td>
</tr>
<tr>
<td>F.3.b</td>
<td>Each State hospital shall ensure that all failures to properly sign the Medication Treatment Record (MTR) or the controlled medication log are treated</td>
<td>Current findings on previous recommendations:</td>
</tr>
</table>

as medication variances, and that appropriate follow-up occurs to prevent recurrence of such variances.

**Recommendation 1, December 2008:**
Implement a tracking system for this requirement to ensure the accuracy of the data.

**Findings:**
As in all DMH facilities, MVRs at PSH are initiated by self-report, supervisor review and auditor review. PSH's Nursing Policy & Procedure 514, 24 Hours Night Shift Medication and Treatment Audit requires that all MTRs will be audited each night by the night shift nursing staff. Any nursing staff discovering an error is responsible for initiating a MVR for all documentation errors, including missing initials. In addition, the policy requires that the Unit Supervisor is also responsible for ensuring that the audit procedure is completed nightly and that variances found are appropriately addressed. Also, the Standards Compliance auditors review random MTRs and if missing initials are found, a copy of the MTR with the missing initials is provided to the supervisor. Although PSH is aware that not all missing initials on the MTRs and Narcotic Logs are being reported, they have made efforts to improve the process and make the Medication Variance System non-punitive to facilitate nursing staff self-report of these variances.

**Recommendation 2, December 2008:**
Continue to monitor this requirement.

**Findings:**
The facility reported the following data:

| Key Indicator Data on MVR Documentation Errors | | | | | | | |
|---|---|---|---|---|---|---|---|
| | 11-08 | 12-08 | 1-09 | 2-09 | 3-09 | 4-09 | Mean |
| N | 3 | 146 | 161 | 33 | 72 | 52 | 78 |
| n | 3 | 146 | 161 | 33 | 72 | 52 | 78 |
| %S | 100 | 100 | 100 | 100 | 100 | 100 | 100 |

N = Number of medication variances for missed signatures, titles and/or initials on MTR

| | | |
|---|---|---|
| | | reported<br>n = Number followed up to prevent recurrence of signature variances<br><br>A review of the current MTRs and Controlled Sheets for Program I, Unit 74; Program VI, Unit 75; and Program VII, Unit 77 found that there were 21 incidents of missing initials on the MTRs and eight incidents had an associated Medication Variance Report. Of these variances, there were a number of vital signs that were not documented for medications that warrant either a pulse and/or blood pressure prior to administration. It is the Standard of Practice to document these values on the MTR; however, PSH indicated that its policy does not include these omissions as medication variances. PSH needs to review its policy regarding medication variances to ensure that all appropriate documentation omissions are included and reported. From conversations with medication nurses, there continues to be inconsistent awareness that not initialing the MTR at the time the individual actually takes the medication or not signing the Controlled Sheet during the count between shifts is considered a medication variance.<br><br>**Other findings:**<br>During the last review, it was discovered that there had been a significant breakdown regarding the tracking of Medication Variance Reports, rendering the data unreliable. Since that review, the Standards Compliance Department has put in a great deal of effort to discover and address this error. The analysis demonstrated that MVRs were inconsistently entered into the database in various stages of completeness, which caused duplication and omissions. The corrective actions that were implemented included:<br><br>• Each Program independently tracks their MVRs, which are reviewed by Dr. Phillip Martin and then forwarded to Standards Compliance for data entry by one specific staff member of the department.<br>• Tracking numbers are assigned to MVRs and entered by Standards |

| | | |
|---|---|---|
| | | Compliance onto the MVR Tracking Log, which is reviewed and updated daily. Once the information is entered by Standards Compliance, the MVRs are then forwarded to the Clinical Review Team. This team reviews the MVRs and determines trends and what actions/recommendations are needed. Once this process is completed, Standards Compliance enters the Clinical Review Team's findings into the MVR database.<br><br>**Compliance:**<br>Partial.<br><br>**Current recommendations**:<br>1. Ensure all appropriate documentation omissions are included and reported as medication variances and clearly stated in the facility policy.<br>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 therapeutic and rehabilitation service plan are required. No nursing diagnoses other than as specified in the therapeutic and rehabilitation service plan, in terms of the current DSM criteria, are required. | **Current findings on previous recommendations:**<br><br>**Recommendation 1, December 2008:**<br>Continue to implement strategies to increase compliance with this requirement.<br><br>**Findings:**<br>See plan of correction included in C.2.l.<br><br>**Recommendation 2, December 2008:**<br>Increase sample size to at least 20%.<br><br>**Findings:**<br>PSH data indicated that the sample size for this data was 13%. PSH needs to increase the sample size to 20%. |

<table>
<tr><td></td><td></td><td>Recommendation 3, December 2008:<br>Continue to monitor this requirement.<br><br>Findings:<br>No nursing care plans or nursing diagnoses other than in the WRPs were found during this review. See also C.2.l for additional findings.<br><br>Compliance:<br>Partial.<br><br>Current recommendation:<br>See C.2.l.</td></tr>
<tr><td>F.3.d</td><td>All nursing staff working with an individual shall be familiar with the goals, objectives and interventions for that individual.</td><td>Current findings on previous recommendations:<br><br>Recommendation 1, December 2008:<br>Continue efforts to provide staff training on all WRP modules.<br><br>Findings:<br>This recommendation was not addressed by PSH.<br><br>Recommendation 2, December 2008:<br>Continue to monitor this requirement.<br><br>Findings:<br>Using the DMH Nursing Staff Familiarity Monitoring Audit, PSH assessed its compliance based on an average sample of 44% of the nursing staff:<br><br>
<table>
<tr><td>8.</td><td>Given a focus and objective(s) for an individual on the nursing staff's caseload, the nursing staff is able to discuss the individual's therapeutic milieu interventions as described in the WRP.</td><td>59%</td></tr>
</table></td></tr>
</table>

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 8. | 31% | 59% |
| Compliance rate in last month of period | | |
| 8. | 35% | 90% |

The barrier to compliance reported by PSH was that the Nursing staff failed to understand the importance of the audit process. However, it was unclear as to what this specifically meant. The plan of action included that as of May 2009, a review process was implemented and if a nursing staff is unfamiliar with his/her assigned individual, the Unit Supervisor will follow up and provide assistance prior to the audit being conducted. In addition, the new shift change process that includes objectives for individuals has improved the knowledge of staff as reflected in an increase in April's data.

A review of the admissions assessments, integrated assessments and WRPs of 40 individuals (AAG, AAN, BJ, BJC, CDP, CMR, CS, DCS, DJ, DSC, EAS, EEG, EJB, EM, ES, EV, GFW, JA, JAO, JJG, JOD, LCB, LM, LMG, MAW, MGM, PMA, RB, RLR, RMM, RP, RWM, SDG, SE, SR, TSS, VFP, VRE, VV and WSB) found that there was some improvement in the nursing objectives and interventions, mainly in the area of infectious diseases. From conversations with unit staff, it was clear that they have a great deal of knowledge about the individuals on their units. However, thus far, this knowledge has not consistently been integrated into the WRPs.

In observations of three WRPCs (Program IV, Units 36 and EB12; Program VIII, Unit N20), two of the WRPTs presented clinically relevant

| | | |
|---|---|---|
| | | information regarding the individual and health and mental health WRP goals, objectives and interventions.<br><br>**Compliance:**<br>Partial.<br><br>**Current recommendation**:<br>Continue to monitor this requirement. |
| F.3.e | Each State hospital shall ensure that nursing staff timely monitor, document and report the status of symptoms, target variables, health, and mental health status, of individuals in a manner that enables interdisciplinary teams to assess each individual's status, and response to interventions, and to modify, as appropriate, individuals' therapeutic and rehabilitation service plans. Each State Hospital shall ensure that all nursing shift changes include a review of changes in status of individuals on the unit. | **Current findings on previous recommendations:**<br><br>**Recommendation 1, December 2008:**<br>Continue to implement the training addressing the provision of and administration of medical care.<br><br>**Findings:**<br>Training rosters indicated that training was provided in December 2008 on the initial Provision of Medical Care.<br><br>**Recommendation 2, December 2008:**<br>Implement strategies addressing shift report to meet the elements of this requirement.<br><br>**Findings:**<br>PSH implemented the Change of Shift Administrative Directive on 2/17/09. The Change of Shift process training was initiated in January 2009.<br><br>**Recommendation 3, December 2008:**<br>Continue to monitor this requirement.<br><br>**Findings:**<br>Using the DMH Medical Transfer Audit, PSH assessed its compliance |

based on a 100% sample of individuals transferred to community hospitals each month during the review period (November 2008 - April 2009):

| | | |
|---|---|---|
| 1. | *There is an appropriate documentation by the nurse that identifies the symptoms of concern and notification of the physician.* | 95% |
| 7. | *The WRP was updated to reflect the individual's current status following hospitalization or emergency room treatment.* | 51% |

Comparative data indicated significant improvement in compliance for item 1 and no change in compliance for item 7 since the previous review period:

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 1. | 70% | 95% |
| 7. | 51% | 51% |
| Compliance rate in last month of period | | |
| 7. | 43% | 60% |
| 7.a | 46% | 42% |
| 7.b | 60% | 78% |

Barriers to compliance included difficulty that the nurses have in incorporating the concepts from training into actual practice regarding how to update objectives and interventions. The plan of correction included initiation of a WRP mentor beginning in April 2009 through May 2009 to assist each unit's WRPTs in updating the case formulation and writing appropriate objectives and interventions.

A review of the records of 12 individuals who were transferred to a community hospital/emergency room (FGC, GNC, JAH, JP, JT, KAF, KAM,

RBK, RCK, RK, RL and ZHO) found that overall there was some improvement in the documentation; however, significant problems noted in all previous reports continue regarding the quality of the nurses' assessment at the time when the individuals' status has changed, at the time the individual is transferred to the hospital or ER and upon return to the facility. In addition, a number of the Change of Status forms were incomplete. These findings do not support PSH's data. The facility needs to ensure that the auditors for this requirement are reviewing for quality and not just completion.

Using the DMH Nursing Services Audit, PSH assessed its compliance based on a 72% sample of Change of Shift Reports observed during in the review months (February 2009 - April 2009):

| | | |
|---|---|---|
| 10. | *Each State Hospital shall ensure that all nursing shift changes include a review of changes in status of individuals on the unit.* | 96% |

(Revised monitoring tool implemented 2/09)

Comparative data indicated significant improvement in compliance between the last month of the previous review period and the last month of the current review period:

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 10. | Not available | 96% |
| Compliance rate in last month of period | | |
| 10.a | 77% | 96% |
| 10.b | 72% | 96% |

Observation of shift report on Unit 36 found that PSH has made significant improvements in the clinical information being reported during

| | | |
|---|---|---|
| | | change of shift. A copy of each individual's Kardex with pertinent medical/psychiatric clinical information was projected on the wall so all staff members could see the Axis diagnoses and WRP objectives when hearing report.<br><br>**Compliance:**<br>Partial.<br><br>**Current recommendations:**<br>1. Ensure that the auditors for this requirement (Change of Status) are reviewing for quality and not just completion.<br>2. Provide real-time review and mentoring for Change of Status situations.<br>3. Continue to mentor staff regarding change of shift report.<br>4. Continue to monitor this requirement. |
| F.3.f | Each State hospital shall develop and implement a system to monitor nursing staff while administering medication to ensure that: | **Compliance:**<br>Partial. |
| F.3.f.i | nursing staff are knowledgeable regarding each individual's prescribed medications; | **Current findings on previous recommendations:**<br><br>**Recommendation 1, December 2008:**<br>Continue efforts to increase sample size to 20%.<br><br>**Findings:**<br>Sample size for these data was 52%.<br><br>**Recommendations 2 and 3, December 2008:**<br>• Ensure accuracy of the data for this requirement.<br>• Continue to monitor this requirement. |

<table>
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Findings:<br>
Using the DMH Medication Administration Monitoring Audit, PSH assessed its compliance based on an average sample of 52% of level of care nursing staff who are licensed and medication-certified:<br><br>
<table>
<tr><td>11.</td><td>Nursing staff are knowledgeable regarding each individual's prescribed medications.</td><td>93%</td></tr>
</table>
<br>
Comparative data indicated that PSH maintained compliance greater than 90% from the previous review period.<br><br>
In the 8 a.m. medication administration observed on Program VI, Unit 02, the medication nurse had a good rapport with the individuals and provided individuals with medication education. In addition, the proper procedures for medication administration were appropriately followed.<br><br>
Current recommendation:<br>
Continue to monitor this requirement.
</td>
</tr>
<tr>
<td>F.3.f.ii</td>
<td>education is provided to individuals during medication administration;</td>
<td>
Current findings on previous recommendation:<br><br>
Recommendation, December 2008:<br>
See F.3.f.i.<br><br>
Findings:<br>
Using the DMH Medication Administration Monitoring Audit, PSH assessed its compliance based on an average sample of 52% of level of care nursing staff who are licensed and medication-certified:<br><br>
<table>
<tr><td>12.</td><td>Education is provided to individuals during medication administration.</td><td>87%</td></tr>
<tr><td>12.a</td><td>If an individual asks a question, the nursing staff is able to competently answer the question.</td><td>98%</td></tr>
</table>
</td>
</tr>
</table>

| | | |
|---|---|---|
| 12.b | *When an individual has been prescribed a new medication, the nursing staff provides education about the medication.* | 94% |
| 12.c | *Nursing staff makes at least one inquiry or comment to the individual about his or her medication at each medication administration.* | 69% |

Comparative data indicated significant improvement in compliance since the previous review period.

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 12. | 39% | 87% |
| Compliance rate in last month of period | | |
| 12. | 50% | 92% |
| 12.a | 100% | 98% |
| 12.b | 100% | 96% |
| 12.c | 50% | 81% |

PSH indicated that Nursing staff initially did not understand the requirements regarding medication education. Modeling of the expectation was initiated to demonstrate to staff how to provide information and education during medication administration. In addition, compliance reports are provided for Program Management and the units. Also, the training curriculum of the Principles of Medication class taught to the new employees was reviewed. An emphasis on how to demonstrate teaching during the Medication Administration was provided to the Staff Development Center.

See also F.3.f.i for reviewer's findings.

<table>
<tr><td></td><td></td><td>Current recommendation:<br>Continue to monitor this requirement.</td></tr>
<tr><td>F.3.f.iii</td><td>nursing staff are following the appropriate medication administration protocol; and</td><td>Current findings on previous recommendation:<br><br>Recommendation, December 2008:<br>See F.3.f.i.<br><br>Findings:<br>Using the DMH Medication Administration Monitoring Audit, PSH assessed its compliance based on an average sample of 52% of level of care nursing staff who are licensed and medication-certified:<br><br><table><tr><td>13.</td><td>Nursing Staff are following the appropriate medication administration protocol.</td><td>99%</td></tr></table><br>Comparative data indicated maintenance of a compliance rate greater than 90% from the previous review period.<br><br>Other findings:<br>A review of the MTRs and the medication variance data from PSH does not fully support PSH's compliance data indicating that medication administration is essentially perfect. Although the facility has made significant efforts regarding the tracking of MVRs, there has been no formal forum addressing issues such as delays in receiving vital signs delaying medication administration, interruptions, the number of individuals for whom one medication nurse is responsible for administering medications, reviewing and noting physician orders, meeting the appropriate time frame for medication administration (one hour before and one hour after the scheduled medication time) as contributing factors to problems regarding medication administration. Nursing needs to analyze all data regarding medication practices to determine and address the etiology of the discrepancies between data.</td></tr>
</table>

<table>
<tr><td></td><td></td><td>Current recommendations:<br>1. Analyze all data regarding nursing medication practices to determine the etiology of the discrepancies between data.<br>2. Continue to monitor this requirement.</td></tr>
<tr><td>F.3.f.iv</td><td>medication administration is documented in accordance with the appropriate medication administration protocol.</td><td>Current findings on previous recommendations:<br><br>Recommendation 1, December 2008:<br>Modify the controlled medication signature sheet to accurately reflect when the narcotic counts occur.<br><br>Findings:<br>PSH has modified the controlled medication signature sheet, which is currently in the approval process.<br><br>Recommendation 2, December 2008:<br>See F.3.f.i.<br><br>Findings:<br>Using the DMH Medication Administration Monitoring Audit, PSH assessed its compliance based on an average sample of 52% of level of care nursing staff who are licensed and medication-certified:<br><br>
<table>
<tr><td>14.</td><td>Medication administration is documented in accordance with the appropriate medication administration protocol.</td><td>94%</td></tr>
</table>
<br>Comparative data indicated maintenance of a compliance rate greater than 90% from the previous review period.<br><br>See F.3.b for reviewer's findings.</td></tr>
</table>

| | | |
|---|---|---|
| | | **Current recommendation**:<br>See F.3.b. |
| F.3.g | Each State hospital shall ensure that individuals remain in a "bed-bound" status only for clinically justified reasons. | **Findings:**<br>There have been no bed-bound individuals at PSH during this review period.<br><br>**Compliance:**<br>Not applicable.<br><br>**Current recommendation**:<br>Continue to monitor this requirement. |
| F.3.h | Each State hospital shall ensure that, before they work directly with individuals, all nursing and psychiatric technicians have successfully completed competency-based training regarding: | **Compliance:**<br>Substantial. |
| F.3.h.i | mental health diagnoses, related symptoms, psychotropic medications and their side effects, monitoring of symptoms and target variables, and documenting and reporting of the individual's status; | **Current findings on previous recommendation:**<br><br>**Recommendation 1, December 2008:**<br>Continue to monitor this requirement.<br><br>**Findings:**<br>Training rosters indicated that Therapeutic Strategy Interventions (TSI) training for PSH staff began in February 2009 for managers and supervisors. Shift Leads were trained on April 2 and 3, 2009. Training will continue to be provided to all staff. Training rosters for this review period for a total of 40 new nursing and PT staff verified that 100% received and passed the Mental Health Nursing Class, PBS and TSI training. In addition, 97% received and passed the Principles of Medication class. |

| | | |
|---|---|---|
| | | **Current recommendation**:<br>Continue to monitor this requirement. |
| F.3.h.ii | the provision of a therapeutic milieu on the units and proactive, positive interventions to prevent and de-escalate crises; and | **Current findings on previous recommendation:**<br><br>**Recommendation, December 2008:**<br>Continue to monitor this requirement.<br><br>**Findings:**<br>See F.3.h.i.<br><br>**Current recommendation**:<br>Continue to monitor this requirement. |
| F.3.h.iii | positive behavior support principles. | **Current findings on previous recommendation:**<br><br>**Recommendation, December 2008:**<br>Continue to monitor this requirement.<br><br>**Findings:**<br>See F.3.h.i.<br><br>**Current recommendation**:<br>Continue to monitor this requirement. |
| F.3.i | Each State hospital shall ensure that, prior to assuming their duties and on a regular basis thereafter, all staff responsible for the administration of medication has successfully completed competency-based training on the completion of the MTR and the controlled medication log. | **Current findings on previous recommendation:**<br><br>**Recommendation, December 2008:**<br>Continue to monitor this requirement.<br><br>**Findings:**<br>Training rosters verified that 90% of existing licensed nursing staff has successfully completed the Principles of Medication class. See F.3.h.i for |

| | | |
|---|---|---|
| | | newly hired staff data.<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendation**:<br>Continue to monitor this requirement. |

| 4. Rehabilitation Therapy Services | | |
|---|---|---|
| | Each State hospital shall provide adequate, appropriate, and timely rehabilitation therapy services to each individual in need of such services, consistent with generally accepted professional standards of care. | **Methodology:**<br><br>Interviewed:<br>1. Alejandro Fernandez, Senior Rehabilitation Therapist<br>2. Billy Mange, Senior Vocational Rehabilitation Counselor<br>3. Chris Keierleber, Acting Senior Rehabilitation Therapist<br>4. Colleen O'Neill, Vocational Services Rehabilitation Therapist<br>5. Cynthia Siples, Vocational Services Rehabilitation Therapist<br>6. Greg Siples, Chief of Rehabilitation Therapy Services<br>7. Jack Baum, Senior Vocational Rehabilitation Counselor<br>8. Jacqueline Doss-Haynes, Senior Rehabilitation Therapist<br>9. Jay Gehrke, Industrial Therapist<br>10. Mark Camero, Senior Rehabilitation Therapist<br>11. Mike Gomes, Senior Rehabilitation Therapist<br>12. Renata Geyer, Acting Senior Rehabilitation Therapist<br>13. Stan Hydinger, Senior Rehabilitation Therapist<br><br>Reviewed:<br>1. DMH Rehabilitation Therapy F.4 audit tool and instructions<br>2. DMH MH-C 9090 POST Monthly Progress Note<br>3. F.4 audit data for November 2008-April 2009<br>4. PSH Mall course schedule for Rehabilitation Therapy PSR Mall groups for week of review<br>5. Records for the following 17 individuals participating in observed Mall groups: CBL, CC, DTD, JB, JG, JHB, JLG, KS, MB, NCC, NS, PD, SS, TT, VB, WAM and ZB<br>6. List of individuals who received direct Physical Therapy services from November 2008-April 2009<br>7. Records for the following five individuals who received direct Physical Therapy services between November 2008-April 2009: DB, MM, RCO, RLE and TN<br>8. List of individuals who received direct Speech Therapy services from |

| | | |
|---|---|---|
| | | November 200 8- April 2009<br>9. Records for the following four individuals who received direct Speech Therapy services from November 2008-April 2009: AKA, JAC, PH and PSC<br>10. List of individuals who received direct Occupational Therapy services from November 200 8- April 2009<br>11. Records for the following four individuals who received direct Occupational Therapy services from November 2008-April 2009: DS, FD, JW and YMH<br>12. List of individuals with 24-hour rehabilitation support plans<br>13. Record for the following three individuals with 24-hour rehabilitation support plans: DO, HLS and RR<br>14. DMH MH-C 9091 24-Hour Rehabilitation Support Plan guidelines and instructions<br>15. Individualized Nursing Physical and Occupational Therapy Plan (INPOP) procedure<br>16. Records for the following two individuals with INPOPs: DCM and RJS<br>17. Vocational Services binder and lesson plans<br>18. Seasonal Sports PSR Mall group lesson plan<br>19. Leisure Skills PSR Mall group lesson plan<br>20. Writing Music and Art PSR Mall group lesson plan<br>21. Developing Social Skills with Ceramics PSR Mall group lesson plan<br>22. Culinary Arts PSR Mall group lesson plan<br>23. Horticulture PSR Mall group lesson plan<br><br><u>Observed</u>:<br>1. Seasonal Sports PSR Mall group<br>2. Leisure Skills PSR Mall group<br>3. Writing Music and Art PSR Mall group<br>4. Developing Social Skills with Ceramics PSR Mall group<br>5. Culinary Arts PSR Mall group<br>6. Horticulture PSR Mall group |

| | | |
|---|---|---|
| F.4.a | Each State hospital shall develop and implement policies and procedures, consistent with generally accepted professional standards of care, related to the provision of rehabilitation therapy services that address, at a minimum: | **Compliance:**<br>Partial. |
| F.4.a.i | the provision of direct services by rehabilitation therapy services staff; and | **Current findings on previous recommendations:**<br><br>**Recommendation 1, December 2008:**<br>Ensure that data from the F.4 audit tool is reliable and valid.<br><br>**Findings:**<br>The facility reported that inter-rater agreement was established and maintained for all data over the six-month review period. Data reported by the facility appear to be generally consistent with data observed during the court monitoring review.<br><br>**Recommendation 2, December 2008:**<br>Provide quality direct services by Occupational, Physical and Speech Therapy staff to ensure that there is alignment between assessment findings and treatment activities; changes to programs are made as needed; adequate foci, objectives and interventions are aligned and incorporated into the WRP; and progress with direct services is documented in the Present Status section of the WRP.<br><br>**Findings:**<br>The data below presents the number of scheduled vs. completed visits for direct services provided by OT, PT, and SLP for the week of March 9-13: |

| | Scheduled | Provided |
|---|---|---|
| PT | 6 | 6 |
| OT | 29 | 29 |
| SLP | 16 | 12 |

The facility reported that four scheduled Speech Therapy sessions were cancelled due to individual refusal. The sessions were rescheduled at a later date.

In March 2009, POST clinicians began to provide direct input into each applicable individual's WRP document regarding direct treatment foci, objectives and interventions and progress towards objectives. Prior to March, it was the sole responsibility of the RT on each individual's WRPT to perform this task.

Using the DMH F.4 Monitoring Tool, PSH assessed its compliance based on an average sample of 90% of individuals per month (mean of 10 per month) receiving Speech, Occupational and/or Physical Therapy direct treatment during the review period of November 2008 - April 2009:

| | | |
|---|---|---|
| 1. | *The provision of direct services by rehabilitation therapy services staff* | 54% |
| 1.a | *There is an appropriate Focus of Hospitalization (typically Focus 6).* | 65% |
| 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.* | 35% |
| 1.c | *The intervention aligned with this objective states what OT, PT, and SLP will do to assist the individual in achieving the objective.* | 61% |
| 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.* | 56% |

Comparative data indicated improvement in compliance since the previous

review period:

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 1. | 6% | 54% |
| Compliance rate in last month of period | | |
| 1. | 9% | 88% |
| 1.a | 32% | 100% |
| 1.b | 18% | 75% |
| 1.c | 45% | 100% |
| 1.d | 41% | 75% |

The facility reviewed the data and reported that the new process implemented in March by which the POST team clinicians enter data directly into the WRP has improved compliance with item 1 and sub-items; this is reflected in the improvements noted during the last month of the review period.

A review of the records of four individuals receiving direct Occupational Therapy treatment to assess compliance with F.4.a.i criteria found one record in substantial compliance (JW) and three records in partial compliance (DS, FD and YMH). Identified areas of deficiency that the facility should focus on in order to improve compliance include:

1. OT foci, objectives and interventions are not consistently included in the WRP.
2. Progress in Occupational Therapy treatment is not consistently documented in the Present Status section of the WRP.

A review of the records of five individuals receiving direct Physical Therapy treatment to assess compliance with F.4.a.i criteria found one record in substantial compliance (DB) and four records in partial

| | | |
|---|---|---|
| | | compliance (MM, RCO, RLE and TN). Identified areas of deficiency that the facility should focus on in order to improve compliance include:<br><br>1. PT foci, objectives and interventions are not consistently included in the WRP.<br>2. Progress in Physical Therapy treatment is not consistently documented in the Present Status section of the WRP.<br><br>A review of the records of four individuals receiving direct Speech Therapy treatment to assess compliance with F.4.a.i criteria found one record in substantial compliance (AKA) and three records in partial compliance (JAC, PH and PSC). An identified area of deficiency that the facility should focus on in order to improve compliance is that progress in Speech Therapy treatment is not consistently documented in the Present Status section of the WRP.<br><br>**Compliance:**<br>Partial.<br><br>**Current recommendation:**<br>Provide quality direct services by Occupational, Physical and Speech Therapy staff to ensure that there is alignment between assessment findings and treatment activities; changes to programs are made as needed; adequate foci, objectives and interventions are aligned and incorporated into the WRP; and progress with direct services is documented in the Present Status section of the WRP. |
| F.4.a.ii | the oversight by rehabilitation therapists of individualized physical therapy programs implemented by nursing staff. | **Current findings on previous recommendations:**<br><br>**Recommendation 1, December 2008:**<br>Develop 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.

**Findings:**
The INPOP program was finalized and implemented in January 2009.

**Recommendation 2, December 2008:**
Develop and implement a facility-wide database to track individuals receiving these services, as well as when staff has received competency-based training/return demonstration if indicated, and how often the individual should be re-assessed by the Physical or Occupational Therapist to determine the continued appropriateness of the program.

**Findings:**
The database was implemented in January 2009.

**Other findings:**
Using the DMH F.4 Monitoring Tool, PSH assessed its compliance based on an average sample of 57% of plans completed during the review period of November 2008 - April 2009:

| | | |
|---|---|---|
| 2.a | *The oversight by rehabilitation therapists of individualized physical therapy programs implemented by nursing staff.* | 100% |
| 2.b | *There is documentation in the Present Status Section of the individual's WRP of the current status of the PT and/or OT interventions implemented by the nurses.* | 100% |

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

<table>
<tr>
<td></td>
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<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>2.a</td><td>73%</td><td>100%</td></tr>
<tr><td>2.b</td><td>35%</td><td>100%</td></tr>
</table>
<br>
A review of three records of individuals with individualized OT/PT programs implemented by nursing found that all three were in substantial compliance with F.4.a.ii requirements.<br><br>
Compliance:<br>
Substantial.<br><br>
Current recommendation:<br>
Ensure that the oversight by rehabilitation therapists of individualized Occupational or Physical Therapy programs implemented by nursing staff occurs as needed, and that results are documented in the Present Status section of the WRP.
</td>
</tr>
<tr>
<td>F.4.b</td>
<td>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.</td>
<td>
Current findings on previous recommendation:<br><br>
Recommendation, December 2008:<br>
Ensure that competency-based training on the use and care of adaptive equipment, transferring, and positioning, as well as the need to promote individuals' independence, occurs as needed.<br><br>
Findings:<br>
The facility reported that 90% of staff requiring training during the review period was trained to competency (a total of 127 out of 141).<br><br>
Compliance:<br>
Substantial.
</td>
</tr>
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| | | |
|---|---|---|
| | | **Current recommendation:**<br>Ensure that competency-based training on the use and care of adaptive equipment, transferring, and positioning, as well as the need to promote individuals' independence, occurs as needed. |
| F.4.c | Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services. | **Current findings on previous recommendations:**<br><br>**Recommendation 1, December 2008:**<br>Ensure that for all individuals receiving treatment by Rehabilitation Therapists in PSR Mall groups, progress towards objectives is documented in the Present Status section of the WRP, and quality foci, objectives, and interventions are documented in the WRP and are aligned.<br><br>**Findings:**<br>Using the DMH F.4 Monitoring Tool, PSH assessed its compliance based on an average sample of 20% of individuals participating in PSR Mall groups facilitated by Rehabilitation Therapists and Vocational Rehabilitation staff each month during the review period of November 2008 - April 2009: |

| | | |
|---|---|---|
| 4. | *Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.* | 53% |
| 4.a | *There is an appropriate Focus of Hospitalization.* | 73% |
| 4.b | *The objective aligned with this focus of hospitalization is functional for the individual and written in behavioral, observable, and/or measurable terms.* | 43% |
| 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* | 48% |

| | | |
|---|---|---|
| | *staff to assist the individual in achieving this objective.* | |
| 4.d | *There is documentation in the Present Status Section of the individual's WRP of interventions provided by the RT and Voc Rehab.* | 47% |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 4. | 5% | 53% |
| Compliance rate in last month of period | | |
| 4. | 10% | 65% |
| 4.a | 75% | 72% |
| 4.b | 36% | 43% |
| 4.c | 38% | 48% |
| 4.d | 26% | 44% |

The facility reported that after the RT standardized policy for incorporating Rehabilitation Therapy input into the WRP was implemented, there was some progress in data compliance through January. In January, the Supervising RTs discovered inter-rater agreement issues and differing interpretations of the requirements. After resolving the discrepancies, the service was re-trained based on the revised interpretation of the F.4.c instructions in early February. The drop in February's data is attributed to the revised auditing standards and increased inter-rater agreement. In late March, a plan was developed to have the Supervising RTs review all RT input into each quarterly WRP to verify qualitative compliance and to ensure that any needed revisions are completed prior to finalization. The facility reported that interdepartmental staff competency in creating appropriate focus

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| | | statements, objectives and interventions; staff shortage; staff being held responsible for focus statements and objectives that they did not create; and the recent facility-wide PSR Mall restructuring/cleanup project have all been barriers to compliance.<br><br>The facility took the following actions to improve compliance:<br><br>• Hired 11 RTs to fill unit vacancies; and<br>• Instructed unit RTs to review and correctly align all focus statements, objectives and interventions related to RT-specific treatment per established standard, with oversight by Supervising RTs.<br><br>A review of the records of 17 individuals participating in Rehabilitation Therapist- and Vocational Rehabilitation staff-facilitated PSR Mall groups to assess compliance with F.4.c criteria found two records in substantial compliance (JB and NS), 12 records in partial compliance (CBL, CC, DTD, JG, JHB, JLG, KS, MB, NCC, PD, SS and TT) and three records not in compliance (VB, WAM and ZB). Identified areas of deficiency that the facility should focus on in order to improve compliance include:<br><br>1. Objectives are not consistently functional, behavioral, observable and measurable.<br>2. Progress is not consistently documented in the Present Status section of the WRP.<br><br>**Recommendation 2, December 2008:**<br>Provide training to Rehabilitation Therapy staff on writing quality foci, objectives and interventions based on content of the revised PSR Mall Manual.<br><br>**Findings:**<br>Training materials on Focus 10 and on writing Focus statements, |

objectives, and interventions were reviewed and appear to meet accepted standards. On 4/29/09, 48 out of 48 RTs were trained to competency on these materials.

**Recommendation 3, December 2008:**
Ensure that all individuals with 24-hour Rehabilitation Support plans meet criteria for 24-hour plans, and receive provision of timely and adequate Rehabilitation Therapy services.

**Findings:**
Three 24-hour support plans were reviewed and were found to align with plan criteria outlined in the corresponding procedure.

**Other findings:**
The Vocational Services program continues to develop and expand. Vocational PSR Mall groups have increased from nine one year ago to 28 currently; all have lesson plans which were reviewed and appear to meet accepted standards. A distance learning program is being developed and is pending implementation and integration with the PSR Mall. In addition, the Workforce Skills Certification program has been selected for use with individuals, which aligns with the CASAS and with considerations for community vocational placement.

Using the DMH F.4 Monitoring Tool, PSH assessed its compliance based on an average monthly sample of 44% of individuals with 24-hour support plans during the review period of November 2008 - April 2009:

| | | |
|---|---|---|
| 4.b | *Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.* | 90% |

Comparative data indicated improvement in compliance from 45% in the previous review period.

<table>
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<td>A review of records for three individuals with 24-hour support plans to assess compliance with F.4.c. criteria found one record (RR) in substantial compliance and two records (HLS, DO) in partial compliance.<br><br>The facility provided the following data regarding the numbers of scheduled vs. actual hours of PSR Mall services provided during the week of 3/9-3/13/09:<br><br>
<table>
<tr><td></td><td>Scheduled</td><td>Provided</td></tr>
<tr><td>RT</td><td>647</td><td>537</td></tr>
<tr><td>Voc Rehab</td><td>39</td><td>28</td></tr>
</table>
<br>The facility reported that the discrepancy between hours scheduled and provided was due to staff furloughs, vacation, illness, staff shortage, lockdowns and mandatory training.<br><br>Compliance:<br>Partial.<br><br>Current recommendation:<br>Ensure that for all individuals receiving Rehabilitation Therapy services, progress towards objectives is documented in the Present Status section of the WRP, and quality foci, objectives, and interventions are aligned and documented in the WRP.</td>
</tr>
<tr>
<td>F.4.d</td>
<td>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.</td>
<td>Current findings on previous recommendation:<br><br>Recommendation, December 2008:<br>Ensure that each individual who requires adaptive equipment is provided with equipment that meets his/her assessed needs and promotes his/her independence, and provide individuals with training and support to use such equipment.</td>
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**Findings:**
Using the DMH F.4 Monitoring Tool, PSH assessed its compliance based on an average sample of 100% of individuals added to the adaptive equipment database each month during the review period November 2008 - April 2009:

| | | |
|---|---|---|
| e. | *The individual was assessed for the appropriateness of adaptive equipment by an RT professional* | 100% |
| f. | *The individual was provided with the equipment as per the doctor's order* | 100% |
| g. | *The individual's level of functioning related to independence versus supports needed was assessed.* | 100% |
| h. | *Training for the individual on the use of adaptive equipment was provided.* | 100% |
| i. | *Reassessment of adaptive equipment, if clinically indicated* | 98% |

Comparative data indicated maintenance of compliance greater than 90% from the previous review period for items e., f., h. and i., and improvement in compliance for item g. as follows:

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| g. | 80% | 100% |

**Compliance:**
Substantial.

**Current recommendation:**
Continue current practice.

| 5. Nutrition Services | | |
|---|---|---|
| | Each State hospital shall provide the individuals it serves, particularly those experiencing weight-related problems, adequate and appropriate dietary services consistent with generally accepted professional standards of care. | **Methodology:**<br><br>Interviewed:<br>1. Brian Starck-Riley, Assistant Director of Nutrition Services<br>2. Diana Tran, Assistant Director of Nutrition Services<br>3. Grace Ferris, Assistant Director of Nutrition Services<br>4. Jeanie Kim, Assistant Director of Nutrition Services<br>5. Kitchie Miana, Assistant Director of Nutrition Services<br>6. Tai Kim, Director of Nutrition Services<br><br>Reviewed:<br>1. Lists of individuals with Nutrition Care Assessments due from November 200 8- April 2009 for each assessment type<br>2. Records for the following 54 individuals with type a-j.ii assessment from November 2008-April 2009: ADC, ALM, AMO, BDT, BJ, BQ, CMJ, DE, DM, DMH, EAL, ECF, ELG, END, ES, EV, EZW, GAF, GRA, HLP, HP, JAC, JB, JCT, JD, JEP, JJF, JLH, JPM, JR, KJ, LES, LEW, LSB, LW, ME, MES, MP, MSB, MSMC, NG, PF, RCR, RH, RLL, RME, RTE, RTW, SRF, TCH, TJM, WCS, WG and WSB<br>3. Meal Accuracy Report audit data from November 2008 - April 2009<br>4. Nutrition Care Monitoring Tool audit data from November 2008 - April 2009 regarding Nutrition Education Training, response to MNT, and WRP integration of Nutrition Services recommendations (weighted mean across assessment sub-types)<br>5. Facility training data and competency scores for RNs and Dietitians, as well as raw data binders<br>6. Records for the following individuals participating in the Weight Management (WOW) PSR Mall group: ELF, LAT and LB<br>7. Weight Management (WOW) lesson plan<br>8. Outcome assessment data for Interdisciplinary Weight Management PSR Mall group pilot |

| | | |
|---|---|---|
| | | Observed:<br>Weight Management (WOW) PSR Mall group |
| F.5.a | Each State hospital shall modify policies and procedures to require that the therapeutic and rehabilitation service plans of individuals who experience weight problems and/or related health concerns include adequate strategies and methodologies to address the identified problems and that such strategies and methodologies are implemented in a timely manner, monitored appropriately, and revised, as warranted, consistent with generally accepted professional standards of care. | **Current findings on previous recommendation:**<br><br>**Recommendation, December 2008:**<br>Continue current practice.<br><br>**Findings:**<br>Using the DMH Nutrition Care Monitoring Tool, PSH assessed its compliance with these indicators based on an average sample of 25% of Nutrition Assessments (all types) due each month from November 2008 - April 2009 (total of 568 out of 2305):<br><br>7. *Nutrition education is documented* 95%<br>8 *Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified* 99%<br><br>Comparative data indicated that PSH maintained compliance rates greater than 90% from the previous review period.<br><br>A review of the records of 51 individuals to assess compliance with documentation of provision of Nutrition Education Training and of response to Medical Nutrition Training found 49 records in substantial compliance (ADC, ALM, AMO, BDT, BJ, CMJ, DE, DM, DMH, EAL, ECF, ELG, ES, EZW, GAF, GRA, HLP, HP, JAC, JB, JCT, JD, JEP, JJF, JLH, JPM, JR, KJ, LES, LEW, LSB, ME, MES, MP, MSB, MSMC, NG, PF, RCR, RH, RLL, RME, RTE, RTW, SRF, TCH, TJM, WG and WSB), one record in partial compliance (WCS) and one record not in compliance (BQ).<br><br>**Other findings:**<br>According to review of Meal Accuracy Report data, 99% of trays (regular |

<table>
<tr><td></td><td></td><td>and modified diets) audited from November 2008 - April 2009 (total of 2143 out of 9041, for a 24% sample) were 100% accurate.<br><br>Comparative data indicated that PSH maintained a compliance rate greater than 90% from the previous review period.<br><br>Compliance:<br>Substantial.<br><br>Current recommendation:<br>Continue current practice.</td></tr>
<tr><td>F.5.b</td><td>Each State hospital shall ensure that one or more treatment team members demonstrate competence in the dietary and nutritional issues affecting the individuals they serve and the development and implementation of strategies and methodologies to address such issues.</td><td>Current findings on previous recommendations:<br><br>Recommendation 1, December 2008:<br>Continue current efforts to achieve compliance.<br><br>Findings:<br>Using the DMH Nutrition Care Monitoring Tool, PSH assessed its compliance with WRP integration based on an average sample of 25% of Nutrition Assessments (all types) due each month from November 2008 - April 2009 (568 out of 2305):<br><br>
<table>
<tr><td>19.</td><td>The WRP has at least ONE Focus that pertains to nutrition recommendations as clinically indicated</td><td>84%</td></tr>
<tr><td>20.</td><td>The WRP has at least one objective and interventions linked to the Focus that pertains to the nutrition recommendation as clinically indicated</td><td>34%</td></tr>
</table>
<br>Comparative data indicated mixed changes in compliance since the previous review period:</td></tr>
</table>

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 19. | 78% | 84% |
| 20. | 54% | 34% |
| Compliance rate in last month of period | | |
| 19. | 76% | 94% |
| 20. | 37% | 41% |

The facility reviewed the data and reported that compliance for item 20 decreased from 54% to 34% since the previous reporting period due to a change in monitoring criteria beginning in October 2009.

A review of the records of 15 individuals with completed Nutrition Care assessments to assess compliance with integration of adequate focus, objective and intervention into the WRP found three records in substantial compliance (LEW, NG and SRF), 10 records in partial compliance (BDT, ECF, ELG, END, JPM, LSB, LW, PF, RH and TCH) and two records not in compliance (BJ and RTW). Identified areas of deficiency that the facility should focus on in order to improve compliance include:

1. Objectives are not consistently functional, behavioral, observable and measurable.
2. Foci, objectives and interventions are not consistently included in the WRP.
3. Interventions are not consistently written according to facility requirements.

**Other findings:**
A review of records of three individuals participating in the Weight Management PSR Mall group (ELF, LAT and LB) to assess compliance with

| | | |
|---|---|---|
| | | provision of timely and adequate Nutrition services found all records in partial compliance. An identified pattern of deficiency that the facility should focus on in order to improve compliance is that objectives and interventions are not consistently included in the WRP.<br><br>Observation of the Weight Management PSR Mall group found that the appropriate lesson plan was in use and that the group provided activities that were in line with the individuals' assessed needs.<br><br>A pilot of the interdisciplinary weight management group was completed during the review period, with an outcome study performed. The study was reviewed and revealed promising outcomes in weight reduction and reduction of weight-related risk factors for participating individuals.<br><br>**Compliance:**<br>Partial.<br><br>**Current recommendation:**<br>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:**<br><br>**Recommendation, December 2008:**<br>Continue current practice.<br><br>**Findings:**<br>The DMH Statewide Dietetics Department Policy: Dysphagia and Aspiration Management addresses the dietitian's role in the team process regarding dysphagia and aspiration prevention and management and appears to meet generally accepted standards of practice. This procedure is currently being revised to align with system changes. |

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| | | **Compliance:**<br>Substantial.<br><br>**Current recommendation:**<br>Continue current practice. |
| F.5.d | Each State hospital shall ensure that staff with responsibilities for assessments and interventions regarding aspiration and dysphagia has successfully completed competency-based training commensurate with their responsibilities. | **Current findings on previous recommendation:**<br><br>**Recommendation, December 2008:**<br>Continue current practice.<br><br>**Findings:**<br>One new Dietitian was hired during the review period and was trained to competency on basic issues related to aspiration and dysphagia.<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendation:**<br>Continue current practice. |
| F.5.e | Each State hospital shall develop and implement policies and procedures requiring treatment of the underlying causes for tube feeding placement, and ongoing assessment of the individuals for whom these treatment options are utilized, to determine the feasibility of returning them to oral intake status. | **Current findings on previous recommendation:**<br><br>**Recommendation, December 2008:**<br>Continue current practice.<br><br>**Findings:**<br>The DMH Statewide Dietetics Department Policy for Tube Feeding appears to meet accepted standards of practice.<br><br>**Compliance:**<br>Substantial. |

| | | |
|---|---|---|
| | | **Current recommendation:**<br>Continue current practice. |

| 6. Pharmacy Services | | |
|---|---|---|
| | Each State hospital shall provide adequate and appropriate pharmacy services consistent with generally accepted professional standards of care. Each State hospital shall develop and implement policies and procedures that require: | **Methodology:**<br><br>Interviewed:<br>1. Laura Yao, Business Manager II<br>2. Phung Thi Chau, Pharmacy Services Manager<br>3. Washington Ubillus, Jr., Acting Pharmacist II<br><br>Reviewed:<br>1. PSH self-assessment monitoring data<br>2. Summary of pharmacy recommendations where the physician did not follow a recommendation and did not provide adequate documentation |
| 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 recommendation:**<br><br>**Recommendation, December 2008:**<br>Continue to monitor this requirement and provide results.<br><br>**Findings:**<br>PSH presented the following data regarding the recommendations made during the current review period: |

| | | Current period |
|---|---|---|
| 1. | Drug-drug interactions | 183 |
| 2. | Side effects | 18 |
| 3. | Need for laboratory testing | 99 |
| 4. | Dose adjustment | 81 |
| 5. | Indications | 0 |
| 6. | Contraindications | 21 |
| 7. | Need for continued treatment | 0 |
| 8. | Others | 76 |
| Total number of recommendations | | 478 |

<table>
<tr><td></td><td></td><td>PSH reported an increase in total recommendations from 194 during the previous reporting period to 478 during the current period. The facility did not provide comparison data for the specific categories of recommendations.<br><br>Compliance:<br>Substantial.<br><br>Current recommendations:<br>1. Continue current practice.<br>2. Provide monitoring data by specific type of recommendations and comparisons with previous review.</td></tr>
<tr><td>F.6.b</td><td>Physicians to consider pharmacists' recommendations, and for any recommendations not followed, document in the individual's medical record an adequate clinical justification.</td><td>Current findings on previous recommendations:<br><br>Recommendation 1, December 2008:<br>Continue to monitor this requirement and provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period).<br><br>Findings:<br>The facility provided the following data:<br><br>
<table>
<tr><td></td><td>Current period</td></tr>
<tr><td>Recommendations followed</td><td>367</td></tr>
<tr><td>Recommendations not followed, but rationale documented</td><td>56</td></tr>
<tr><td>Recommendations not followed and rationale/response not documented</td><td>55</td></tr>
</table>
<br>The facility did not provide comparative data.</td></tr>
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| | | **Recommendation 2, December 2008:**<br>Provide information about the outcome of follow-up in situations in which the physician did not respond to the pharmacist's recommendation and/or disagreed with the recommendation without documented acceptable rationale.<br><br>**Findings:**<br>The facility reported a mean compliance rate with recommendations of 88%, compared to 85% during the previous review period. The rate for the last month of this review period was 90% compared to 94% during the last month of the previous review period.<br><br>PSH reported that it intends to implement a system to ensure timely physician response to pharmacist recommendations on June 22, 2009. A summary follows:<br><br>1. Pharmacists will e-mail recommendations to the applicable physician.<br>2. Physicians will respond to the pharmacy recommendations by e-mail.<br>3. Supervisors will receive two types of notification weekly:<br>a. The Pharmacy will e-mail Senior Psychiatrists or Chief Physician a list of their supervisees who have not responded to pharmacy recommendations.<br>b. The Business Manager II will e-mail the Chief of Psychiatry a list of any recommendations still outstanding following Senior notification.<br><br>**Other findings:**<br>This monitor reviewed the facility's data regarding all 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 |

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| | | decision not to follow the recommendation.<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendations**:<br>1. Provide monitoring data by specific category of recommendations followed/not followed and comparisons with previous review.<br>2. Provide information about the outcome of follow-up in situations in which the physician did not respond to the pharmacist's recommendation and/or disagreed with the recommendation without documented acceptable rationale. |

| 7. General Medical Services | | |
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| | | **Methodology:**<br><br>Interviewed:<br>1. Alan Ta, MD, Physician and Surgeon<br>2. Arporn Sung, MD, Physician and Surgeon<br>3. Aung Zin, MD, Physician and Surgeon<br>4. Bong Doan, MD, Physician and Surgeon<br>5. Chris Elder, RN, Nursing Coordinator in Medical Services<br>6. Cung Nguyen, MD, Physician and Surgeon<br>7. Darryl Brown, MSA, Administrator of Medical Services<br>8. Dien Mach, MD, Acting Chief Physician and Surgeon<br>9. Dominique Tran, MD, Physician and Surgeon<br>10. George Christison, MD, Acting Medical Director<br>11. J. Stephen Maurer, MD, Chief of Medical Staff<br>12. Javier Diaz, Supervising RN in Medical Services<br>13. Jian Zhang, MD, Physician and Surgeon<br>14. Josh Horsley, MD, Staff Psychiatrist and MOD<br>15. Khanh Ngo, MD, Physician and Surgeon<br>16. Khue Nguyen, MD, Physician and Surgeon<br>17. Luzmin Inderias, MD, Physician and Surgeon<br>18. Mohamed Hafez, MD, Physician and Surgeon<br>19. Nittin Kulkarni, MD, Staff Psychiatrist and MOD<br>20. Sandra Dorner, RN, Acting Nursing Administrator<br>21. Talat Khan, MD, Physician and Surgeon<br>22. Tim Alder, MD, Staff Psychiatrist and MOD<br><br>Reviewed:<br>1. The charts of the following ten individuals: CF, CS, JH, JM, JT, KF, LR, OZ, RC and RK<br>2. DMH Reference for Assessment and Notification (RAN) – Abdominal Pain<br>3. DMH Reference for Assessment and Notification (RAN) – Altered |

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| | | Mental Status<br>4. DMH Reference for Assessment and Notification (RAN) – Cardiovascular<br>5. DMH Reference for Assessment and Notification (RAN) – Gastrointestinal Bleed<br>6. DMH Reference for Assessment and Notification (RAN) – Infection<br>7. DMH Reference for Assessment and Notification (RAN) – Respiratory<br>8. PSH Nursing Policy and Procedure 400, Change of Physical/Behavioral Condition/Status, April 2008<br>9. PSH AD 10.52, Provision of Medical Care to Individuals, implemented February 17, 2009<br>10. PSH AD 10.53, RN and Physician Communication About Physical Status Change, implemented February 17, 2009<br>11. PSH AD 10.54, Transfer to and Return from Another Facility for Evaluation and/or Medical or Surgical Treatment, implemented February 17, 2009<br>12. List of all individuals admitted to external hospitals during the review period<br>13. Memo dated 3/19/09 from Administrator of Medical Services describing courier services for obtaining medical records from outside medical facilities<br>14. Communication between PSH staff and outside medical facilities regarding obtaining medical records<br>15. Revised Physician and Surgeon Duty Statements<br>16. PSH Department of Medicine Physician Performance Profile<br>17. PSH Guidelines for Medical Care for Patients with Osteoporosis, May 2009<br>18. PSH Guidelines of Medical Care for Individuals with Diabetes Mellitus<br>19. PSH policy (draft), Refusal of Medical Treatment<br>20. DMH Medical Surgical Progress Notes Auditing Form<br>21. DMH Medical Surgical Progress Notes Auditing Form Instructions<br>22. PSH Medical Surgical Progress Notes Auditing Form summary data |

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| | | (November 2008 to April 2009)<br>23. DMH Integration of Medical Conditions into the WRP Auditing Form<br>24. DMH Integration of Medical Conditions into the WRP Auditing Form Instructions<br>25. PSH Integration of Medical Conditions into the WRP Auditing summary data (November 2008 to April 2009)<br>26. DMH Medical Transfer Auditing Form<br>27. DMH Medical Transfer Auditing Form Instructions<br>28. PSH Medical Transfer Auditing summary data (November 2008 to April 2009)<br>29. DMH Diabetes Mellitus Auditing Form<br>30. DMH Diabetes Mellitus Auditing Form Instructions<br>31. PSH Diabetes Mellitus Auditing summary data (November 2008 to April 2009)<br>32. DMH Hypertension Auditing Form<br>33. DMH Hypertension Auditing Form Instructions<br>34. PSH Hypertension Auditing summary data (November 2008 to April 2009)<br>35. DMH Dyslipidemia Auditing Form<br>36. DMH Dyslipidemia Auditing Form Instructions<br>37. PSH Dyslipidemia Auditing summary data (November 2008 to April 2009)<br>38. DMH Asthma/COPD Auditing Form<br>39. DMH Asthma/COPD Auditing Form Instructions<br>40. PSH Asthma/COPD Auditing summary data (November 2008 to April 2009) |
| 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 | **Current findings on previous recommendations:**<br><br>**Recommendation 1, December 2008:**<br>Ensure easy access by physicians to the laboratory information system, radiology data/reports, chart notes and consultation reports. |

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| | 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. | **Findings:**<br>PSH reported that it gained access (through the facility's laboratory vendor) to electronic real-time lab results in February 2009. Additionally, a courier service was established (effective May 15, 2009) to assist physicians in retrieving medical records from outside facilities.<br><br>**Recommendation 2, December 2008:**<br>Finalize DMH SO 136, Provision of Medical Care to Individuals and ensure that all facilities' ADs and medical policies and procedures are aligned with the finalized SO.<br><br>**Findings:**<br>DMH Special Order 136, Provision of Medical Care to Individuals, was finalized and implemented in November 2008.<br><br>**Recommendation 3, December 2008:**<br>Finalize new formats and protocols for nursing assessment and documentation of changes in the status of individuals, and provide training to ensure proper implementation.<br><br>**Findings:**<br>PSH reported that the DMH completed several actions during this review period. These actions are summarized below:<br><br>1. DMH developed standardized policies and documentation policies related to:<br>a. Provision of Medical Care to Individuals;<br>b. Transfer to and Return from Another Facility for Evaluation and/or Medical or Surgical Treatment;<br>c. Psychiatric and Medical Coverage; and<br>d. Registered Nurse and Physician Communication about Change in Physical Status.<br>2. DMH developed documentation templates that align with the newly |

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| | | developed policies:<br>a. Sick Call Referral Log;<br>b. Physician Note: Transfer to Outside Facility for Emergency or other Services;<br>c. Physician Order Form (Transfer to Outside Facility);<br>d. Nursing Transfer Note; and<br>e. RN Change in Physical Status Note.<br>3. DMH developed a series of reference materials (Reference for Assessment and Notification). These documents are designed to assist RNs in assessing high-risk changes in status and communicating relevant information to the physician. References were developed for the high-risk areas of cardiovascular, altered mental status, infection, abdominal pain, gastrointestinal bleeding and respiratory.<br>4. To standardize practice, DMH developed joint medical and nursing policies for the high-risk areas of constipation, dehydration, diabetes, hypertension, asthma, COPD, seizures, weight management and pressure ulcers and wounds.<br><br>The above-listed policies, templates and references were implemented during November 2008.<br><br>**Recommendation 4, December 2008:**<br>Ensure proper oversight of medical services to correct this monitor's clinical findings of deficiencies (listed in Other Findings in this cell in the previous report).<br><br>**Findings:**<br>PSH reported that it has continued previous practice for oversight. The previous Chief Physician and Surgeon retired December 30, 2008. The facility indicated that it anticipates hiring a Chief Physician and Nursing Administrator to further strengthen departmental oversight. |

**Other findings:**
This monitor reviewed the charts of nine individuals who were transferred to an outside medical facility during this reporting period. The following table outlines the episodes of transfer by date/time of physician evaluation at the time of transfer and the reason for the transfer (individuals have been anonymized):

| Individual | Date of MD evaluation | Reason for transfer |
|---|---|---|
| 1. | 12/04/08 | Probable Pneumonia |
| 2. | 12/24/08 | Altered Mental Status |
| 3. | 12/23/08 | Abdominal Pain |
| 4. | 11/17/08 | Ruptured Appendicitis |
| 5. | 11/16/08 | R/0 Small Bowel Obstruction |
| 6. | 11/25/08 | Foreign Body Ingestion (Recurrent) |
| 7. | 12/08/08 | R/0 Small Bowel Obstruction |
| 8. | 11/07/08 | Altered Mental Status |
| 9. | 04/14/09 | Gastrointestinal Bleed |

The review found general evidence of timely and appropriate care in most charts. In general, this monitor found improved documentation in a few charts of the physicians' evaluation of individuals upon their returns from outside hospitalization and fewer process deficiencies compared to the last review. The following are examples of the persistent deficiencies, including some of the facility's corrective actions as indicated:

1. The nursing assessments of individuals who complained of abdominal pain and upper respiratory symptoms were incomplete. The facility's new nursing guidelines (references) for assessment of changes in the physical status of individuals were implemented as corrective actions in February 2009 (subsequent to these incidents).
2. The WRP did not address an individual's repeated refusals of neurology consultations despite recurrent seizure activity on current

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| | | anticonvulsant regimen. As a corrective action, the facility recently developed a draft procedure that outlined adequate expectations to address individuals' refusal of medical care from an inter-disciplinary perspective.<br>3. The physician's evaluation of an individual who developed alteration of level of consciousness did not document an attempt to conduct a neurological examination.<br>4. There was no documentation of a physician's order to nursing staff to monitor the clinical status of an individual to assess for possible evolving appendicitis. The physician reported that verbal instructions were provided to nursing staff, but there was no documentation of these instructions.<br>5. An individual who was transferred for recurrent ingestion of foreign bodies received appropriate medical care. However, the behavioral interventions that addressed this issue did not meet generally accepted standards.<br>6. An individual experienced an episode of alcohol intoxication while at the facility. The WRP attributed the incident to the ingestion of the contents of a bottle of Purell. However, the blood alcohol level was 0.25, which suggested another source. At any rate, the WRP did not document special precautions to address this incident.<br>7. The assessment sections of the nursing change in physical condition notes appeared to repeat the information related to medical assessments/interventions without mention of nursing assessments/ interventions.<br><br>**Compliance:**<br>Partial (improved compared to the last review).<br><br>**Current recommendations**:<br>1. Implement corrective actions to address the monitor's findings of deficiencies in this report.<br>2. Finalize and implement the facility's draft policy, Refusal of Medical |

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| | | Treatment. |
| F.7.b | Each State hospital shall develop and implement protocols and procedures, consistent with generally accepted professional standards of care, that: | Please see sub-cells for compliance findings. |
| F.7.b.i | require the timely provision of initial and ongoing assessments relating to medical care, including but not limited to, vision care, dental care, and laboratory and consultation services; | **Current findings on previous recommendations:**<br><br>**Recommendation 1, December 2008:**<br>Same as in F.7.a.<br><br>**Findings:**<br>Same as in F.7.a.<br><br>**Recommendation 2, December 2008:**<br>Same as in D.1.c.i.<br><br>**Findings:**<br>Same as in D.1.c.i.<br><br>**Recommendations 2 and 3, December 2008:**<br>• Monitor this requirement using the DMH Medical-Surgical Progress Note Auditing Form based on at least a 20% sample.<br>• Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period).<br><br>**Findings:**<br>PSH used the DMH Medical Surgical Progress Notes Auditing Form to assess compliance. The average sample was 19% of all individuals with at least one diagnosis on Axis III during the review period (November 2008 – April 2009). The following is a summary of the data: |

| | | |
|---|---|---|
| 1. | *There is a quarterly note that documents reassessment of the individual medical status.* | 80% |
| 2. | *Significant conditions for which the individual is at risk for complications are identified.* | 96% |
| 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.* | 65% |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 1. | 54% | 80% |
| 2. | 92% | 96% |
| 3. | 25% | 65% |
| Compliance rate in last month of period | | |
| 1. | 59% | 89% |
| 2. | 90% | 94% |
| 3. | 64% | 60% |

PSH reported that staffing shortages contributed negatively to compliance. The facility indicated it hired two physicians and surgeons during the review period (in January and March 2009.) Additionally, PSH reported that it is exploring avenues to establish Senior Physicians and Surgeons to increase the mentoring and training of staff.

**Compliance:**
Partial.

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| | | **Current recommendations**:<br>1. Monitor this requirement using the DMH Medical-Surgical Progress Note Auditing Form based on at least a 20% sample.<br>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).<br>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:**<br><br>**Recommendations 2 and 3, December 2008:**<br>• Monitor this requirement using the DMH Medical Transfer and Integration of Medical Conditions into the WRP Auditing Forms to assess compliance.<br>• Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period).<br><br>**Findings:**<br>Using the DMH Medical Transfer Auditing Form, PSH assessed its compliance based on an average sample of 100% of medical transfers during the review period: |

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| 1. | *There is appropriate documentation by the nurse that identifies the symptoms of concern and notification of the physician.* | 95% |
| 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.* | 67% |

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| 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.* | 74% |
| 5. | *Upon return from acute medical treatment, the accepting physician provides an appropriate note describe the course of treatment provided at the acute medical facility.* | 82% |
| 6. | *Timely written progress notes by the regular medial physician shall address the treatment provided at the acute medical facility and follow-up treatment provided at the DMH hospital.* | 87% |
| 7. | *The WRP was updated to reflect the individual's current status following hospitalization or emergency room treatment.* | 51% |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 1. | 70% | 95% |
| 2. | 63% | 87% |
| 3. | 46% | 67% |
| 4. | 73% | 74% |
| 5. | 79% | 82% |
| 6. | 84% | 87% |
| 7. | 51% | 51% |
| Compliance rate in last month of period | | |
| 1. | 63% | 95% |
| 2. | 59% | 93% |

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|---|---|---|
| 3. | 54% | 70% |
| 4. | 86% | 70% |
| 5. | 76% | 82% |
| 6. | 78% | 85% |
| 7. | 43% | 60% |

PSH also used the DMH Integration of Medical Conditions into the WRP Auditing Form to assess compliance. The average sample was 13% of the WRPs due each month for individuals with at least one diagnosis on Axis III during the review period (November 2008 – April 2009). The following is a summary of the data:

| | | |
|---|---|---|
| 1. | *All medical conditions listed in Axis III are included on the Medical Conditions form* | 61% |
| 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* | 11% |
| 4. | *There is an appropriate objective for each medical condition or diagnosis* | 41% |
| 5. | *There are appropriate intervention(s) for each objective* | 25% |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 1. | 64% | 61% |
| 2. | 56% | 57% |

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| 3. | 5% | 11% |
| 4. | 8% | 41% |
| 5. | 1% | 25% |
| Compliance rate in last month of period | | |
| 1. | 61% | 66% |
| 2. | 50% | 59% |
| 3. | 9% | 15% |
| 4. | 8% | 46% |
| 5. | 0% | 30% |

**Recommendation 3, December 2008:**
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.

**Findings:**
PSH did not address this recommendation during the review period.

**Recommendation 4, December 2008:**
Develop and implement a system to assess timeliness and appropriateness of various specialty consultation services.

**Findings:**
PSH reported that it has developed a plan for collecting this information in the future. However, no data was reported during this review period.

**Compliance:**
Partial.

**Current recommendations**:
1. Finalize the monitoring tools regarding the medical emergency response system and drills for use across state facilities.
2. Develop and implement a system to assess timeliness and

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| | | appropriateness of various specialty consultation services.<br>3. Monitor this requirement using the DMH Medical Transfer Auditing Form, the DMH Integration of Medical Conditions into the WRP Auditing Form and the facility's audit regarding timeliness of consultations off-site, based on at least a 20% sample.<br>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.<br>5. Provide a summary outline of 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:**<br><br>**Recommendation, December 2008:**<br>Finalize DMH SOs regarding Provision of Medical Care to Individuals and Risk Management, and align the duty statements with these SOs.<br><br>**Findings:**<br>The DMH SOs regarding Provision of Medical Care to Individuals and Risk Management were finalized during the review period. PSH indicated that physician duty statements were updated to include the Provisions of Medical Care to Individuals Special Order but not the Special Order regarding Risk Management.<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendation**:<br>Continue current practice. |
| F.7.b.iv | ensure a system of after-hours coverage by primary care physicians with formal psychiatric training (i.e., privileging and proctorship) and | **Current findings on previous recommendation:** |

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| | psychiatric backup support after hours; and | **Recommendation, December 2008:**<br>Continue current practice.<br><br>**Findings:**<br>PSH reported that it has continued its practice for after-hours coverage during the review period.<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendation**:<br>Continue current practice. |
| F.7.b.v | endeavor to obtain, on a consistent and timely basis, an individual's medical records after the individual is treated in another medical facility. | **Current findings on previous recommendations:**<br><br>**Recommendation 1, December 2008:**<br>Continue efforts to improve receipt of records from regional medical centers.<br><br>**Findings:**<br>The facility reported that it had liaisoned with two external facilities to improve receipt of medical records.<br><br>**Recommendation 2, December 2008:**<br>Provide self-assessment data regarding this requirement.<br><br>**Findings:**<br>The facility presented data relevant to this recommendation but did not include the sample size assessed during the review period (November 2008 – April 2009). PSH reported that it received an average of 40% of records following discharge from an external facility. PSH did not provide comparative data. The facility reported that as a corrective action, a courier service was established (effective May 15, 2009) to |

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| | | assist physicians in retrieving medical records from outside facilities.<br><br>**Other findings:**<br>This monitor's chart reviews (see F.7.a) found improvement in the availability of discharge summaries from outside hospitals compared to the last review period.<br><br>**Compliance:**<br>Partial (improved compared to last review).<br><br>**Current recommendations**:<br>1. Continue efforts to improve receipt of records from regional medical centers.<br>2. Monitor this requirement based on a 100% sample.<br>3. Provide data analysis that evaluates low compliance and delineates relative improvement (during the reporting period and compared to the last period). |
| F.7.c | Each State hospital shall ensure that physicians monitor each individual's health status indicators in accordance with generally accepted professional standards of care, and, whenever appropriate, modify their therapeutic and rehabilitation service plans to address any problematic changes in health status indicators. | **Current findings on previous recommendations:**<br><br>**Recommendations 1 and 2, December 2008:**<br>• Monitor this requirement using the DMH standardized tools for specific medical conditions, based on at least a 20% sample.<br>• Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period).<br><br>**Findings:**<br>PSH used the DMH standardized tools to assess compliance regarding the management of diabetes mellitus, hypertension, dyslipidemia and asthma/COPD. The average samples were 18% (diabetes mellitus), 19% (hypertension), 19% (dyslipidemia) and 18% (COPD/asthma) of individuals diagnosed with these disorders during the review months (November |

2008 – April 2009). The following tables summarize the facility's data:

Diabetes Mellitus

| | | |
|---|---|---|
| 1. | *The individual has been evaluated and supporting documentation is completed at least quarterly.* | 71% |
| 2. | *HgbA1C was ordered quarterly.* | 81% |
| 3. | *The HgbA1C is equal to or less than 7%.* | 96% |
| 4. | *Blood sugar is monitored regularly.* | 97% |
| 5. | *Urinary micro albumin is monitored annually.* | 81% |
| 6. | *If the urine micro albumin level is greater than 30, ACE or ARP is prescribed, if not otherwise contraindicated.* | 81% |
| 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.* | 93% |
| 9. | *Blood pressure is monitored weekly.* | 81% |
| 10. | *If blood pressure is greater than 130/80, there is a plan of care in place to appropriately lower the blood pressure.* | 96% |
| 11. | *An eye exam by an ophthalmologist/optometrist was completed at least annually.* | 86% |
| 12. | *Podiatry care was provided by a podiatrist at least annually.* | 83% |
| 13. | *A dietary consultation was considered and the recommendation followed, as applicable.* | 91% |
| 14. | *Diabetes is addressed in Focus 6 of the WRP.* | 97% |
| 15. | *Focus 6 for Diabetes has appropriate objectives and interventions for this condition.* | 92% |

Comparative data indicated maintenance of compliance rates of 90% or

greater since the previous review period for items 3, 4, 7, 10 and 14, and general improvement in compliance for the remaining indicators:

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 1. | 76% | 71% |
| 2. | 70% | 81% |
| 5. | 66% | 81% |
| 6. | 82% | 81% |
| 8. | 89% | 93% |
| 9. | 75% | 81% |
| 11. | 73% | 86% |
| 12. | 72% | 83% |
| 13. | 80% | 91% |
| 15. | 60% | 92% |
| Compliance rate in last month of period | | |
| 1. | 75% | 95% |
| 2. | 89% | 93% |
| 5. | 71% | 90% |
| 6. | 83% | 96% |
| 9. | 83% | 78% |
| 11. | 78% | 94% |
| 12. | 76% | 94% |

Hypertension

| | | |
|---|---|---|
| 1. | *The individual has been evaluated and supporting documentation completed at least quarterly.* | 72% |
| 2. | *Blood pressure is monitored weekly.* | 94% |
| 3. | *Blood pressure is less than 140/90 or there is an appropriate plan of care in place to reduce blood* | 96% |

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|---|---|---|
| | *pressure.* | |
| 4. | *If the individual is 40 or older, aspirin has been ordered unless contraindicated.* | 77% |
| 5. | *Hypertension is addressed in Focus 6 of the WRP.* | 95% |
| 6. | *Focus 6 for Hypertension has appropriate objectives and interventions.* | 88% |
| 7. | *A dietary consult was considered and the recommendation was followed, as applicable.* | 89% |
| 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.* | 88% |
| 9. | *An exercise program has been initiated.* | 85% |
| 10. | *If the individual is currently a smoker, smoking cessation has been discussed and included in the WRP.* | 75% |

Comparative data indicated maintenance of compliance rates of 90% or greater since the previous review period for items 2, 3 and 5, and general improvement in compliance for the remaining indicators:

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 1. | 75% | 72% |
| 4. | 78% | 77% |
| 6. | 56% | 88% |
| 7. | 75% | 89% |
| 8. | 94% | 88% |
| 9. | 56% | 85% |
| 10. | 49% | 75% |
| Compliance rate in last month of period | | |
| 1. | 71% | 86% |

| | | |
|---|---|---|
| 4. | 77% | 83% |
| 6. | 62% | 95% |
| 7. | 82% | 97% |
| 8. | 90% | 92% |
| 9. | 74% | 88% |
| 10. | 53% | 90% |

Dyslipidemia

| | | |
|---|---|---|
| 1. | *The individual has been evaluated and supporting documentation completed at least quarterly.* | 76% |
| 2. | *A lipid panel was ordered at least quarterly.* | 82% |
| 3. | *The HDL level is >40(M) or >50(F) or a plan of care is in place.* | 86% |
| 4. | *The LDL level is ≤ 130 or a plan of care is in place.* | 95% |
| 5. | *The Triglyceride level is ≤ 200 of a plan of care is in place.* | 95% |
| 6. | *Dyslipidemia is addressed in focus 6 of the WRP.* | 94% |
| 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.* | 89% |
| 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.* | 88% |
| 10. | *An exercise program has been initiated.* | *86%* |
| 11. | *If non-pharmacological interventions have been ineffective to control Dyslipidemia, medications have been considered or initiated.* | 94% |

Comparative data indicated maintenance of compliance rates of 90% or

greater since the previous review period for items 4, 5 and 11, and general improvement in compliance for the remaining indicators:

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 1. | 76% | 76% |
| 2. | 71% | 82% |
| 3. | 81% | 86% |
| 6. | 89% | 94% |
| 7. | 51% | 86% |
| 8. | 79% | 89% |
| 9. | 80% | 88% |
| 10. | 67% | 86% |
| Compliance rate in last month of period | | |
| 1. | 71% | 89% |
| 2. | 78% | 95% |
| 3. | 79% | 94% |
| 7. | 79% | 86% |
| 8. | 75% | 98% |
| 9. | 80% | 91% |
| 10. | 87% | 89% |

Asthma/COPD

| | | |
|---|---|---|
| 1. | *The individual has been evaluated and supporting documentation completed at least quarterly.* | 73% |
| 2. | *For individuals with a diagnosis of COPD, a baseline chest x-ray has been completed.* | 86% |
| 3. | *If a rescue inhaler is being used more than 2 days a week, the individual has been assessed and an appropriate plan of care has been developed.* | 81% |

| | | |
|---|---|---|
| 4. | *If the individual is currently a smoker, a smoking cessation program has been discussed and included in the WRP.* | 72% |
| 5. | *Asthma or COPD is addressed in focus 6 of the WRP.* | 93% |
| 6. | *Focus 6 for Asthma/COPD has appropriate objectives and interventions.* | 81% |
| 7. | *The individual has been assessed for a flu vaccination.* | 70% |
| 8. | *If the individual has a diagnosis of COPD, a Pneumococcal vaccine has been offered, unless contraindicated.* | 69% |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 1. | 73% | 73% |
| 2. | 77% | 86% |
| 3. | 77% | 81% |
| 4. | 48% | 72% |
| 5. | 88% | 93% |
| 6. | 55% | 81% |
| 7. | 55% | 70% |
| 8. | 58% | 69% |
| Compliance rate in last month of period | | |
| 1. | 76% | 91% |
| 2. | 79% | 95% |
| 3. | 95% | 89% |
| 4. | 64% | 89% |
| 6. | 76% | 84% |
| 7. | 92% | 72% |

| | | |
|---|---|---|
| | | 8. 85% 70%<br><br>**Compliance:**<br>Partial (improved compared to the last review).<br><br>**Current recommendations**:<br>1. Monitor specific medical conditions including Diabetes Mellitus, Hypertension, Dyslipidemia and Asthma/COPD using the standardized tools based on at least a 20% sample.<br>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).<br>3. Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.<br>4. Monitor preventive care and care of cardiac disease using NSH's indicators. |
| F.7.d | Each State Hospital shall monitor, on a continuous basis, outcome indicators to identify trends and patterns in the individual's health status, assess the performance of medical systems, and provide corrective follow-up measures to improve outcomes. | **Current findings on previous recommendations:**<br><br>**Recommendation 1, December 2008:**<br>Develop and implement a quality performance profile for the physicians and surgeons.<br><br>**Findings:**<br>PSH reported that beginning in March 2009, all Physicians and Surgeons received a monthly Medical Report Card (MRC). This report summarizes performance on each of the EP requirements. The facility indicated that it would report trends and patterns in this data at the next review.<br><br>**Recommendation 2, December 2008:**<br>Provide a summary description of the current physician peer review system and how the system is utilized in reprivileging of the physicians and surgeons. |

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| | | **Findings:**<br>PSH reported that the following indicators of performance are utilized in the Reappointment and Re-privileging profile:<br><br>1. Twenty-four peer-review audits of relevant work products (laceration repair, consults, quarterly progress notes, ECG interpretation);<br>2. Clinician-specific pharmacologic practice as evidenced by MVRs, ADRs due to prescribing errors and policy adherence (this is reviewed also by the Chair of the Pharmacy and Therapeutics Committee);<br>3. Professionalism as measured by courteous treatment of other staff;<br>4. Adherence to the appropriate scope of practice; and<br>5. Timeliness, quality and legibility of the notes as well as clinical judgment.<br><br>This process does not appear to ensure that the reprivileging process at PSH incorporates an objective data-based review of physicians' practice.<br><br>**Recommendation 3, December 2008:**<br>Provide peer review data analysis regarding practitioner and group trends, with corrective actions as indicated.<br><br>**Findings:**<br>The facility indicated that it would report trends and patterns in this data at the next review.<br><br>**Recommendation 4, December 2008:**<br>Update practice guidelines guided by current literature and relevant clinical experience.<br><br>**Findings:**<br>The facility reported that it updated practice guidelines for Diabetes Mellitus and Osteoporosis effective May 2009. |

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|---|---|---|
| | | **Recommendation 5, December 2008:**<br>Identify trends and patterns in the health status of individuals based on clinical and process outcomes, with corrective actions, as indicated.<br><br>**Findings:**<br>PSH did not address this recommendation during this review period.<br><br>**Recommendation 6, December 2008:**<br>Implement current efforts to facilitate data collection in medical risk management.<br><br>**Findings:**<br>Per provisions in Special Order 262, PSH reported that each individual was assessed for medical risk in February 2009. In April 2009, a WRP mentor trained the WRPTs on incorporating medical risk factors in the case formulation and developing objectives and interventions.<br><br>**Compliance:**<br>Partial.<br><br>**Current recommendations**:<br>1. Implement a quality performance profile for the physicians and surgeons.<br>2. Ensure that the process of reprivileging incorporates indicators and operational instructions that provide an objective evaluation of physicians' performance in the areas of diagnosis/differential diagnosis, admission medical assessment, quarterly reassessments, evaluations upon transfers to an outside facility and upon return to PSH, emergency medical response, integration of medical conditions into the WRPs, and medication management (ADRs, DUEs and MVRs) as clinically appropriate.<br>3. Provide peer review data analysis regarding practitioner and group |

| | | |
|---|---|---|
| | | trends, with corrective actions as indicated.<br>4. Update practice guidelines guided by current literature and relevant clinical experience.<br>5. Identify trends and patterns in the health status of individuals based on clinical and process outcomes, with corrective actions, as indicated.<br>6. Implement current efforts to facilitate data collection in medical risk management. |

| 8. Infection Control | | |
|---|---|---|
| | Each State hospital shall develop and implement infection control policies and procedures to prevent the spread of infections or communicable diseases, consistent with generally accepted professional standards of care. | **Methodology:**<br><br>Interviewed:<br>1. Chloe Cummings, PHN II<br>2. Cindy Blaire, RN<br>3. Donna Rowe, PHN II<br>4. Maria Remetir, PHN I<br>5. Rose Bui, MD, PHO<br>6. Sandra Doerner, Acting Nurse Administrator<br><br>Reviewed:<br>1. PSH's progress report and data<br>2. PSH's Enhancement Plan Infection Control Flowchart<br>3. Draft of the Refusal of Medical Treatment Protocol and Policy<br>4. WRP Revisions Phase I curriculum<br>5. Sample plans of care for infectious diseases<br>6. PSH's Infection Control key indicator data<br>7. PSH Enhancement Plan Action Team Leader minutes dated 1/9/09, 2/20/09, 3/20/09 and 4/17/09<br>8. PSH Infection Control Committee minutes dated 11/20/08, 12/18/08, 1/15/09, 2/19/09, 3/12/09 and 4/16/09<br>9. PSH Department of Medicine Meeting minutes dated 11/5/08, 12/3/08, 1/7/09, 2/4/09, 3/4/09 and 4/1/09<br>10. PSH Department of Medicine/Psychiatry Meeting minutes dated 2/25/09, 3/25/09 and 5/27/09<br>11. Summary of Changes in HIV Counseling, Testing and Documentation at PSH, June 2009<br>12. PSH Infection Control Report Interpretation of February, March, April, Data report<br>13. Special Order 104.02, HIV/AIDS Prevention and Management<br>14. Medical records for the following 124 individuals: AAN, AB, AC, AET, AGC, AHI, ALQ, AS, ASB, ATR, AUQ, AV, BCD, BKB, BLT, BMC, BRG, |

| | | |
|---|---|---|
| | | BT, BV, CDP, CDR, CF, CHS, CHW, CJT, CLC, CLS, CMR, CNM, COG, CS, CT, DAL, DAM, DCS, DDM, DNL, DOC, DVF, EAS, EC, ECC, EM, ERF, ERM, ES, EUK, EV, FG, FHT, GFW, GGE, HCD, HK, HLP, HLW, HOD, HTN, JA, JAO, JEG, JES, JO, KSG, LEB, LJA, LM, LR, LRB, LW, MAW, MC, MD, MGM, MID, MKB, MLC, MNL, MY, ND, NEG, NM, NS, PC, QDB, RAD, RAS, RAW, RCE, RD, RFA, RIM, RLR, RMB, RNE, ROW, RP, RTM, RWM, SBH, SDG, SH, SLH, SLL, SR, SRR, SSP, TBF, TE, THF, TK, TLS, TRF, TSS, VB, VFP, VK, VLS, VMT, VTT, VV, WB, WLT and YG |
| F.8.a | Each State hospital shall establish an effective infection control program that: | **Compliance:**<br>Partial. |
| F.8.a.i | actively collects data regarding infections and communicable diseases; | **Current findings on previous recommendation:**<br><br>**Recommendation, December 2008:**<br>Continue to monitor this requirement.<br><br>**Findings (by test/disease):**<br><br>**<u>Admission PPD</u>**<br>The DMH IC Admission PPD Audit, based on an average sample of 81% of individuals admitted to the hospital with a negative PPD in the review months (November 2008 - April 2009), indicated the following: |

| | | |
|---|---|---|
| 1. | *Notification by the unit via a PPD form is sent to the Infection Control Department for all PPD readings.* | 59% |
| 2. | *PPDs were ordered by the physician during the admission procedure.* | 97% |
| 3. | *PPDs were administered by the nurse within 24 hours of the physicians order.* | 87% |
| 4. | *1st step PPDs were read by the nurse within 7 days of administration.* | 93% |

| | | |
|---|---|---|
| 5. | *2nd step PPDs were read by the nurse within 48-72 hours of administration.* | 92% |

F.8.a.ii: Assesses these data for trends

Comparative data indicated maintenance of compliance rates of 90% or greater since the previous review period for items 2 and 4, and improvement in compliance for the remaining items:

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 1. | 49% | 59% |
| 3. | 83% | 87% |
| 5. | 87% | 92% |
| Compliance rate in last month of period | | |
| 1. | 50% | 88% |
| 3. | 83% | 100% |

F.8.a.iii: Initiates inquiries regarding problematic trends

Item 1: The notification of the individual's PPD status by the unit to the Infection Control Department has remained problematic. Although nurses are aware of the requirement, workload issues have contributed to poor compliance.

Item 3: Nurses have continued to struggle to administer first-step PPDs within 24 hours of the order due to tracking and the variability of admissions.

F.8.a.iv: Identifies necessary corrective action

Items 1 and 3: Since April 2009, two full-time PPD/Immunization nurses have been hired to administer PPDs, read PPD results and administer immunizations throughout the hospital.

F.8.a.v: Monitors to ensure that appropriate remedies are achieved
Item 1: Compliance has improved to 88% in April from an average of 54% over the previous five months.
Item 3: Compliance has improved to 100% in April from an average of 85% over the previous five months.

A review of the records of 21 individuals admitted during the review period (AAN, CDP, CMR, CS, DCS, EAS, EM, ES, EV, GFW, JAO, LM, MAW, MGM, RLR, RP, RWM, SR, TSS, VFP and VV) found that all had a physician's order for PPD upon admission and 18 PPDs were timely administered and read.

**Annual PPD**
The DMH IC Annual PPD Audit, based on an average sample of 37% of individuals needing an annual PPD during the review months (November 2008 - April 2009), indicated the following:

| | | |
|---|---|---|
| 1. | *Notification by the unit via a PPD form sent to the Infection Control Department for all PPD readings.* | 38% |
| 2. | *PPDs were ordered by the physician during the annual review procedure.* | 95% |
| 3. | *PPDs were administered by the nurse within 24 hours of the order.* | 83% |
| 4. | *PPDs were read by the nurse within 48-72 hours of administration.* | 91% |

F.8.a.ii: Assesses these data for trends
Comparative data indicated maintenance of a compliance rate greater than 90% from the previous review period for item 2, and generally modest improvement in compliance for the remaining items:

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 1. | 36% | 38% |
| 3. | 70% | 83% |
| 4. | 87% | 91% |
| Compliance rate in last month of period | | |
| 1. | 55% | 89% |
| 3. | 67% | 100% |

F.8.a.iii: Initiates inquiries regarding problematic trends
Item 1: Notification of the PPD status of individuals on the long-term units to the Infection Control Department has not been consistent.
Item 3: Due to inconsistent staffing, compliance with this item has been problematic.

F.8.a.iv: Identifies necessary corrective action
Items 1 and 3: See F.8.a.iv under Admission PPD above in this cell.

F.8.a.v: Monitors to ensure that appropriate remedies are achieved
Item 1: The Public Health Department has provided additional training to the PPD/Immunization nurse team and has requested an additional RN for the team to improve oversight and decrease workload barriers.
Item 3: Since addition of the IC nurses, compliance has improved to 100% in April from an average of 82% over the previous five months.

A review of the records of 22 individuals requiring an annual PPD during the review period (AET, AHI, AS, BCD, BMC, CT, ERM, EUK, HCD, HK, KSG, LJA, MNL, MY, NS, RAW, RMB, RNE, SLL, TLS, VK and WB) found that all had a physician's order and 15 PPDs were timely given and read.

**Hepatitis C**

The DMH IC Hepatitis C Audit, based on an average sample of 92% of individuals admitted to the hospital in the review months (November 2008 - April 2009) who were positive for Hepatitis C, 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.* | 95% |
| 5. | *A Focus 6 is opened for Hepatitis C.* | 99% |
| 6. | *Appropriate objective is written to include treatment as required by the Hepatitis C Tracking Sheet* | 86% |
| 7. | *Appropriate interventions are written to include treatment as required by the Hepatitis C Tracking Sheet, or as required by the WRP Manual* | 76% |

F.8.a.ii: Assesses these data for trends

Comparative data indicated maintenance of compliance rates greater than 90% for items 1-3 and 5, and significant improvement in compliance since the previous review period for the remaining items:

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 4. | 47% | 95% |

| | | |
|---|---|---|
| 6. | 41% | 86% |
| 7. | 7% | 76% |

F.8.a.iii: Initiates inquiries regarding problematic trends
No Hepatitis C conversion trends were identified. With regard to items 6 and 7, the nurses continue to struggle with using the WaRMSS system for the development of treatment plan attachments.

F.8.a.iv: Identifies necessary corrective action
Items 6 and 7: The Infection Control nurse contacts the unit nurses regarding any individuals who test positive for Hepatitis C. The HSS also follows up to ensure that the WRP is appropriate. Five student assistants were hired in May 2009 to provide training on WaRMSS to write the WRP attachments.

F.8.a.v: Monitors to ensure that appropriate remedies are achieved
Items 6 and 7: These items have shown significant improvement over the reporting period.

A review of the records of 18 individuals who were admitted Hepatitis C positive during the review period (ASB, BLT, CHS, CHW, COG, ERF, JEG, LEB, LR, MID, RFA, RIM, ROW, SSP, THF, TK, VB and YG) found documentation that the medication plan and immunizations were evaluated and an open Focus 6 problem for Hepatitis C in all cases, and adequate and appropriate objectives and interventions in eight WRPs.

**HIV Positive**
The DMH IC HIV Positive Audit, based on a 100% sample (six individuals) of individuals who were positive for HIV antibody in the review months (November 2008 - April 2009), indicated the following:

| | | |
|---|---|---|
| 1. | *Notification by the lab was made to the infection control department identifying the individual with a* | 100% |

| | | |
|---|---|---|
| | *positive HIV Antibody.* | |
| 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.* | 100% |
| 5. | *The individual is seen initially and followed up, as clinically indicated, by the appropriate clinic every three months for ongoing care and treatment, unless another timeframe is ordered by the physician.* | 100% |
| 6. | *A Focus 6 is opened for HIV (unspecified viral illness)* | 100% |
| 7. | *Appropriate objective is written to address the progression of the disease.* | 83% |
| 8. | *Appropriate interventions are written.* | 92% |

F.8.a.ii: Assesses these data for trends

Comparative data indicated maintenance of compliance rates of 90% or greater from the previous review period for items 1-6, and improvement in compliance for the remaining items:

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 7. | 70% | 83% |
| 8. | 70% | 92% |
| Compliance rate in last month of period | | |
| 7. | 67% | 100% |
| 8. | 67% | 100% |

F.8.a.iii: Initiates inquiries regarding problematic trends
Items 7: WRP training was provided due to low compliance rates in November and December.

F.8.a.iv: Identifies necessary corrective action
Item 7: The Public Health nurse continues to provide follow-up and training to nurses.

F.8.a.v: Monitors to ensure that appropriate remedies are achieved
Item 7: Data has been at 100% since January 2009.

A review of the records of five individuals who were admitted during the review period with HIV (AV, CLC, MAW, MC and MKB) found that four were in compliance regarding clinic referrals and follow-up and four had appropriate objectives and/or interventions in the WRPs.

**Immunizations**
The DMH IC Immunization Audit, based on an average sample of 59% of individuals admitted to the hospital during the review months (November 2008 - April 2009), indicated the following:

| | | |
|---|---|---|
| 1. | *Notification by the lab was made to the Infection Control Department of an individual's immunity status.* | 100% |
| 2. | *Notification by the lab was made to the unit housing the individual of his/her immunity status.* | 99% |
| 3. | *Immunizations were ordered by the physician within 30 days of receiving notification by the lab.* | 100% |
| 4. | *Immunizations were administered by the nurse within 24 hours of the physician order and completed within timeframes.* | 73% |

F.8.a.ii: Assesses these data for trends
Comparative data indicated maintenance of compliance rates of 90% or greater from the previous review period for items 1-3, and improvement in compliance for the remaining items:

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 4. | 69% | 73% |
| Compliance rate in last month of period | | |
| 4. | 67% | 79% |

F.8.a.iii: Initiates inquiries regarding problematic trends
Item 4: Compliance for this item remains low due to workload issues on the admissions units.

F.8.a.iv: Identifies necessary corrective action
Item 4: In April 2009, two full-time PPD/Immunization nurses were hired to administer PPDs, read PPD results and administer immunizations throughout the hospital.

F.8.a.v: Monitors to ensure that appropriate remedies are achieved
Item 4: The Public Health Department provided training to the PPD/Immunization nurse team and has requested an additional RN for the team to improve oversight and decrease workload barriers.

A review of the records of 21 individuals (AAN, CDP, CMR, CS, DCS, EAS, EM, ES, EV, GFW, JAO, LM, MAW, MGM, RLR, RP, RWM, SR, TSS, VFP and VV) found that all had documentation that the immunizations were ordered by the physician within 30 days of receiving notification by the lab. Administration of immunizations was timely in 15 instances.

**Immunization Refusals**

The DMH IC Immunization Refusal Audit, based on a 100% sample (53 individuals) of individuals in the hospital who refused to take their immunizations during the review months (November 2008 - April 2009), indicated the following:

| | | |
|---|---|---|
| 1. | *Notification by the unit was made to the Infection Control Department of the individual's refusal of the immunization(s* | 90% |
| 2. | *There is a Focus 6 opened for the refusal of the immunization(s).* | 53% |
| 3. | *There are appropriate objective(s) developed for the refusal of immunization(s).* | 32% |
| 4. | *There are appropriate interventions written for the objective(s) developed for the refusal of immunization(s).* | 27% |
| 5. | *The unit notified the Infection Control Department when the individual consented and received the immunization(s).* | NA |

F.8.a.ii: Assesses these data for trends

Comparative data indicated maintenance of compliance rates of 90% or greater from the previous review period for item 1, and improvement in compliance for the remaining items:

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 2. | 19% | 53% |
| 3. | 0% | 32% |
| 4. | 0% | 27% |
| 5. | NA | NA |

| | Previous period | Current period |
|---|---|---|
| Compliance rate in last month of period | | |
| 2. | 33% | 46% |
| 3. | 0% | 100% |
| 4. | 0% | 67% |

F.8.a.iii: Initiates inquiries regarding problematic trends
The WRPTs have not been addressing immunization refusals.

F.8.a.iv: Identifies necessary corrective action
The WRP Mentors will be providing training to WRPTs regarding refusal of treatments and will be provided written instructions regarding the documentation requirements for individuals who refuse immunizations. A Refusal of Medical Treatment Protocol and policy has been developed and approved by the medical staff and will be implemented July 2009.

F.8.a.v: Monitors to ensure that appropriate remedies are achieved
The above corrective action will be implemented in July 2009 and will be monitored.

A review of the records of 17 individuals who refused immunizations during the review period (AC, ATR, BKB, CF, CJT, FG, FHT, HLP, HLW, JES, MD, RTM, SLH, TBF, TRF, VLS and VTT) found that nine had an open Focus 6 and objectives and interventions.

**MRSA**
The DMH IC MRSA Audit, based on a 75% sample (23 individuals) of individuals in the hospital who tested positive for MRSA during the review months (November 2008 - April 2009), indicated the following:

| | | |
|---|---|---|
| 1. | *Notification by the lab was made to the Infection* | 100% |

| | | |
|---|---|---|
| | *Control Department when an individual has a positive culture for MRSA.* | |
| 2. | *Notification by the lab was made to the unit housing the individual that a positive culture for MRSA was obtained* | 100% |
| 3. | *The individual is placed on contact precaution per MRSA policy.* | 69% |
| 4. | *The appropriate antibiotic was ordered for treatment of the infection(s).* | 100% |
| 5. | *The public health office contacts the unit RN and provides MRSA protocol and guidance for the care of the individual.* | 100% |
| 6. | *A Focus 6 is opened for MRSA.* | 100% |
| 7. | *Appropriate objective is written to include prevention of spread of infection* | 95% |
| 8. | *Appropriate interventions are written to include contact precautions.* | 90% |

F.8.a.ii: Assesses these data for trends

Comparative data indicated maintenance of compliance rates of 90% or greater from the previous review period for items 1, 2, 4 and 5, and improvement in compliance for the remaining items with the exception of item 3:

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 3. | 81% | 69% |
| 6. | 81% | 100% |
| 7. | 72% | 95% |
| 8. | 50% | 90% |

| | Previous period | Current period |
|---|---|---|
| Compliance rate in last month of period | | |
| 3. | 75% | 100% |

F.8.a.iii: Initiates inquiries regarding problematic trends
Item 3: Compliance for documentation of contact precautions has been inconsistent; however, a review by the IC Department found that staff are consistently practicing contact precautions. There has been no transmission of MRSA identified.

F.8.a.iv: Identifies necessary corrective action
Item 3: The IC nurse works with unit nursing staff when an individual is identified with MRSA.

F.8.a.v: Monitors to ensure that appropriate remedies are achieved
Item 3: April data demonstrated improvement to 100% compliance.

A review of the records of 10 individuals with MRSA (CDR, CLS, EC, HTN, JA, LW, ND, NM, RAD and RD) found that six were placed on contact precautions, all were placed on the appropriate antibiotic and nine had appropriate objectives and interventions in the WRPs.

**Positive PPD**
The DMH IC Positive PPD Audit, based on an average sample of 100% of individuals in the hospital who had a positive PPD test during the review months (November 2008 - April 2009), indicated the following:

| | | |
|---|---|---|
| 1. | *Notification by the unit via a PPD form is sent to Public Health Office for all PPD readings.* | 100% |
| 2. | *All positive PPDs received PA and Lateral Chest X-ray.* | 100% |
| 3. | *All positive PPDs received an evaluation by the Med-* | 95% |

| | | |
|---|---|---|
| | *Surg Physician.* | |
| 4. | *If active disease is identified, then individual is transferred to medical isolation and appropriate treatment is provided.* | NA |
| 5. | *If LTBI is present, there is a Focus 6 opened.* | 91% |
| 6. | *If LTBI is present, there are appropriate objectives written to provide treatment and to prevent spread of the disease.* | 71% |
| 7. | *If LTBI is present, there are appropriate interventions written to prevent the progression of the disease.* | 71% |

F.8.a.ii: Assesses these data for trends

Comparative data indicated maintenance of compliance rates of 90% or greater from the previous review period for items 1 and 5, and improvement in compliance for the remaining items:

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 2. | 81% | 100% |
| 4. | NA | NA |
| 5. | 86% | 91% |
| 6. | 17% | 71% |
| 7. | 22% | 71% |
| Compliance rate in last month of period | | |
| 6. | 0% | 100% |
| 7. | 0% | 100% |

F.8.a.iii: Initiates inquiries regarding problematic trends

Items 6 and 7: Unit nurses continue to struggle with the use of WaRMSS for the development of WRP attachments.

F.8.a.iv: Identifies necessary corrective action
Items 6 and 7: The Infection Control nurse works with the unit nurses for individuals who have a positive PPD. Also, the HSS now follows up to determine if the WRP is appropriate. The student assistants are providing training on WaRMSS to the nursing staff on writing the WRP attachments.

F.8.a.v: Monitors to ensure that appropriate remedies are achieved
Items 6 and 7: Data demonstrated significant improvement over the reporting period.

A review of the records of 16 individuals who had a positive PPD (AUQ, BRG, BT, DAL, DAM, DNL, DOC, GGE, HOD, JO, MLC, NEG, RAS, TE, VMT and WLT) found that 15 had the required chest x-rays, all had documentation of an evaluation from the physician, and nine had appropriate objectives and interventions in the WRP.

**Refusal of Admitting or Annual Lab Work or Diagnostic Tests**
The DMH IC DMH IC Refused Admitting or Annual Lab Work or Diagnostic Test Audit, based on a 100% sample of individuals in the hospital who refused their admission lab work, admission PPD, or annual PPD during the review months (November 2008 - April 2009), 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.* | 31% |
| 2. | *There is a Focus opened for the lab work or PPD refusal* | 52% |
| 3. | *There are appropriate objectives written for the lab work or PPD refusal.* | 25% |

| | | |
|---|---|---|
| 4. | *There are appropriate interventions written for the lab work or PPD refusal.* | 23% |

F.8.a.ii: Assesses these data for trends
Comparative data indicated generally modest changes in compliance since the previous review period:

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 1. | 27% | 31% |
| 2. | 28% | 52% |
| 3. | 16% | 25% |
| 4. | 17% | 23% |
| Compliance rate in last month of period | | |
| 1. | 28% | 90% |
| 2. | 33% | 48% |
| 3. | 38% | 50% |
| 4. | 50% | 50% |

F.8.a.iii: Initiates inquiries regarding problematic trends
See F.8.a.iii under Immunization Refusal above in this cell.

F.8.a.iv: Identifies necessary corrective action
See F.8.a.iv under Immunization Refusal above in this cell.

F.8.a.v: Monitors to ensure that appropriate remedies are achieved
See F.8.a.v under Immunization Refusal above in this cell.

A review of the records of nine individuals who refused admitting or annual labs/diagnostics (DDM, DVF, LRB, PC, QDB, RCE, SBH, SDG and SH) found that five of the refusals were adequately addressed in the WRPs.

**Sexually Transmitted Diseases**

The DMH IC Sexually Transmitted Disease (STD) Audit, based on an average sample of 97% of individuals in the hospital who tested positive for an STD during the review months (November 2008 - April 2009), indicated the following:

| | | |
|---|---|---|
| 1. | *Notification by the lab was made to the Infection Control Department of a positive STD.* | 100% |
| 2. | *Notification by the lab was made to the unit housing the individual that he/she has a STD.* | 100% |
| 3. | *An RPR is ordered during the admission process for each individual.* | NA |
| 4. | *An HIV antibody test is offered to every individual upon admission.* | NA |
| 5. | *A Chlamydia and Gonorrhea test are ordered during the admission process for all female individuals* | NA |
| 6. | *If the individual was involved in a sexual incident, he/she was offered appropriate STD testing.* | NA |
| 7. | *Focus 6 is opened for an individual testing positive for an STD.* | 96% |
| 8. | *Appropriate objective(s) are written.* | 79% |
| 9. | *Appropriate interventions are written.* | 91% |

F.8.a.ii: Assesses these data for trends

Comparative data indicated maintenance of compliance rates of 90% or greater from the previous review period for items 1, 2 and, and improvement in compliance for the remaining 5items:

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 3. | NA | NA |

| | | |
|---|---|---|
| 4. | NA | NA |
| 5. | NA | NA |
| 6. | NA | NA |
| 8. | 57% | 79% |
| 9. | 43% | 91% |
| Compliance rate in last month of period | | |
| 8. | 0% | 100% |
| 9. | 25% | 100% |

F.8.a.iii: Initiates inquiries regarding problematic trends
See F.8.a.iii under Positive PPD above in this cell.

F.8.a.iv: Identifies necessary corrective action
See F.8.a.iv under Positive PPD above in this cell.

F.8.a.v: Monitors to ensure that appropriate remedies are achieved
Items 8 and 9: Data demonstrates significant improvement over the reporting period.

A review of the records of seven individuals with diagnosed STDs (AB, AGC, ALQ, BV, CNM, ECC and SRR) found that six had appropriate WRPs.

**Compliance:**
Partial. With continued implementation of Infection Control's strategies, the facility should be able to attain substantial compliance by the next review period.

**Current recommendations**:
1. Continue collaboration between the Infection Control Department and nursing.
2. Continue to monitor this requirement.

| | | |
|---|---|---|
| F.8.a.ii | assesses these data for trends; | **Current findings on previous recommendation:**<br><br>**Recommendation, December 2008:**<br>Continue to monitor this requirement.<br><br>**Findings:**<br>See F.8.a.i. In addition, a review of PSH's Infection Control Committee meeting minutes and monthly reports verifies that they consistently identify trends in the IC surveillance data.<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendation**:<br>Continue to monitor this requirement. |
| F.8.a.iii | initiates inquiries regarding problematic trends; | **Current findings on previous recommendation:**<br><br>**Recommendation, December 2008:**<br>Continue to monitor this requirement.<br><br>**Findings:**<br>See F.8.a.i.<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendation**:<br>Continue to monitor this requirement. |
| F.8.a.iv | identifies necessary corrective action; | **Current findings on previous recommendation:** |

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|---|---|---|
| | | **Recommendation, December 2008:**<br>Continue to monitor this requirement.<br><br>**Findings:**<br>PSH has implemented a number of strategies to increase compliance, especially in the areas in which the unit nurses had responsibilities related to Infection Control and the WRPs. The addition of the Infection Control nurse team to the department has already resulted in increases in compliance in areas that had made little to no progress in the past.<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendation**:<br>See F.8.a.i. |
| F.8.a.v | monitors to ensure that appropriate remedies are achieved; and | **Current findings on previous recommendation:**<br><br>**Recommendation, December 2008:**<br>Continue to monitor this requirement.<br><br>**Findings:**<br>See F.8.a.i.<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendation**:<br>Continue to monitor this requirement. |
| F.8.a.vi | integrates this information into each State hospital's quality assurance review. | **Current findings on previous recommendation:** |

| | | |
|---|---|---|
| | | **Recommendation, December 2008:**<br>Continue to monitor this requirement.<br><br>**Findings:**<br>A review of the minutes of the Infection Control Committee meetings, PSH Department of Medicine meetings, Department of Medicine/Psychiatry meetings, PSH Enhancement Plan Action Team Leader meetings and the Standards Compliance trigger data validated that several IC issues have been discussed with plans of action integrated into the different departments.<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendation**:<br>Continue to monitor this requirement. |

| 9. Dental Services | | |
|---|---|---|
| | Each State hospital shall provide individuals with adequate, appropriate and timely routine and emergency dental care and treatment, consistent with generally accepted professional standards of care. | **Methodology:**<br><br>Interviewed:<br>1. Amy Santimalapong, DDS, Chief Dentist<br>2. Kathryn Smith, RN, Nurse Auditor<br><br>Reviewed:<br>1. PSH's progress report and data<br>2. Dental appointment logs<br>3. Sample documentation from Dental software<br>4. WaRMSS Appointment Scheduler data<br>5. Medical records for the following 142 individuals: AFK, AM, ATC, ATC, ATK, AYH, AYL, BDM, BM, BNB, BNJ, BRC, BT, BTD, CAK, CCK, CG, CGG, CHS, CM, CMR, CVR, CYB, DAL, DB, DC, DDH, DGD, DLF, DNL, DNR, DRM, DRR, EB, EDJ, EEC, EH, ERA, EZT, FDD, FG, GAD, GIW, GLC, GMR, GSH, GTB, GWT, HCC, HJR, HV, JAC, JAG, JCM, JCP, JES, JG, JHJ, JJL, JJP, JLD, JML, JOS, JS, JSO, JTJ, JWB, JWC, JYM, KC, KCA, KEA, KVM, LAF, LAT, LB, LNP, LNS, LPS, LSS, MAR, MCD, MER, MFW, MH, MHD, MIL, MIL, MIW, MLP, MLS, MMS, MOM, MSB, MSD, MW, MYD, NM, NMT, OVM, PNH, RAH, RAT, RBR, RC, RCP, RCW, RDS, REB, RF, RGP, RH, RLZ, ROH, RPU, RRJ, RWT, RZ, SC, SCW, SEC, SH, SHH, SJC, SLV, SON, SSC, ST, STH, TAH, TEM, TH, TI, TMF, TMQ, TT, TWL, TY, WDB, WGC, WI and YO |
| F.9.a | Each State hospital shall retain or contract with an adequate number of qualified dentists to provide timely and appropriate dental care and treatment to all individuals it serves; | **Current findings on previous recommendation:**<br><br>**Recommendation, December 2008:**<br>Continue current practice.<br><br>**Findings:**<br>The number of Dental Staff has remained the same from the past review period: |

| | | |
|---|---|---|
| | | • One chief dentist<br>• Two staff dentists<br>• Two registered dental assistants<br>• Two dental assistants<br><br>Data from the past two reviews indicated that when the Dental Department experienced staffing issues (vacations, leaves), compliance rates significantly decreased. In addition, issues related to the increase in monitoring and tracking of dental services and system changes including the implementation of the new Dental software has added to the department's workload. In response to these issues, the chief dentist submitted a 2009/2010 Budget Change Proposal to the Executive Director on 05/20/09 requesting expansion of the dental clinics and office space and the addition of dental staff as follows:<br><br>• Two dentists<br>• Two dental hygienists<br>• Three dental assistants<br><br>**Other findings:**<br>In April 2009, PSH completed the installation of the hardware and software for the new Dental software. Training on the new dental software was conducted on April 13, 14, 15 and 23 and full implementation began on May 1, 2009.<br><br>**Compliance:**<br>Partial.<br><br>**Current recommendations**:<br>1. Pursue recommendations included in the 2009/2010 Budget Change Proposal.<br>2. Continue to monitor this requirement. |

| | | |
|---|---|---|
| F.9.b | Each State hospital shall develop and implement policies and procedures that require: | **Compliance:**<br>Partial. |
| F.9.b.i | comprehensive and timely provision of dental services; | **Current findings on previous recommendations:**<br><br>**Recommendation 1, December 2008:**<br>Provide comparison data for sub-items, barriers to compliance and plans of correction as appropriate.<br><br>**Findings:**<br>PSH provided the above information.<br><br>**Recommendation 2, December 2008:**<br>Continue to monitor this requirement.<br><br>**Findings:**<br>Using the DMH Dental Services Audit, PSH assessed its compliance based on a 25% mean sample of individuals scheduled for comprehensive dental exams during the review months (November 2008 - April 2009):<br><br>1.a *Comprehensive dental exam was completed* 94%<br><br>Comparative data indicated improvement in compliance from 72% in the previous review period.<br><br>A review of the records of 24 individuals (AYL, BT, DGD, DNL, DNR, GAD, GIW, GMR, GWT, LNP, RAT, RBR, RCP, SEC, SHH, SLV, ST, TEM, TI, TMF, TMQ, TY, WDB and YO) found that 22 had a comprehensive dental exam completed.<br><br>Using the DMH Dental Services Audit, PSH assessed its compliance based on a 21% mean sample of individuals who have been in the hospital for 90 days or less during the review period (November 2008 - April |

2009):

| | | |
|---|---|---|
| 1.b | *If admission examination date was 90 days or less* | 57% |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 1.b | 81% | 57% |
| Compliance rate in last month of period | | |
| 1.b | 100% | 22% |

Barriers to compliance included an increase in staff absences beginning in February due to training, vacations and illness. This resulted in increased cancellations and reduced availability of open appointment times. In addition, in February 2009, the WaRMSS appointment scheduler was implemented. However, a number of problematic issues such as software problems and system issues resulted in the need to maintain an internal dental appointment back-up system. The increased time demands created by these issues pulled two out of the four dental assistants from clinical tasks. In addition, a number of individuals arrive late for scheduled appointments, which results in the loss of clinical chair time. Additional barriers include non-timely notification from the units to the dental clinic when individuals cancel or refuse to come for their appointments, which again results in unused clinical chair time. A newly developing barrier relates to the dentists having to use back-up systems and duplicating documentation, which also has taken time from clinical care.

The plan of correction includes the submission of the Budget Change Proposal for 2009/2010 requesting additional staff and dental space. The ED has been briefed on the issues regarding the WaRMSS scheduler

software and it has been proposed to establish a central appointment data system and to have a clerk to free up clinical staff from data entry tasks. By August 1, 2009, the department plans to simplify the dental charting system.

A review of the records of 24 individuals (AYL, BT, DGD, DNL, DNR, GAD, GIW, GMR, GWT, LNP, RAT, RBR, RCP, SEC, SHH, SLV, ST, TEM, TI, TMF, TMQ, TY, WDB and YO) found 17 were timely seen for their admission exam

Using the DMH Dental Services Audit, PSH assessed its compliance based on a 21% mean sample of individuals due for annual routine dental examinations during the review months (November 2008 - April 2009):

| | | |
|---|---|---|
| 1.c | *Annual date of examination was within anniversary month of admission* | 33% |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 1.c | 64% | 33% |
| Compliance rate in last month of period | | |
| 1.c | 65% | 44% |

Along with the barriers noted above, the PSH policy requires the prompt rescheduling of individuals who refused an annual exam, which usually results in additional unused appointment times and inefficient use of dental chair time. A revision to the treatment refusal protocol will be submitted proposing that after the first refusal, the second appointment will not be scheduled until the WRPT meets with the individual and he or

she agrees to attend an appointment.

A review of the records of 25 individuals (ATC, BNB, BTD, DDH, DRM, EDJ, HCC, JJL, JML, JSO, KVM, LSS, MER, MHD, MIW, MLP, MMS, MSD, MW, RCW, RGP, SC, SJC, SSC and TH) found 15 were timely completed.

Using the DMH Dental Services Audit, PSH assessed its compliance based on a 84% mean sample of individuals with dental problems identified on admission or annual examination during the review months (November 2008 - April 2009):

| | | |
|---|---|---|
| 1.d | *Individuals with identified problems on admission or annual examination receive follow-up care, as indicated, in a timely manner* | 99% |

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

A review of the records of 49 individuals (ATC, AYL, BNB, BT, BTD, DDH, DGD, DNL, DNR, DRM, EDJ, GAD, GIW, GMR, GWT, HCC, JJL, JML, JSO, KVM, LNP, LSS, MER, MHD, MIW, MLP, MMS, MSD, MW, RAT, RBR, RCP, RCW, RGP, SC, SEC, SHH, SJC, SLV, SSC, ST, TEM, TH, TI, TMF, TMQ, TY, WDB and YO) found 47 were timely seen for follow-up care.

Using the DMH Dental Services Audit, PSH assessed its compliance based on a 57% mean sample of individuals with dental problems identified other than on admission or annual examination during the review months (November 2008 - April 2009):

| | | |
|---|---|---|
| 1.e | *Individuals with identified problems during their hospital stay, other than on admission or annual* | 99% |

| | | |
|---|---|---|
| | | examination, receive follow-up care, as indicated, in a timely manner |
| | | Comparative data indicated maintenance of a compliance rate greater than 90% from the previous review period.<br><br>A review of the records of 25 individuals (ATK, AYH, BDM, BNJ, CHS, CVR, CYB, DC, DLF, EEC, EZT, GLC, JCP, JJP, JWC, KEA, LB, MIL, MLS, PNH, RAH, ROH, RZ, SON and TAH) found that all received timely follow-up care.<br><br>**Current recommendations**:<br>1. Implement strategies to increase compliance.<br>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 recommendations:**<br><br>**Recommendation 1, December 2008:**<br>Provide comparison data for sub-items, barriers to compliance and plans of corrections as appropriate.<br><br>**Findings:**<br>PSH provided the above required information.<br><br>**Recommendation 2, December 2008:**<br>Continue to monitor this requirement.<br><br>**Findings:**<br>Using the DMH Dental Services Audit, PSH assessed its compliance based on a 21% mean sample of individuals scheduled for follow-up dental care during the review months (November 2008 - April 2009):<br><br>2. *Documentation of dental services, including but not* 88% |

| | | |
|---|---|---|
| | *limited to, findings, descriptions of any treatment provided, and the plans of care.* | |
| 2.a | *The current status* | 86% |
| 2.b | *Findings of the examination* | 88% |
| 2.c | *Plan of care* | 88% |
| 2.d | *The plans of care are consistent with examination findings* | 88% |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 2. | 69% | 88% |
| Compliance rate in last month of period | | |
| 2. | 78% | 96% |
| 2.a | 83% | 95% |
| 2.b | 78% | 100% |
| 2.c | 83% | 95% |
| 2.d | 78% | 95% |

PSH indicated that in January 2009, the dentists were not consistently using the stamp in their documentation, which resulted in low compliance during that month. The dentists were reminded to use the stamp and the data increased in subsequent months.

A review of dental documentation for 49 individuals (ATC, AYL, BNB, BT, BTD, DDH, DGD, DNL, DNR, DRM, EDJ, GAD, GIW, GMR, GWT, HCC, JJL, JML, JSO, KVM, LNP, LSS, MER, MHD, MIW, MLP, MMS, MSD, MW, RAT, RBR, RCP, RCW, RGP, SC, SEC, SHH, SJC, SLV, SSC, ST, TEM, TH, TI, TMF, TMQ, TY, WDB and YO) found that 42 were in compliance

| | | |
|---|---|---|
| | | with the documentation requirements.<br><br>**Current recommendation:**<br>Continue to monitor this requirement. |
| F.9.b.iii | use of preventive and restorative care whenever possible; and | **Current findings on previous recommendations:**<br><br>**Recommendation 1, December 2008:**<br>Ensure that the most current monitoring tool is used for data collection for the next review.<br><br>**Findings:**<br>PSH's data reflect they are using the most current Dental monitoring tools.<br><br>**Recommendation 2, December 2008:**<br>Develop and implement a system to track preventative and restorative care provided.<br><br>**Findings:**<br>PSH continues to use a handwritten log to track dental services but has revised the process to track preventive and restorative procedures separately. EagleSoft dental software has been recently implemented and should assist in tracking services provided.<br><br>**Recommendation 3, December 2008:**<br>Continue to monitor this requirement.<br><br>**Findings:**<br>Using the DMH Dental Services Audit, PSH assessed its compliance based on a 21% mean sample of individuals due for annual routine dental examinations during the review months (November 2008 - April 2009): |

| | | |
|---|---|---|
| 3.a | *Preventative care was provided, including but not limited to cleaning, root planning, sealant, fluoride application* | 33% |

PSH's comparison data was not available from last reporting period since the data were collected using a different method.

PSH's lack of a dental hygienist has resulted in preventive care being provided by dentists whose skills are required for more urgent procedures. This issue has resulted in preventive procedures being given lower priority than other dental problems. The Budget Change proposal 2009/2010 described in F.9.b.9 included a request for a hygienist to provide routine preventive dental care.

A review of the records of 25 individuals (ATC, BNB, BTD, DDH, DRM, EDJ, HCC, JJL, JML, JSO, KVM, LSS, MER, MHD, MIW, MLP, MMS, MSD, MW, RCW, RGP, SC, SJC, SSC and TH) found that 16 were provided preventive care.

Using the DMH Dental Services Audit, PSH assessed its compliance based on a 100% mean sample of individuals scheduled for Level 1 restorative care during the review months (November 2008 - April 2009):

| | | |
|---|---|---|
| 3.c | *Restorative care was provided including permanent or temporary restorations (fillings)* | 100% |

As noted above, comparison data were not available.

A review of the records of 20 individuals (CAK, CCK, CGG, CM, EH, GTB, HJR, JAG, JCM, JES, JOS, JS, JWB, MSB, RDS, RPU, RWT, SH, TT and WI) found that all received restorative care.

<table>
<tr><td></td><td></td><td>Current recommendation:<br>Continue to monitor this requirement.</td></tr>
<tr><td>F.9.b.iv</td><td>tooth extractions be used as a treatment of last resort, which, when performed, shall be justified in a manner subject to clinical review.</td><td>Current findings on previous recommendation:<br><br>Recommendation, December 2008:<br>Continue current practice.<br><br>Findings:<br>Using the DMH Dental Services Audit, PSH assessed its compliance based on a 100% mean sample of individuals who had tooth extractions during the review months (November 2008 - April 2009):<br><br>
<table>
<tr><td>4.</td><td>Tooth extractions be used as a treatment of last resort, which, when performed, shall be justified in a manner subject to clinical review. Periodontal conditions, requirement for denture construction, non-restorable tooth or severe decay or if none of the above reasons is included, other reason stated is clinically appropriate.</td><td>100%</td></tr>
</table>
<br>Comparative data indicated maintenance of a compliance rate greater than 90% from the previous review period.<br><br>A review of the records of 32 individuals (AFK, AM, BM, BRC, CG, CMR, DAL, EB, ERA, FG, HV, JAC, JG, JHJ, JLD, JTJ, KC, KCA, MFW, MH, MOM, NM, NMT, OVM, RC, REB, RF, RH, RRJ, SCW, STH and WGC) found that 30 were in compliance.<br><br>Current recommendation:<br>Continue current practice.</td></tr>
</table>

<table>
<tr>
<td>F.9.c</td>
<td>Each State hospital shall ensure that dentists demonstrate, in a documented fashion, an accurate understanding of individuals' physical health, medications, allergies, and current dental status and complaints.</td>
<td>

**Current findings on previous recommendation:**

**Recommendation, December 2008:**
Continue current practice.

**Findings:**
Using the DMH Dental Services Audit, PSH assessed its compliance based on a 25% mean sample of individuals who received comprehensive dental examinations or follow-up dental care during the review months (November 2008 - April 2009):

<table>
<tr>
<td>5.</td>
<td>Each State hospital shall ensure that dentists demonstrate, in a documented fashion, an accurate understanding of individuals' physical health, medications, allergies, and current dental status and complaints.</td>
<td>95%</td>
</tr>
</table>

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

A review of the records of 49 individuals (ATC, AYL, BNB, BT, BTD, DDH, DGD, DNL, DNR, DRM, EDJ, GAD, GIW, GMR, GWT, HCC, JJL, JML, JSO, KVM, LNP, LSS, MER, MHD, MIW, MLP, MMS, MSD, MW, RAT, RBR, RCP, RCW, RGP, SC, SEC, SHH, SJC, SLV, SSC, ST, TEM, TH, TI, TMF, TMQ, TY, WDB and YO) found that 47 were in compliance with the documentation requirements.

**Compliance:**
Substantial.

**Current recommendation**:
Continue current practice.

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

| F.9.d | Each State hospital shall ensure that transportation and staffing issues do not preclude individuals from attending dental appointments, and individuals' refusals are addressed to facilitate compliance. | **Current findings on previous recommendation:**<br><br>**Recommendation, December 2008:**<br>Continue to monitor this requirement.<br><br>**Findings:**<br>Using the DMH Dental Services Audit, PSH assessed its compliance based on a 100% mean sample of individuals scheduled for dental appointments during the review months (November 2008 - April 2009):<br><br>6.a *The individual attended the scheduled appointment* 92%<br><br>Comparative data indicated maintenance of a compliance rate greater than 90% from the previous review period.<br><br>The facility provided the following data on missed appointments:<br><br>Month / Refused to come to appt / Unit staff procedural problem / Transportation problem<br>Nov 08 / 74 / 16 / 1<br>Dec 08 / 109 / 7 / 0<br>Jan 09 / 87 / 24 / 0<br>Feb 09 / 85 / 14 / 0<br>Mar 09 / 57 / 14 / 0<br>Apr 09 / 120 / 16 / 0<br><br>PSH's Dental appointment log data demonstrates that refusals are the main reason for missed appointments. Currently, the department reports the refusals using the WRP input form and forwards it to the unit supervisors. However, this system has not impacted refusals. PSH's Medical Staff Refusal Committee is in the process of developing a facility-wide refusal policy that should be implemented in the next few |
|---|---|---|

| | | |
|---|---|---|
| | | months.<br><br>A review of the PSH's Dental Appointment Logs verified that a majority of missed appointments were not related to staffing or transportation issues. The majority of missed appointments were due to refusals.<br><br>**Compliance:**<br>Partial.<br><br>**Current recommendation**:<br>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 recommendation:**<br><br>**Recommendation, December 2008:**<br>Continue to monitor this requirement.<br><br>**Findings:**<br>Using the DMH Dental Services Audit, PSH assessed its compliance based on a 20% mean sample of individuals scheduled for but refusing to attend dental appointments during the review months (February - April 2009):<br><br>7. *Each state hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to overcome individual's refusals to participate in dental appointments* — 5%<br>7.a *Refusals are documented in the Present Status section of the Case Formulation in the individual's WRP.* — 4%<br>7.b *When a pattern of refusal is evident or there is potential for adverse outcome, there are objectives and interventions dealing with the* — 5% |

| | | |
|---|---|---|
| | | *refusal in the individual's WRP.* |

No comparison data was available since the tool for this requirement was implemented in February 2009.

Since the beginning of 2008, the PSH's Dental Department has reported the refusal of dental care using the WRP input form and forwarded the form to the Unit Supervisor. There has been no improvement from this system. At the current time, a facility-wide refusal policy is still in the developmental phase. Until this policy is finalized, the Dental Department will revise the existing dental refusal policy. The Standards Compliance Department will be providing the WRPTs with instructions regarding the documentation requirements for individuals who refuse dental appointments.

A review of the records of 16 individuals (ATC, DB, DRR, FDD, GSH, JYM, LAF, LAT, LNS, LPS, MAR, MCD, MIL, MYD, RLZ and TWL) found that one had an open focus with interventions addressing refusals included in the WRP.

**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:**<br>Please refer to Sections D, E, F and H for judgments on the progress PSH has made towards aligning documentation practices with the requirements of the EP. |

| H. Restraints, Seclusion, and PRN and Stat Medication | | |
|---|---|---|
| H | | **Summary of Progress:**<br>1. PSH has made significant improvements in most areas regarding the documentation of Seclusion and Restraint.<br>2. Strategies in place by which the WRPTs are to address the needs of individuals who reach trigger thresholds should increase compliance scores.<br>3. PSH has maintained substantial compliance regarding staff training for PRN/Stat medication and 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:**<br><br>Interviewed:<br>1. George Christison, MD, Acting Medical Director<br>2. Harry Oreol, Program Director<br>3. Lidia Lau, RN, Assistant Coordinator of Nursing Services<br>4. Sandra Doerner, Acting Nurse Administrator<br>5. Willie Harris, DO, Acting Chief of Psychiatry<br><br>Reviewed:<br>1. PSH's progress report and data<br>2. AD 15.14, Seclusion or Restraint (January 13, 2009)<br>3. Special Order 902.01, Therapeutic Strategies and Interventions<br>4. Draft of RN Nursing Process for Activating Event form<br>5. PSH's training rosters<br>6. Emergency Use of Seclusion or Restraint Daily Log<br>7. Medical records for the following 25 individuals: AR, CHF, CO, GL, HC, JAC, JMB, JR, KEC, KL, KLK, LIL, MEK, MH, MLB, MMR, MR, MS, MS-2, OC, RC, REA, REB, RK and RW |
| H.1 | Each State hospital shall revise, as appropriate, and implement policies and procedures regarding | **Current findings on previous recommendation:** |

| | | |
|---|---|---|
| | 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. | **Recommendation, December 2008:**<br>Continue current practice.<br><br>**Findings:**<br>AD 15.14, Seclusion or Restraint was appropriately revised to include specific criteria for physician/psychiatrist assessment of individuals in seclusion and restraints. Also, Special Order 902.01, Therapeutic Strategies and Interventions, was implemented on 11/17/08, replacing the PMAB training. In addition, a review of 35 episodes of seclusion and restraint found no use of prone restraints, containment or transportation.<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendation**:<br>Continue current practice. |
| H.2 | Each State hospital shall ensure that restraints and seclusion: | **Compliance:**<br>Partial. |
| H.2.a | are used in a documented manner and only when individuals pose an imminent danger to self or others and after a hierarchy of less restrictive measures has been considered in a clinically justifiable manner or exhausted; | **Current findings on previous recommendation:**<br><br>**Recommendation, December 2008:**<br>Continue to monitor this requirement.<br><br>**Findings:**<br>Using the DMH Seclusion/Restraint Audit, PSH assessed its compliance based on a 100% sample (nine episodes) of initial seclusion orders each month during the review period (November 2008 - April 2009):<br><br>1. *Restraints and seclusion are used in a documented manner.* 95%<br>2. *Restraints and seclusion are used only when the* 90% |

| | | |
|---|---|---|
| | *individual posed an imminent danger to self or others.* | |
| 3. | *Restraints and seclusion are used after a hierarchy of less-restrictive measures has been considered in a clinically justifiable manner or exhausted.* | 89% |
| 3.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.* | 78% |
| 3.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.* | 100% |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 1. | 86% | 95% |
| 2. | 86% | 90% |
| 3. | 71% | 89% |
| Compliance rate in last month of period | | |
| 3. | 50% | 89% |
| 3.a | 50% | 78% |
| 3.b | 100% | 100% |

A review of five episodes of seclusion for five individuals (AR, KL, LIL, MMR and RC) found that the documentation for four episodes supported the decision to place the individual in seclusion. Less restrictive alternatives attempted were documented in three episodes and orders

included specific behaviors in four episodes.

Using the DMH Seclusion/Restraint Audit, PSH assessed its compliance based on a 100% sample (301 episodes) of initial restraint orders each month during the review period (November 2008 - April 2009):

| | | |
|---|---|---|
| 1. | *Restraints and seclusion are used in a documented manner.* | 95% |
| 2. | *Restraints and seclusion are used only when the individual posed an imminent danger to self or others.* | 98% |
| 3. | *Restraints and seclusion are used after a hierarchy of less-restrictive measures has been considered in a clinically justifiable manner or exhausted.* | 96% |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 1. | 83% | 95% |
| 2. | 92% | 98% |
| 3. | 82% | 96% |

A review of 30 episodes of restraint for 18 individuals (CHF, GL, HC, JAC, JMB, JR, KEC, KLK, MEK, MH, MLB, MR, MS, OC, REA, REB, RK and RW) found that the documentation for 26 episodes supported the decision to place the individual in restraints. Less restrictive alternatives attempted were documented in 26 episodes and orders included specific behaviors in 25 episodes.

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

| | | |
|---|---|---|
| H.2.b | are not used in the absence of, or as an alternative to, active treatment, as punishment, or for the convenience of staff; | **Current findings on previous recommendation:**<br><br>**Recommendation, December 2008:**<br>Continue to monitor this requirement.<br><br>**Findings:**<br>Using the DMH Seclusion/Restraint Audit, PSH assessed its compliance based on a 100% sample of initial seclusion orders each month during the review period (November 2008 - April 2009):<br><br>4. *Restraints and seclusion are not used in the absence of, or as an alternative to, active treatment.* 93%<br>5. *The individual has been in Seclusion and the staff did NOT....* 81%<br>5.a *Use restraints or seclusion in an abusive manner.* 100%<br>5.b *Keep the individual in restraints or seclusion even when the individual was calm.* 22%<br>5.c *Use restraints or seclusion in a manner to show a power differential that exists between staff and the individual.* 100%<br>5.d *Use restraints or seclusion as coercion.* 100%<br>6. *Staff used and documented the use of information in the Seclusion and Restraint Preference and Family Notification Form (MSH 1185) regarding the individual's preferences in gaining control of behavior as provided by the individual, or there is clinical justification as to why they were not used.* 44%<br><br>Comparative data indicated improvement in mean compliance since the previous review period: |

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 4. | 86% | 93% |
| 5. | 29% | 81% |
| 6. | 0% | 44% |
| Compliance rate in last month of period | | |
| 5. | 50% | 81% |
| 5.a | 50% | 100% |
| 5.b | 50% | 22% |
| 5.c | 50% | 100% |
| 5.d | 50% | 100% |
| 6. | 0% | 44% |

Barriers to compliance included that the staff are documenting that the individual has been "calm" when they have been calm for only the last few minutes of the 15-minute interval, which is scored on the audit as noncompliance. Also, the staff has not consistently been using the Preference Plans. Training will be provided to the HSSs and to the unit nurses regarding the proper documentation of calmness. In addition, the Unit Supervisors and Nursing Coordinators will review all documentation of seclusion and restraint episodes within 24 hours. Also, the RN Activating Event form will be revised to include a prompt for documentation regarding the use of a Preference Plan.

A review of five episodes of seclusion for five individuals (AR, KL, LIL, MMR and RC) found documentation in all five WRPs addressing behaviors, objectives and interventions. Documentation in one incident indicated that the individual was released when calm.

Using the DMH Seclusion/Restraint Audit, PSH assessed its compliance based on a 100% sample of initial restraint orders each month during the

review period (November 2008 - April 2009):

| | | |
|---|---|---|
| 4. | *Restraints and seclusion are not used in the absence of, or as an alternative to, active treatment.* | 93% |
| 5. | *Restraints and seclusion are not used as punishment.* | 89% |
| 5.a | *The staff did not use restraints or seclusion in an abusive manner.* | 97% |
| 5.b | *The staff did not keep the individual in restraints or seclusion even when the individual was calm.* | 61% |
| 5.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% |
| 5.d | *The staff did not use restraints or seclusion as coercion.* | 99% |
| 6. | *Staff used and documented the use of information in the Seclusion and Restraint Preference and Family Notification Form (MSH 1185) regarding the individual's preferences in gaining control of behavior as provided by the individual, or there is clinical justification as to why they were not used.* | 21% |

Comparative data indicated improvement in mean compliance for items 4 and 5 since the previous review period:

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 4. | 82% | 93% |
| 5. | 46% | 89% |
| 6. | 21% | 21% |
| Compliance rate in last month of period | | |
| 5. | 57% | 89% |

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<tr><td>5.a</td><td>98%</td><td>97%</td></tr>
<tr><td>5.b</td><td>57%</td><td>61%</td></tr>
<tr><td>5.c</td><td>98%</td><td>99%</td></tr>
<tr><td>5.d</td><td>98%</td><td>99%</td></tr>
<tr><td>6.</td><td>4%</td><td>21%</td></tr>
</table>
<br>
A review of 30 episodes of restraint for 18 individuals (CHF, GL, HC, JAC, JMB, JR, KEC, KLK, MEK, MH, MLB, MR, MS, OC, REA, REB, RK and RW) found documentation in 16 individuals' WRPs addressing behaviors, objectives and interventions. Documentation in 18 incidents indicated that the individual was released when calm.<br><br>
See above for barriers and plan of correction.<br><br>
**Current recommendation**:<br>
Continue to monitor this requirement.
</td>
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<tr>
<td>H.2.c</td>
<td>are not used as part of a behavioral intervention; and</td>
<td>
**Current findings on previous recommendation:**<br><br>
**Recommendation, December 2008:**<br>
Continue current practice.<br><br>
**Findings:**<br>
See F.2.c.iv.<br><br>
**Current recommendation**:<br>
See F.2.c.iv.
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<tr>
<td>H.2.d</td>
<td>are terminated as soon as the individual is no longer an imminent danger to self or others.</td>
<td>
**Current findings on previous recommendation:**<br><br>
**Recommendation, December 2008:**<br>
Continue to monitor this requirement.
</td>
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**Findings:**
Using the DMH Seclusion/Restraint Audit, PSH assessed its compliance based on a 100 % sample of episodes of seclusion each month during the review period (November 2008 - April 2009):

| | | |
|---|---|---|
| 7. | *Restraints and seclusion are terminated as soon as the individual is no longer an imminent danger to self or others.* | 75% |
| 7.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.* | 33% |
| 7.b | *The individual did not continue to be in restraints or seclusion after remaining calm for 15 minutes.* | 22% |
| 7.c | *The individual did not continue to be in restraints or seclusion because he/she was unable to contract for safety.* | 100% |
| 7.d | *The individual did not continue to be in restraints or seclusion because he/she was unable to agree to cease using offensive language.* | 89% |
| 7.e | *The individual did not continue to be in restraints or seclusion because he/she did not cease making verbal threats.* | 78% |
| 7.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.* | 100% |
| 7.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.* | 100% |

Comparative data indicated improvement in mean compliance since the

previous review period:

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 7. | 29% | 79% |
| Compliance rate in last month of period | | |
| 7. | 50% | 75% |
| 7.a | 50% | 33% |
| 7.b | 50% | 22% |
| 7.c | 100% | 100% |
| 7.d | 100% | 89% |
| 7.e | 100% | 78% |
| 7.f | 100% | 100% |
| 7.g | 100% | 100% |

PSH has created a guide for the staff regarding the requirements for documentation for restraint or seclusion. See H.2.c for barriers and plan of correction.

See H.2.b for review findings.

Using the DMH Seclusion/Restraint Audit, PSH assessed its compliance based on a 100% sample of episodes of restraint each month during the review period (November 2008 - April 2009):

| | | |
|---|---|---|
| 7. | *Restraints and seclusion are terminated as soon as the individual is no longer an imminent danger to self or others.* | 85% |
| 7.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* | 60% |

| | | |
|---|---|---|
| | *or met the release criteria on the restraints or seclusion order.* | |
| 7.b | *The individual did not continue to be in restraints or seclusion after remaining calm for 15 minutes.* | 62% |
| 7.c | *The individual did not continue to be in restraints or seclusion because he/she was unable to contract for safety.* | 94% |
| 7.d | *The individual did not continue to be in restraints or seclusion because he/she was unable to agree to cease using offensive language.* | 95% |
| 7.e | *The individual did not continue to be in restraints or seclusion because he/she did not cease making verbal threats.* | 91% |
| 7.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.* | 96% |
| 7.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.* | 98% |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 7. | 43% | 85% |
| Compliance rate in last month of period | | |
| 7. | 57% | 85% |
| 7.a | 57% | 60% |
| 7.b | 59% | 62% |

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<tr><td>7.c</td><td>98%</td><td>94%</td></tr>
<tr><td>7.d</td><td>98%</td><td>95%</td></tr>
<tr><td>7.e</td><td>96%</td><td>91%</td></tr>
<tr><td>7.f</td><td>93%</td><td>96%</td></tr>
<tr><td>7.g</td><td>100%</td><td>98%</td></tr>
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<br>
See H.2.b for review findings and H.2.c for barriers and plan of correction.<br><br>
Current recommendation:<br>
Continue to monitor this requirement.
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<tr>
<td>H.3</td>
<td>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.</td>
<td>
Current findings on previous recommendation:<br><br>
Recommendation, December 2008:<br>
Continue to monitor this requirement.<br><br>
Findings:<br>
Using the DMH Seclusion/Restraint Audit, PSH assessed its compliance based on a 100% sample of initial seclusion orders each month during the review period (November 2008 - April 2009):<br><br>
<table>
<tr><td>8.</td><td>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.</td><td>100%</td></tr>
</table>
<br>
Comparative data indicated improvement in compliance from 86% in the previous review period.<br><br>
A review of five episodes of seclusion for five individuals (AR, KL, LIL, MMR and RC) found that the RN timely conducted an assessment and the individual was timely seen by the psychiatrist in all episodes.
</td>
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Using the DMH Seclusion/Restraint Audit, PSH assessed its compliance based on a 100% sample of initial restraint orders each month during the review period (November 2008 - April 2009):

| | | |
|---|---|---|
| 8. | *Each State Hospital shall comply with 42 C.F.R., 483.360(f) requiring assessments by a physician or licensed clinical professional of any individual placed in seclusion or restraints within one hour.* | 94% |

Comparative data indicated improvement in compliance from 79% in the previous review period.

A review of 30 episodes of restraint for 18 individuals (CHF, GL, HC, JAC, JMB, JR, KEC, KLK, MEK, MH, MLB, MR, MS, OC, REA, REB, RK and RW) found that the RN timely conducted an assessment in 25 episodes and the individual was timely seen by the psychiatrist in 22 episodes.

The facility provided the following additional data regarding Prevention and Management of Seclusion or Restraint/Therapeutic Strategies and Interventions Training:

| | Nov 2008 | Dec 2008 | Jan 2009 | Feb 2009 | Mar 2009 | April 2009 |
|---|---|---|---|---|---|---|
| N | 1284 | 1280 | 1280 | 1273 | 1275 | 1293 |
| n | 1114 | 1132 | 1119 | 1169 | 1189 | 1293 |
| %C | 87 | 88 | 87 | 92 | 93 | 100 |

N= Number of nursing staff who monitor individuals while in restraints or seclusion.
n= Number of target staff who have completed The Prevention and Management of Seclusion or Restraint (PMAB) or Therapeutic Strategies and Interventions (TSI) Training within the last 12 months.

PSH's training rosters verified that in April, 100% of staff had completed the required training.

| | | |
|---|---|---|
| | | **Compliance:**<br>Partial.<br><br>**Current recommendation**:<br>Continue to monitor this requirement. |
| H.4 | Each State hospital shall ensure the accuracy of data regarding the use of restraints, seclusion, psychiatric PRN medications, or Stat medications. | **Current findings on previous recommendations:**<br><br>**Recommendations 1 and 2, December 2008:**<br>• Continue to implement the MedSelect System as outlined.<br>• Continue to monitor this requirement.<br><br>**Findings:**<br>PSH has fully implemented the MedSelect System. The Pharmacy department provides daily reports of PRN/Stat usage based on when the medications are removed from the machine, which is an accurate tracking system for capturing the administration of PRN/Stat medications. Restraint and/or Seclusion episodes are reported using the daily Health Services Specialist (HSS) reports and the CIS SIR database, and are reconciled through a single office. There is a 100% reconciliation of information between these tracking systems. HSS reports are used to generate a daily "Trigger: Emergency Use of Seclusion or Restraint Daily Log," which is provided to the PSH Executive Committee and the Special Incident Report database. These daily logs are used to ensure that every restraint or seclusion episode is identified and the data is accurately reported to the Oryx database.<br><br>A review of 35 seclusion and restraint episodes found that all were entered in the databases.<br><br>**Compliance:**<br>Substantial. |

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|---|---|---|
| | | **Current recommendation**:<br>Continue to monitor this requirement. |
| H.5 | Each State hospital shall revise, as appropriate, and implement policies and procedures to require the review within three business days of individuals' therapeutic and rehabilitation service plans for any individuals placed in seclusion or restraints more than three times in any four-week period, and modification of therapeutic and rehabilitation service plans, as appropriate. | **Current findings on previous recommendation:**<br><br>**Recommendation, December 2008:**<br>Continue to monitor this requirement.<br><br>**Findings:**<br>PSH has had no instances of Seclusion triggers during the review period.<br><br>Using the DMH Seclusion/Restraint Audit, PSH assessed its compliance based on a 100% sample of individuals who were in restraints more than three times in 30 days during the review period (November 2008 - April 2009):<br><br>9. *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* — 35%<br>9.a *The review was held within 3 business days for any individual who had 4 or more episodes of Seclusion or Restraints within the last 30 days* — 22%<br>9.b *The Present Status in the Case Formulation section of the WRP documented that a review of the incident(s) was done* — 33%<br>9.c *If the team decided to revise the WRP, a statement as to what part of the WRP was revised, OR if the team decided not to revise the WRP, a brief clinical justification as to why, was* — 50% |

| | | |
|---|---|---|
| | *documented in the Present Status in the Case Formulation Section of the WRP* | |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 9. | 4% | 35% |
| Compliance rate in last month of period | | |
| 9. | 0% | 35% |
| 9.a | 0% | 22% |
| 9.b | 0% | 33% |
| 9.c | NA | 50% |

The lack of an automated system that documents restraint/seclusion episodes in real time was identified as the barrier to compliance. Until an automated system is developed, the CNS Office will provide the Executive Committee with a daily report for any seclusion or restraint episodes and triggering episodes will be provided to the appropriate Program and Unit.

A review of the records of nine individuals who were in restraint more than three times in 30 days during the review period (CO, HC, JMB, JR, KLK,MH, MS, REA and REB) found compliance in seven instances.

**Compliance:**
Partial.

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

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|---|---|---|
| H.6 | Each State hospital shall develop and implement policies and procedures consistent with generally accepted professional standards of care governing the use of psychiatric PRN medication and Stat medication, requiring that: | **Compliance:**<br>See F.1.b. |
| H.6.a | such medications are used in a manner that is clinically justified and are not used as a substitute for adequate treatment of the underlying cause of the individual's distress. | **Current findings on previous recommendations:**<br><br>**Recommendation 1, December 2008:**<br>Same as in F.1.b.<br><br>**Findings:**<br>See F.1.b.<br><br>**Recommendation 2, December 2008:**<br>Continue to monitor this requirement.<br><br>**Current recommendation**<br>See F.1.b. |
| H.6.b | PRN medications, other than for analgesia, are prescribed for specified and individualized behaviors. | **Current findings on previous recommendations:**<br><br>**Recommendation 1, December 2008:**<br>Same as in F.1.b.<br><br>**Findings:**<br>See F.1.b.<br><br>**Current recommendation:**<br>See F.1.b. |
| H.6.c | PRN medications are appropriately time limited. | **Current findings on previous recommendation:** |

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|---|---|---|
| | | **Recommendation, December 2008:**<br>Continue current practice.<br><br>**Findings:**<br>See F.1.b.<br><br>**Current recommendation**:<br>See F.1.b. |
| H.6.d | nursing staff assess the individual within one hour of the administration of the psychiatric PRN medication and Stat medication and documents the individual's response. | **Current findings on previous recommendation:**<br><br>**Recommendation, December 2008:**<br>See F.3.a.iii.<br><br>**Findings:**<br>See F.3.a.iii.<br><br>**Current recommendation**:<br>See F.3.a.iii. |
| H.6.e | A psychiatrist conducts a face-to-face assessment of the individual within 24 hours of the administration of a Stat medication. The assessment shall address reason for Stat administration, individual's response, and, as appropriate, adjustment of current treatment and/or diagnosis. | **Current findings on previous recommendation:**<br><br>**Recommendation, June 2008:**<br>Same as in D.1.f, F.1.b and H.6.a.<br><br>**Findings:**<br>Same as in D.1.f, F.1.b and H.6.a<br><br>**Current recommendations**:<br>Same as in D.1.f, F.1.b and H.6.a. |
| H.7 | Each State hospital shall ensure that all staff whose responsibilities include the implementation | **Current findings on previous recommendation:** |

| | | |
|---|---|---|
| | 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. | **Recommendation, December 2008:**<br>Continue current practice.<br><br>**Findings:**<br>PSH's training rosters verified that 86% of the required staff has successfully completed training on assessment and implementation of PRN and Stat medications in the Principles of Medication training class. See H.3.<br><br>**Compliance:**<br>Partial.<br><br>**Current recommendation**:<br>Continue to monitor this requirement. |
| H.8 | Each State hospital shall: | **Compliance:**<br>Not applicable. |
| H.8.a | develop and implement a plan to reduce the use of side rails as restraints in a systematic and gradual way to ensure individuals' safety; and | **Current findings on previous recommendation:**<br><br>**Recommendation, December 2008:**<br>Continue to monitor this requirement.<br><br>**Findings:**<br>There have been no incidents of the use of side rails as restraints during this review period.<br><br>**Current recommendation**:<br>Continue to monitor this requirement. |
| H.8.b | ensure that, as to individuals who need side rails, their therapeutic and rehabilitation service plans expressly address the use of side rails, including | **Current findings on previous recommendation:** |

| | | |
|---|---|---|
| | 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. | **Recommendation, December 2008:**<br>Continue to monitor this requirement.<br><br>**Findings:**<br>There have been no incidents of the use of side rails as restraints during this review period.<br><br>**Current recommendation**:<br>Continue to monitor this requirement. |

| I. Protection from Harm | | |
|---|---|---|
| I | Each State hospital shall provide the individuals it serves with a safe and humane environment and ensure that these individuals are protected from harm. | **Summary of Progress:**<br>1. The Statewide Incident and Risk Management module of WaRMSS was being tested during the week on site and is expected to be operational by the end of June. In conjunction with its initiation, DMH has agreed to make efforts to ensure that all of the facilities are using the same business rules for inputting data.<br>2. The facility has spent time and resources to ensure that the reports generated by the Record Management System accurately reflect the data in the system. PSH plans further training for hospital police who put data into the system in an effort to improve its accuracy. These plans include the completion of a user manual and competency testing following training.<br>3. The RMS was used during this report period to produce reports on the type of involvement of individuals and staff in A/N incidents, the location of A/N incidents and the day of the week and time of the incidents.<br>4. The minutes of the IRC meetings reflect the committee's review of the completeness of the investigations. When clarification or additional information is needed, the Supervising Special Investigator returns the investigation to the investigator at the request of the IRC. The IRC will review those incidents in which there is question about whether the allegation constitutes abuse or neglect prior to OSI undertaking a full investigation.<br>5. Investigators are far more frequently documenting their attempts to identify witnesses to an incident.<br>6. PSH has implemented all levels of committee review as required by the Risk Management Special Order. The ASH-developed Task Tracker is used to communicate approved recommendations to the WRPTs. Various other databases are used to gather trigger data.<br>7. Twenty of 21 sampled actions proposed by WRPTs in response to triggers had been implemented.<br>8. The facility administration has examined data on the level of violence |

| | | |
|---|---|---|
| | | in the facility, noted its increase and is taking measures to reduce it. Measures include focused attention on WRPs, redesign of the Mall, increased supplemental recreational opportunities and other measures to increase a spirit of community. The facility has enlisted the perspective of the individuals being served and has added two individuals to the membership of the Quality Council.<br>9. The facility continues to refit the bathrooms in order to reduce the suicide hazards present. It also has continued to purchase and will be replacing the wardrobes in individuals' bedrooms, which presently present a suicide hazard. Replacement of some of the vents in private areas is planned after the bathroom renovations are complete.<br>10. All individuals sampled who had the problem of incontinence had Focus 6 interventions and objectives addressing the problem. |
| 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:**<br><br><u>Interviewed</u>:<br>1. B. Sherer, Hospital Administrator<br>2. C. Brown, Standards Compliance/Risk Manager<br>3. D. Bienstock, Information Systems Analyst<br>4. G. Richardson, Director of Standards Compliance<br>5. J. Olive, Supervising Senior Special Investigator<br>6. S. Sandoval, Standards Compliance<br><br><u>Reviewed</u>:<br>1. Seventeen Investigation Reports and RMS forms<br>2. Twenty SIRs<br>3. All materials related to the review of the deaths of four individuals<br>4. Incident Review Committee minutes for December 2008—April 2009<br>5. IRC task tracking form<br>6. Data for variables related to abuse/neglect incidents |

| | | |
|---|---|---|
| | | 7. Ten Headquarters Reportable Briefs<br>8. OSI investigation log<br>9. Quality Council minutes<br>10. Graphed aggression data |
| I.1.a | Each State hospital shall review, revise, as appropriate, and implement incident management policies, procedures and practices that are consistent with generally accepted professional standards of care. Such policies, procedures and practices shall require: | **Compliance:**<br>Partial. Guidance is needed from DMH to all facilities on SIR business rules for coding involvement of staff and individuals to ensure consistency. |
| I.1.a.i | that each State hospital not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of individuals; | **Current findings on previous recommendation:**<br><br>**Recommendation, December 2008:**<br>Continue current practice.<br><br>**Findings:**<br>The October 28, 2009 minutes of the Incident Review Committee document the referral of staff members to Human Resources for appropriate action for failure to report an allegation of abuse in a timely manner, in violation of DMH policy.<br><br>**Current recommendation**:<br>Continue current practice. |
| I.1.a.ii | identification of the categories and definitions of incidents to be reported, and investigated; immediate reporting by staff to supervisory personnel and each State hospital's executive director (or that official's designee) of serious incidents, including but not limited to, | **Current findings on previous recommendation:**<br><br>**Recommendation, December 2008:**<br>See recommendations in subsequent cells.<br><br>**Findings:**<br>The identification of sexual incidents remains problematic, for example |

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| | death, abuse, neglect, and serious injury, using standardized reporting across all settings, including school settings; | use of the "sexual abuse" type when no staff member was involved and use of the "sexual assault" and "sexual contact between adults" types when the sexual activity was consensual. For example, the SIR for the incident of sexual contact between two individuals (TN and FV) was coded as sexual abuse.<br><br>In its reluctance to identify the named staff member as the aggressor, PSH is coding the involvement of the named staff member in A/N allegation incidents differently than the other facilities. Instead, in many of the A/N investigations reviewed, the named staff member is coded either "I" (involved) or "U" (undetermined).<br><br>The review of 20 randomly selected SIRs revealed the following:<br><br>SIR # — Issue<br>6-0149, 3-0238, 7-0191 8-0229*, 6-0460 — Named staff (alleged perpetrator) coded as U<br>8-0060, 8-0229* — Named staff (alleged perpetrator) coded as I<br>8-0115, 7-0191 — Victim coded as I<br>1-0233 — Suicide attempt—individual listed as I<br>8-0295 — Suicide attempt—individual listed as A (aggressor)<br>1-0205 — Aggressive act to self—no involvement code selected<br><br>* Two staff members were identified as the alleged perpetrators of physical abuse; one was coded I and the other U.<br><br>**Other findings:**<br>The Statewide Incident Management System is expected to be operational by the end of June. Staff at PSH will be expected to enter incident data directly into the system on the units. The conversion from |

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| | | paper to electronic entry will require a substantial commitment to staff training. The facility plans classroom training, on-site training, and the establishment of a help desk.<br><br>**Current recommendations**:<br>1. Review SIRs to identify and correct coding errors.<br>2. Undertake staff training efforts in preparation for electronic SIR entry as planned.<br>3. DMH should ensure that all facilities are using the same SIR coding business rules, so that the new Statewide Incident Management System will have comparable data across all the facilities. |
| I.1.a.iii | mechanisms to ensure that, when serious incidents such as allegations of abuse, neglect, and/or serious injury occur, staff take immediate and appropriate action to protect the individuals involved, including removing alleged perpetrators from direct contact with the involved individuals pending the outcome of the facility's investigation; | **Current findings on previous recommendation:**<br><br>**Recommendation, December 2008:**<br>Document in investigation reports the Clinical Administrator's agreement or disagreement with the decision not to remove a named staff member pending the results of an abuse investigation.<br><br>**Findings:**<br>The investigations reviewed did not consistently identify whether the named staff person was removed. Examples of investigations in which the decision to remove or not remove the named staff member was documented include:<br><br>• Allegation of physical abuse (1/29/09)<br>• Allegation of physical and verbal abuse (1/26/09)<br>• Allegation of psychological abuse (12/29/08)<br>• Allegation of psychological abuse (1/26/09)<br><br>In two investigations reviewed (1/26/09 allegation of verbal and physical abuse of NC and 12/29/08 allegation of psychological abuse), the Clinical Administrator's agreement with the decision to remove or not remove |

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| | | the staff member was documented.<br><br>**Other findings:**<br>During the investigation of the allegation of physical abuse made by DK (2/11/09), DK asked to be moved to another unit for his protection. The request was granted.<br><br>**Current recommendation:**<br>Consistently document in the investigation report whether the named staff person(s) was removed from contact with the alleged victim. |
| I.1.a.iv | adequate competency-based training for all staff on recognizing and reporting potential signs and symptoms of abuse or neglect, including the precursors that may lead to abuse; | **Current findings on previous recommendation:**<br><br>**Recommendation, December 2008:**<br>Continue current practice.<br><br>**Findings:**<br>Review of the A/N training for a sample of 15 staff members (below) representing seven job classifications reveals that three staff members have not received training within the last year. There is no record of A/N training for one staff member, despite his having been found to have verbally and psychologically abused an individual in 2008. |

| | Date of: | | | |
|---|---|---|---|---|
| Staff member* | Hire | Background clearance | Signing of Mandatory Reporter | Most recent A/N training |
| _V | 7/1/87 | 7/1/87 | 7/1/87 | 7/08 |
| _A | 10/3/88 | 10/3/88 | 10/3/88 | 4/09 |
| _M | 5/31/96 | 5/31/96 | 1/3/95 | 1/09 |
| _P | 7/1/96 | 7/1/97 | 7/1/97 | 4/08 |
| _S | 7/31/96 | 7/31/96 | 7/31/96 | 2/09 |
| _W | 9/2/97 | 7/22/07 | 7/7/08 | 7/08 |

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<tr><td>_B</td><td>9/1/98</td><td>6/17/98</td><td>4/3/95</td><td>12/08</td></tr>
<tr><td>_C</td><td>10/1/98</td><td>7/31/98</td><td>10/1/98</td><td>1/08</td></tr>
<tr><td>_W</td><td>4/1/99</td><td>3/1/97</td><td>4/1/99</td><td>12/08</td></tr>
<tr><td>_W</td><td>8/31/00</td><td>7/29/00</td><td>8/31/00</td><td>No record</td></tr>
<tr><td>_L</td><td>1/31/01</td><td>11/24/00</td><td>1/31/01</td><td>12/08</td></tr>
<tr><td>_O</td><td>10/1/03</td><td>8/21/03</td><td>10/1/03</td><td>8/08</td></tr>
<tr><td>_L</td><td>8/2/04</td><td>6/24/04</td><td>5/21/97</td><td>5/09</td></tr>
<tr><td>_S</td><td>12/2/04</td><td>9/24/04</td><td>12/2/04</td><td>2/09</td></tr>
<tr><td>_W</td><td>1/3/06</td><td>11/30/05</td><td>1/3/06</td><td>3/09</td></tr>
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*Only last initials are provided to protect confidentiality.<br><br>
**Current recommendations**:<br>
1. Ensure the staff member cited above and any other staff with no record of A/N training attend the training as soon as possible.<br>
2. If not already a practice, make attendance at mandatory annual trainings part of performance evaluations.
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<td>I.1.a.v</td>
<td>notification of all staff when commencing employment and adequate training thereafter of their obligation to report abuse or neglect to each State hospital and State officials. All staff persons who are mandatory reporters of abuse or neglect shall sign a statement that shall be kept with their personnel records evidencing their recognition of their reporting obligations. Each State hospital shall not tolerate any mandatory reporter's failure to report abuse or neglect;</td>
<td>
**Current findings on previous recommendation:**<br><br>
**Recommendation, December 2008:**<br>
Continue current practice.<br><br>
**Findings:**<br>
As shown in the table in the cell above, all of the sampled staff members have signed the mandatory reporter acknowledgement form. Most were signed near to the date of hire, but one staff member hired in 1997 signed in 2008, reflecting the facility's efforts to ensure that all staff members have signed the form acknowledging their responsibility to report dependent adult abuse.<br><br>
**Other findings:**<br>
The issue of failure to report allegations of abuse/neglect did not surface in any of the investigation reports reviewed.
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| | | **Current recommendation**:<br>Continue current practice. |
| I.1.a.vi | mechanisms to inform individuals and their conservators how to identify and report suspected abuse or neglect; | **Current findings on previous recommendation:**<br><br>**Recommendation, December 2008:**<br>Take additional measures to ensure that rights and responsibilities are discussed with individuals at annual WRPCs and ask individuals to sign the form at that time.<br><br>**Findings:**<br>In nine of the 17 clinical records reviewed, the individual had signed the statement of Rights and Responsibilities within the last year. Staff were not able to locate two signed statements, and with one exception, the remainder were signed several years ago. |

| Individual | Date of most recent signing |
|---|---|
| JH | 5/18/09 |
| GP | 4/9/09 |
| KH | 3/30/09 |
| GR | 2/17/09 |
| SH | 2/3/09 |
| ES | 1/28/09 |
| MV | 12/15/08 |
| ID | 11/12/08 |
| VR | 6/24/08 |
| JD | 3/24/08 |
| SR | 11/30/06 |
| JL | 9/16/05 |
| PD | 9/16/05 |

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| | | SC 9/16/05<br>SC 9/5/05<br>CC Cannot locate<br>RH Cannot locate<br><br>**Current recommendation**:<br>At annual WRPCs, discuss rights and responsibilities with individuals and request they sign the form. |
| I.1.a.vii | posting in each living unit and day program site a brief and easily understood statement of individuals' rights, including information about how to pursue such rights and how to report violations of such rights; | **Current findings on previous recommendation:**<br><br>**Recommendation, December 2008:**<br>Continue current practice.<br><br>**Findings:**<br>There was no statement of rights posted on Unit 73 because the Plexiglas cover had been destroyed a week earlier. Staff had completed a work order for its replacement. All other units toured had a statement of rights posted in a public area that included directions for contacting the Patient Rights Advocate.<br><br>**Current recommendation**:<br>Continue current practice. |
| I.1.a.viii | procedures for referring, as appropriate,<br><br>allegations of abuse or neglect to law<br><br>enforcement; and | **Current findings on previous recommendation:**<br><br>**Recommendation, December 2008:**<br>Continue to work with the vendor and other RMS administrators to solve the problems that result in inaccurate data output from the system.<br><br>**Findings:**<br>The Hospital Administrator is confident that the reports presently being generated by the RMS are accurate. Since the last reporting period, the |

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| | | facility has taken measures to check the accuracy of data being put into the system and provided training for all DPS officers and others who use the system. The facility plans to expand this training to include a training manual and a test of competency.<br><br>See the Performance Improvement section of the report (Section I.2) for specific reports produced using the RMS.<br><br>**Other findings:**<br>Several investigations reviewed documented the rationale for referring or not referring an individual to law enforcement. For example, in the incident involving serious bodily harm to GM (11/24/08) the assailant TR was transported to and booked at the West Valley Detention Center. In contrast, the investigation of misdemeanor battery (2/13/09) found per the review by his psychiatrist that the assailant was "so psychotic that he would not know what he did or what was happening." This case was not forwarded to the District Attorney's office. The April 30, 2009 IRC minutes document the referral of battery with serious injury hate crime (individual-to-individual) to the District Attorney's Office.<br><br>**Current recommendation**:<br>Continue to improve the referral process. |
| 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 | **Current findings on previous recommendation:**<br><br>**Recommendation, December 2008:**<br>Continue current practice.<br><br>**Findings:**<br>In two investigations reviewed, the facility took appropriate action to protect individuals who feared retaliation:<br><br>• D_ reported on 1/22/09 that all the unit staff and residents were |

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| | manner. | threatening him because he was willing to tell hospital police who was using and who was supplying drugs. When questioned by the police, he refused to give any names. Further review revealed that D_ had positive drug screens more often than anyone else on the unit. Staff are aware of possible retaliation from other individuals who may mistakenly believe D_ turned them in. (Last initial not provided because of safety concerns).<br>• In the investigation that sustained allegations of psychological abuse and neglect of HG (reported 1/26/09), HG believed that his peers might hurt him because he would not cooperate with and had reported the named staff member's scheme to sell marijuana and coffee to other individuals. HG asked to be placed on 1:1. His request was immediately granted.<br><br>**Current recommendation**:<br>Continue current practice of investigating all allegations of retaliation or fear of retaliation and alerting staff to possibly dangerous situations, so that they can take appropriate action. |
| I.1.b | Each State hospital shall review, revise, as appropriate, and implement policies and procedures to ensure the timely and thorough performance of investigations, consistent with generally accepted professional standards of care. Such policies and procedures shall: | **Compliance:**<br>Partial. |
| I.1.b.i | require investigations of all deaths, as well as allegations of abuse, neglect, serious injury, and theft. The investigations shall be conducted by qualified investigator(s) who have no reporting obligations to the program or elements of the facility associated with the allegation and have expertise in conducting investigations and | **Current findings on previous recommendations:**<br><br>**Recommendation 1, December 2008:**<br>Identify the decedent by name and provide date of death in the MIRC minutes before any discussion of the circumstances of his/her death or care at the facility. |

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| | working with persons with mental disorders; | **Findings:**<br>The MIRC minutes reviewed identified the individual and the date of death at the beginning of the discussion of the death.<br><br>**Recommendation 2, December 2008:**<br>Ensure that the classification of deaths as expected or unexpected follows the definitions in SO 205.05 and the proper review protocol is followed.<br><br>**Findings:**<br>The facility reports that the Medical Director reviews each death and determines if the death meets the definition of expected or unexpected in the Mortality Review Special Order. No questions arose regarding the determinations made during this review period.<br><br>**Recommendation 3, December 2008:**<br>Take steps to secure autopsy reports and death certificates in a timely manner.<br><br>**Findings:**<br>Securing autopsies in a timely manner remains problematic due not to the lack of diligence on the facility's part, but because the Medical Examiner's Office has a four-month backlog (reported to PSH on June 5, 2009). In the reviews of the four deaths for which information was provided, an autopsy had been completed in two. |

| Individual | Date of death | Classification | Autopsy reviewed/ case closed |
|---|---|---|---|
| GM | 12/8/08 | Unexpected | Autopsy completed 12/10/08. Signed and dated 4/2/09. |
| AS | 1/8/09 | Unexpected | Autopsy completed 1/12/09. Signed and dated 3/17/09. |

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| RL | 2/27/09 | Unexpected | Autopsy outstanding |
| MW | 4/6/09 | Expected | Autopsy outstanding |

**Recommendation 4, December 2008:**
Ensure that medical and nursing death reviews focus on outcomes and provision of treatment as well as documentation and treatment planning.

**Findings:**
A psychological autopsy dated 5/21/09 was performed following the suicide death of AS. It made several recommendations for consideration. The nursing death review (reportedly revised) identifies several gaps in staff's performance. The Independent External Review of AS's death was completed on 2/13/09 and made recommendations for performance improvement in four areas: charting, communication, attention to the needs of staff and individuals affected by the death, and safety issues. The materials provided by the facility did not include a MIRC meeting following the external review, as required by the Mortality Review Special Order.

The facility did not supply a copy of the MIRC review of the death of MW. Recommendations from the Morbidity/Mortality Case Review (4/13/09) were forwarded to the MIRC Chair on 4/13/09. The medical death summary was finalized on 5/8/09 and did not make any recommendations.

The nursing death summary prepared on 12/9/08 following the death of GM identifies numerous recommendations for performance improvement. The MIRC conducted on 12/23/08 reflected many of the recommendations made in the nursing death summary. The party responsible for implementation of the recommendation is not identified in the MIRC minutes. Per the documents provided, there has not yet been an external independent review of this unexpected death.

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| | | A Second Level Internal Discipline Review of the death of RL was completed on 3/11/09, which made systemic two recommendations for performance improvement calling for more "mock code drills" and the need for better communication between PSH and outside treatment facilities. It also cited numerous findings specific to the care provided to RL where care could have been improved. Per the documents provided, there has not yet been an external independent review of this unexpected death. The autopsy is still outstanding and may be the reason for the delay in the conducting the external review. The initial MIRC meeting (3/11/09) identifies four recommendations for corrective actions related to the handling of medical emergencies.<br><br>**Recommendation 5, December 2008:**<br>Identify in the MIRC minutes the party responsible for ensuring implementation of the recommended corrective actions and request feed-back on the measures undertaken.<br><br>**Findings:**<br>See above.<br><br>**Current recommendation**:<br>Implement Special Order 205.05: Mortality Review with specific attention to carrying forward for discussion and approval at the MIRC meetings all recommendations or findings of fact that would reasonably imply recommendations for corrective actions made during other reviews. Write MIRC-approved recommendations in clear terms and identify the persons responsible for effecting implementation and reporting results back to the MIRC. |
| 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 | **Current findings on previous recommendation:**<br><br>**Recommendation, December 2008:**<br>Continue current practice. |

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| | investigations of allegations of petty theft and all other unusual incidents; | **Findings:**<br>In addition to the investigation of allegations of A/N, the Office of Special Investigations investigated incidents involving assaults between peers, positive drug screens, allegations of sexual assault and deaths of individuals.<br><br>**Current recommendation**:<br>Continue current practice. |
| I.1.b.iii | investigations required by paragraph I.1.b.i, (above) provide for the safeguarding of evidence; | **Current findings on previous recommendation:**<br><br>**Recommendation, December 2008:**<br>Continue current practice.<br><br>**Findings:**<br>Several investigations reviewed noted that photos were taken and transferred to a disc and where they were stored.<br><br>**Other findings:**<br>This monitor found no reason to believe that evidence is not being handled and safeguarded appropriately.<br><br>**Current recommendation**:<br>Continue current practice. |
| I.1.b.iv | investigations required by paragraph I.1.b.i, (above) require the development and implementation of standardized procedures and protocols for the conduct of investigations that are consistent with generally accepted professional standards. Such procedures and protocols shall | **Current findings on previous recommendation:**<br><br>**Recommendation, December 2008:**<br>Provide continued IRC and supervisory attention to investigation reports to ensure their completeness. |

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| | require that: | **Findings:**<br>The minutes of several meetings of the IRC document the committee's return of an investigation for additional work or clarification, indicating the committee's attention to the quality of investigations. For example, the investigations of incidents 3172, 2256 and 0331 were returned with a request for additional interviews.<br><br>**Other findings:**<br>Several of the initial investigations reviewed completed by DPS contained the note, "[Named staff] not interviewed due to departmental policy." This practice results in the initial investigation documenting the alleged victim's version of events, but no information from the alleged perpetrator. The Supervising Special Investigator stated that there is no hospital policy that restricts the police officer from interviewing the named staff member. He agreed to advise the Chief of Police of the problem and ensure its correction.<br><br>**Current recommendation**:<br>Ensure that DPS practice is changed, so that officers conducting preliminary A/N investigations interview the named staff member(s). |
| I.1.b.iv.1 | investigations commence within 24 hours or sooner, if necessary, of the incident being reported | **Current findings on previous recommendation:**<br><br>**Recommendation, December 2008:**<br>Conduct interviews in a timely manner to avoid jeopardizing the integrity of investigations.<br><br>**Findings:**<br>In several of the investigations reviewed, OSI interviews were delayed. For example, in the investigation of the allegation of verbal abuse made by VM on 12/25/08, the named staff member was interviewed by the Special Investigator on 3/10/09. The OSI interview of the named staff member in the allegation of psychological abuse of HG reported on |

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<td>1/26/09 occurred on 4/22/09. This delay was the result of the investigator's vacation.<br><br>Other findings:<br>A preliminary DPS or an OSI investigation of each of incidents reviewed was begun within 24 hours of the report of the incident.<br><br>Current recommendations:<br>1. Continue current practice of beginning investigations within 24 hours of the report of an incident.<br>2. Ensure that interviews are conducted in a timely manner.</td>
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<td>I.1.b.iv.2</td>
<td>investigations be completed within 30 business days of the incident being reported, except that investigations where material evidence is unavailable to the investigator, despite best efforts, may be completed within 5 business days of its availability;</td>
<td>Current findings on previous recommendation:<br><br>Recommendation, December 2008:<br>Continue working on the timely completion of investigations and investigation reports.<br><br>Findings:<br>Eight of the 17 investigation reports reviewed did not meet the EP's 30-business-day timeline for closure as shown below. The facility reported that 39% of the sampled investigations met the EP timeline during the review period. Self-assessment sample sizes ranged from 100% in December to 5% in March.
<table>
<tr><th>Incident type</th><th>Date incident reported</th><th>Date investigation closed</th></tr>
<tr><td>Psychological abuse allegation</td><td>12/1/08</td><td>12/23/08</td></tr>
<tr><td>Sexual contact between peers</td><td>12/12/08</td><td>12/22/08</td></tr>
<tr><td>Sexual assault</td><td>12/12/08</td><td>12/24/08</td></tr>
<tr><td>Verbal abuse allegation</td><td>12/25/08</td><td>3/10/09</td></tr>
<tr><td>Psychological abuse allegation</td><td>12/29/08</td><td>4/29/09</td></tr>
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| | | |
|---|---|---|
| Sexual assault | 1/8/09 | 4/6/09 |
| Sexual assault | 1/20/09 | 4/10/09 |
| Psychological abuse allegation | 1/20/09 | 5/7/09 |
| Psychological abuse allegation | 1/22/09 | 3/3/09 |
| Physical and verbal abuse allegation | 1/26/09 | 4/2/09 |
| Sexual abuse allegation | 1/28/09 | Not dated, but after 5/20/09 |
| Physical abuse allegation | 1/29/09 | 5/12/09 |
| Neglect allegation | 2/11/09 | 2/20/09 |
| Physical assault by peer | 2/13/09 | 2/13/09 |
| Sexual assault | 2/15/09 | 3/9/09 |
| Physical abuse allegation | 2/19/09 | 3/18/09 |
| Physical assault by peer | 2/23/09 | 2/24/09 |

On 12/1/08, DB alleged she was psychologically abused because a staff member looked at her strangely and gave her an apple when she requested candy at the nurses' station. One means of addressing the workload and timeliness issue is to ensure that an OSI investigation is initiated only when (following the preliminary DPS investigation) the allegation, if true, would rise to the level of abuse/neglect. Discussion with the Hospital Administrator and the Supervising Special Investigator resulted in the decision that any questionable cases would be brought to the Incident Review Committee for its opinion.

**Current recommendations**:

1. Follow the plan outlined above to limit OSI A/N investigations to those allegations which, if true (after the initial DPS investigation), would meet the SIR definitions. Include the IRC review of the cases in question.
2. Continue other efforts to complete investigations in a timely manner.

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| 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:**<br><br>**Recommendation 1, December 2008:**<br>IRC and investigation supervisors should continue to review incident investigation reports for completeness and ensure that deficiencies are corrected.<br><br>**Findings:**<br>The Incident Review Committee minutes reflect its review of investigations and follow-up when clarification is needed. See also I.1.b.iv.<br><br>**Recommendation 2, December 2008:**<br>DMH should determine if or under what circumstances a chokehold is an acceptable form of restraint in the facilities and make its determination clear to the facility administrators, police officers and facility staff members.<br><br>**Findings:**<br>Special Order 912.03 Law Enforcement Intervention (effective 9/23/08) states, "The use of any neck restraint hold that restricts a person's airway is prohibited, unless a situation arises where the use of lethal force is permissible under existing law and Department policy." The SO restricts the use of lethal force to situations to protect human life or prevent serious bodily injury to another and when all lesser means have been employed and failed or cannot be reasonably utilized.<br><br>Recommendations to send an investigation to Human Resources for determination of disciplinary action and referral to law enforcement were commonly made in the investigations reviewed. Other types of recommendations were made less frequently. Additional recommendations were rarely made by the IRC, as reflected in the minutes. A notable exception was the need for a policy to direct staff in |

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| | | how to prevent someone from biting another and how to prevent an individual from immediately ingesting a harmful substance.<br><br>Review of 15 randomly selected items from the IRC task tracking form revealed that the necessary actions had been completed for 11 of the 15. The remaining items from March and April IRC meetings were still outstanding.<br><br>**Current recommendation**:<br>The IRC should review investigations with the objective of identifying any additional programmatic recommendations. |
| I.1.b.iv.3(i) | each allegation of wrongdoing investigated; | **Current findings on previous recommendation:**<br><br>**Recommendation, December 2008:**<br>Implement change so that investigators do not use the term "exonerated" when making determinations about cases involving alleged staff misconduct. Reserve such determinations for investigations involving peace officers.<br><br>**Findings:**<br>The facility is no longer using the term "exonerated" in investigations of staff misconduct.<br><br>**Other findings:**<br>There was no investigation of the allegation of neglect made on behalf of RB on 2/11/09 because of a misreading of the comments made by the Executive Director on the SIR. When pointed out, the Supervising Special Investigator and the ED agreed that OSI would open an investigation. There were no other instances of allegations not being investigated in the investigation reports reviewed. |

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| | | **Current recommendation**:<br>Complete the investigation of the 2/11/09 allegation of neglect of RB. |
| I.1.b.iv.3(ii) | the name(s) of all witnesses; | **Current findings on previous recommendation:**<br><br>**Recommendation, December 2008:**<br>Continue practice of asking involved parties if other persons might have heard or seen an incident under investigation.<br><br>**Findings:**<br>Several of the investigations reviewed specifically noted the investigator's attempt to locate witnesses. Examples include:<br><br>• In an investigation of physical assault (2/13/09), the investigator asked one staff witness if anyone else could have seen the incident.<br>• A notation in an investigation of assault (2/23/09) states, "A search for witnesses met with negative results."<br>• The investigator interviewed the individual who found two individuals engaged in sexual contact (12/12/08) and the "finder" told about what he had found.<br>• The investigator asked who else was in the medication line in the investigation of an allegation of psychological abuse (12/29/08).<br>• In the investigation of an allegation of sexual assault (1/20/09), the investigator interviewed the alleged victim's roommates, although the incidents allegedly occurred months earlier.<br><br>**Current recommendation**:<br>Continue current practice. |
| I.1.b.iv.3(iii) | the name(s) of all alleged victims and perpetrators; | **Current findings on previous recommendation:**<br><br>**Recommendation, December 2008:**<br>Ensure that in compound allegations, all victims are identified and |

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| | | entered into the RMS.<br><br>**Findings:**<br>The RMS forms for the investigations reviewed contained the names of all of the alleged victims and perpetrators.<br><br>**Current recommendation**:<br>Continue current practice. |
| I.1.b.iv.3(iv) | the names of all persons interviewed during the investigation; | **Current findings on previous recommendation:**<br><br>**Recommendation, December 2008:**<br>Continue to question whether other persons may have heard or seen an incident and interview anyone who is identified as a possible witness.<br><br>**Findings:**<br>See I.1.b.iv.3(ii) and I.1.b.iv.<br><br>**Other findings:**<br>The names of all persons interviewed were identified in the investigation reports.<br><br>**Current recommendation**:<br>Continue current practice. |
| I.1.b.iv.3(v) | a summary of each interview; | **Current findings on previous recommendation:**<br><br>**Recommendation, December 2008:**<br>Continue current practice.<br><br>**Findings:**<br>All of the investigation reports reviewed contained a summary of each interview conducted. |

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| | | **Current recommendation**:<br>Continue current practice. |
| I.1.b.iv.3(vi) | a list of all documents reviewed during the investigation; | **Current findings on previous recommendation:**<br><br>**Recommendation, December 2008:**<br>Continue current practice.<br><br>**Findings:**<br>All investigation reports reviewed listed the documents reviewed during the investigation. Examples included WRPs and other sections of clinical records, staffing logs, 1:1 monitoring sheets and physician's orders.<br><br>**Current recommendation**:<br>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 recommendation:**<br><br>**Recommendation, December 2008:**<br>Include documentation of the review of the incident history of named staff members and individuals in investigation reports.<br><br>**Findings:**<br>Documentation of the review of the incident history of the individual and the named staff member was present in some but not all of the investigation reports reviewed. For example:<br><br>• During the investigation of the incident reported on 1/8/09, the investigator found that JK had made one prior abuse allegation.<br>• Similarly, in investigations related to the 12/29/08 allegation of psychological abuse and the 2/15/09 allegation of sexual assault, the investigator noted that the individuals had made no prior abuse |

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| | | allegations.<br>• The named staff member in the investigation of physical and verbal abuse of NC was found to have had no prior abuse allegations made against him.<br>• LF had made two prior abuse allegations—a fact documented in the investigation of the 1/29/09 allegation of physical abuse.<br><br>**Current recommendation**:<br>Document the findings of the review of the incident history of both the individuals and named staff members in all A/N investigation reports. |
| I.1.b.iv.3(viii) | the investigator's findings, including findings related to the substantiation of the allegations as well as findings about staff's adherence to programmatic requirements; and | **Current findings on previous recommendation:**<br><br>**Recommendation, December 2008:**<br>DMH should identify its expectations concerning the issue of night rounds, addressing whether they are necessary in all instances or only under certain conditions, the frequency and the methods that are appropriate for various circumstances.<br><br>**Findings:**<br>This recommendation was not addressed. Persons in leadership positions said that DMH has not provided guidance related to night rounds.<br><br>**Other findings:**<br>All of the investigation reports reviewed documented the investigator's findings and used the SIR definitions as a basis for the determinations.<br><br>**Current recommendation**:<br>Continue current practice. |
| I.1.b.iv.3(ix) | the investigator's reasons for his/her conclusions, including a summary indicating how potentially conflicting | **Current findings on previous recommendation:** |

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| | evidence was reconciled; and | **Recommendation, December 2008:**<br>Review closely the rationales for determinations made at the close of investigations.<br><br>**Findings:**<br>The investigation reports reviewed provided clear rationales for the determinations. In several instances, the investigators were able to identify factors that likely contributed to the incident. These included recent refusal of medication by an individual and desire to move to another unit or to have a specific staff member removed.<br><br>**Current recommendation**:<br>Continue current practice. |
| I.1.b.iv.4 | staff supervising investigations review the written report, together with any other relevant documentation, to ensure that the investigation is thorough and complete and that the report is accurate, complete, and coherent. Any deficiencies or areas of further inquiry in the investigation and/or report shall be addressed promptly. As necessary, staff responsible for investigations shall be provided with additional training and/or technical assistance to ensure the completion of investigations and investigation reports consistent with generally accepted professional standards of care. | **Current findings on previous recommendation:**<br><br>**Recommendation, December 2008:**<br>Continue the work of the IRC and the supervising investigator in reviewing investigation reports to ensure their completeness and timeliness (including timeliness of interviews).<br><br>**Findings:**<br>All of the investigation reports reviewed were approved and signed by the Supervising Special Investigator. See I.1.b.iv for examples of oversight of investigations by the IRC. The April 30 IRC minutes request the investigators to document the reason for the delay when the investigation was not completed within the EP timeframe.<br><br>**Current recommendation**:<br>Continue current practice. |
| I.1.c | Each State Hospital shall ensure that whenever disciplinary or programmatic action is | **Current findings on previous recommendation:** |

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| | 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. | **Recommendation, December 2008:**<br>Continue current practice of identifying programmatic issues in IRC meeting and addressing them directly or referring them to the appropriate body.<br><br>**Findings:**<br>The IRC is on occasion identifying programmatic issues and making recommendations. The Director of Standards Compliance has, upon review of an investigation report in the IRC, referred individuals to the Enhanced Trigger Review Committee and the Facility Review Committee (see January 13, 2009 minutes).<br><br>**Other findings:**<br>Review of the facility's actions taken in response to sustained cases of A/N revealed that disciplinary action was taken or is pending in four of the five cases reviewed, and a letter of instruction was presented to the fifth staff member for sleeping while on duty.<br><br>[The data provided by the facility for this cell was not useful, since it did not identify the number of cases in which disciplinary or programmatic action was necessary or the number in which the actions were completed. This cell is consistently scored 100% compliance.]<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendation**:<br>Provide meaningful data that identifies the number of investigations completed each month in which programmatic or disciplinary action was recommended and the number in which the actions recommended were completed. |

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| I.1.d | Each State hospital shall have a system to allow the tracking and trending of investigation results. Trends shall be tracked by at least the following categories: | **Compliance:**<br>Partial, but substantial progress has been made. |
| I.1.d.i | type of incident; | **Current findings on previous recommendations:**<br><br>**Recommendation 1, December 2008:**<br>Identify the extent of the problem in the mismatch between the RMS data and the SIR data and take steps to correct it.<br><br>**Findings:**<br>In several of the investigations reviewed, the DPS or OSI found errors in the SIRs and reported them to Standards Compliance, so that the SIR database would be corrected.<br><br>**Recommendation 2, December 2008:**<br>Convert lists into tracking and pattern reports with analysis when the lists are reliable.<br><br>**Findings:**<br>The facility reports that it is confident that the RMS contains reliable data as of May 2009. It will be providing tracking and pattern reports to the Quality Council during the next review period.<br><br>**Other findings:**<br>The facility reported that during the review period, there were a total of 125 allegations of abuse or neglect and 47 investigations of allegations of abuse or neglect were closed, with 10 sustained and 37 not sustained. Review of the RMS printout of A/N closed cases for the report period (11/1/08—4/30/09) found that 52 cases were closed, with 10 sustained.<br><br>Closer review of the printout provides the following information related to the number of closed A/N incidents by type during the report period |

<table>
<tr>
<td></td>
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<td>as compared to the facility's report<br>.<br>
<table>
<tr><th>Incident type</th><th>RMS printout</th><th>Facility report</th></tr>
<tr><td>Physical abuse</td><td>17</td><td>15</td></tr>
<tr><td>Verbal abuse</td><td>13</td><td>12</td></tr>
<tr><td>Psychological abuse</td><td>6</td><td>4</td></tr>
<tr><td>Sexual abuse</td><td>7</td><td>7</td></tr>
<tr><td>Neglect</td><td>8</td><td>8</td></tr>
<tr><td>Exploitation</td><td>1</td><td>1</td></tr>
</table>
<br>Current recommendation:<br>Implement plans to provide tracking and pattern reports regarding incidents to the Quality Council.</td>
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<td>I.1.d.ii</td>
<td>staff involved and staff present;</td>
<td>Current findings on previous recommendations:<br><br>Recommendation 1, December 2008:<br>Identify and work with the vendor to correct errors in extracting data from the Records Management System.<br><br>Findings:<br>As reported, the facility is confident that as of May 2009, the data in the RMS is reliable and accurate.<br><br>Recommendation 2, December 2008:<br>DMH should ensure that written business rules for data entry into the RMS system apply to all of the facilities.<br><br>Findings:<br>This matter will be discussed at the next meeting of Standards Compliance Directors.</td>
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| | | **Recommendation 3, December 2008:**<br>Continue to review RMS records for accuracy.<br><br>**Findings:**<br>Review of the RMS records for the investigations reviewed found no errors.<br><br>**Other findings:**<br>The facility is able to run a listing of all of the persons involved in any single incident with the involvement code of each. It is also able to run a listing of all cases in which a staff member has been involved, with the staff member's involvement code. Specifically, during the review period 144 staff persons were involved in one incident (may have been the named aggressor, reporting party or witness), 17 were involved in two incidents and four were involved in more than two incidents<br><br>**Current recommendation**:<br>Identify how this information is used to improve the safety of the individuals and staff. |
| I.1.d.iii | individuals directly and indirectly involved; | **Current findings on previous recommendation:**<br><br>**Recommendation, December 2008:**<br>See relevant recommendations in I.1.d.ii.<br><br>**Current recommendation**:<br>See recommendation in I.1.d.ii above. |
| I.1.d.iv | location of incident; | **Current findings on previous recommendation:**<br><br>**Recommendation, December 2008:**<br>Use the location listing of incidents as the basis for trending and pattern data after ensuring the list is complete. |

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| | | **Findings:**<br>The facility provided a table indicating the number of incidents occurring on each unit. Units 32, 25, 12 and 1 had the greatest number of incidents (presumably during the review period, although the specific time period for the data in the table is not identified), with Units 32 and 25 having 10 and nine incidents respectively and units 12 and 1 having eight incidents each. Because it was not matched with the type of incident, this data provided very limited information.<br><br>**Current recommendation**:<br>Implement plans to provide useful data and analysis on incidents to the Quality Council during the next review period. This would include the type of incidents matched with their location. |
| I.1.d.v | date and time of incident; | **Current findings on previous recommendation:**<br><br>**Recommendation, December 2008:**<br>Ensure accuracy and completeness of RMS incident listing before using the information for tracking or pattern reports.<br><br>**Findings:**<br>Considerable work was done with the RMS to make it accurate and reliable.<br><br>**Other findings:**<br>The facility determined that during the review period, incidents were quite equitably distributed Sunday through Friday as shown below.<br><br>Sunday: 17; Monday: 21; Tues.: 19; Weds.: 20; Thurs.: 18; Friday: 20; Sat.: 10<br><br>The facility's review of the times of day incidents occurred during the |

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| | | review period revealed that the greatest number (17) occurred between 8AM—10AM and 4PM—6PM, followed by noon—2PM (14 incidents).<br><br>**Current recommendation**:<br>Provide analyses of the data as an aid to the bodies reviewing the data to identify possible explanations and recommendations for addressing the issues identified. |
| I.1.d.vi | cause(s) of incident; and | **Current findings on previous recommendations:**<br><br>**Recommendation 1, December 2008:**<br>Review Headquarters Reportable Briefs to ensure the Analysis section is complete.<br><br>**Findings:**<br>Review of 10 Headquarters Reportable Briefs found no errors in six (log numbers 09-026, 08-023, 09-022, 09-011, 09-002 and 09-005). Errors in the remaining four included:<br><br>• 09-007-- No analysis of contributing factors on this report designated as final.<br>• 09-008-- Designated a final report, although the investigation had not yet been completed.<br>• 09-019-- Investigation noted as not sustained in one section of the report, but another section states disciplinary action will be taken pending the results of the investigation. This was designated a final report.<br>• 09-024--Actions specific to the alleged aggressor cited as pending on page 1, but documented as moved off the unit on page 2. This was designated a final report.<br><br>**Recommendation 2, December 2008:**<br>Request investigators and staff members completing SIRs to note any |

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| | | environmental or other conditions that may have contributed to the incident. These might include understaffing, staff unfamiliar with the individuals on the unit, particularly noisy environment, bathroom facilities out of order, virtual Mall day, etc.<br><br>**Findings:**<br>The statewide Incident Management WaRMSS module will have a drop-down menu for identifying contributing factors to incidents that will include environmental, behavioral and therapeutic selections. When sufficient data has been put in the system, the facility will be able to present pattern reports based on cause data.<br><br>**Current recommendations**:<br>1. Continue with plans to have the IRC review HQ briefs to identify the causes and contributing factors for incidents.<br>2. Implement the Incident Management WaRMSS module as soon as testing proves its reliability.<br>3. Review HQ Briefs for accuracy and timeliness. |
| I.1.d.vii | outcome of investigation. | **Current findings on previous recommendation:**<br><br>**Recommendation, December 2008:**<br>If the RMS will be used as the basis for the trending and pattern reports required by the Enhancement Plan, ensure retrieved data is accurate.<br><br>**Findings:**<br>Each of the listings of cases described in I.1.d.i, ii, iii, and iv contains the outcome (determination) of the investigation.<br><br>**Current recommendation**:<br>Continue current practice. |

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| 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:**<br><br>**Recommendation, December 2008:**<br>Continue current practice.<br><br>**Findings:**<br>See the table in I.1.a.iv. With the exception of two staff members hired in 1996 and 1997, the remaining 13 staff members reviewed had cleared the background check before they were hired. The two exceptions have since been cleared.<br><br>**Other findings:**<br>As noted previously the decision (and a rationale) to remove or not remove a named staff member is sometimes documented in the investigation. It was consistently documented in the relevant HQ Briefs reviewed.<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendation**:<br>Ensure investigation reports state whether the named staff member was removed from the unit. |

| 2. Performance Improvement | | |
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| I.2 | Each State hospital shall develop, revise as appropriate, and implement performance improvement mechanisms that enable it to comply fully with this Plan, to detect timely and adequately problems with the provision of protections, treatment, rehabilitation, services and supports, and to ensure that appropriate corrective steps are implemented. Each State hospital shall establish a risk management process to improve the identification of individuals at risk and the provision of timely interventions and other corrective actions commensurate with the level of risk. The performance improvement mechanisms shall be consistent with generally accepted professional standards of care and shall include: | **Methodology:**<br><br><u>Interviewed</u>:<br>1. Andeline Gloster, RN, Unit N21 nurse<br>2. Andrew Blaine, MD, Unit 71 psychiatrist<br>3. Anne Oliveros, Unit N24 psychiatric technician<br>4. B. DePalmer, Standards Compliance and MRMC facilitator<br>5. B. Sherer, Hospital Administrator<br>6. Barbara Streit, Unit 25 rehabilitation therapist<br>7. C. Brown, Risk Manager<br>8. Christopher Michaels, PhD, Unit 25 psychologist<br>9. Christy Crespin, LCSW, Unit 71 social worker<br>10. Clarence Patterson, Unit N21 psychiatric technician<br>11. Crystal Mueller, PhD, Unit 71 psychologist<br>12. D. Bienstock, Information Systems Analyst<br>13. Delores Conner, LCSW, Unit 25 psychiatric social worker<br>14. Eleanor Laway-Pinchot, RN, Unit N24 nurse<br>15. Erin Cross, Unit N21 rehabilitation therapist<br>16. G. Christison, MD, Medical Director<br>17. G. Richardson, Director of Standards Compliance<br>18. George Proctor, MD, Unit 25 psychiatrist<br>19. Jennifer Utley, PsyD, Unit N24 psychologist<br>20. Joseph Munyiri, RN, Unit 71 nurse<br>21. Joshua Horsley, MD, Unit N21 psychiatrist<br>22. Kate Madigan, Unit 71 rehabilitation therapist<br>23. Kim Braxton, LCSW Unit N24 social worker<br>24. Miyoko Oaks, Unit N21 clinical social worker<br>25. Oscar Abenes, Unit 71 psychiatric technician<br>26. Paul Kratofil, DO, Unit N24 psychiatrist<br>27. Phuong Lam, RN, Unit 25 nurse<br>28. S. Doerner, Acting Nurse Administrator<br>29. S. Sandoval, Standards Compliance |

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| | | 30. Stephanie Chatman, Unit 25 psychiatric technician<br>31. Stephen Wurz, Support Services Assistant<br>32. Tim Alder, MD, Unit EB11 psychiatrist<br>33. Vicki McWain, PhD, Unit N21 psychologist<br><br><u>Reviewed</u>:<br>1. The charts of five individuals (BN, ED, JC, JT and TF) to review implementation of the process and clinical application of Special Order 262<br>2. PSH Patient Data for BN<br>3. PSH Patient Data for ED<br>4. Task Tracker for ED<br>5. PSH Patient Data for JC<br>6. Task Tracker for JC<br>7. PSH Patient Data for TF<br>8. ETRC/PSSC meeting tracking forms<br>9. Medical Risk Management Committee tracking forms<br>10. MRMC Committee Case reviews and minutes for 6/8/09<br>11. Risk Profiles for 11 individuals<br>12. Review of the clinical records of nine individuals for trigger follow-up<br>13. Data on peer-to-peer violence<br>14. Aggregate trigger data<br><br><u>Observed</u>:<br>1. ETRC/PSSC meeting<br>2. Facility 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:**<br>Partial. |

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| I.2.a.i | data collection tools and centralized databases to capture and provide information on various categories of high-risk situations; | **Current findings on previous recommendation:**<br><br>**Recommendation, December 2008:**<br>Continue with plans to expand implementation of the Risk Management system.<br><br>**Findings:**<br>All of the review committees identified in the Risk Management Special Order 262 are meeting and reviewing individuals. Several databases are presently used to track trigger data. The statewide WaRMSS includes a Risk Management component that is scheduled to be available for use by the end of June. (The system was being tested the week the court monitoring team was on site.) The Task Tracker (developed by ASH) is being used to collect and communicate recommendations made by the various review committees and to track the Risk Profile developed for each individual in the facility.<br><br>**Other findings:**<br>The Risk Profiles of 11 individuals identified each individual's risks and the criteria the individual met to be considered at risk for the specific medical or behavioral condition. For example, KB was at high risk for MRSA because she had engaged in self-injurious behavior that resulted in a break in skin integrity within the last three months. She did not meet the other MRSA risk criteria: refuses wound treatment, history of MRSA, significant blood exposure, decubitus ulcer.<br><br>The facility's data shows an increase in both the number of individuals involved in peer-to-peer altercations and the number of incidents of peer-to-peer violence:<br><br>[illegible] |

| | May – Oct 08 | Nov 08 – Apr 09 |
|---|---|---|
| Peer-to-peer altercations | | |
| Total number | 522 | 629 |

| | | |
|---|---|---|
| Monthly mean | 87 | 105 |
| Number of individuals involved in peer-to-peer altercations | | |
| Total number | 817 | 1003 |
| Monthly mean | 136 | 167 |
| Number of positive drug screens | | |
| Total number | 54 | 75 |
| Monthly mean | 9 | 13 |

The facility has taken measures to address the peer-to-peer violence that include:

- Realignment of the WRPs that included training for and review and approval of each case formulation. This work was completed in April 2009.
- Ongoing work on WRPs that includes training provided by Psychology, Social Work, Rehabilitation Therapy and Nursing to WRPTs focusing on objectives and interventions.
- Mall Realignment that included a Mall needs assessment of each individual and staff sign-up for the redesigned Mall groups.
- Development of a Refusal of Medical Treatment Protocol and Policy. This policy has been approved and will be implemented shortly.
- Proposal submission for a Patton Wellness Center to assist individuals in addressing weight-related issues.
- Measures to promote a spirit of community among individuals that include "Good Morning, Patton" broadcast and increased supplemental recreational opportunities (craft night, scavenger hunt, facility-wide BINGO, Patton Idol, weekend volleyball, basketball, etc.)

**Current recommendations**:

1. Continue the implementation of initiatives to reduce the level of violence on the campus.
2. See the recommendation in I.2.a.ii regarding implementation of the Risk Management Special Order.

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| I.2.a.ii | establishment of triggers and thresholds that address different levels of risk, as set forth in Appendix A; and | **Current findings on previous recommendation:**<br><br>**Recommendation, December 2008:**<br>Continue implementation of the Risk Management Special Order in a manner that complies with the order while best meeting the needs of the individuals and using efficiently the time and talents of the staff members involved.<br><br>**Findings:**<br>Review of the meeting schedule for the four levels of review yielded the following: each Program Review Committee is meeting weekly, the PSSC/ETRC is meeting four times a week, the Facility Review Committee is meeting three times a month, and the Medical Risk Management Committee (MRMC) is meeting twice weekly.<br><br>Agreement was reached for an alternate review process to reduce the workload of the MRMC that would require the physician or nurse practitioner to review the medical risks of the individuals and the interventions in place and determine them to be adequate or not adequate and thereby referred to the MRMC.<br><br>There is also concern that the number of individuals being referred to the Facility Review Committee in a month (between 50-60) is more than the committee can accommodate, although it is meeting four times each month. The facility needs to triage the cases and address the most critical ones first.<br><br>The facility questions the utility of the Program Review Committee and has suggested that a form modeled after the one to divert cases from the MRMC, which focuses on behavioral interventions and is signed by the psychologist and psychiatrist, would prove more useful in ensuring appropriate individualized interventions. Several recommendations made at the Facility Review Committee meeting, such as aligning groups with |

objectives, could have been made earlier in the review process at the Program level.

This monitor and his experts interviewed WRPTs who supported individuals who had crossed established risk management triggers. The following summarizes these episodes:

| Individual | Unit | Indicator | Trigger | Date(s) |
|---|---|---|---|---|
| BN | 25 | N/A | Verbal aggression to peer that prompted 1:1 observation | 4/8/09 |
| ED | N24 | Suicide | Suicide attempt | 4/26/09 |
| JC | N21 | Aggressive Act to Self | Aggression to self with injury | 5/14/09 |
| JT | EB11 | N/A | Repeated transfers to outside medical facility | --- |
| TF | 71 | Suicide | Suicide threat | 4/5/09<br>4/9/09 |

With regard to process, the interviews revealed the following:

- PSH implemented the Risk Management Special Order during this review period.
- WRPT members appeared knowledgeable with regard to the first and second levels of the risk management procedures, including how to access these interventions.
- The risk management database appeared consistent in terms of date and category with the reviewed risk episodes.
- WRPT members were able to easily locate documentation within the medical record.
- Recommendations from the second level reviews had been entered into the task tracker.

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| | | With regard to clinical care, some areas of progress were noted:<br><br>1. In all cases, the process of referral to the PSSC was appropriate when the teams determined that the trigger had a behavioral component.<br>2. Documentation of a timely review of the incident by a psychiatrist (including addressing measures to ensure safety) was completed consistently.<br>3. The Present Status section of the case formulation was updated to reflect the trigger event.<br><br>However, it was noted that ETRC and PSSC findings and recommendations were not consistently integrated into the individual's record, specifically the Present Status section of the WRP.<br><br>**Current recommendations**:<br>1. Ensure full implementation of the Risk Management Special Order and solicit feedback from facilities regarding any operational refinements that may be necessary.<br>2. Ensure that reviews at the second level (ETRC, PSCC, MRMC) include adequate clinical review and rationale for each recommendation.<br>3. Ensure that the second level review generates a clinical document that is filed within the individual's record.<br>4. Ensure appropriate referrals for assessments throughout each level of risk management review. |
| I.2.a.iii | identification of systemic trends and patterns of high risk situations. | **Current findings on previous recommendation:**<br><br>**Recommendation, December 2008:**<br>Continue to provide expert clinical attention to individuals at high risk for aggression and to their victims. |

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| | | **Findings:**<br>The facility is providing expert clinical attention to individuals through the review committee structure implemented in accordance with the Risk Management Special Order.<br><br>**Other findings:**<br>Review of the High Risk Profiles for 11 individuals revealed that victimization is one of the behavioral factors considered in addition to aggression to self and others. See also data on aggression in I.2.a.i.<br><br>**Current recommendation**:<br>See recommendations in I.2.a.i. |
| I.2.b | Mechanisms for timely interventions and other corrective actions by teams and disciplines to prevent or minimize risk of harm to individuals. These mechanisms shall include, but not be limited to: | **Compliance:**<br>Partial. |
| I.2.b.i | a hierarchy of interventions by clinical teams that correspond to triggers and thresholds; | **Current findings on previous recommendation:**<br><br>**Recommendation, December 2008:**<br>Ensure that in dealing with persons involved in aggressive incidents resulting in serious injury, equal attention is paid to identifying and providing psychological services as well as physical services to individuals who are victims.<br><br>**Findings:**<br>See the findings in I.3.d that suggest that psychological services are not consistently being offered to individuals involved in sexual incidents.<br><br>**Current recommendation**:<br>Ensure that individuals suffering serious injury are provided psychological as well as physical services. |

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| I.2.b.ii | timely corrective actions by teams and/or disciplines to address systemic trends and patterns; | **Current findings on previous recommendation:**<br><br>**Recommendation, December 2008:**<br>As the information system capacity develops, identify patterns and trends in trigger data.<br><br>**Findings:**<br>See the table in cell I.2.b.v and the facility's measures to address violence presented in I.2.a.i. As shown in the table in I.2.a.i, there has been an increase in the number of positive drug screens, which some individuals associate with the cigarette smoking ban. Individuals also asked for assurance that there will be consequences for individuals found to have engaged in violent behavior at the same time as using street drugs. The ED has agreed to submit a plan addressing illicit drug use.<br><br>**Other findings:**<br>In the case of CJ (see I.2.a.ii), the behavior guideline underwent numerous reviews without completion of a comprehensive assessment by the Positive Behavior Support team, and implementation of the guideline lacked fidelity.<br><br>**Current recommendations**:<br>1. Continue implementation of measures aimed at reducing violence on campus.<br>2. Develop, as agreed, a plan for addressing illicit drug use on campus. |
| I.2.b.iii | formalized systems for the notification of teams and needed disciplines to support appropriate interventions and other corrective actions; | **Current findings on previous recommendation:**<br><br>**Recommendation, December 2008:**<br>Continue implementing the Risk Management Special Order.<br><br>**Findings:**<br>The facility continues to operate a reliable system of notification when an |

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| | | individual reaches a trigger. The facility reports that it issued 490 trigger alerts to WRPTs during the review period.<br><br>Since full implementation of the Risk Management Special Order, Standards Compliance provides a schedule on a weekly basis to the Program Review Committee members identifying the individuals to be reviewed, the specific incident and the incident date. Standards Compliance provides a similar schedule that identifies the individual, trigger and trigger date to all members of the ETRC/PSSC and the Facility Review Committee members.<br><br>**Current recommendation**:<br>Continue current practice. |
| I.2.b.iv | formalized systems for feedback from teams and disciplines to the standards compliance department regarding completed actions; and | **Current findings on previous recommendation:**<br><br>**Recommendation, December 2008:**<br>Continue to expand implementation of the Risk Management system.<br><br>**Findings:**<br>The facility reports that during the review period, the response rate back from WRPTs to Standards Compliance was 57% (an improvement over the 48% rate from the previous reporting period). The response rate for the current period ranged from a high of 69% to a low of 26%.<br><br>The Task Tracking forms for the combined ETRC/PSSC and for the committees when they meet separately identify the recommendations made, track the current status of implementation, and provide a follow-up review date where appropriate<br><br>**Current recommendations**:<br>1. As planned, begin using the WaRMSS system as soon as it is operational to track WRPTs' responses to triggers. |

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| | | 2. Continue current practice of tracking review committee recommendations. |
| 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:**<br><br>**Recommendation, December 2008:**<br>Continue to implement the Risk Management system in a manner that complies with the Special Order and meets the needs of the individuals by making best use of the talents and time of the clinicians who treat and/or supervise those who treat them.<br><br>**Findings:**<br>See findings in various cells that describe the present status of implementation of the Risk Management Special Order.<br><br>**Other findings:**<br>PSH does not presently have the capacity to monitor the implementation of actions proposed by the WRPTs in response to triggers. It is, however, tracking the recommendations made by the various committees as evidenced by the Risk Tracker printouts, which serve as the committee minutes. The facility acknowledges that with the full implementation of the WaRMSS Risk Management module, it will be better able to monitor implementation of the recommendations made by the ETRC/PSSC and the Facility Review Committee.<br><br>Review of the implementation of 21 actions proposed by WRPTs or a review committee in response to triggers involving nine individuals as determined by the review of the individual's clinical record yielded the following positive results: |

| Indiv-idual | Trigger date | WRPT response | Implementation documented |
|---|---|---|---|
| HC | Homicide threat 3/6/09 | Medication change<br>2:1 initiated | Yes<br>Yes |
| ED | Diabetes w/new antipsychotic med 3/31/09 | MRMC: diabetic ed and medication adjustment | Yes<br>Yes |
| SH | 2 or ↑ agg acts in 7 cons. Days 4/9/09 | ETRC: clarify dx,<br>Consider PBS | Yes<br>Yes |
| AV | Hospitalization 4/28/09 | Order cultures<br>Open a temporary condition | Yes<br>Yes |
| LS | Fall→injury 4/24/09 | Fall risk updated<br>Open temporary condition | Yes<br>Yes |
| JP | SIB→injury 3/11/09 | ETRC/PSSC:<br>Implement BG<br>PBS assessment | Yes<br>Yes |
| KK | Suicide attempt 3/5/09 | Med change<br>Suicide risk assessment | Yes<br>No |
| ED | Suicide attempt 4/26/09 | ETRC/PSSC: Get med level<br>Initiate involuntary meds | Yes<br>Yes |
| KK | Hospitalization 3/16—19/09 | MRMC: Add medication to regimen | Yes |
| MH | Suicide attempt 3/10/09 | PBS assessment<br>Suicide assessment<br>Med change<br>WRP attachment | Yes for all |

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| | | **Current recommendation**:<br>Undertake the planned monitoring of implementation of recommendations and proposed actions in response to incidents and triggers when the statewide WaRMSS incident and risk management module becomes operational. |
| 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:**<br><br>**Recommendation, December 2008:**<br>Continue efforts to meet the requirements of the EP as resources become available.<br><br>**Findings:**<br>The facility has been faithful in developing strategies to improve the quality of WRPs, introducing measures to reduce the level of violence in the facility and implementing the Risk Management Special Order. The introduction of the Incident and Risk Management components of the WaRMSS system will be a valuable information technology tool assisting the facility to meet its service goals.<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendation**:<br>Continue implementation of plans to use the WaRMSS Incident and Risk Management components to advance the facility's achievement of its service goals. |

| 3. Environmental Conditions | | |
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| I.3 | Each State hospital shall develop and implement a system to review regularly all units and areas of the hospital to which individuals being served have access to identify any potential environmental safety hazards and to develop and implement a plan to remedy any identified issues, consistent with generally accepted professional standards of care. Such a system shall require that: | **Methodology:**<br><br>Interviewed:<br>1. B. Ray, Health & Safety Officer<br>2. B. Sherer, Hospital Administrator<br>3. D. Both, Plant Operations<br>4. E. Halsell, Chief of Plant Operations<br><br>Reviewed:<br>1. Environmental Conditions Random Spot Checks report<br>2. Environment of Care Grid<br>3. Clinical records of 10 individuals with the problem of incontinence<br>4. Environment of Care Checklist Record<br>5. Clinical records of 10 individuals named in sexual contact incidents<br><br>Toured:<br>Five units: 24, 36, 71, 73 and 75 |
| I.3.a | Potential suicide hazards are identified and prioritized for systematic corrective action, and such action is implemented on a priority basis as promptly as feasible; | **Current findings on previous recommendations:**<br><br>**Recommendation 1, December 2008:**<br>Develop and implement a plan to refit those air vents that are positioned in private areas in such a way that they do not present a suicide hazard.<br><br>**Findings:**<br>The facility plans to replace the air vents once it has completed the remodeling of the bathrooms. The proposed timeframe for replacement of the vents has the retrofitting scheduled for completion in the 70 Building by November 1, 2009. The work in the other buildings will follow. All of the bathrooms in the 30 Building and most of the units in the N Building have been remodeled with push-button shower on-off fixtures, improved lighting and retiled shower enclosures. Remodeling of bathrooms in the 70 |

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| | | Building is due to begin in the early fall.<br><br>**Recommendation 2, December 2008:**<br>Replace the lockers as soon as possible.<br><br>**Findings:**<br>Wardrobes are being replaced with storage units that do not require the use of combination locks secured with metal chains. The lock and chain combination represents a suicide hazard. This suicide hazard was specifically identified in the independent review of the death of AS.<br><br>**Other findings:**<br>The corners of the metal plumbing access shields have been pried away from the ceiling in a bathroom on Unit 70. These could represent a suicide and/or weapon hazard.<br><br>The facility maintains a running report on the status of projects to improve the safety of the environment. Excerpts include:<br><br>• The projects to replace the door handles on 995 doors and renovate with continuous hinges have been suspended due to budget constraints.<br>• The plan to replace windows with security glazing was not funded because of the state budget crisis.<br>• The project to convert from spring to pan beds has been completed.<br><br>The facility reports that in early April 2009, the Health & Safety office provided training to supervisors on potential suicide risks.<br><br>See also I.1.b.i for additional information regarding the suicide death of AS.<br><br>**Compliance:**<br>Partial. |

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| | | **Current recommendations**:<br>1. Continue current practice of improving the safety of the environment as resources are made available.<br>2. Repair or replace the plumbing access shields on Unit 70 noted above.<br>3. Complete the review of the suicide death of AS. Identify, implement and monitor implementation of the recommendations forthcoming from the review. |
| I.3.b | All areas of the hospital that are occupied by individuals being served have adequate temperature control and deviations shall be promptly corrected; | **Current findings on previous recommendations:**<br><br>**Recommendation 1, December 2008:**<br>Ensure that plastic containers individuals commonly use to prepare food are washed regularly.<br><br>**Findings:**<br>Dirty food containers kept in bedrooms were not an issue during this review. The facility has permitted unit staff to bring the plastic containers to the cafeteria for dishwasher cleaning.<br><br>**Recommendation 2, December 2008:**<br>Replace hall lighting as needed.<br><br>**Findings:**<br>Non-functioning hall lighting was not an issue during this review.<br><br>**Other findings:**<br>In late afternoon, it took quite a while for hot water to reach the bathroom faucets. The facility acknowledged that this is a problem. Individuals who choose to shower in the evening/night run the water for several minutes before showering.<br><br>The most common environmental problem on the units toured that did not |

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| | | represent a suicide hazard was the lack of linen on beds or dirty linen. This was particularly problematic on Unit 73. The facility's Random Spot Check report documented the same problem on this unit on 12/10/08. The report noted that it was linen exchange day, which may have accounted for the finding.<br><br>The facility reports that all urgent work orders in the review period were responded to on the same or next business day. Work orders related to temperature control would be considered urgent work orders.<br><br>The Environment of Care Checklist Record indicates that during the review period, 57 (65%) of the 88 areas inspected were individual-occupied areas. In each case in which deficiencies were noted, the program responded with a plan of correction to the Health & Safety Department.<br><br>**Compliance:**<br>Substantial as related to temperature and based on the facility's self-report.<br><br>**Current recommendation**:<br>Continue current practice. |
| I.3.c | Each State hospital reviews, revises, as appropriate, and implements procedures and practices so that individuals who are incontinent are assisted to change in a timely manner; | **Current findings on previous recommendations:**<br><br>**Recommendation 1, December 2008:**<br>Continue efforts to ensure that physicians and nurses address the problem of incontinence in WRPs.<br><br>**Findings:**<br>Review of the records of ten individuals identified as having the problem of incontinence (AT, DB, HR, JC, KM, ML, RB, RJ, RS and YR) revealed that in each record, Focus 6 included objectives and interventions related to the problem. Use of an Elimination Pattern Worksheet was mentioned in |

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| | | half of the records reviewed. Follow-up on a sample of these found them in use on the unit. These positive findings are consistent with the training efforts the facility undertook to comply with this section of the EP. However, the facility provided no data on its monitoring of persons with the problem of incontinence for the review period.<br><br>**Recommendation 2, December 2008:**<br>Take measures to ensure that clinicians document discussions/counseling and other interventions identified in the WRP when they occur.<br><br>**Findings:**<br>See above.<br><br>**Compliance:**<br>Substantial (based on a small sample).<br><br>**Current recommendation**:<br>Monitor performance and report the monitoring data for the next review period. |
| I.3.d | Each State hospital thoroughly reviews and revises, as appropriate, its policy and practice regarding sexual contact among individuals served at the hospital. Each State hospital shall establish clear guidelines regarding staff response to reports of sexual contact and monitor staff response to incidents. Each State hospital documents comprehensively therapeutic interventions in the individual's charts in response to instances of sexual contact; and | **Current findings on previous recommendations:**<br><br>**Recommendation 1, December 2008:**<br>Ensure that proper clinical attention is paid to the alleged victim and aggressor in instances of nonconsensual sexual contact.<br><br>**Findings:**<br>Review of the clinical records of 10 individuals named in sexual contact yielded the findings in the following table. The incident under review was not mentioned in the next WRP in half of the cases and a sixth WRP had not been updated following the incident as planned. |

| Individual Incident date | Incident type | WRPT response |
|---|---|---|
| AP 4/13/09 | Questionable consensual contact | Counseled re safe sex. WRP 4/20/09 makes no reference to incident. |
| BS 4/20/09 | Alleged victim in non-consensual sexual contact | Incident addressed in Focus 3 in WRP dated 4/30/09. WRP contains inconsistent victimization risk scores. |
| CG 4/13/09 | Questionable consensual contact | WRP (4/22/09) no mention of this incident. Focus 2.1 attend groups to learn to identify when he is socially inappropriate. |
| DJ 2/11/09 | Alleged aggressor in non-consensual sexual contact | 2/26/09 WRP cites this incident. Focus 3 addresses inappropriate behaviors around women, but objective is inactive, while stage is action stage. |
| GD 11/7/08 | Inappropriate touching of female staff | Placed on 1:1. WRP (12/4/08) states, "No impulsive behavior since 8/08." No mention of this incident. |
| PB 4/24/09 | Consensual contact | Safe sex teaching provided. Counseled re appropriate behavior. WRP (5/15/09) references this incident. |
| RF 3/4/09 | Alleged aggressor in non-consensual sexual contact | No counseling provided re: incident. WRP dated 6/1/09 incident listed among triggers. No further mention. |

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| SH 4/20/09 | Alleged aggressor in non-consensual sexual contact | Placed on 2:1. Plan was to update WRP, but not done. Most recent WRP in clinical record was 2/17/09. |
| TT 11/14/08 | Consensual contact | No IDN note re incident. WRP (11/21/08) no mention of the incident. |
| VM 11/14/08 | Consensual contact | WRP (12/9/08) discharge barrier: promiscuous behavior. No mention of this specific incident. |

**Recommendation 2, December 2008:**
Address victimization and aggressor behavior in the WRPs of individuals involved in nonconsensual sexual incidents.

**Findings:**
See above.

**Other findings:**
The facility provided no information on its internal audit of the handling of sexual contact incidents.

**Compliance:**
Partial.

**Current recommendation**:
Begin auditing the response of WRPTs to sexual contact incidents in order to provide necessary guidance and corrective measures.

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| 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 | **Current findings on previous recommendation:** |

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.

**Recommendation, December 2008:**
Continue efforts to provide all non-unit staff Mall facilitators with the full training curriculum.

**Findings:**
The number of non-unit staff providing Mall groups increased from 191 in November 2008 to 232 in April 2009. As demonstrated in the table below, the facility has trained more non-clinical Mall providers during the review period. In six of the seven mandatory courses, compliance exceeds 85%.

| Course | May—Oct 08 | Nov 08—Apr 09 |
|---|---|---|
| PMAB | 74% | 94% |
| CPR | 82% | 88% |
| First Aid | 87% | 94% |
| Recovery (chapter 1) | 73% | 79% |
| By Choice | 84% | 87% |
| Patients Rights | 70% | 88% |
| Neglect and Abuse | 91% | 94% |
| Mean Compliance Rate | 75% | 87% |

The figures cited above are provided by the facility.

**Compliance:**
Substantial.

**Current recommendation:**
Continue ensuring that non-clinical Mall providers receive the designated training.

| J. First Amendment and Due Process | | |
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| J | | **Summary of Progress:**<br>1. Two individuals now have seats on the Quality Council and report the concerns of the individuals to the Council and report the work of the Council back to the individuals during Senate meetings.<br>2. Individuals have taken an active role in identifying factors that may be influencing the level of violence in the facility and in making suggestions for lowering the level of violence.<br>3. Senate members identified those actions by the administration that they believed were helpful in reducing the level of violence.<br>4. The individuals and facility administration have implemented measures that have improved the timeliness of the delivery of packages to individuals.<br>5. Forty percent of the items on the individuals' surveys were scored more positively in February 2009 than in the previous review period.<br>6. Individuals remain respectful of the rules of order in meetings and in following procedures for the submission of proposals to the administration. |
| J | Each State hospital unconditionally permits individuals to exercise their constitutional rights of free speech, including the right to petition the government for redress of grievances without State monitoring, and provides them due process. | **Methodology:**<br><br><u>Interviewed</u>:<br>1. Individuals on the units toured and at the Senate meeting<br>2. C. Clark, Administrative Liaison<br><br><u>Reviewed</u>:<br>1. Cell J Survey results<br>2. Central Council/Administration Meeting minutes of May 15, 2009<br>3. Individuals' report on factors affecting violence<br><br><u>Participated</u>:<br>Senate Meeting |

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**Current findings on previous recommendations:**

**Recommendation 1, December 2008:**
Review telephone access to ensure that individuals can maintain appropriate and necessary contact with people outside the facility, including family members, legal representatives and advocates.

**Findings:**
Telephone access remains problematic. Senate members reported that outgoing non-collect calls are limited to venues within eight miles of the facility. All calling cards are considered contraband. They further reported that social workers were sometimes, but not always, agreeable to allowing individuals to call beyond that limit. The eight-mile limit restricted communication with family members, advocates and legal advisors.

**Recommendation 2, December 2008:**
Determine methods for improving the timeliness of delivering packages to individuals.

**Findings:**
The Senate representatives reported vast improvement in the timeliness with which packages are delivered to the unit and distributed.

**Other findings:**
The facility reported the following results for the survey conducted in February 2009, to which 318 individuals responded:

| Item | Percentage of positive responses |
|---|---|
| Feel safe? | 60% |
| Treated with respect? | 70% |
| Environment clean? | 68% |

| | |
|---|---|
| Encouraged to be of service to others? | 58% |
| Staff make sure rules are followed? | 74% |
| Unit's rules are fair? | 61% |
| Staff believe I can get better? | 71% |
| I have input into hospital rules and policies. | 52% |

Individuals answered eight of the 20 survey questions more positively in February 2009 than in the same survey six months earlier. Half of the 20 questions received a positive score of 65% or greater in the February 2009 survey.

Discussion with Senate members, the review of the May Central Council/Administration Meeting minutes and discussions with staff revealed concern about violence on the campus. Individuals have responded to the request to identify factors contributing to violence on campus with a two-page list. The primary factors identified during the Senate meeting were the black market in cigarettes and its sequelae, the lack of consequences for violent individuals, roaming gangs, and the effects of worry and stress (related to economic conditions and uncertainty) on staff members. Some staff members noted street drugs brought into the facility as a contributing factor. The minutes of the Council/Administration Meeting and the Senate members cited the SAFE program as a successful program for combating violence on campus.

**Compliance:**
Partial compliance related to concerns on the severe restrictions on non-collect outgoing calls.

**Current recommendation**:
Investigate methods for broadening telephone communication, such as the use of calling cards that have been found acceptable in other facilities.