

REPORT 2
METROPOLITAN STATE HOSPITAL EVALUATION

March 19 - 23, 2007

THE HUMAN POTENTIAL CONSULTING GROUP
ALEXANDRIA, VIRGINIA

NOTE

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

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

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Introduction

A. Background Information

The evaluation team, consisting of the Court Monitor (Mohamed El-Sabaawi, M.D.) and four expert consultants (Vicki Lund, Ph.D., M.S.N, A.R.N.P.; Ramasamy Manikam, Ph.D.; Elizabeth Chura, M.S.R.N.; and Kevin Sutherland, Ph.D.) visited Metropolitan State Hospital (MSH) from March 19-23, 2007 to evaluate the facility's progress regarding compliance with the Enhancement Plan (EP). The evaluators' objective was to develop a detailed assessment of the status of compliance with all action steps of the EP.

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

1. The methodology of evaluation, summarized in one cell at the beginning of each section or major subsection (C1, C2, D1 through D.7, E, F1 through F 10, G, H., I and J);
2. Findings of the facility's progress in each step of the EP. The findings are listed in reference to each corresponding recommendation in the Court Monitor's baseline assessment of September 2006. This is followed by other findings that relate to the requirements of each step. The findings include, as appropriate, the facility's internal monitoring data and the evaluators' monitoring data;
3. Compliance status in terms of the EP; and
4. Recommendations.

The evaluators' recommendations are suggestions, not stipulations for future findings of compliance. The facility is free to respond in any way it chooses to the recommendations as long as it meets the requirements in every action step in the EP.

B. Methodology

The evaluation team reviewed a variety of documents prior to, during and after the on-site evaluation. The documents included, but were not limited to, charts of individuals, facility administrative directives (ADs), policies and procedures, the state's special orders,

and the 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 and clinical staff and some individuals and observed a variety of therapeutic, rehabilitative and other service delivery processes. The data provided by the facility were verified, on a random basis, to ensure accuracy and reliability.

C. Statistical Reporting

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

Abbreviation	Definition
N	Total target population
n	Target population reviewed
%S	Sample size; target population reviewed (n) divided by total target population (N)
%C	Compliance rate

Means over time were calculated by adding the compliance rates for the months and dividing by the number of months for which data was provided. For example, if one month of data was missing over a six-month period, the denominator used was five months rather than six.

In some cases, the facility began averaging its own data more recently than September 2006, reportedly due to changes in data collection methods. In those cases, the report contains all available data but shades the columns that have been excluded from the average.

Means (averages) across a set of indicators were calculated by adding the compliance rates for the indicators and dividing by the number of indicators.

D. Findings

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

1. Key indicator data

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

- a) The key indicator data provide a global assessment of and insights into the clinical and process outcomes at the facility over time and should not be seen as just another requirement of the EP.
- b) At present, MSH has collected nine months of key indicator data (June 2006 through February 2007). This amount of data is forming a foundation for moving beyond interpretations that are at present necessarily tentative due to lack of sufficient longitudinal data. Additionally, the accumulation of data over time will permit comparisons across facilities. However, at this stage interpretations must remain somewhat reserved.
- c) The additional data accumulated since the baseline report suggests some positive trends, including:
 - i. A decrease in the number and percentage of individuals that are overweight (with a body mass index between 25.0 and 29.9);
 - ii. A decrease in the number and percentage of individuals that experience rapid short-term weight gain;
 - iii. No falls in the past four months; and
 - iv. An overall decline in the use of PRN medications.
- d) At the same time, the key indicator data reveals trends that should be investigated and explained by the facility. It is not sufficient for the facilities to simply report data without context or explanation; this leads to the impression that the data are not reviewed thoroughly to gain insights that are subsequently used to inform practice. Examples of trends that should be investigated and explained include:
 - i. Acts of aggression to self and to others peaked in September and October 2006, then fell through year-end 2006 before rising in early 2007. It is unclear what is driving this dynamic—changes in individual population, changes in facility practices, some kind of seasonality, or other factors.
 - ii. Allegations of abuse, neglect, and/or exploitation spiked in February 2007.
 - iii. As at Napa State Hospital, changes in body mass index are markedly cyclical, reversing from increase to decrease to increase over consecutive months.
 - iv. The use of combined pharmacotherapy has steadily increased over the reporting period. While there may be a justification for this trend, it bears observation and comment from the facility.

- e) Key indicators also reveal some trends that raise questions about the thoroughness of detection, data capture and reporting. For example:
- i. MSH reports very few incidents of individuals testing positive for the use of illicit substances considering the individual population size. Are there truly few individuals using illicit substances or are there untapped opportunities to enhance the detection of illicit substance use?
 - ii. The decline in reported medication variances stemming from transcription errors is positive on its face, but should not be accepted unquestioningly due to empirical findings of inadequate systems for capturing variances of all types.
 - iii. Given the volume of medication variances reported, it is striking that the facility also reports that no variances resulted in a major injury or exacerbation of a disease or disorder. Experience suggests that systems may not be capturing the negative outcomes of variances.

2. Monitoring

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

- a) The California Department of Mental Health (DMH) has made significant progress in streamlining and standardizing monitoring systems across hospitals, especially in the tools that are used to monitor the process and content of the Wellness and Recovery Plan (WRP). Although much remains to be done, this progress is noteworthy.
- b) Each hospital should have a consistent and enduring group of trained staff to collect data using each of these tools.
- c) The DMH has developed written operational instructions that accompany the WRP monitoring tools. These instructions contain appropriate guidelines regarding the use of each tool.
- d) The three WRP monitoring tools should be used to collect monthly data on each of the following WRPs (Chart Audits and Clinical Chart Audits) and WRP conferences (Observations): seven-day, 14-day, monthly and annual. Data should be collected on a 20% sample of each WRP conference or WRP, or the total sample if the number of "cases" is less than 20, whichever is the larger number.
- e) The facility has continued the process of internal monitoring using the above-mentioned tools in addition to a variety of other forms that are aligned with the requirements of the EP. Examples of the other forms include the tools related to court assessments, inter-unit transfers, high-risk medication uses (e.g. PRN medications, benzodiazepines, anticholinergics and polypharmacy) and psychological assessments.

- f) MSH has improved the chart sampling methods, and inter-rater reliability also appears to have improved since the baseline assessment.
- g) Completeness and reliability of MSH's monitoring data remain to be an issue. The Court Monitor found errors in the computation of some data as well as missing data, and the facility made necessary corrections at the monitor's request. All monitoring data should clearly specify the following:
 - i. The monitoring form and the monitoring indicator(s) used to assess compliance.
 - ii. The target population or subpopulation (N).
 - iii. The population or subpopulation reviewed (n).
 - iv. The sample size (%S).
 - v. The compliance rates (%C).
- h) Overall, the sample sizes are still too small and the method of selection is unstated. The sample size must be representative of the total population or subpopulations that are being assessed. In general, the sample size should be 20% of the total population or target population. If the target population is very small (i.e., less than 20), the total target population should be sampled.
- i) The facility has developed appropriate monitoring tools to assess high-risk medication uses and care provided to individuals that suffer from emergent and non-emergent medical conditions. Some of these tools can be consolidated to facilitate the monitoring process and ensure better alignment with intent the EP.
- j) The tools are not all accompanied by instructions and operational definitions that can standardize the use within and across the facilities.
- k) The reliability data on internal monitoring is still insufficient. Approximately 20% of the data collected should be assessed for reliability.
- l) Given the amount of monitoring that is required, the tools and data collection must be automated.

3. Self-Evaluation

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

- a) The above-mentioned monitoring deficiencies must be corrected to ensure that that the process is meaningful.
- b) With regards to written text, the facility's progress report followed the requirements of the Court Monitor as presented to the facilities by the Chief CRIPA Consultant.
- c) The facility provided copious amounts of data to illustrate compliance and progress. The monitor has the following comments on the data provided:
 - i. Amount of data: MSH provided significantly more data and other information than is necessary to monitor compliance. For example, one CD provided prior to the tour contained 1,946 files. A carefully thought-out illustration of progress can be achieved without providing this degree of information.
 - ii. Organization of data: Much of the data provided was disorganized or organized in formats that precluded ready understanding of what it purported to illustrate.
 - iii. Correctness of data: Some of the data was incorrect—for example, a number of means (averages) were reported incorrectly or calculated using an undisclosed subset of the data. This naturally calls into question the monthly data provided. For the purposes of this report, the monitor has reported all monthly data as it was provided, but corrected the means where necessary.
 - iv. Data revisions: Some data was revised during and after the tour. This detracts from the monitor's ability to structure the tour and heightens the risk that facility-provided data will be misreported.

It is essential for the facilities to provide accurate data presented in a readily understandable way. Excel spreadsheets are generally preferable to Word documents for reporting data as they provide ample room for text and also can be used to double-check calculations.

Every effort was made by the monitor's team to accurately capture the facility's monitoring data in alignment with the relevant clauses of the EP. However, due to the issues listed above, this was an unusually challenging task.

- d) In the process of verifying the validity and reliability of the data, the Court Monitor and expert consultants require that the facilities readily demonstrate methods of data collection, where the data is documented and specific information about timeliness, completeness and quality of the documentation. A summary report of specific progress must be presented for each recommendation and each step. The monitoring team will request that raw data be provided in order to assess the context for the summary data that are being provided.

- e) To ensure the proper utilization of the current monitoring tools in the process of self-evaluation, the tools must address quality of services and not be limited to timeliness and presence or absence of various components. It is expected that quality indicators change slowly overtime, but the process must be oriented to these indicators from the beginning.

4. Implementation of the EP

a) Structure of current and planned implementation:

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

b) Function of current and planned implementation:

- i. The DMH WRP Manual has been revised to fully meet all requirements of the EP. This manual is an excellent guide in the principles and practice of the recovery model. To facilitate and standardize implementation of the recovery model, the manual should be the main reference for Wellness and Recovery Planning in the facilities.
- ii. MSH has made progress in developing a WRP training curriculum, establishing a core of dedicated program trainers and providing WRP training to WRPT members.
- iii. The extensive training in the WRP, psychiatric rehabilitation and therapeutic milieu has been of very high quality. However, this training has yet to translate into practice on a day-to-day basis.
- iv. MSH has made progress in the implementation of assessments and WRP reviews according to the schedules required by the EP.
- v. MSH has developed and begun implementation of a variety of processes to improve linkages between objectives specified on the WRPs and interventions provided in the PSR mall.

- vi. MSH has developed processes to improve tracking of individuals that reach triggers of non-adherence to WRPs and responses of the WRPTs to these situations.
- vii. MSH has a Forensic Review Panel that provides needed oversight to the WRPTs. This mechanism appears to have improved the structure and quality of many of the court reports submitted for individuals admitted under PC 1026 and PC 1370.
- viii. MSH has decreased the unjustified high risk uses of psychiatric medications (benzodiazepines and anticholinergic medications).
- ix. Nutrition Services continues to make good progress.
- x. The facility has implemented many of the Court Monitor's baseline recommendations.
- xi. Overall, the facility has made progress in several areas since the baseline evaluation. However, this progress must be accelerated to achieve compliance with the EP within the timeframes set by the court order. There are two main barriers that interfere with timely compliance: shortfalls in the implementation of the matrix system and serious staffing shortages, including in key clinical disciplines.
- xii. The DMH has begun a review of its implementation of the matrix system, but this process must be hastened to achieve timely compliance with the EP.
- xiii. The DMH must be commended for its recent success in addressing the main reason for staffing shortages. The interventions to minimize the gap in the pay differential with the California Department of Corrections and Rehabilitation (CDCR) can provide the facilities with needed staffing resources to improve safety and security of both individuals and staff and to ensure timely compliance with requirements of the EP.
- xiv. Many of the staff members that we met on the units and in various programs are very enthusiastic, caring and motivated to provide quality services.
- xv. Some staff members require further training to improve their knowledge of the key changes that they need to make to comport with requirements of the EP.
- xvi. Functional outcomes of the current structural changes have yet to be developed and implemented to guide further implementation.

5. Staffing

The MSH staffing table below shows the staffing pattern at the hospital as of March 1, 2007. These data were provided by the facility. The table shows that there is a major shortage of staff in several key areas: staff psychiatrists, senior psychiatrists,

staff psychologists, senior psychologists, pharmacy personnel, social workers and rehabilitation therapists. Staffing shortages are also a concern for registered nurses and psychiatric technicians.

Metropolitan State Hospital Vacancy Totals as of 3/1/2007				
Identified Clinical Positions	Allocated Positions, Third Quarter	Filled	Vacancies	Vacancy Rate
Assistant Coordinator of Nursing Services	5.00	4.00	1.00	20.00%
Assistant Director of Dietetics	2.00	2.00	0.00	0.00%
Audiologist I	0.00	0.00	0.00	0.00%
Chief Dentist	0.00	0.00	0.00	0.00%
Chief Physician & Surgeon	0.00	0.00	0.00	0.00%
Chief, Central Program Services	1.00	1.00	0.00	0.00%
Chief Psychologist	0.00	0.00	0.00	0.00%
Clinical Dietician/Pre-Reg. Clin. Dietician	8.00	6.50	1.50	18.75%
Clinical Laboratory Technologist	5.00	4.00	1.00	20.00%
Clinical Social Worker	53.60	41.30	12.30	22.95%
Coordinator of Nursing Services	1.00	1.00	0.00	0.00%
Coordinator of Volunteer Services	1.00	1.00	0.00	0.00%
Dental Assistant	2.00	2.00	0.00	0.00%
Dentist	2.00	2.00	0.00	0.00%
Dietetic Technician	2.00	2.00	0.00	0.00%

Metropolitan State Hospital Vacancy Totals as of 3/1/2007

Identified Clinical Positions	Allocated Positions, Third Quarter	Filled	Vacancies	Vacancy Rate
E.E.G. Technician	1.00	1.00	0.00	0.00%
Food Service Technician I and II	82.00	72.50	9.50	11.59%
Hospital Worker	6.00	6.00	0.00	0.00%
Health Record Technician I	28.00	21.00	7.00	25.00%
Health Record Techn II Sp	4.00	3.00	1.00	25.00%
Health Record Techn II Sup	3.00	1.00	2.00	66.67%
Health Record Techn III	2.00	2.00	0.00	0.00%
Health Services Specialist	32.00	31.00	1.00	3.13%
Institution Artist Facilitator	1.00	0.00	1.00	100.00%
Licensed Vocational Nurse	53.00	48.60	4.40	8.30%
Medical Technical Assistant	0.00	0.00	0.00	0.00%
Medical Transcriber	6.00	4.00	2.00	33.33%
Medical Transcriber Sup	0.00	0.00	0.00	0.00%
Sr Medical Transcriber	0.00	0.00	0.00	0.00%
Nurse Instructor	4.00	3.00	1.00	25.00%
Nurse Practitioner	1.00	1.00	0.00	0.00%
Nursing Coordinator	6.00	5.00	1.00	16.67%

Metropolitan State Hospital Vacancy Totals as of 3/1/2007

Identified Clinical Positions	Allocated Positions, Third Quarter	Filled	Vacancies	Vacancy Rate
Office Technician	52.50	37.00	15.50	29.52%
Pathologist	0.00	0.00	0.00	0.00%
Pharmacist I	18.60	16.60	2.00	10.75%
Pharmacist II	2.00	2.00	0.00	0.00%
Pharmacy Services Manager	1.00	1.00	0.00	0.00%
Pharmacy Technician	13.60	11.60	2.00	14.71%
Physician & Surgeon (includes 1 Prog. Dir.-Medical)	16.70	16.70	0.00	0.00%
Podiatrist	1.00	1.00	0.00	0.00%
Pre-licensed Pharmacist	0.00	0.00	0.00	0.00%
Pre-licensed Psychiatric Technician	11.00	11.00	0.00	0.00%
Program Assistant	7.00	6.00	1.00	14.29%
Program Consultant (RT, PSW)	2.00	1.00	1.00	50.00%
Program Director	6.00	6.00	0.00	0.00%
Psychiatric Nursing Education Director	1.00	1.00	0.00	0.00%
Psychiatric Technician *	309.90	275.60	34.30	11.07%
Psychiatric Technician Trainee*	0.00	0.00	0.00	0.00%
Psychiatric Technician Assistant*	52.00	52.00	0.00	0.00%

Metropolitan State Hospital Vacancy Totals as of 3/1/2007

Identified Clinical Positions	Allocated Positions, Third Quarter	Filled	Vacancies	Vacancy Rate
Psychiatric Technician Instructor	1.00	1.00	0.00	0.00%
Psychologist-HF, (Safety)	40.30	34.00	6.30	15.63%
Public Health Nurse II/I	2.00	2.00	0.00	0.00%
Radiologic Technologist	1.00	1.00	0.00	0.00%
Registered Nurse *	163.10	135.60	27.50	16.86%
Reg. Nurse Pre Registered	0.00	0.00	0.00	0.00%
Rehabilitation Therapist	57.30	42.10	15.20	26.53%
Special Investigator	1.00	0.00	1.00	100.00%
Special Investigator, Senior	3.10	2.00	1.10	35.48%
Speech Pathologist I	0.00	0.00	0.00	0.00%
Sr. Psychiatrist	9.50	6.00	3.50	36.84%
Sr. Psychologist (Spvr and Spec)	10.00	2.00	8.00	80.00%
Sr. Psych Tech(Safety)	50.00	46.00	4.00	8.00%
Sr. Radiologic Technologist (Specialist)	1.00	1.00	0.00	0.00%
Sr. Voc. Rehab. Counselor/Voc. Rehab. Counselor	0.00	0.00	0.00	0.00%
Staff Psychiatrist	43.60	32.50	11.10	25.46%
Supervising Psychiatric Social Worker	0.00	0.00	0.00	0.00%

Metropolitan State Hospital Vacancy Totals as of 3/1/2007

Identified Clinical Positions	Allocated Positions, Third Quarter	Filled	Vacancies	Vacancy Rate
Supervising Registered Nurse	9.00	5.00	4.00	44.44%
Supervising Rehabilitation Therapist	0.00	0.00	0.00	0.00%
Teacher-Adult Educ./Vocational Instructor	7.00	7.00	0.00	0.00%
Teaching Assistant	10.00	6.00	4.00	40.00%
Unit Supervisor	21.00	18.00	3.00	14.29%
Vocational Services Instructor	2.00	1.00	1.00	50.00%
The Hourly Intermittent FTE is not included in filled column.				
* Plus, Registered Nurse - 10.17 FTE				
* Plus, Psychiatric Technician - 14.5 FTE				
*Plus, Psychiatric Technician Trainee - 4.0 FTE				
*Plus, Psychiatric Technician Assistant - 4.0 FTE				

As in other DMH facilities, the staffing shortage at MSH has been worsened by the recent actions of the Court Receiver at the California Department of Corrections and Rehabilitation (CDCR), especially the pay raise in the specialties of psychiatry, psychology and pharmacy. As mentioned in earlier reports, the staffing shortage at the DMH facilities has reached a level that may threaten the safety and security of individuals and staff. The recent timely and decisive actions by the DMH have the potential of resolving this crisis and reversing the negative impact on its mental health institutions.

E. Monitor's Evaluation of Compliance

The status of compliance is assessed considering the following factors:

1. An objective review of facility's data and records;
2. Observations of individuals, staff and service delivery processes.
3. Interviews with individuals, staff, facility and state administrative and clinical leaders.

F. Next Steps

1. The Court Monitor's team is scheduled to tour Atascadero State Hospital (ASH) April 23-27, 2007 for a follow-up evaluation.
2. All compliance reports should be reviewed and utilized, as applicable, by all facilities to guide implementation efforts regardless of the schedule of facility-specific assessments.

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

<p>encouraged to participate in identifying his or her needs and goals, and in selecting appropriate treatment options. Therapeutic and rehabilitation services shall be designed to address each individual's needs and to assist individuals in meeting their specific recovery and wellness goals, consistent with generally accepted professional standards of care. Each State hospital shall ensure clinical and administrative oversight, education, and support of its staff in planning and providing care and treatment consistent with these standards.</p>	
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C	Integrated Therapeutic and Rehabilitation Services Planning	
	<p>Each State hospital shall provide coordinated, comprehensive, individualized protections, services, supports, and treatments (collectively "therapeutic and rehabilitation services") for the individuals it serves, consistent with generally accepted professional standards of care. In addition to implementing the therapeutic and rehabilitation planning provisions set forth below, each State hospital shall establish and implement standards, policies, and practices to ensure that therapeutic and rehabilitation service determinations are consistently made by an interdisciplinary team through integrated therapeutic and rehabilitation service planning and embodied in a single, integrated therapeutic and rehabilitation service plan.</p>	<p>Summary of Progress:</p> <ol style="list-style-type: none"> 1. The DMH Wellness and Recovery Planning manual has been revised and currently meets all requirements of the EP. The manual contains all required elements to serve as the main reference for WRP statewide. 2. The DMH has refined, streamlined and standardized the monitoring instruments related to WRP. The revised instruments are aligned with requirements of the EP. 3. DMH has developed appropriate operational instructions that accompany the monitoring instruments. 4. MSH has made progress in developing a WRP training curriculum, establishing a core of dedicated program trainers and providing WRP training to WRPT members. 5. MSH has improved the sample sizes in its monitoring of WRP. 6. MSH has made progress in the implementation of assessments and WRP reviews according to the schedules required by the EP. 7. MSH has improved the organization and presentation of data to review its progress since the baseline evaluation. 8. MSH has developed and begun implementation of a variety of processes to improve linkages between objectives specified on the WRPs and interventions provided in the PSR mall. 9. MSH has developed processes to improve tracking of individuals that reach triggers of non-adherence to WRPs and responses of the WRPTs to these situations. 10. In general, the interdisciplinary staff members at MSH are caring, well-intentioned and motivated to provide quality services to individuals entrusted to their care.
1	Interdisciplinary Teams	
	<p>The interdisciplinary team's membership shall be dictated by the particular needs and strengths of the individual in the team's care. At a minimum, each State Hospital shall ensure that the team shall:</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Kenneth Layman, Treatment Enhancement Coordinator xxx 2. Michael Barsom, M.D., Acting Medical Director.

		<ol style="list-style-type: none"> 3. Nady Hanna, M.D., Acting President of Medical Staff. 4. Bala Gulasekaram, M.D., Chief of Psychiatry Department. 5. Juanita Coleman, Assistant Treatment Enhancement Coordinator. <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. DMH WRP Manual (March 2007). 2. AD #3133 Wellness and Recovery Plan (WRP). 3. MSH WRP Training Curriculum. 4. MSH Master Training Competency Database. 5. WRP Trainers' Competency Audit. 6. Overview document regarding WRP Knowledge Assessment. 7. WRP Knowledge Assessment Test and Answer Key. 8. Treatment Planning Post-Test Database. 9. Facility's database regarding WRP team staffing levels and attendance of core members. 10. Consistent Enduring Team (CET) Report Form. 11. CET Report summary data (September 2006 to February 2007). 12. Overview document regarding Wellness and Recovery Observation. 13. Wellness and Recovery Observer Audit Inter-rater Reliability Data. 14. Health Information Management WRP Rater & Reliability data. 15. WRP Observation Monitoring Form 16. WRP Observation Monitoring Form Instructions 17. Observation Monitoring summary data (7-day, 14-day, quarterly, monthly and annual meetings) September 2006 to February 2007. 18. Team Leadership Monitoring (Psychiatrist) Form. 19. Team Leadership Monitoring (Psychiatrist) Form summary data January 2007. 20. WRP Chart Audit Form. 21. WRP Chart Audit Form Instructions. 22. WRP Clinical Chart Auditing Form. 23. WRP Clinical Chart Auditing Form Instructions. 24. Staff Psychiatrist Manual.
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		<p>25. WRP Conference Schedule.</p> <p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. WRPT meeting (unit 407) for monthly review of FN. 2. WRPT meeting (unit 415) for monthly review of JM. 3. WRPT meeting (unit 411) for annual review of LD.
a	<p>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.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Finalize, approve and implement the DMH WRP manual.</p> <p>Findings: The manual has been revised to address recommendations from the baseline report. The finalized and approved version of the DMH WRP Manual (March 2007) incorporates the changes requested during the Court Monitor's baseline evaluation.</p> <p>Recommendation 2, September 2006: Provide documentation that WRP trainers and WRP team members have been trained to competency.</p> <p>Findings: The facility developed and implemented a training curriculum regarding WRP. The curriculum consists of five modules: Engagement, Case Formulation, Foci and Objectives, Interventions and Mall Integration. The facility's CRIPA consultant, Dr. Singh, and Chief of Psychiatry, Dr. Bala Gulasekaram, provided training to five WRP trainers selected from each program from different disciplines. The WRP trainers have been trained to competency as evidenced by WRP Knowledge Assessment scores. The WRP trainers have also been evaluated by behavioral demonstration through the use of the WRP Trainer's Competency Audit conducted by the Chief of Psychiatry.</p>

		<p>The following is a list of the WRP master trainers at MSH:</p> <p>Program I: Jennifer Escude, PSW Program II: Dr. Nady Hanna, Senior Psychiatrist Program III: Dr. Kelli Colbert, Psychologist Program V: Carolyn Sabol, Rehabilitation. Therapist Program VI: Mary Ann Dehesa, RN, HSS</p> <p>The WRP trainers provided eight hours of training to 176 staff members from September 2006 to March 2007. The training records indicate that 116 (out of 188) core members of the WRPTs received this training. Of the core members trained, 109/188 (58%) met competency-based standards. As of the baseline visit, 0% of WRPTs were trained to competency.</p> <p>In addition, 40 staff members received one-hour WRP training as part of the new employee orientation. The training was based on the DMH WRP manual and provided by the Chief of Psychiatry. All members met competency by post-test knowledge assessment. Of that group, 12 nursing staff received the training.</p> <p>Recommendation 3, September 2006: Continue and strengthen current training program. In particular, the facility needs to ensure that each program has a dedicated trainer, to build the competency of program trainers and to increase training sessions for all members of the WRP teams.</p> <p>Findings: As above.</p> <p>Recommendation 4, September 2006: Streamline and refine current WRP monitoring instruments to reflect the specific</p>
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		<p>recommendations in each of sections C.1.b through C.1.g below. The monitoring instruments should contain operational criteria that address the specific requirements in each section.</p> <p>Findings: The facility has modified the process observation, chart audit and case formulation (now incorporated in the DMH WRP Clinical Chart Auditing Form) monitoring instruments to eliminate redundancy and improve alignment with the EP requirements. The facility has yet to implement the WRP Clinical Chart Auditing Form. These monitoring instruments have been standardized statewide. Each form is now accompanied by instructions that provide clear and adequate definitions of the appropriate operational components of each item.</p> <p>Recommendation 5, September 2006: Standardize the WRP monitoring instruments and sampling methods across State facilities.</p> <p>Findings: The DMH consultants have standardized the monitoring instruments and sampling methods.</p> <p>Recommendation 6, September 2006: Ensure that monitoring data are based on adequate monthly samples of at least 20% of team meetings and charts. This recommendation is relevant to all applicable items in Sections C.1. and C.2.</p> <p>Findings: The WRP Chart Audit data are now based on at least 20% sample. MSH has yet to achieve 20% samples in all other monitoring tools relevant to sections C1 and C2.</p> <p>The following table outlines current sample sizes used in process observation data ("N" represents all WRP meetings i.e. target population, "n" is the number of meetings observed and %S is the sample size):</p>
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	7-Day	14-Day	30-Day	90-Day	Annual	Totals
SEP	N=46 n=3	N=91 n=5	N=377 n=35	N=169 n=14	N=30 n=3	N=713 n=60 %S=8
OCT	N=48 n=2	N=91 n=4	N=377 n=28	N=169 n=11	N=30 n=3	N=715 n=48 %S=7
NOV	N=36 n=1	N=100 n=7	N=356 n=21	N=203 n=4	N=35 n=1	N=730 n=34 %S=5
DEC	N=55 n=5	N=67 n=9	N=430 n=19	N=151 n=10	N=36 n=1	N=739 n=44 %S=6
JAN	N=56 n=1	N=99 n=8	N=361 n=15	N=162 n=11	N=25 n=3	N=703 n=38 %S=5
FEB	N=28 n=2	N=99 n=10	N=361 n=4	N=162 n=6	N=25 n=0	N=675 n=22 %S=3

Recommendation 7, September 2006:

Ensure that the AD regarding WRP is aligned with all the provisions in the DMH WRP Manual.

Findings:

AD #3133 regarding the WRP was edited to reflect provisions in the DMH WRP Manual.

Recommendation 8, September 2006:

Ensure a stable core of process observers and chart auditors who have been trained to

		<p>competency by the state consultants.</p> <p>Findings: The facility has ensured a stable core of process observers and chart auditors since the baseline evaluation. The facility added one observer in order to increase the sample sizes. All observers have been trained by the DMH Consultant. Inter-rater reliability for process observers is currently reported at 91%.</p> <p>At present, there are 11 auditors from Health Information Management who conduct chart audits. All have been trained by the DMH consultant.</p> <p>Other findings: The facility has revised its WRP knowledge assessment test. The new test is based on the review questions listed for each chapter of the DMH WRP manual.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Implement the revised DMH WRP Manual. 2. Continue training provided to WRP trainers and documentation of training to competency. 3. Ensure competency-based training of all members of the WRPTs. 4. Ensure that all WRPTs at the facility receive the same level of training. 5. Continue new employee WRP training (for non-nursing disciplines).
b	Be led by a clinical professional who is involved in the care of the individual.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Monitor both presence and proper participation by the team leaders in all WRP meetings.</p>

Findings:

The facility used the WRP Observation Monitoring Form to assess its compliance with this item. The following is a review of the facility's data. The monitoring indicator is listed in italics before the corresponding data table:

Each team is led by a clinical professional who is involved in the care of the individual.

	Sep	Oct	Nov	Dec	Jan	Feb	Mean
n	60	47	35	44	37	23	
%C	84	82	82	100	100	96	91

MSH developed the Team Leadership Monitoring Form to assess participation by psychiatrists as team leaders. The form includes appropriate indicators. The facility began implementation in January 2007 by reviewing a pilot of three meetings. Monitoring was done by four senior psychiatrists. Inter-rater reliability has not been established. This is not a statewide tool. Based on a limited sample, the facility reports 89% compliance.

Recommendation 2, September 2006:

Develop and implement a peer mentoring system to ensure competency in team leadership skills.

Findings:

MSH plans to utilize the Team Leadership Monitoring process to assist in mentoring team leaders. Each senior psychiatrist is expected to attend at least two WRPCs per month and to provide feedback to team leaders.

Recommendation 3, September 2006:

The staff psychiatrist manual should include specific requirements regarding WRP leadership. The requirements must be aligned with the WRP team responsibilities that are outlined in the DMH WRP manual

		<p>Findings: The medical staff revised the MSH Staff Psychiatrist Manual to address this recommendation. Section 4.6 regarding Treatment Planning was added to address this recommendation. The section is incomplete.</p> <p>Recommendation 4, September 2006: The DMH WRP manual should address the leader's responsibility to ensure that members provide concise presentation of the results of their assessments prior to the discussion of objectives and interventions.</p> <p>Recommendation 5, September 2006: The DMH WRP manual should specify the leader's responsibility to ensure appropriate parameters for participation by the individual in their treatment, rehabilitation and enrichment activities.</p> <p>Recommendation 6, September 2006: The DMH WRP manual should address the leader's responsibility to ensure that the present status section of the case formulation is updated during the WRP team meetings and that other sections in the formulation are consequently updated as clinically indicated.</p> <p>Recommendation 7, September 2006: The DMH WRP manual should combine tables 5.1 and 5.2 regarding team responsibilities during WRP reviews to include the same expectations regarding discussion of PBS data, MOSES data and the individual's current medical condition.</p> <p>Findings: The revised DMH WRP manual meets all the above requirements.</p>
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		<p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to monitor the presence and participation by team leaders in the WRPCs. 2. Standardize the process of monitoring of the presence and participation by team leaders across facilities. 3. The revised Psychiatric Physician Manual should address the leader's responsibility to ensure a sequence of tasks that facilitates WRP as well as proper participation by individuals in the WRP conferences. 																								
c	Function in an interdisciplinary fashion.	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Same as in C.1.a. and C.1.b.</p> <p>Findings: Same as in C.1.a and b.</p> <p>Other findings: The facility used the WRP Observation Monitoring Form to assess compliance with this item. The following is a review of the facility's monitoring data:</p> <p><i>Each team functions in an interdisciplinary fashion.</i></p> <table border="1" data-bbox="835 1203 1619 1317"> <thead> <tr> <th></th> <th>Sep</th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>n</td> <td>60</td> <td>47</td> <td>35</td> <td>44</td> <td>37</td> <td>23</td> <td></td> </tr> <tr> <td>%C</td> <td>14</td> <td>25</td> <td>29</td> <td>25</td> <td>31</td> <td>32</td> <td>26</td> </tr> </tbody> </table>		Sep	Oct	Nov	Dec	Jan	Feb	Mean	n	60	47	35	44	37	23		%C	14	25	29	25	31	32	26
	Sep	Oct	Nov	Dec	Jan	Feb	Mean																			
n	60	47	35	44	37	23																				
%C	14	25	29	25	31	32	26																			

		<p>Charts reviewed (as per Section C.2) by this monitor demonstrate deficiencies in the content of planning (e.g. proper development and revision of case formulations, foci of hospitalization and interventions) that are at least partly a result of ineffective interdisciplinary functions.</p> <p>Compliance: Partial.</p> <p>Current recommendations: Monitor adequate sample of WRP conferences regarding this requirement.</p>
d	<p>Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary, and appropriate psychiatric and medical care.</p>	<p>Current findings on previous recommendations:</p> <p><i>Note that the first recommendation in the Baseline Report was not numbered. Baseline Report numbering has been retained to avoid confusion.</i></p> <p>Recommendation, September 2006: Same as in C.1.a, b and c.</p> <p>Findings: Same as in C.1.a, b and c.</p> <p>Recommendation 1, September 2006: Continue current practice of surveying the views of team members regarding the functions of their designated leaders.</p> <p>Findings: MSH has not continued its practice pending more adequate training to the WRPT leaders. The facility will resume surveying team members after all teams have been trained concerning team leader functions as specified in the DMH WRP Manual.</p>

		<p>Recommendation 2, September 2006: The staff psychiatrist manual should include specific requirements regarding psychiatrists' role as team leaders that are aligned with the functions of the team leaders as outlined in the WRP Manual.</p> <p>Findings: As in C.1.b.</p> <p>Other findings: The facility has developed a DMH WRP Clinical Chart Auditing Form to be completed only by clinicians. The tool and its operational instructions adequately address this requirement. Implementation is pending.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Resume the practice of surveying team members once adequate training has been provided to the team leaders. 2. Implement the DMH WRP Clinical Chart Auditing Form.
e	<p>Ensure that each member of the team participates appropriately in competently and knowledgeably assessing the individual on an ongoing basis and in developing, monitoring, and, as necessary, revising the therapeutic and rehabilitation services.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, September 2006:</p> <ul style="list-style-type: none"> • Same as in C.1.a through C.1.d. • Same as in D.1.a through D.1.e. <p>Findings: Same as in C.1.a through C.1.d. and D.1.a through D.1.e.</p>

Recommendation 3, September 2006:

Improve clinical oversight to ensure competency in the processes of assessments, reassessments, interdisciplinary team functions and proper development and timely and proper updates of case formulations, foci of hospitalization, objectives and interventions.

Findings:

The facility has six senior psychiatrists who currently participate in a new system of mentoring, as described in C.1.b.

Recommendation 4, September 2006:

Ensure that the monitoring tools adequately address the quality of assessments.

Findings:

Discipline chiefs are currently involved in a statewide process to refine monitoring of the quality of disciplinary assessments.

Other findings:

The facility used WRP Observation Monitoring Form to assess compliance with this item. The following is an outline of the data:

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.

	Sep	Oct	Nov	Dec	Jan	Feb	Mean
n	60	47	35	44	37	23	
%C	61	72	20	13	25	9	33

The team meetings attended by the monitor show some progress in the overall structure of

		<p>the team meetings, primarily in the sequence of tasks regarding review of assessments and the individual's progress in treatment and rehabilitation interventions. However, the monitor observed a general pattern of deficiencies in the implementation of many key process elements in this section. In addition, this monitor found deficiencies in the implementation of the main content elements of the WRP system as outlined in Section C (case formulation, foci of hospitalization, objectives and interventions) and Section D (psychiatric assessments and reassessments). These deficiencies must be corrected in order to achieve compliance with the EP requirements. As mentioned earlier, the revised DMH WRP manual fully meets plan requirements. Proper implementation of this manual in the day-to-day practice of WRP is necessary for the facility to make significant progress in this area.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Monitor quality of assessments for all disciplines. 2. Continue to monitor this requirement using process observation. 3. Assess and correct factors related to low compliance with this requirement.
f	<p>Ensure that assessment results and, as clinically relevant, consultation results, are communicated to the team members, along with the implications of those results for diagnosis, therapy and rehabilitation by no later than the next review.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Same as in C.1.a. through C.1.e.</p> <p>Findings: Same as in C.1.a through C.1.e.</p> <p>Other findings: Using the WRP Observation Monitoring Form, the facility reports the following compliance data:</p>

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.

	Sep	Oct	Nov	Dec	Jan	Feb	Mean
n	60	47	35	44	37	23	
%	53	48	35	24	25	41	38

Observations of the team meetings attended by the monitor indicate some progress in the presentation of results of the assessments. However, the analysis of those results to assess implications for diagnosis, treatment and/or rehabilitation of individuals continues to be inadequate.

Compliance:

Partial.

Current recommendations:

1. Continue to monitor this requirement using process observation.
2. Assess and correct factors related to low compliance rates.

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 recommendation:

Recommendation, September 2006:

Address deficiency in the implementation of this requirement and ensure compliance.

Findings:

MSH used the WRP Observation Monitoring Form to assess its compliance with this requirement. The following summarizes the facility's data:

		<p><i>The team identified someone to be responsible for the scheduling and coordination of assessments and team meetings, the drafting of integrated treatment plans, and the scheduling and coordination of necessary progress reviews.</i></p> <table border="1" data-bbox="835 383 1619 500"> <thead> <tr> <th></th> <th>Sep</th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>n</td> <td>60</td> <td>47</td> <td>35</td> <td>44</td> <td>37</td> <td>23</td> <td></td> </tr> <tr> <td>%</td> <td>67</td> <td>57</td> <td>18</td> <td>23</td> <td>31</td> <td>35</td> <td>39</td> </tr> </tbody> </table> <p>Other findings: Review of charts by this monitor (see Section D) shows overall progress regarding the implementation of assessments and WRP reviews according to schedules required by the EP.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Assess and correct factors related to the shortage of staff needed to implement the EP.</p>		Sep	Oct	Nov	Dec	Jan	Feb	Mean	n	60	47	35	44	37	23		%	67	57	18	23	31	35	39
	Sep	Oct	Nov	Dec	Jan	Feb	Mean																			
n	60	47	35	44	37	23																				
%	67	57	18	23	31	35	39																			
h	<p>Consist of a stable core of members, including at least the individual served; the treating psychiatrist, treating psychologist, treating rehabilitation therapist, the treating social worker; registered nurse and psychiatric technician who know the individual best; and one of the individual's teachers (for school-age individuals), and, as appropriate, the individual's family, guardian, advocates, attorneys, and the pharmacist and other staff.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: MSH needs to address and correct the deficiencies regarding attendance by core members in light of the facility's very low vacancy rate.</p> <p>Findings: MSH has a tracking mechanism to assess the attendance of all core members. The facility has monitoring data (process roll-call) that indicate the following attendance rates (September 2006 to February 2007). The data are derived from information regarding attendance by core members on the Observation Monitoring Form.</p>																								

	#	Indiv	MD	PhD	SW	RT	RN	PT	Mean
Sep	60	X	90%	82%	92%	65%	98%	13%	73%
Oct	47	X	87%	64%	87%	70%	98%	0%	68%
Nov	35	12%	83%	74%	80%	57%	78%	6%	56%
Dec	44	23%	91%	52%	96%	61%	98%	9%	61%
Jan	37	65%	89%	78%	73%	54%	89%	16%	66%
Feb	23	70%	96%	22%	91%	87%	96%	39%	72%
Mean	41	43%	89%	62%	87%	62%	93%	14%	

The facility has identified deficiencies in the attendance of psychiatric technicians (PTs), recreational therapists (RTs) and psychologists (PhDs). The facility does not have data regarding contributing factors and corrective actions.

Recommendation 2, September 2006:

MSH needs to assess and correct discrepancies in the data regarding attendance by psychiatric technicians in the WRP meetings.

Findings:

The facility utilizes observer roll-call data because it is seen as the most accurate and is provided by trained and competent observers. The team's reported attendance data was seen as unreliable because of self-reporting bias and large numbers of raters.

Recommendation 3, September 2006:

MSH should continue to monitor the attendance by core members in the WRP team conferences.

Findings:

Same as recommendation 1.

		<p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Assess and correct factors related to low compliance rates. 2. Continue to monitor the attendance by core team members. 																																																								
i	<p>Not include any core treatment team members with a case load exceeding 1:15 in admission teams (new admissions of 90 days or less) and, on average, 1:25 in all other teams at any point in time.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Ensure consistent compliance with this requirement.</p> <p>Findings: The facility developed and implemented the CET Report, which is completed monthly by the Assistant Treatment Enhancement Coordinator. Using this tool, MSH reports data regarding this requirement. The data from September 2006 to February 2007 show the average caseloads by discipline (only core members are included). The following show that the case loads exceed plan requirements for some disciplines.</p> <p>ADMISSIONS</p> <table border="1" data-bbox="835 1019 1751 1286"> <thead> <tr> <th></th> <th>Sep</th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>MD</td> <td>17.4</td> <td>16.5</td> <td>16.1</td> <td>14.6</td> <td>16.3</td> <td>14.6</td> <td>15.9</td> </tr> <tr> <td>PhD</td> <td>17.2</td> <td>16.5</td> <td>16.9</td> <td>16.6</td> <td>16.3</td> <td>19.0</td> <td>17.1</td> </tr> <tr> <td>SW</td> <td>16.1</td> <td>15.3</td> <td>13.2</td> <td>13.0</td> <td>17.5</td> <td>17.2</td> <td>15.4</td> </tr> <tr> <td>RT</td> <td>14.5</td> <td>13.3</td> <td>13.2</td> <td>14.0</td> <td>14.8</td> <td>14.6</td> <td>14.1</td> </tr> <tr> <td>RN</td> <td>11.6</td> <td>17.0</td> <td>15.4</td> <td>8.7</td> <td>13.0</td> <td>13.0</td> <td>13.1</td> </tr> <tr> <td>PT</td> <td>27.3</td> <td>19.3</td> <td>16.3</td> <td>12.0</td> <td>13.0</td> <td>13.0</td> <td>16.8</td> </tr> </tbody> </table>		Sep	Oct	Nov	Dec	Jan	Feb	Mean	MD	17.4	16.5	16.1	14.6	16.3	14.6	15.9	PhD	17.2	16.5	16.9	16.6	16.3	19.0	17.1	SW	16.1	15.3	13.2	13.0	17.5	17.2	15.4	RT	14.5	13.3	13.2	14.0	14.8	14.6	14.1	RN	11.6	17.0	15.4	8.7	13.0	13.0	13.1	PT	27.3	19.3	16.3	12.0	13.0	13.0	16.8
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		<p>LONG TERM</p> <table border="1"> <thead> <tr> <th></th> <th>Sep</th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>MD</td> <td>21.5</td> <td>24.5</td> <td>18.5</td> <td>25.4</td> <td>25.3</td> <td>24.2</td> <td>23.2</td> </tr> <tr> <td>PhD</td> <td>23.7</td> <td>29.1</td> <td>30.1</td> <td>34.5</td> <td>30.1</td> <td>29.3</td> <td>29.5</td> </tr> <tr> <td>SW</td> <td>19.6</td> <td>22.1</td> <td>24.1</td> <td>24.2</td> <td>22.9</td> <td>24.2</td> <td>22.9</td> </tr> <tr> <td>RT</td> <td>24.0</td> <td>23.9</td> <td>24.7</td> <td>18.5</td> <td>24.7</td> <td>21.5</td> <td>22.9</td> </tr> <tr> <td>RN</td> <td>27.4</td> <td>28.7</td> <td>28.7</td> <td>27</td> <td>26.7</td> <td>x</td> <td>27.7</td> </tr> <tr> <td>PT</td> <td>27.4</td> <td>31.2</td> <td>28.5</td> <td>x</td> <td>x</td> <td>x</td> <td>29.0</td> </tr> </tbody> </table> <p>Recommendation 2, September 2006: Same as in recommendation #3 under C.1.h.</p> <p>Findings: Same as in C.1.h.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Assess and correct factors related to low compliance rates for some disciplines.</p>		Sep	Oct	Nov	Dec	Jan	Feb	Mean	MD	21.5	24.5	18.5	25.4	25.3	24.2	23.2	PhD	23.7	29.1	30.1	34.5	30.1	29.3	29.5	SW	19.6	22.1	24.1	24.2	22.9	24.2	22.9	RT	24.0	23.9	24.7	18.5	24.7	21.5	22.9	RN	27.4	28.7	28.7	27	26.7	x	27.7	PT	27.4	31.2	28.5	x	x	x	29.0
	Sep	Oct	Nov	Dec	Jan	Feb	Mean																																																			
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PT	27.4	31.2	28.5	x	x	x	29.0																																																			
j	Not include staff that is not verifiably competent in the development and implementation of interdisciplinary wellness and recovery plans.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Same as in C.1.a. through C.1.f.</p> <p>Recommendation 2, September 2006: Ensure the development and implementation of mechanisms to ensure that all WRP team</p>																																																								

		<p>members are competent in all phases of WRP training.</p> <p>Findings: Same as in C.1.a through C.1.f.</p> <p>Other findings: This monitor's observations of team meetings reveal that most team leaders and members are not yet fully trained to meet this requirement.</p> <p>Compliance: Partial.</p> <p>Current recommendations: Same as in C.1.a through C.1.f.</p>
2	Integrated Therapeutic and Rehabilitation Service Planning (WRP)	
	<p>Each State hospital shall develop and implement policies and protocols regarding the development of therapeutic and rehabilitation service plans, referred to as "Wellness and Recovery Plans" [WRP] consistent with generally accepted professional standards of care, to ensure that:</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Four individuals (HC, FR, EF, and JW). 2. Kenneth Layman, Treatment Enhancement Coordinator 3. Michael Barsom, M.D., Acting Medical Director. 4. Nady Hanna, M.D., Acting President of Medical Staff. 5. Bala Gulasekaram, M.D., Chief of Psychiatry Department. 6. Donna Gilland, Acting Clinical Administrator. 7. Denise Nicks, Substance Abuse Program Coordinator. 8. Lisa Adams, Mall Director. 9. Lisa Dieckmann, Ph.D., Standards Compliance Psychologist. 10. Barbara Justice, MD, Psychiatrist and Team Leader, Unit 405, WRPT II.x 11. James Park, Psychiatric Social Worker, Unit 405, WRPT II.

12. Vincenta Gonzalez, Registered Nurse, Unit 405, WRPT II.
13. Sarah Moon, Rehabilitation Therapist, Unit 405, WRPT II.
14. Don Magner, Psychiatric Technician, Unit 405, WRPT II.
15. Christopher Shahzad, MD, Fellow in Forensic Psychiatry, Unit 405, WRPT II.
16. Jocelyn Agtarap, R.N.
17. Linda Gross, Nurse Coordinator.
18. Jane Critia, Communication coordinator.
19. Kathrine Mulford, Program Coordinator.
20. Lisa Adams, Mall Coordinator.
21. Gretchen Hunt, BY CHOICE Coordinator.
22. Karen Chong, LCSW, Program Director.
23. Cynthia Formley, Psychiatric Technician.
24. Edwin Claudia, Registry.
25. Donna Gilland, Program Director.
26. Lisa Adams, Mall Director.

Reviewed:

1. Charts of 61 individuals (GA, RB, JM, NV, EV, TC, RD, RS, JLB, LB, DR, GB, MW, MTR, GR, RTL, VRF, DC, EA, FEA, TR, KR, MJA, SW, WH, JV, CR, PL, NM, DY, JD, LN, SF, EF, AF, JS, KM, WW, VR, KR, MM, DH, JD, RM, JA, DM, PB, DC, FR, MC, MH, TP, HC, AA, PT, BR, CD, RC, RD, AL, and TB).
2. WRP Training Module: Engagement of Individuals in the WRPC.
3. WRP Training Module: Case Formulation.
4. WRP Training Module: Foci and Objectives.
5. WRP Training Module: Interventions and Mall Integration.
6. Health Information Management WRP Rater & Reliability data.
7. WRP Chart Audit Form.
8. WRP Chart Audit summary data (September 2006 to February 2007).
9. DMH Clinical Chart Auditing Form.
10. DMH Clinical Chart Auditing Form Instructions.

		<ol style="list-style-type: none"> 11. Mall Alignment Monitoring Tool. 12. Mall Alignment Monitoring Tool summary data (November 2006 to February 2007). 13. Nursing Staff Seizure Disorder Monitoring Form. 14. Case Formulation Monitoring Form. 15. Case formulation Monitoring Form Instructions. 16. Case Formulation Monitoring summary data (January and February 2007). 17. MSH's data regarding audit of active treatment hours listed in the WRPs and MAPP data of hours scheduled and attended (February 2007). 18. WRP Scheduling Flowchart. 19. WRPC Planning Schedule Flowchart. 20. WRP/Mall Alignment Check Protocol. 21. Mall Manual Addendum (Chapter 3). 22. MSH's data regarding audit of active treatment hours listed in the WRPs and MAPP data of hours scheduled and attended (February 2007) for civilly committed individual. 23. Template for DMH PSR Mall Facilitator Monthly Progress Note. 24. DMH Draft Policy regarding Substance Abuse Screening (SAS). 25. Substance Abuse Assessment and Treatment Audit Form. 26. Minutes of the meetings of the Substance Abuse Leadership Committee between November 14, 2006 and March 14, 2007. 27. MSH Substance Recovery Curriculum. 28. Draft clinical and process outcomes and measurement tools for the substance abuse program. 29. Training material regarding Integrating Substance Abuse and Mental Illness, including pre and post-tests. 30. Integrated Therapeutic and Services Planning form. 31. MAPP data regarding number of groups providing education regarding WRPs (October 2006 to February 2007) and medications (September 2006 to February 2007). 32. Integrated Therapeutic and Services Planning summary data (November 2006 to January 2007). 33. Training material regarding Motivational Interviewing.
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		<p>34. AD #3133.1 Trigger Response.</p> <p>35. Tracking Trigger Response Form.</p> <p>36. Key indicator data.</p> <p>37. DMH Psychology Manual.</p> <p>38. DMH BY CHOICE Manual.</p> <p>39. DMH WRP Manual.</p> <p>40. DMH MSH Psychosocial Rehabilitation Malls Manual (V2, July 1, 2005).</p> <p>41. DMH WRP/Mall Alignment check Protocol, V1.3 (November 1, 2006).</p> <p>42. DMH Mall Manual Addendum, Chapter 3.</p> <p>43. MSH Mall Group Activity Request Form.</p> <p>44. MSH Strengths Survey.</p> <p>45. Substance Abuse Group Provider Monitoring form</p> <p>46. PSR Mall Facilitator Monthly Progress Note.</p> <p>47. Mall Progress Notes Compliance Process Instructions.</p> <p>48. WaRMSS Schedule.</p> <p>49. Room Visit Schedule.</p> <p>50. Curriculum For Bed Bound Residents.</p> <p>51. Room Visit Schedule List</p> <p>52. Supplemental Treatment Program - Training for Trainers.</p> <p>53. Supplemental Treatment Database</p> <p>54. Family Satisfaction Survey Instrument.</p> <p>55. List of Individuals who met discharge criteria and are still hospitalized</p> <p>56. Supplemental Treatment Program-Attendance Roster.</p> <p>57. List of staff training on PBS</p> <p>58. List of Substance Abuse Group Providers.</p> <p>59. Substance Abuse Staff Training and Competency Record.</p> <p>60. Substance Recovery Provider Competency Criteria.</p> <p>61. Group Facilitator Monitoring Form.</p> <p>62. DMH WRP/Mall Alignment Check Protocol.</p>
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		<p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. WRPT meeting (unit 407) for monthly review of FN. 2. WRPT meeting (unit 415) for monthly review of JM. 3. WRPT meeting (unit 411) for annual review of LD. 4. BY CHOICE store incentive exchange. 5. Individuals (MW, JK, HC, and FR). 6. WRPT meetings to review MW and JK. 7. Mall Groups (DBT, Welcome to Reality, and Rational Emotive Behavioral Therapy) 																								
a	<p>Individuals have substantive input into the therapeutic and rehabilitation service planning process, including but not limited to input as to mall groups and therapies appropriate to their WRP.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Same as in C.1.a. through C.1.f.</p> <p>Findings: Same as in C.1.a through C.1.f.</p> <p>WRP Observation Monitoring Form Item #6 <i>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.</i></p> <table border="1" data-bbox="835 1089 1619 1206"> <thead> <tr> <th></th> <th>Sep</th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>n</td> <td>60</td> <td>47</td> <td>35</td> <td>44</td> <td>37</td> <td>23</td> <td></td> </tr> <tr> <td>%</td> <td>32</td> <td>71</td> <td>56</td> <td>49</td> <td>65</td> <td>76</td> <td>58</td> </tr> </tbody> </table> <p>Recommendation 2, September 2006: Ensure that monitoring items are not redundant and/or overinclusive, and are focused on the specific requirement to be monitored.</p>		Sep	Oct	Nov	Dec	Jan	Feb	Mean	n	60	47	35	44	37	23		%	32	71	56	49	65	76	58
	Sep	Oct	Nov	Dec	Jan	Feb	Mean																			
n	60	47	35	44	37	23																				
%	32	71	56	49	65	76	58																			

		<p>Findings: As mentioned in C.1.a, DMH monitoring tools regarding WRP have been revised and new tools developed and approved. These tools are better aligned with requirements of the EP and more focused and streamlined.</p> <p>Recommendation 3, September 2006: Continue and strengthen WRP training that focuses on the process of engaging the individual in providing substantive input.</p> <p>Findings: MSH has developed and implemented a curriculum intended to teach WRP core team members all areas of the new DMH WRP Manual that pertain to engaging the individuals in providing substantive input into their WRPs. The training is competency-based. The module appropriately covers basics of engagement and role of team members in the process as well as practice vignettes. Refer to C.1.a for more information regarding WRP training..</p> <p>Other findings: MSH utilized the WRP Observation Monitoring Form to assess compliance with this item. The data in the table under Findings for Recommendation 1, September 2006 was captured using this form.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue WRP training that focuses on the process of engaging the individual in providing substantive input. 2. Address and correct factors related to low compliance with this requirement.
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b	Therapeutic and rehabilitation service planning provides timely attention to the needs of each individual, in particular:	Please see sub-cells for compliance findings.																								
b.i	initial therapeutic and rehabilitation service plans (Admission-Wellness and Recovery Plan ("A-WRP") are completed within 24 hours of admission;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Continue current practice.</p> <p>Findings: MSH has continued its current practice of completing the A-WRPs within 24 hours of admission. The facility has monitoring data based on the Chart Audit Form. The following is a summary:</p> <p><i>The initial therapeutic and rehabilitation service plans (Admission Wellness and Recovery Plan (A-WRP) was developed within 24 hours of admission.</i></p> <table border="1" data-bbox="835 833 1650 948"> <thead> <tr> <th></th> <th>Sep</th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>n</td> <td>18</td> <td>20</td> <td>15</td> <td>25</td> <td>21</td> <td>7</td> <td></td> </tr> <tr> <td>%</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> </tr> </tbody> </table> <p>Recommendation 2, September 2006: Standardize chart sampling methods in the chart audit mechanisms and correct the discrepancies in findings regarding the timelines of the A-WRP.</p> <p>Findings: MSH has improved chart sampling methods by selecting the most reliable monitoring methodology and establishing inter-rater reliability of auditors. One rater reliability audit is completed for each rater per month. Starting January 2007 the facility has implemented a system to obtain a second audit and in-service the auditor (one-on-one) based on the number of errors noted in the audit.</p>		Sep	Oct	Nov	Dec	Jan	Feb	Mean	n	18	20	15	25	21	7		%	100	100	100	100	100	100	100
	Sep	Oct	Nov	Dec	Jan	Feb	Mean																			
n	18	20	15	25	21	7																				
%	100	100	100	100	100	100	100																			

		<p>Other findings: This monitor reviewed the charts of ten individuals (GA, RB, JM, RM, NV, EV, TC, RD, RS and JLB). The sample was randomly selected. All charts met this requirement.</p> <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue implementation of the A-WRP within 24 hours of the admission. 2. Continue monitoring to ensure that A-WRPs are completed within 24 hours of all admissions. 3. Ensure that monitoring of the A-WRP includes 20% sample of all admissions. 																								
b.ii	<p>master therapeutic and rehabilitation service plans ("Wellness and Recovery Plan" (WRP)) are completed within seven days of admission; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Address and correct factors related to inconsistent compliance with this requirement.</p> <p>Findings: MSH has assessed this item and determined that a scheduling problem contributed to its inconsistent compliance. This issue has been addressed in the new training curriculum. The facility reports improved compliance with this requirement. The following data are based on the Chart Audit form:</p> <p><i>The master therapeutic and rehabilitation service plan (WRP) was developed on or before the seventh work day after admission.</i></p> <table border="1" data-bbox="835 1240 1619 1352"> <thead> <tr> <th></th> <th>Sep</th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>n</td> <td>20</td> <td>20</td> <td>13</td> <td>31</td> <td>24</td> <td>8</td> <td></td> </tr> <tr> <td>%</td> <td>60</td> <td>60</td> <td>100</td> <td>61</td> <td>67</td> <td>88</td> <td>73</td> </tr> </tbody> </table>		Sep	Oct	Nov	Dec	Jan	Feb	Mean	n	20	20	13	31	24	8		%	60	60	100	61	67	88	73
	Sep	Oct	Nov	Dec	Jan	Feb	Mean																			
n	20	20	13	31	24	8																				
%	60	60	100	61	67	88	73																			

		<p>Other findings: Reviewing the charts of ten individuals (GA, RB, JM, RM, NV, EV, TC, RD, RS and JLB), this monitor found compliance in all cases.</p> <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue implementation of the master WRP within seven days of the admission. 2. Continue monitoring of the master WRP within seven days of all admissions. 3. Ensure that monitoring of the master WRP is based on a 20% sample of all admissions. 4. Implement the DMH Clinical Chart Auditing Form. 																								
b.iii	<p>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.</p>	<p>Recommendation, September 2006: Same as above.</p> <p>Findings: Same as above. The facility's monitoring data, based on the Chart Audit form, are summarized as follows:</p> <p><i>The WRP was reviewed and revised as per WRP schedule (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.</i></p> <table border="1" data-bbox="835 1198 1619 1317"> <thead> <tr> <th></th> <th>Sep</th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>n</td> <td>137</td> <td>136</td> <td>110</td> <td>137</td> <td>156</td> <td>96</td> <td></td> </tr> <tr> <td>%</td> <td>54</td> <td>51</td> <td>58</td> <td>54</td> <td>37</td> <td>63</td> <td>53</td> </tr> </tbody> </table>		Sep	Oct	Nov	Dec	Jan	Feb	Mean	n	137	136	110	137	156	96		%	54	51	58	54	37	63	53
	Sep	Oct	Nov	Dec	Jan	Feb	Mean																			
n	137	136	110	137	156	96																				
%	54	51	58	54	37	63	53																			

		<p>Other findings: This monitor reviewed the charts of ten individuals (GA, RB, JM, RM, NV, EV, TC, RD, RS and JLB). The reviews show compliance in seven charts and non-compliance in three (JM, NV and JLB).</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Implement the required WRP conference schedule on all teams. 2. Continue to monitor the implementation of the required WRP conference schedule on all admission and long-term teams. 3. Ensure that monitoring of the WRP reviews includes a 20% sample of all admissions. 4. Implement the DMH Clinical Chart Auditing Form.
c	<p>Treatment rehabilitation and enrichment services are goal-directed, individualized, and informed by a thorough knowledge of the individual's psychiatric, medical, and psychosocial history and previous response to such services;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Develop a new monitoring tool to assess the overall quality of the integrated elements in the WRP in order to adequately address this requirement. The review must be done only by clinicians.</p> <p>Findings: The newly developed DMH Clinical Chart Auditing Form includes appropriate indicators and operational instructions that address this requirement.</p> <p>Recommendation 2, September 2006: Continue and strengthen training of WRP teams to ensure that:</p> <ul style="list-style-type: none"> • The case formulation include appropriate review and analysis of assessments to identify the individual's needs in the psychiatric, medical and psychosocial domains,

and

- Foci of hospitalization addresses all identified needs of the individual in the above domains.

Findings:

MSH has developed and implemented a WRP training curriculum intended to teach WRP core team members all areas in the new DMH WRP Manual pertaining to the development of the Case Formulation, the foci, objectives and interventions. Section C.1.a contains more information regarding this training.

Recommendation 3, September 2006:

Develop and implement audit items to ensure that cognitive disorders, if present, are documented as a focus and that individualized and appropriate objectives and interventions are provided.

Findings:

The new Clinical Chart Auditing Form includes indicators and operational instructions that address this requirement. MSH has yet to implement this mechanism.

The facility has developed and implemented a Mall Alignment Monitoring Tool that address appropriateness of group interventions to the individual's cognitive level. The following is a summary of the facility's data for November 2006 through January 2007:

If cognitive limitations or strengths are documented on the WRP, it is within the range of the cognitive level assigned to the group intervention.

	Nov	Dec	Jan	Mean
n	18	35	6	
%	0	0	0	0

Recommendation 4, September 2006:

Develop and implement audit items to ensure that substance abuse, if present, is documented as a focus and that individualized and appropriate objectives and interventions are provided.

Findings:

The DMH Clinical Chart Auditing Form Instructions are aligned with this recommendation. At present, the facility uses the Chart Audit form to assess its compliance with this item. The following is a summary of the data:

When substance abuse is diagnosed on Axis I it is documented in Focus 5 and there is at least one objective and intervention.

	Sep	Oct	Nov	Dec	Jan	Feb	Mean
n	92	78	67	89	78	68	
%	76	76	79	81	71	87	78

Recommendation 5, September 2006:

Develop and implement audit items to ensure that seizure disorders, if present, are documented as a focus and that individualized and appropriate objectives and interventions are provided. The documentation needs to address the interface between seizure disorders (and its treatment), psychiatric status (and its treatment) and psychosocial functioning of the individual.

Findings:

The newly developed Chart Auditing Form instructions address this requirement. As mentioned earlier, the facility has yet to implement this instrument.

The nursing service has developed the Nursing Staff Seizure Disorder Monitoring Form to assess: a) the documentation of foci, objectives and interventions related to seizure disorders; and b) nursing staff's knowledge of the interface between seizure disorders,

		<p>psychiatric status and psychosocial functioning of the individual. The tool has not been implemented yet.</p> <p>Other findings: Chart reviews by this monitor indicate that treatment, rehabilitation and enrichment services tend to ignore some important needs of individuals suffering from a range of disorders that require specialized objectives and interventions. The following are chart examples of individuals in each category of these disorders:</p> <ol style="list-style-type: none"> 1. Seizure disorders: <ol style="list-style-type: none"> a) LB, DR, RS, GB, MW and MTR have documented diagnoses of Epilepsy and Dementia Due to a variety of medical causes. The individuals receive anticonvulsant treatment with phenytoin and/or phenobarbital. In all these cases, the seizure disorder is listed as a focus, but the WRP does not include objectives/interventions to assess the risks of treatment and to minimize its impact on the behavior and cognitive dysfunction b) JM has Seizure Disorder and Mild Mental Retardation, and receives treatment with phenytoin. The WRP does not identify focus, objective or interventions related to the seizure disorder. c) GR is diagnosed with Seizure Disorder and, Dementia Due to Cerebral Anoxia. There is a focus for the seizure disorder, but the written objective and interventions are not tailored to the individual's needs. 2. Cognitive disorders: <ol style="list-style-type: none"> a) WRPs do not include a focus or objectives/interventions that address the cognitive dysfunction in individuals diagnosed with Dementia Due to Multiple Medical Aetiologies (RTL), Cognitive Disorder, NOS (VRF) and Dementia of the Alzheimer's Type, Late onset, With Behavioral Disturbance (DC). b) WRPs identify the cognitive disorder as a focus, but the objectives and interventions are not appropriate to the level of cognitive impairment (e.g. EA). c) WRPs address the cognitive disorder as a focus, but do not include
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		<p>objectives/interventions to address the possible negative impact of treatment and to minimize its risks (see examples under seizure disorders).</p> <p>3. Substance abuse: See monitor's findings in C.2.o.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Implement the DMH Clinical Chart Auditing Form to monitor this requirement and address the deficiencies identified above. 2. Continue training of WRPTs to ensure that: <ol style="list-style-type: none"> a. The case formulation includes appropriate review and analysis of assessments to identify the individual's needs in the psychiatric, medical and psychosocial domains, and b. Foci of hospitalization address all identified needs of the individual in the above domains.
d	Therapeutic and rehabilitation service planning is based on a comprehensive case formulation for each individual that emanates from interdisciplinary assessments of the individual consistent with generally accepted professional standards of care. Specifically, the case formulation shall:	<p>Compliance: Partial.</p>
d.i	be derived from analyses of the information gathered from interdisciplinary assessments, including diagnosis and differential diagnosis;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Continue and strengthen training of the WRP teams to ensure that the case formulation adequately addresses the requirements in C.2.d.</p>

		<p>Findings: The facility's WRP training curriculum contains a Case Formulation Module that meets requirements of the EP. Section C.1.a contains more information regarding WRP training at MSH.</p> <p>Recommendation 2, September 2006: Implement the newly developed case formulation monitoring instrument. This instrument should consolidate most of the items in the current variety of tools as well as provide a more meaningful process. It should serve as the main tool to assess the quality of case formulations.</p> <p>Findings: As mentioned earlier, the Case Formulation Monitoring Form has been revised and standardized statewide. The monitors represent the disciplines of nursing, rehabilitation therapy, social work, psychology, and psychiatry. Monitoring was implemented in January 2007. Inter-rater reliability was established between three pairs of raters. Two of the three pairs of raters demonstrated reliability of more than 90%.</p> <p>The case formulation requirements have been included in the new DMH WRP Clinical Chart Auditing Form, which will replace the current Case Formulation Monitoring Form and has yet to be implemented. This new form consolidates most of the items in the current variety of tools and provides a more meaningful clinical monitoring process.</p> <p>The facility has data based on the Case Formulation Monitoring form. The facility reviewed a sample of seven charts (2%) in January 2007 and 29 (8%) in February 2007. Data show overall compliance rates of 1% and 6% respectively.</p> <p>Other findings: Chart reviews by this monitor show improvement in the range of clinical information in the</p>
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		<p>case formulations, including updates of the status of individuals in the present status section and consistency in utilizing the 6-p format of clinical formulation. This improvement indicates that the facility is currently the process of transitioning from an old disciplinary system to a new system of Wellness and Recovery Planning. However, the following deficiencies were noted during this monitor chart reviews:</p> <ol style="list-style-type: none"> 1. The case formulations are not appropriately completed in the 6-p format. 2. The present status sections do not include sufficient review and analysis of important clinical events that require modifications in WRP interventions. For example, the review of the use of restrictive interventions is limited to a reiteration of the circumstances that led to this use, without much analysis of contributing factors or review of needed modifications in medication and other interventions in order to reduce the risk. In addition, individual's progress towards discharge is documented in generic terms, without evidence of discussion by the team regarding the individual's progress in achieving objectives that are stated in terms of what the individual has learned or has yet to learn 3. The linkages within different components of the formulations are often missing. 4. The formulations contain inadequate analysis of assessments and derivation of hypothesis regarding the individual's diagnosis, differential diagnosis, treatment, rehabilitation and enrichment needs. 5. There is inadequate linkage between the material in the case formulations and other key components of the WRP (e.g. foci of hospitalization, life goals, objectives and interventions). <p>These deficiencies must be corrected in order to achieve substantial compliance with this requirement.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Same as in C.2.c. 2. Continue the case formulation training related to this requirement and ensure that the training includes clinical case examples.
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		<p>3. Implement the Clinical Chart Auditing Form to monitor this requirement and ensure a 20% sample of the target population.</p> <p>4. Address and correct factors related to low compliance.</p>												
d.ii	include a review of: pertinent history; predisposing, precipitating and perpetuating factors; previous treatment history, and present status;	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Same as above.</p> <p>Findings: Same as above.</p> <p>Other findings: Using the Case Formulation Monitoring Form, the facility assessed its compliance with this item. The following is an outline of the average compliance rate. The monitoring indicators are the same as the requirements of this cell.</p> <table border="1"> <thead> <tr> <th></th> <th>Jan</th> <th>Feb</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>n</td> <td>7</td> <td>29</td> <td></td> </tr> <tr> <td>%C</td> <td>0</td> <td>5</td> <td>3</td> </tr> </tbody> </table> <p>Current recommendations: Same as above.</p>		Jan	Feb	Mean	n	7	29		%C	0	5	3
	Jan	Feb	Mean											
n	7	29												
%C	0	5	3											
d.iii	consider biomedical, psychosocial, and psychoeducational factors, as clinically appropriate, for each category in § [III.B.4.b] above	<p>Recommendation, September 2006: Same as above.</p> <p>Findings: Same as above.</p>												

		<p>Other findings: The following is a summary of the facility's data based on the Case Formulation Monitoring Form. The monitoring indicator is aligned with the requirement.</p> <table border="1"> <thead> <tr> <th></th> <th>Jan</th> <th>Feb</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>n</td> <td>7</td> <td>29</td> <td></td> </tr> <tr> <td>%C</td> <td>0</td> <td>5</td> <td>3</td> </tr> </tbody> </table> <p>Current recommendations: Same as above.</p>		Jan	Feb	Mean	n	7	29		%C	0	5	3
	Jan	Feb	Mean											
n	7	29												
%C	0	5	3											
d.iv	consider such factors as age, gender, culture, treatment adherence, and medication issues that may affect the outcomes of treatment and rehabilitation interventions;	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Same as above.</p> <p>Findings: Same as above.</p> <p>Other findings: The facility has no monitoring data regarding this requirement. The current Case Formulation Monitoring Form does not have indicators that specifically measure this requirement. The new DMH WRP Clinical Chart Audit Form contains appropriate indicator for this monitoring.</p> <p>Current recommendations: Same as above.</p>												
d.v	support the diagnosis by diagnostic formulation, differential diagnosis and	<p>Current findings on previous recommendation:</p>												

	<p>Diagnostics and Statistical Manual DSM-IV-TR (or the most current edition) checklists; and</p>	<p>Recommendation, September 2006: Same as above.</p> <p>Findings: Same as above.</p> <p>Other findings: The facility has the following monitoring data derived from the Case Formulation Monitoring Form. The monitoring indicator is aligned with the requirement.</p> <table border="1" data-bbox="835 610 1236 724"> <thead> <tr> <th></th> <th>Jan</th> <th>Feb</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>n</td> <td>7</td> <td>29</td> <td></td> </tr> <tr> <td>%C</td> <td>0</td> <td>3</td> <td>2</td> </tr> </tbody> </table> <p>Current recommendations: Same as above.</p>		Jan	Feb	Mean	n	7	29		%C	0	3	2
	Jan	Feb	Mean											
n	7	29												
%C	0	3	2											
d.vi	<p>enable the interdisciplinary team to reach sound determinations about each individual's treatment, rehabilitation, enrichment and wellness needs, the type of setting to which the individual should be discharged, and the changes that will be necessary to achieve discharge.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Same as above.</p> <p>Findings: Same as above.</p> <p>Other findings: Based on the Case Formulation Monitoring Form, the facility reports the following compliance rates:</p>												

		<table border="1" data-bbox="835 277 1236 391"> <tr> <td></td> <td>Jan</td> <td>Feb</td> <td>Mean</td> </tr> <tr> <td>n</td> <td>7</td> <td>29</td> <td></td> </tr> <tr> <td>%C</td> <td>0</td> <td>17</td> <td>9</td> </tr> </table> <p>Current recommendations: Same as above.</p>		Jan	Feb	Mean	n	7	29		%C	0	17	9												
	Jan	Feb	Mean																							
n	7	29																								
%C	0	17	9																							
e	<p>The therapeutic and rehabilitation service plan specifies the individual's focus of hospitalization (goals), assessed needs (objectives), and how the staff will assist the individual to achieve his or her goals/objectives (interventions);</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Same as in C.2.c, C.2.f, C.2.g and C.2.o.</p> <p>Findings: Same as in C.2.c, C.2.f and C.2.o.</p> <p>Other findings: The facility used the Chart Audit Form to assess compliance with this item. The following is an outline of the indicator and compliance rates. The indicator does not address the intent of this requirement. The new Clinical Chart Auditing Form is more aligned with this requirement.</p> <p><i>There are at least one objective and intervention for each focus of hospitalization.</i></p> <table border="1" data-bbox="835 1130 1619 1243"> <tr> <td></td> <td>Sep</td> <td>Oct</td> <td>Nov</td> <td>Dec</td> <td>Jan</td> <td>Feb</td> <td>Mean</td> </tr> <tr> <td>n</td> <td>138</td> <td>140</td> <td>112</td> <td>137</td> <td>156</td> <td>98</td> <td></td> </tr> <tr> <td>%C</td> <td>59</td> <td>58</td> <td>46</td> <td>59</td> <td>47</td> <td>60</td> <td>55</td> </tr> </table> <p>Chart reviews by this monitor indicate deficiencies in the following areas:</p>		Sep	Oct	Nov	Dec	Jan	Feb	Mean	n	138	140	112	137	156	98		%C	59	58	46	59	47	60	55
	Sep	Oct	Nov	Dec	Jan	Feb	Mean																			
n	138	140	112	137	156	98																				
%C	59	58	46	59	47	60	55																			

		<ol style="list-style-type: none"> 1. Identification of foci of hospitalization that address individuals' special needs (see monitor's findings in C.2.c and C.2.o). 2. Proper formulation and execution of objectives and interventions (see the monitor's findings in C.2.f). 3. Appropriate revision of foci and objectives (see the monitor's finding in C.2.g). <p>These deficiencies must be corrected in order to achieve substantial compliance.</p> <p>Compliance: Partial.</p> <p>Current recommendations: Same as in C.2.c, C.2.f, C.2.g and C.2.o.</p>
f	<p>Therapeutic and rehabilitation service planning is driven by individualized needs, is strengths-based (i.e., builds on an individual's current strengths), addresses the individual's motivation for engaging in wellness activities, and leads to improvement in the individual's mental health, health and well being, consistent with generally accepted professional standards of care. Specifically, the interdisciplinary team shall:</p>	<p>Please see sub-cells for compliance findings.</p>
f.i	<p>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</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Continue and strengthen training of WRP teams to ensure that objectives and interventions are implemented in accordance with the requirements in the DMH WRP manual.</p>

not addressed, provide a rationale for not addressing the need;

Findings:

MSH has developed and implemented curriculum designed to teach WRP core team members those areas in the new DMH WRP Manual that pertain to the development and prioritizing of goals/objectives that build on strengths.

Recommendation 2, September 2006:

Address and resolve the discrepancies between process and audit data regarding this requirement.

Findings:

Revisions in the two forms have minimized potential for discrepant findings.

Recommendation 3, September 2006:

Develop and implement a monitoring system to assess if goals/objectives are reasonable and attainable, if they address the identified need and if there is a rationale for not addressing the need.

Findings:

MSH used the current WRP Chart Audit Form to assess compliance with this requirement. The following outlines the monitoring indicator and compliance data:

There is a documented rationale if a focus of hospitalization does not have an objective and/or an intervention.

	Sep	Oct	Nov	Dec	Jan	Feb	Mean
n	141	140	121	144	159	99	
%C	12	31	5	14	7	14	14

These data partially addresses the recommendation, but the new DMH WRP Clinical Chart Auditing Form is better aligned with the requirement...

		<p>Other findings: This monitor reviewed six charts and found partial compliance in one (KR) and non-compliance in five (RTL, TR, VRF, MJA and FEA).</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue and reinforce training of WRPTs to ensure that objectives and interventions are implemented in accordance with the requirements in the DMH WRP manual. 2. Implement the Clinical Chart Auditing Form to monitor this requirement. 3. Address and correct factors related to low compliance with this requirement.
f.ii	<p>ensure that the objectives/ interventions address treatment (e.g., for a disease or disorder), rehabilitation (e.g., skills/supports, motivation and readiness), and enrichment (e.g., quality of life activities);</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Same as in recommendation #1 in C.2.f.i.</p> <p>Findings: Same as in C.2.f.i.</p> <p>Recommendation 2, September 2006: Develop and implement monitoring tools that clearly address the key required elements.</p> <p>Findings: At present, the facility does not have monitoring data. The new DMH WRP Clinical Chart Auditing Form addresses this requirement. This tool has yet to be implemented.</p> <p>Recommendation 3, September 2006: Same as in C.2.e.</p>

		<p>Findings: Same as in C.2.e.</p> <p>Other findings: This monitor found non-compliance in all charts reviewed (KR, RTL, TR, VRF, MJA and FEA).</p> <p>Compliance: Non-compliance.</p> <p>Current recommendations: Same as above.</p>
f.iii	write the objectives in behavioral, observable, and/or measurable terms;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Same as in recommendation #1 in C.2.f.i.</p> <p>Findings: Same as in C.2.f.i.</p> <p>Recommendation 2, September 2006: Address and correct the discrepancy between process observation and chart audit data regarding this requirement.</p> <p>Findings: MSH currently monitors this requirement using the Chart Audit Form as the only tool. The facility's data are summarized as follows.</p> <p><i>The WRP plan includes observable, measurable and behaviorally worded objectives written in terms of</i></p>

		<p><i>what the individual will do.</i></p> <table border="1" data-bbox="835 305 1619 422"> <thead> <tr> <th></th> <th>Sep</th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>n</td> <td>138</td> <td>139</td> <td>112</td> <td>137</td> <td>157</td> <td>98</td> <td></td> </tr> <tr> <td>%C</td> <td>29</td> <td>43</td> <td>29</td> <td>32</td> <td>23</td> <td>27</td> <td>31</td> </tr> </tbody> </table> <p>This mechanism is adequate for monitoring, but only clinicians should perform this function. This should occur with the implementation of the Clinical Chart Auditing Form.</p> <p>Other findings: In reviewing six charts, this monitor found partial compliance in one (FEA) and non-compliance in five (KR, RTL, TR, VRF and MJA).</p> <p>Compliance: Partial.</p> <p>Current recommendations: Same as above.</p>		Sep	Oct	Nov	Dec	Jan	Feb	Mean	n	138	139	112	137	157	98		%C	29	43	29	32	23	27	31
	Sep	Oct	Nov	Dec	Jan	Feb	Mean																			
n	138	139	112	137	157	98																				
%C	29	43	29	32	23	27	31																			
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;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Same as in recommendation #1 in C.2.f.i.</p> <p>Findings: Same as in C.2.f.i.</p> <p>Recommendation 2, September 2006: Same as in C.2.e.</p>																								

		<p>Findings: Same as in C.2.e.</p> <p>Other findings: MSH does not have monitoring data based on the current tools. The new DMH WRP Chart Auditing Form has an indicator that is aligned with this requirement.</p> <p>This monitor reviewed six charts and found non-compliance in all cases (KR, RTL, TR, VRF, MJA and FEA).</p> <p>Compliance: Non-compliance.</p> <p>Current recommendations: Same as above.</p>
f.v	<p>ensure that there are interventions that relate to each objective, specifying who will do what, within what time frame, to assist the individual to meet his/her needs as specified in the objective;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Same as in recommendation #1 in C.2.f.i.</p> <p>Findings: MSH has developed and implemented a training curriculum designed to teach WRP core team members areas in the DMH WRP Manual that pertain to the proper development of interventions. The indicators include who will do what, by when and whether the interventions are linked to objectives that meet the individuals' needs.</p> <p>Other findings: The facility's progress report does not include data regarding this item.</p>

		<p>Chart reviews by this monitor show and non-compliance in four charts (KR, TR, VRF and MJA) and partial compliance in two (RTL and FEA).</p> <p>Compliance: Partial.</p> <p>Current recommendations: Same as above.</p>
f.vi	<p>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;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Assess and address the factors related to inadequate scheduling by the WRP teams and/or participation by individuals to ensure compliance with the requirement.</p> <p>Findings: MSH is addressing this requirement by increasing the number of active treatment interventions for individuals in their WRPs as well as improving the alignment between WRPs with mall interventions. Staff has received training on the requirement (i.e. 20 hours) and was provided procedures that include instructions regarding: a) the addition of mall groups at the individual's WRPC; b) changing the individual's PSR mall schedule and c) requesting the development of a new mall group to better meet the individual's needs. These instructions are outlined in the Mall Manual Addendum (Chapter 3). In addition, flow charts and forms (e.g. WRP Scheduling Flowchart, WRPC Planning Schedule Flowchart, 7-Day Mall Group Add Process, Group Change Request Flowchart and New Group Activity Request Process) were developed to assist in the alignment between the individual's WRP and their mall schedule. In addition, MSH plans to increase monitoring by program managers and mall staff of individuals' mall attendance and participation.</p>

Recommendation 2, September 2006:

Monitor hours of active treatment scheduled and attended.

Findings:

The facility reviewed a random sample of 20 charts selected from various units to assess the number of active treatment hours that were identified on the most recent WRPs and the number of hours scheduled and attended as per MAPP (in February 2007). The review show that, on average, the WRPs, identified approximately eight hours and that the numbers of hours scheduled and attended, as per MAPP were 15 and eight, respectively.

Other findings:

This monitor reviewed six charts (KR, RTL, TR, VRF, MJA and FEA) to determine the number of active treatment hours listed on the most recent WRP and the number of hours scheduled and attended per MAPP. The review shows that WRPs still generally fail to identify the required hours and that inconsistency exists between WRP and MAPP data regarding scheduled hours and actual hours attended.

Individual	Scheduled hours (WRP)	Scheduled hours (MAPP)	Attended hours (MAPP)
KR	Does not specify	6	4
RTL	13	12	3
TR	Does not specify	20	7
VRF	11	18	9
MJA	6	11	3
FEA	9	20	10

Compliance:

Partial.

		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Correct factors related to inadequate scheduling by the WRPTs, inaccurate reporting of hours scheduled on the WRP, disconnection between WRP and MAPP data and inadequate participation by individuals. 2. Continue efforts to monitor hours of active treatment (scheduled and attended). 																								
f.vii	<p>maximize, consistent with the individual's treatment needs and legal status, opportunities for treatment, programming, schooling, and other activities in the most appropriate integrated, non-institutional settings, as clinically appropriate; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation 1, September 2006: Address and correct factors related to lack of programs.</p> <p>Findings: The facility used the Chart Audit Form to assess its compliance with this requirement. The following is an outline of the data:</p> <p><i>When Legal status permits (Civil Commitments), the individual is scheduled for off groups for community integration e.g. unemployment office, education, employment, recreation, or skills development.</i></p> <table border="1" data-bbox="835 927 1619 1044"> <thead> <tr> <th></th> <th>Sep</th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>n</td> <td>51</td> <td>34</td> <td>24</td> <td>33</td> <td>46</td> <td>33</td> <td></td> </tr> <tr> <td>%C</td> <td>6</td> <td>12</td> <td>13</td> <td>3</td> <td>7</td> <td>6</td> <td>8</td> </tr> </tbody> </table> <p>In addition, the facility reviewed the charts of 20 individuals under civil commitment to assess whether the community activities are listed on the WRPs and the MAPP. In this process, WRPs were reviewed for interventions that meet this requirement, as well as MAPP data to determine actual attendance The facility found 0% compliance.</p> <p>Other findings: This monitor reviewed the charts of three civilly committed individuals and found non-compliance in all cases (KR, TR and FEA).</p>		Sep	Oct	Nov	Dec	Jan	Feb	Mean	n	51	34	24	33	46	33		%C	6	12	13	3	7	6	8
	Sep	Oct	Nov	Dec	Jan	Feb	Mean																			
n	51	34	24	33	46	33																				
%C	6	12	13	3	7	6	8																			

		<p>Compliance: Non-compliance.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Monitor 20% sample of civilly committed individuals. 2. Assess and correct factors related to lack of programs.
f.viii	<p>ensure that each therapeutic and rehabilitation service plan integrates and coordinates all services, supports, and treatments provided by or through each State hospital for the individual in a manner specifically responsive to the plan's therapeutic and rehabilitation goals. This requirement includes but is not limited to ensuring that individuals are assigned to mall groups that link directly to the objectives in the individual's WRP and needs.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Develop and implement a mechanism to ensure proper linkage between type and objective of mall activities and objectives outlined in the WRP, as well as documentation of this linkage.</p> <p>Findings: The facility has initiated a variety of processes to address this requirement. These processes are outlined in the findings related to recommendation 1 in C.2.f.vi. The current WRP Mall Alignment Protocol does not address this requirement</p> <p>Recommendation 2, September 2006: Revise the WRP/mall alignment check protocol to properly address this requirement.</p> <p>Findings: The facility has yet to implement this recommendation.</p> <p>Recommendation 3, September 2006: Implement electronic progress note documentation by all mall and individual therapy providers.</p> <p>Findings: The DMH has developed a template for an electronic version of DMH Mall note. The</p>

		<p>template is on the network for use by all providers, but most providers have yet to use this version. Two PSR Malls have completed the objectives section for each individual. Providers in other malls can download the electronic form and access objectives in the mall office or on the units using the individual's WRP.</p> <p>Other findings: This monitor reviewed six charts and found compliance in two (KR, MJA), partial compliance in three (RTL, TR, FEA) and non-compliance in one (VRF).</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Implement mechanisms to ensure proper linkage between type and objectives of mall activities and objectives outlined in the WRP as well as documentation of this linkage. 2. Revise the WRP/mall alignment check protocol to address this requirement. 3. Continue the implementation of electronic progress notes by all mall and individual therapy providers. 4. Ensure that WRPTs integrate data from the mall progress notes in the review and modification, as needed of the WRPs.
g	<p>Therapeutic and rehabilitation service plans are revised as appropriate to ensure that planning is based on the individual's progress, or lack thereof, as determined by the scheduled monitoring of identified criteria or target variables, consistent with generally accepted professional standards of care. Specifically, the interdisciplinary team shall:</p>	<p>Please see sub-cells for compliance findings.</p>

g.i	<p>revise the focus of hospitalization, objectives, as needed, to reflect the individual's changing needs and develop new interventions to facilitate attainment of new objectives when old objectives are achieved or when the individual fails to make progress toward achieving these objectives;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Ensure that the DMH WRP manual contains specific requirements for review and revision of foci, objectives and interventions to address changes in the individual's status.</p> <p>Findings: The current DMH WRP Manual incorporates the requested information.</p> <p>Recommendation 2, September 2006: Continue and strengthen training to WRP teams to ensure that foci and objectives are reviewed and revised and that new interventions are developed and implemented as clinically needed</p> <p>Findings: The WRP training module regarding Foci and Interventions addresses this requirement. The information in C.1.a, C2.f.i and C2.f.v are also relevant to this recommendation.</p> <p>Recommendation 3, September 2006: Ensure that monitoring items are based on operational criteria that are focused on the specific requirements in the plan</p> <p>Findings: The current WRP Observation Monitoring Form addresses this requirement. The following data are based on this indicator:</p> <table border="1" data-bbox="835 1198 1619 1312"> <thead> <tr> <th></th> <th>Sep</th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>n</td> <td>60</td> <td>47</td> <td>35</td> <td>44</td> <td>37</td> <td>23</td> <td></td> </tr> <tr> <td>%C</td> <td>89</td> <td>78</td> <td>59</td> <td>56</td> <td>56</td> <td>63</td> <td>67</td> </tr> </tbody> </table>		Sep	Oct	Nov	Dec	Jan	Feb	Mean	n	60	47	35	44	37	23		%C	89	78	59	56	56	63	67
	Sep	Oct	Nov	Dec	Jan	Feb	Mean																			
n	60	47	35	44	37	23																				
%C	89	78	59	56	56	63	67																			

		<p>The facility does not have chart audit data related to this item. The DMH Clinical Chart Auditing Form does not have a corresponding indicator.</p> <p>Other findings: This monitor reviewed five charts and found compliance in one (MJA) and non-compliance in four (KR, TR, RTL and VRF).</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue training to WRPTs to ensure that foci and objectives are reviewed and revised and that new interventions are developed and implemented as clinically needed. 2. Monitor this requirement using both process observation and chart auditing. 3. Add an indicator to address this requirement in the DMH Clinical Chart Auditing Form. 4. Address and correct factors related to low compliance.
g.ii	<p>review the focus of hospitalization, needs, objectives, and interventions more frequently if there are changes in the individual's functional status or risk factors (i.e., behavioral, medical, and/or psychiatric risk factors);</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Same as above.</p> <p>Findings: Same as above.</p> <p>Recommendation 2, September 2006: Revise current monitoring tool to include individuals whose functional status has improved.</p> <p>Findings: New monitoring tools have been developed and approved. The new DMH WRP Chart Auditing</p>

Form addresses this requirement.

Other findings:

The facility has compliance data based on the WRP Observation Monitoring Form. The indicator is aligned with this requirement. The following is a summary of the data:

	Sep	Oct	Nov	Dec	Jan	Feb	Mean
n	60	47	35	44	37	23	
%C	25	80	48	61	56	59	55

The facility does not have monitoring data based on chart audits.

This monitor reviewed the charts of seven individuals who experienced restrictive interventions during the past year. The following two main deficiencies emerged based on a review of the present status section of the WRPs.

1. There is no review of the circumstances of the use of seclusion and/or restraints or treatment modifications to reduce the risk of future use (FEA, KLF and RS).
2. The plans address the circumstances of the use, but do not include appropriate modifications in interventions to reduce the risk (KR, TR, VRF and FR).

Compliance:

Partial.

Current recommendations:

1. Same as above.
2. Revise current monitoring tool to include individuals whose functional status has improved.
3. Implement the DMH Clinical Chart Auditing Form.

g.iii	<p>ensure that the review process includes an assessment of progress related to discharge to the most integrated setting appropriate to meet the individuals assessed needs, consistent with his/her legal status; and</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Continue and strengthen training to WRP teams to ensure consistent implementation of this requirement.</p> <p>Findings: MSH has developed and implemented curriculum intended to teach WRP core team members the DMH WRP Manual sections that address this requirement.</p> <p>Recommendation 2, September 2006: Ensure that the monitoring tool addresses the review of the individual's progress toward discharge, the documentation of the results in the present status section of the case formulation and appropriate revisions of the WRP if no progress has been made (as required by the DMH WRP Manual).</p> <p>Findings: The WRP Observation Monitoring Form includes an indicator that is aligned with this requirement. Using this form, the facility has monitoring data that are summarized as follows:</p> <table border="1" data-bbox="835 1013 1619 1127"> <thead> <tr> <th></th> <th>Sep</th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>n</td> <td>60</td> <td>47</td> <td>35</td> <td>44</td> <td>37</td> <td>23</td> <td></td> </tr> <tr> <td>%C</td> <td>65</td> <td>84</td> <td>35</td> <td>40</td> <td>55</td> <td>38</td> <td>53</td> </tr> </tbody> </table> <p>Other findings: This monitor reviewed the charts of six individuals KR, RTL, TR, VRF, MJA and FEA). Discharge criteria were outlined in all cases, but only one WRP (VRF) included discharge criteria that were sufficiently individualized in terms of learning outcomes and documentation of the team's discussion of the individual's progress towards discharge.</p>		Sep	Oct	Nov	Dec	Jan	Feb	Mean	n	60	47	35	44	37	23		%C	65	84	35	40	55	38	53
	Sep	Oct	Nov	Dec	Jan	Feb	Mean																			
n	60	47	35	44	37	23																				
%C	65	84	35	40	55	38	53																			

		<p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue training of WRPTs to ensure consistent implementation of this requirement. 2. Continue to monitor this requirement. 3. Address and correct factors related to low compliance.
g.iv	<p>base progress reviews and revision recommendations on data collected as specified in the therapeutic and rehabilitation service plan.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Same as C.2.g.i.</p> <p>Findings: Same as C.2.g.i.</p> <p>Recommendation 2, September 2006: Same as recommendation #3 in C.2.f.viii.</p> <p>Findings: Same as C.2.f.viii.</p> <p>Other findings: Reviewing six charts, this monitor found that only one (KR) met compliance based on the integration of mall facilitator's data and appropriate modification of interventions. In the other charts, the mall facilitator notes provided the needed data. However, the WRPTs either failed to integrate the data (TR, RTL and MJA) or to modify the interventions based on this integration (VRF and FEA).</p>

		<p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Same as in C.2.g.i. 2. Same as in C.2.f.viii. 																									
h	<p>Individuals in need of positive behavior supports in school or other settings receive such supports consistent with generally accepted professional standards of care.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Ensure that PBS psychologists have the authority to write orders for the implementation of PBS plans.</p> <p>Findings: MSH's progress report indicated that PBS psychologists at MSH do not have the authority to write orders for the implementation of PBS plans.</p> <p>Recommendation 2, September 2006: Ensure that all staff implement PBS plans and collect reliable and valid outcome data.</p> <p>Findings: MSH's progress report showed that staff implements PBS plans and collects reliable and valid outcome data on average 3% of the time. The following is a summary of the data:</p> <table border="1" data-bbox="835 1166 1346 1351"> <thead> <tr> <th></th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>17</td> <td>27</td> <td>24</td> <td></td> </tr> <tr> <td>n</td> <td>5</td> <td>27</td> <td>24</td> <td></td> </tr> <tr> <td>%S</td> <td>29%</td> <td>100%</td> <td>100%</td> <td></td> </tr> <tr> <td>%C</td> <td>0%</td> <td>0%</td> <td>10%</td> <td>3%</td> </tr> </tbody> </table>		Dec	Jan	Feb	Mean	N	17	27	24		n	5	27	24		%S	29%	100%	100%		%C	0%	0%	10%	3%
	Dec	Jan	Feb	Mean																							
N	17	27	24																								
n	5	27	24																								
%S	29%	100%	100%																								
%C	0%	0%	10%	3%																							

		<p>A review of seven PBS plans (AW, TP, JS, AB, MC, TP, and AA) showed that none of the plans reviewed were implemented with integrity. Zero of the seven plans reviewed were trained across environments. The lack of training to certification on each plan has resulted in poor implementation. For example, TP was denied her PRN and, as a result, she hurt herself. MC's treatment is poorly implemented and staff training has not happened in months.</p> <p>Recommendation 3, September 2006: Hire an additional PBS team.</p> <p>Findings: The facility has yet to implement this recommendation. MSH has two PBS teams. One team does not have a data analyst, and the other team lacks a data analyst and a nurse. In addition, team members are being pulled to work mandatory overtime.</p> <p>Recommendation 4, September 2006: Ensure that PBS team leaders have PBS duties as their primary function. The Chief of Psychology should be responsible for supervising and monitoring the assignment and quality of all work undertaken by the PBS teams.</p> <p>Findings: The PBS team leaders have PBS duties as their primary function. The Chief of Psychology is designated as the person responsible for supervising and monitoring the assignment and quality of work undertaken by the PBS teams, and is specified in 2.1, page 6, of the PBS Manual.</p> <p>Other findings: A number of PBS members have mandated overtime duties that interfere with their full participation in PBS meetings and training. These team members are the used for crisis</p>
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		<p>intervention, because they are PBS team members. This use is inappropriate.</p> <p>Recommendation 5, September 2006: Provide competency-based training to all staff in PBS procedures, and provide on going training and support for PBS team members, as needed.</p> <p>Findings: MSH's progress report data showed that PBS teams and DCAT received training from their Chief CRIPA Consultant on December 13 and 14, 2006 and January 9th and 10th 2007, and February 13, 2007. Additional training was provided by Angela Adkins during the week of January 22-26, 2007.</p> <p>Recommendation 6, September 2006: Ensure that there is full administrative support for the PBS teams.</p> <p>Findings: The administrative support to MSH's PBS teams was evidenced by the Administrations willingness to provide training resources and hiring of new staff for the PBS teams.</p> <p>Compliance: Partial.</p> <p>Current recommendations: Ensure that all PBS plans are trained to certification across environments before implementation.</p>
i	Adequate active psychosocial rehabilitation is provided, consistent with generally accepted professional standards of care, that:	<p>Compliance: Partial.</p>

i.i	<p>is based on the individual's assessed needs and is directed toward increasing the individual's ability to engage in more independent life functions;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: All discipline-specific assessments should include a section that states the implications of the assessment for rehabilitation activities.</p> <p>Findings: This monitor's review of assessment templates of the various disciplines showed that only the psychology assessment contains the "implications of the assessment for rehabilitation activities" section.</p> <p>Recommendation 2, September 2006: The WRP team should integrate these assessments and prioritize the individual's assessed needs.</p> <p>Findings: MSH's progress report showed that 35% of the WRPs reviewed integrated the assessments. The following is a summary of the facility's data (n=number of WRPs reviewed):</p> <table border="1" data-bbox="835 943 1619 1057"> <thead> <tr> <th></th> <th>Sep</th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>n</td> <td>128</td> <td>123</td> <td>100</td> <td>124</td> <td>127</td> <td>84</td> <td></td> </tr> <tr> <td>%C</td> <td>35</td> <td>48</td> <td>33</td> <td>37</td> <td>28</td> <td>29</td> <td>35</td> </tr> </tbody> </table> <p>This monitor's review of six charts (TP, FR, MM, MH, AA, and PT) showed that four of them (FR, TP, MH, and PT) showed partial evidence of integration of information from the assessments into the WRP. However, two of the WRPs (AA and MM) lacked a clear connection between assessment and the WRP. This represents 0% compliance. One consistent weakness among these WRPs is poor case formulation and weak psychosocial information. Much of the information is geared towards managing medical and maladaptive behaviors, with very little that leads to skill-building and promoting independent functioning.</p>		Sep	Oct	Nov	Dec	Jan	Feb	Mean	n	128	123	100	124	127	84		%C	35	48	33	37	28	29	35
	Sep	Oct	Nov	Dec	Jan	Feb	Mean																			
n	128	123	100	124	127	84																				
%C	35	48	33	37	28	29	35																			

Recommendation 3, September 2006:

The WRP team should select all available group and individual therapies that will meet the needs of the individual and then allow the individual to choose from these interventions.

Findings:

Using the WRP Observation Monitoring Form, MSH reports that 58% of the individuals had substantive input into their PSR Mall group activities. The following is a summary of the data (n=WRPCs observed, including 7-day, 14-day, Monthly, Quarterly and Annual):

	Sep	Oct	Nov	Dec	Jan	Feb	Mean
n	60	47	35	44	37	23	
%C	32	71	56	49	65	76	58

This monitor reviewed six Wellness and Recovery Plans (TP, FR, MM, MH, AA, and PT) for appropriate linkage between the needs of the individual based on their diagnoses and discharge criteria and the interventions offered. None of the WRPs reviewed included appropriate linkage between assessed needs and a choice of equivalent interventions from the Mall Catalogue.

This monitor interviewed three individuals (HC, FR, and EF). EF did not get any choice, but HC and FR were given choices of interventions. However, they stated that sometimes the groups that they were offered did not match their needs.

Recommendation 4, September 2006:

Ensure that group leaders are consistent and enduring for specific groups.

Findings:

MSH's progress report data showed that there is no tool to track this requirement. Separately, it was reported that leadership was not consistent in many Mall groups due to

		<p>staff shortages and re-assignments.</p> <p>Recommendation 5, September 2006: Provide Motivational Interviewing, Narrative Therapy and other cognitive behavioral interventions to individuals who refuse to attend groups as specified in their WRPs.</p> <p>Findings: This monitor's review indicates that individuals' Mall attendance was poor. For example, for the month of January the average attendance was 47.3% (program II), 54.9% (program III), 60.1% (program V) and 65.4% (program VI).</p> <p>MSH is not using Motivational Interviewing, Narrative Therapy and other cognitive behavioral interventions to individuals who refuse to attend groups. However, MSH recently trained staff on Motivational Interviewing.</p> <p>Recommendation 6, September 2006: Provide better leadership in the PSR Mall.</p> <p>Findings: This monitor's review of MSH's progress report indicated that in order to provide better leadership in the PSR Mall, weekly meetings are being held between Program Directors and the Mall Coordinator. In addition, programs have initiated curriculum committees and program managers now attend hospital-wide mall meetings.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. All discipline-specific assessments should include a section that states the implications of the assessment for rehabilitation activities. 2. The WRP team should integrate these assessments and prioritize the individual's assessed needs. 3. The WRP team should select all available group and individual therapies that will meet
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		<p>the needs of the individual and then allow the individual to choose from these interventions.</p> <p>4. Ensure that group leaders are consistent and enduring for specific groups.</p> <p>5. Provide Motivational Interviewing, Narrative Therapy and other cognitive behavioral interventions to individuals who refuse to attend groups as specified in their WRPs.</p>																								
i.ii	<p>Has documented objectives, measurable outcomes, and standardized methodology</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Ensure that the objectives are written in behavioral, observable and/or measurable terms, as specified in the DMH WRP Manual.</p> <p>Recommendation 2, September 2006: Ensure that the learning outcomes are stated in measurable terms.</p> <p>Findings: MSH reports that 31% of the charts reviewed had objectives written in behavioral, observable and/or measurable terms.</p> <table border="1" data-bbox="835 943 1619 1060"> <thead> <tr> <th></th> <th>Sep</th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>n</td> <td>138</td> <td>139</td> <td>112</td> <td>137</td> <td>157</td> <td>98</td> <td></td> </tr> <tr> <td>%</td> <td>29</td> <td>43</td> <td>29</td> <td>32</td> <td>23</td> <td>27</td> <td>31</td> </tr> </tbody> </table> <p>This monitor's review of ten charts (FR, PT, AA, MM, DH, JD, RM, JA, JS, and HC) showed that none (0%) of the charts reviewed had all the objectives written in behavioral, observable and/or measurable terms. For example, one of PT's objectives reads, "P will be encouraged to take his medication" and AA's reads, "A will adhere to medication regimen."</p> <p>Recommendation 3, September 2006: Ensure that each objective is directly linked to a relevant focus of hospitalization.</p>		Sep	Oct	Nov	Dec	Jan	Feb	Mean	n	138	139	112	137	157	98		%	29	43	29	32	23	27	31
	Sep	Oct	Nov	Dec	Jan	Feb	Mean																			
n	138	139	112	137	157	98																				
%	29	43	29	32	23	27	31																			

		<p>Findings: MSH's progress report noted that 55% of the foci had at least one objective and intervention.</p> <table border="1" data-bbox="835 423 1619 540"> <thead> <tr> <th></th> <th>Sep</th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb.</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>n</td> <td>138</td> <td>140</td> <td>112</td> <td>137</td> <td>156</td> <td>98</td> <td></td> </tr> <tr> <td>%C</td> <td>59</td> <td>58</td> <td>46</td> <td>59</td> <td>47</td> <td>60</td> <td>55</td> </tr> </tbody> </table> <p>This monitor's review of 13 charts (JS, JA, DM, PB, DC, FR, MC, MH, TP, HC, MM, AA, and PT) showed that seven of them (PT, HC, TP, MH, JA, MC, and FR) had objectives directly linked to a relevant focus of hospitalization. However, these objectives were not well developed. Six of them (AA, MM, DM, DC, PB, and JS) had one or more objectives not directly linked to a relevant focus.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that the objectives are written in behavioral, observable and/or measurable terms, as specified in the DMH WRP Manual. 2. Ensure that the learning outcomes are stated in measurable terms. 3. Ensure that each objective is directly linked to a relevant focus of hospitalization. 		Sep	Oct	Nov	Dec	Jan	Feb.	Mean	n	138	140	112	137	156	98		%C	59	58	46	59	47	60	55
	Sep	Oct	Nov	Dec	Jan	Feb.	Mean																			
n	138	140	112	137	156	98																				
%C	59	58	46	59	47	60	55																			
i.iii	Is aligned with the individual's objectives that are identified in the individual's Wellness and Recovery Plan	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Ensure that WRP teams write objectives in behavioral, observable, and/or measurable terms.</p> <p>Findings: Same as in findings under Recommendation 1 in above cell.</p>																								

		<p>Recommendation 2, September 2006: Ensure that all therapies and rehabilitation services provided in the malls are aligned with the assessed needs of the individuals.</p> <p>Findings: MSH's progress report data recorded 35% compliance. However, MSH's audit was not specific to this requirement.</p> <p>This monitor's review of 16 charts (DM, SJ, MM, CG, HM, SW, JL, JS, DC, BR, CD, RC, RD, AL, TB and KR) showed that some of the therapies and rehabilitation services provided in the Malls aligned with the assessed needs of the individuals. However, it was consistently found that the needs of the individual were not well developed, resulting in poor linkage between needs and appropriate groups. Only two charts (DM and CG) provided clear alignment.</p> <p>Recommendation 3, September 2006: When assigning mall groups, the WRP team members should be familiar with the contents of the group they recommend so that the groups are aligned with the individuals needs.</p> <p>Findings: MSH's progress report noted that WRPTs were trained on this requirement.</p> <p>A review of six charts (MC, MH, TP, HC, RT, and PT) showed that five of them (MC, MH, TP, HC, and PT) had some identified Mall groups that aligned with the individual's focus of hospitalization based on the topic of the group. However, when the mall catalogue was reviewed, some of the interventions listed were no longer active or run by the person listed as the provider. In addition, during c there was no evidence that the team reviewed the Mall Catalogue when choosing groups.</p>
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		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that WRPTs write objectives in behavioral, observable, and/or measurable terms. 2. Ensure that all therapies and rehabilitation services provided in the malls are aligned with the assessed needs of the individuals. 3. When assigning mall groups, the WRP team members should use the Mall Catalogue so that the groups they recommend are aligned with the individual's needs, stage of change and cognitive level.
i.iv	utilizes the individual's strengths, preferences, and interests;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: 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.</p> <p>Findings: MSH's progress report noted that there is not a completed monitoring tool for auditing this requirement.</p> <p>This monitor's review of eight charts showed that four of them (JA, RF, MC, and TP) did not have strengths, preferences, or interests specified in any of the interventions designed for the individual, and four (AA, MM, MH, and HC) had specified the motivation in at least one intervention designed for the individual. However, none (0%) of the WRPs reviewed fully met this criterion.</p> <p>Recommendation 2, September 2006: Ensure that the group facilitators and individual therapists know and use the individual's strengths, preferences and interests when delivering rehabilitation services.</p> <p>Findings: MSH's progress report showed that MSH has implemented the Individual Strengths Survey.</p>

		<p>Copies of the surveys have been given to WRPTs and stored in each Mall office.</p> <p>This monitor observed three groups (DBT Skills Introduction, Welcome to Reality, and Rational Emotive Behavioral Therapy) and interviewed providers for five groups. The facilitator in the one group knew of and used some of the individual's strengths, preferences and interests. This was not the finding in the other four groups. For example, in one group the facilitator had no curriculum or lesson plan, and had difficulty harmonizing the group based on the individual's strengths, preferences and interests. In another group the facilitator was substituting for another. The facilitator was not fully prepared and did not know where to find the list of individuals' strengths and preferences. In fact, the group was spread out with a few of the individuals sleeping, reading, and talking.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that group facilitators and individual therapists use the Individual Strengths Survey. 2. Ensure that the individual's strengths, preferences, and interests are clearly specified in the interventions in the individual's WRP in accordance with the DMH WRP manual and that the facilitators are aware of these.
i.v	focuses on the individual's vulnerabilities to mental illness, substance abuse, and readmission due to relapse, where appropriate;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Undertake clinical case formulation as a team rather than by assigning the task to a team member or to non-team members.</p> <p>Findings: MSH used the Case Formulation Monitoring Form to assess compliance. The data indicate that 7% of the charts reviewed showed evidence of an interdisciplinary approach to case formulation.</p>

	Jan	Feb	Mean
n	7	29	
%C	0	14	7%

This monitor's review of nine charts showed that three (MH, MC, and MM) contained some indication that the clinical case formulation had input from more than a single discipline, and six (PT, HC, TP, FR, JA, and AA) did not.

In two WRPCs observed by this monitor, many of the team members participated in the team discussion. However, the teams did not provide an overall assessment from each discipline prior to discussion and in both instances the teams did not appropriately update the case formulation based on the discussion. It should be noted that one team in particular appropriately used the team member with the best rapport with the individual (in this case the social worker) to lead the WRPC. The team also successfully identified the key issues that should be discussed with the individual prior to his participation in the WRP.

Recommendation 2, September 2006:

Include the individual's vulnerabilities in the case formulation under predisposing, precipitating, and perpetuating factors.

Findings:

MSH's progress data showed that 1% of the charts reviewed identified the individuals' vulnerabilities in their case formulation.

	Jan	Feb	Mean
n	7	29	
%C	0	2	1

This monitor's review of seven charts showed that one (MC) included the individual's vulnerabilities in the case formulation under predisposing, precipitating, and perpetuating

factors, and six of them (MH, AA, MM, JA, FR, and HC) did not.

Recommendation 3, September 2006:

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

Findings:

MSH's progress report noted that 4% of the charts reviewed reflected the individual's vulnerabilities in their Present Status of their WRPs.

	Jan	Feb	Mean
n	7	29	
%C	0	7	4

Of the six charts (MC, MH, AA, MM, JA, and FR) reviewed by this monitor, none incorporated the individuals' vulnerabilities in the present status of their WRPs.

Recommendation 4, September 2006:

Use the staged model of substance abuse training for group facilitators.

Findings:

The facility has yet to implement this recommendation. MSH's progress report indicated that the PSR Mall Facilitator Monitoring Form for Substance Abuse is under revision and has not been implemented.

Recommendation 5, September 2006:

Use the staged model of substance abuse manual for delivering rehabilitation services to individuals with substance abuse issues.

Findings:

The facility has yet to implement this recommendation. MSH's progress report indicated

		<p>that MSH uses the staged model in some of the groups. MSH uses "Group Treatment for Substance Abuse: A Stages-of-Change Therapy Manual", by Velasquez et. al. Provider training based on this text is continuing.</p> <p>Recommendation 6, September 2006: Provide groups regarding the purpose of Wellness Recovery Action Plan to all individuals in order to preempt relapse.</p> <p>Findings: MSH's progress report noted that Mall Curriculum Committee was given the necessary resources and assigned to develop and provide these groups.</p> <p>This monitor's review of Mall groups showed that a total of 59 Wellness Recovery Action Plan groups were offered between October 2006 and January 2007.</p> <p>Recommendation 7, September 2006: Same as in C.1.d.i.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Undertake clinical case formulation as a team rather than by assigning the task to a team member or to non-team members. 2. Include the individual's vulnerabilities in the case formulation under predisposing, precipitating, and perpetuating factors. 3. Update the present status to reflect the current status of these vulnerabilities. 4. Use the staged model of substance abuse training for group facilitators. 5. Use the staged model of substance abuse manual for delivering rehabilitation services to individuals with substance abuse issues. 6. Provide groups regarding the purpose of Wellness Recovery Action Plan to all individuals in order to preempt relapse.
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i.vi	is provided in a manner consistent with each individual's cognitive strengths and limitations;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: PSR mall groups should address the assessed cognitive levels of the individuals participating in the group.</p> <p>Findings: MSH's progress report noted that 0% of the groups were developed based on assessed cognitive levels of individuals participating in the group.</p> <p>Information from the Mall Director indicated that placement of individuals with peers of a narrow range of cognition has not been implemented. Information from group facilitators showed that individuals attending their groups are cognitively heterogeneous.</p> <p>This monitor's review of the Curriculum Committee Meeting notes (Program I, February 22, 2007) showed that cognitive functioning group development was discussed. According to the minutes, groups in both 106 & 404 malls are based on the stages of change. The WRPTs assess the individual's level of cognitive functioning and individual group assignments are based on those assessments.</p> <p>Recommendation 2, September 2006: Psychologists should assess all individuals suspected of cognitive disorders, mental retardation and developmental disabilities and other conditions that may adversely impact an individual's cognitive status.</p> <p>Findings: MSH's progress report indicated that psychologists have started to assess individuals suspected of cognitive disorders, mental retardation and other developmental disabilities and other conditions that may adversely impact an individual's cognitive status. According to Dr. Amy Choi, psychologist, the DCAT team has begun tracking individuals with cognitive</p>
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		<p>disorders to conduct assessments.</p> <p>This monitor's review of MSH's DCAT tracking data of individuals with conditions that could impact their cognitive status showed that as of February 27, 2007, there were 161 individuals fitting one or more of these categories. However, it does not appear that DCAT services are being fully utilized in this area at this time.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. PSR mall groups should address the assessed cognitive levels of the individuals participating in the group. 2. Psychologists should assess all individuals suspected of cognitive disorders, mental retardation and developmental disabilities and other conditions that may adversely impact an individual's cognitive status. 																								
i.vii	Provides progress reports for review by the Wellness and Recovery Team as part of the Wellness and Recovery Plan review process	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Ensure that all group and individual therapy providers provide the WRP teams with progress reports on all individuals prior to each individual's scheduled WRP review.</p> <p>Findings: MSH's progress report indicated 63% compliance with the provision (by group and individual therapy providers) of progress notes when required.</p> <table border="1" data-bbox="835 1128 1619 1243"> <thead> <tr> <th></th> <th>Sept</th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>n</td> <td>387</td> <td>347</td> <td>NA</td> <td>NA</td> <td>383</td> <td>334</td> <td></td> </tr> <tr> <td>%C</td> <td>62</td> <td>62</td> <td>NA</td> <td>NA</td> <td>69</td> <td>57</td> <td>63</td> </tr> </tbody> </table> <p>The data are based on Program I Mall Progress Notes Tracking Form.</p>		Sept	Oct	Nov	Dec	Jan	Feb	Mean	n	387	347	NA	NA	383	334		%C	62	62	NA	NA	69	57	63
	Sept	Oct	Nov	Dec	Jan	Feb	Mean																			
n	387	347	NA	NA	383	334																				
%C	62	62	NA	NA	69	57	63																			

This monitor's review of eight charts (JS, DH, RM, JL, QV, CD, JB, and AF) showed that five of them (JS, AF, JB, CD, and JL) had PSR Mall Facilitator Progress notes for some of the groups, and three of them (QV, RM, and DH) did not have the notes for any of the groups. In some instances, the notes contained inconsistent data. This is 0% compliance.

Recommendation 2, September 2006:

Automate this system to make it feasible for the group facilitators and individual therapists to provide progress notes in a timely manner.

Findings:

This monitor's interview with the Mall Director indicated that electronic version of the standardized mall note is on the network for use by all providers. Furthermore, the WaRMSS WRP module is able to contain the electronic version of the mall progress notes.

Recommendation 3, September 2006:

Use the data from the PSR Monthly Mall Progress Notes in the WRP review process.

Findings:

Using the WRP Observation Monitoring Form, the facility has monitoring data showing 57% compliance. In this process, the WRPTs were observed to determine if the WRP reviews used the data from monthly Mall Progress Notes for revision and recommendations.

	Sept	Oct	Nov	Dec	Jan	Feb	Mean
n	34	35	35	44	37	23	
%C	52	87	87	34	48	35	57

This monitor observed two WRPCs and PSR Mall Facilitator Progress Notes were not reviewed at either session. When interviewed, the team reported that the Progress Notes were not available for all the groups.

		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that all group and individual therapy providers provide the WRP teams with progress reports on all individuals prior to each individual's scheduled WRP review. 2. Automate this system to make it feasible for the group facilitators and individual therapists to provide progress notes in a timely manner. 3. Use the data from monthly Mall Progress Notes in the WRP review process.
i.viii	<p>is provided five days a week, for a minimum of four hours a day (i.e., two hours in the morning and two hours in the afternoon each weekday), for each individual or two hours a day when the individual is in school, except days falling on state holidays;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Provide PSR mall groups as required by the EP, five days a week, for a minimum of four hours a day (i.e. two hours in the morning and two hours in the afternoon each weekday), for each individual or two hours a day when the individual is in school, except days falling on State holidays.</p> <p>Findings: This monitor's interview with the Mall Director indicated that PSR Mall groups are provided five days a week, Mondays through Fridays. Mall hours for Programs I and VI conform to EP requirements of four hours per day, with two hours in the morning and two hours in the afternoon each weekday. For example, programming hours for program I, the Discovery Bay 404 Adult Mall group, are 10:00AM to 10:50AM, 11:00AM to 11:50AM, 1:15PM to 2:05PM and 2:05PM to 2:55PM. However, Mall hours for the rest of the programs do not comport with this requirement.</p> <p>Recommendation 2, September 2006: Mandate that all staff at MSH, other than those who attend to emergency medical needs of individuals, will provide services at the PSR Mall. This includes clinical, administrative and support staff.</p>

		<p>Findings: MSH did not address this recommendation directly, but presented MAPP data of hours of service provided by disciplines. Please see data presented in the second table on page 94.</p> <p>Recommendation 3, September 2006: All Mall sessions must be 50 minutes in length. Sessions less than 20 minutes do not contribute to an individual's active treatment hours.</p> <p>Findings: This monitor's interview with the Mall Director indicated that all Mall group activities were planned for 50 minutes. This monitor observed Mall activity and the groups were conducted for 50 minutes. Facilitators reported that they planned for and conducted groups for 50 minutes. Review of documents (Mall schedules, WaRMSS Schedule, and the DMH PSR Mall Manual) also showed that Mall group activities were programmed for 50 minutes each.</p> <p>Recommendation 4, September 2006: Provide groups as needed by the individuals and written in the individuals' WRPs.</p> <p>Findings: MSH has not addressed this recommendation.</p> <p>This monitor interviewed Kenneth Layman, Program Director, who reported that a needs assessment was conducted and forms to request new groups have been developed, but are not fully implemented.</p> <p>Recommendation 5, September 2006: Add new groups as the needs are identified in new/revised WRPs.</p> <p>Findings: MSH's progress report noted that MSH has not developed a monitoring tool to address this</p>
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		<p>recommendation.</p> <p>This monitor's review of MSH's Mall Outcomes Report 2007, showed that in November 2006, 23 new groups were added, and in January 2007, 73 new groups were added via the Mall Request Form process.</p> <p>However a review of WRPs and Mall attendance indicates that many groups should be developed to meet individual needs. In addition, Mall attendance is low for many individuals. This would indicate the need for Motivational Interviewing, Narrative Therapy and other cognitive behavioral interventions. These groups should be developed and offered to individuals who refuse to attend groups.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Provide PSR mall groups as required by the EP, five days a week, for a minimum of four hours a day (i.e. two hours in the morning and two hours in the afternoon each weekday), for each individual or two hours a day when the individual is in school, except days falling on State holidays. 2. Mandate that all staff at MSH, other than those who attend to emergency medical needs of individuals, will provide services at the PSR Mall. This includes clinical, administrative and support staff. 3. Provide groups as needed by the individuals and written in the individuals' WRPs. 4. Add new groups as the needs are identified in new/revised WRPs.
i.ix	is provided to individuals in bed-bound status in a manner and for a period that is commensurate with their medical status;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Include individuals' skill-building activities with bed-bound individuals commensurate with their cognitive status, medical, health, and physical limitations.</p>

		<p>Findings: This monitor observed a bed-bound individual (EF). Jocelyn Agtarap, R.N. and Linda Gross, Nurse Coordinator reported that EF receives regular visits from Occupational Therapists and Psychiatric Technicians for his mall therapy/services. On the day of this survey, EF refused all therapies and services. EF was upset that his scheduled discharge was cancelled due to Medicare problems. Jane Critia, Communication Coordinator and Kathrine Mulford, Program Coordinator talked with EF to calm him down using his interests. They were able to engage him. EF spoke with this monitor. He stated that he received Mall Services and that much of his activities still consisted of movies and videos, in addition to reading, movement, and ball activities.</p> <p>This monitor's review of the "Curriculum For Bed-Bound Residents" showed that the list contained a wide variety of activities. Examples of activities found in the Curriculum include: Exercise, Relaxation, Board Games, Room Gardening, Pet Therapy, Arts and Crafts, My Health, Community Reintegration Through Virtual Travel, My Wellness and Recovery Team, and Social Time. Scheduling of hours of service showed a range from 12 to 20 hours. However, when this monitor attempted to observe the three scheduled groups for this unit, all but one had been cancelled due to the psychologist calling in sick and another provider's scheduled time off. All the individuals were sitting in a room watching T.V. for their group activity.</p> <p>Recommendation 2, September 2006: Therapy can be provided in any physical location within the hospital as long as the services are structured and consistent with scheduled Mall activities.</p> <p>Findings: This monitor's interview of the Mall Director revealed that Mall group activities were held in residential units and unit space. Non-ambulatory individuals (Program 6) were provided support as necessary to move them (as in a wheelchair); otherwise room visits are conducted to provide the activities. In addition, a schedule has been established for non-ambulatory</p>
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		<p>individuals.</p> <p>Recommendation 3, September 2006: Ensure that all activities are documented.</p> <p>Findings: This monitor's review showed that some activities were documented through the Mall progress notes, in addition to a separate list of activities conducted with these individuals.</p> <p>Recommendation 4, September 2006: Widen the repertoire of activities individuals in bed-bound status receive.</p> <p>Findings: This monitor's review of the Curriculum for bed-bound individuals showed a wide variety of activities generated from numerous domains. Sample activities offered to bed-bound individuals included: Exercise, Relaxation, Board Games, Room Gardening, Pet Therapy, Arts and Crafts, My Health, Community Reintegration Through Virtual Travel, My Wellness and Recovery Team, and Social Time. However, across two monitoring tours, this monitor has yet to see these activities in action.</p> <p>Current recommendations: Implement the Curriculum for bed-bound individuals.</p>
i.x	routinely takes place as scheduled;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Implement a more focused mall program that is regularly scheduled, implemented, and provided within the individual's cognitive, medical, physical and functional status.</p>

Findings:

MSH has partially implemented this recommendation. This monitor's review showed that MSH has conducted training of staff to address this requirement. Furthermore, a Curriculum Committee regularly meets to review and revise Mall programs.

Recommendation 2, September 2006:

Ensure that mall groups and individual therapies are cancelled rarely, if ever.

Findings:

MSH's progress report showed that over a five-month period there were 1176 cancellations, ranging from 3 to 314 cancellations across programs.

Recommendation 3, September 2006:

Ensure that all disciplines facilitate a specified minimum number of hours of mall groups.

Findings:

The facility has yet to implement this recommendation. In a review of disciplines facilitating Mall group activities along with their scheduled hours per week, the following data were reported:

Discipline	Hours per week
Nursing	2.5
Psychology	4.9
Medical staff	2.7

Discipline	Hours per week
Rehabilitation	9.6
Social work	6.8
Dietary	2.0
Vocational instruction	8.0

		<p>This falls well below the minimum number outlined for each discipline.</p> <p>Recommendation 4, September 2006: Ensure that administrators and support staff facilitate a minimum of one mall group per week.</p> <p>Findings: MSH's progress report showed that all administrative divisions facilitate Mall groups and this monitor's review confirmed it. The hours served were as follows:</p> <table border="1" data-bbox="835 646 1707 873"> <thead> <tr> <th>Administrative division (number of staff)</th> <th>Average hours scheduled/week.</th> <th>Average hours provided/week</th> </tr> </thead> <tbody> <tr> <td>Administration(28)</td> <td>38</td> <td>18</td> </tr> <tr> <td>Psych Interns (5)</td> <td>15</td> <td>14</td> </tr> <tr> <td>CPS (7)</td> <td>22</td> <td>18</td> </tr> <tr> <td>Plant Ops(6)</td> <td>55</td> <td>19</td> </tr> </tbody> </table> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Implement a more focused mall program that is regularly scheduled, implemented, and provided within the individual's cognitive, medical, physical and functional status. 2. Ensure that mall groups and individual therapies are cancelled rarely, if ever. 3. Ensure that all disciplines facilitate a specified minimum number of hours of mall groups. 4. Ensure that administrators and support staff facilitate a minimum of one mall group per week. 	Administrative division (number of staff)	Average hours scheduled/week.	Average hours provided/week	Administration(28)	38	18	Psych Interns (5)	15	14	CPS (7)	22	18	Plant Ops(6)	55	19
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i.xi	includes, in the evenings and weekends, additional activities that enhance the individual's quality of life; and	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Develop a list of all enrichment activities available along with staff names competent in</p>															

		<p>facilitating the activities in accordance with generally accepted professional standards of care.</p> <p>Findings: MSH's Supplemental Treatment Database, reviewed by this monitor, contains the following categories of detail: Program Unit, Group, Hours, Providers, Training Date, and Competency. The number of enrichment activities is large and diverse.</p> <p>This monitor reviewed MSH's Supplemental Treatment Program, used for training trainers. The training roster showed that 226 staff members were trained between February and March of 2007.</p> <p>Recommendation 2, September 2006: 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.</p> <p>Findings: This monitor's review showed that MSH has not developed a system to monitor enrichment activities.</p> <p>Recommendation 3, September 2006: Increase the number of hours of enrichment activities per individual provided in the evenings and weekends.</p> <p>Findings: This monitor's review of the Supplemental Treatment Database showed that the weekly hours of enrichment activities by program are as follows:</p>
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		<table border="1" data-bbox="835 277 1396 545"> <thead> <tr> <th>Program</th> <th>Weekly hours of enrichment activities</th> </tr> </thead> <tbody> <tr> <td>Program I</td> <td>85.00</td> </tr> <tr> <td>Program II</td> <td>102.25</td> </tr> <tr> <td>Program III</td> <td>81.75</td> </tr> <tr> <td>Program IV</td> <td>55.00</td> </tr> <tr> <td>Program V</td> <td>88.25</td> </tr> </tbody> </table> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Plan and organize these activities such that there is minimal interruption, individuals are reinforced to participate regularly in these activities, and as much as possible eliminate competing activities that act as a barrier for individuals to participate in such activities. 2. Increase the number of hours of enrichment activities per individual provided in the evenings and weekends. 	Program	Weekly hours of enrichment activities	Program I	85.00	Program II	102.25	Program III	81.75	Program IV	55.00	Program V	88.25												
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i.xii	is consistently reinforced by staff on the therapeutic milieu, including living units.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Ensure that all WRPs have therapeutic milieu interventions clearly specified in the intervention sections.</p> <p>Findings: MSH has monitoring data based on the Chart Audit form. The data show that the individuals' therapeutic milieu interventions were specified in the interventions section of the individuals' WRPs in 24% of the charts reviewed.</p> <table border="1" data-bbox="835 1247 1619 1359"> <thead> <tr> <th></th> <th>Sept</th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>n</td> <td>137</td> <td>140</td> <td>111</td> <td>136</td> <td>157</td> <td>98</td> <td></td> </tr> <tr> <td>%</td> <td>23</td> <td>32</td> <td>28</td> <td>22</td> <td>14</td> <td>26</td> <td>24</td> </tr> </tbody> </table>		Sept	Oct	Nov	Dec	Jan	Feb	Mean	n	137	140	111	136	157	98		%	23	32	28	22	14	26	24
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This monitor's review of six charts (LP, QV, DY, FW, SS, and JT) showed that one of them (DY) specified the individual's therapeutic milieu interventions in the interventions section of the WRP and five of them (LP, QV, FW, SS, and LP) did not. This is 17% compliance.

Recommendation 2, September 2006:

Ensure that unit staff know what the individuals are learning in the malls and individual therapies and reinforce their learning in all settings.

Findings:

MSH's progress report showed that 14.6% of the unit staff audited knew what the individuals are learning in the malls and individual therapies and reinforced their learning in all settings. The facility used the Therapeutic Milieu Observation Monitor to assess compliance. The following is a summary of the data (n=number of units reviewed per month in the hospital):

	Sept	Oct	Nov	Dec	Jan	Feb	Mean
n	7	NA	1	10	10	8	
%	0	NA	0	20	40	13	14.6

This monitor observed staff reinforce individuals. For example, Lisa Adams, Mall Director, reinforced HC in the hallway; Kathrine Mulford, Program Coordinator, reinforced EF at his bedside, and Jeff Weber, Social Worker, reinforced MW, during his WRPC. However, Facilitators do not provide verbal reinforcement on the individual's participation when signing BY CHOICE point cards; unit staff provide general reinforcement but not specific to what the individual was learning in the malls and individual therapies.

Current recommendations:

1. Ensure that all WRPs have therapeutic milieu interventions clearly specified in the intervention sections.

		2. Ensure that unit staff know what the individuals are learning in the malls and individual therapies and reinforce their learning in all settings.																																																													
j	Adequate, individualized group exercise and recreational options are provided, consistent with generally accepted professional standards of care.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Establish group exercises and recreational activities for all individuals.</p> <p>Findings: MSH's progress report indicated that there were a number of exercise and recreational groups for each program.</p> <table border="1" data-bbox="835 683 1404 951"> <thead> <tr> <th>Programs</th> <th>Exercise/ Recreational Groups</th> </tr> </thead> <tbody> <tr> <td>I</td> <td>9</td> </tr> <tr> <td>II</td> <td>9</td> </tr> <tr> <td>III</td> <td>34</td> </tr> <tr> <td>IV</td> <td>10</td> </tr> <tr> <td>V</td> <td>21</td> </tr> </tbody> </table> <p>The number of individuals served by Exercise and Recreational Groups per Mall was 560. The following is an outline:</p> <table border="1" data-bbox="835 1092 1619 1360"> <thead> <tr> <th>Mall</th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>Bridge Recov</td> <td>203</td> <td>199</td> <td>202</td> <td>197</td> <td>223</td> <td>205</td> </tr> <tr> <td>Disc B</td> <td>17</td> <td>19</td> <td>55</td> <td>21</td> <td>23</td> <td>27</td> </tr> <tr> <td>Disc B 404</td> <td>33</td> <td>40</td> <td>16</td> <td>24</td> <td>25</td> <td>28</td> </tr> <tr> <td>Out Bound</td> <td>75</td> <td>72</td> <td>99</td> <td>76</td> <td>86</td> <td>82</td> </tr> <tr> <td>New Horiz</td> <td>144</td> <td>147</td> <td>158</td> <td>165</td> <td>171</td> <td>157</td> </tr> <tr> <td>Inspir Island</td> <td>60</td> <td>75</td> <td>59</td> <td>56</td> <td>60</td> <td>62</td> </tr> </tbody> </table>	Programs	Exercise/ Recreational Groups	I	9	II	9	III	34	IV	10	V	21	Mall	Oct	Nov	Dec	Jan	Feb	Mean	Bridge Recov	203	199	202	197	223	205	Disc B	17	19	55	21	23	27	Disc B 404	33	40	16	24	25	28	Out Bound	75	72	99	76	86	82	New Horiz	144	147	158	165	171	157	Inspir Island	60	75	59	56	60	62
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		<p>This monitor's review of MSH's Supplemental Treatment Database showed that a variety of exercise/games and enrichment activities are offered during the evenings and weekends.</p> <p>Recommendation 2, September 2006: Provide training to Mall facilitators to conduct the activities appropriately.</p> <p>Findings: MSH's progress report indicated that 53 providers have been trained to conduct the activities appropriately.</p> <p>Recommendation 3, September 2006: Track and review participation of individuals in scheduled group exercise and recreational activities.</p> <p>Findings: This monitor's review of individuals' attendance of their scheduled exercise and recreational activities showed that 80 of them had very poor attendance (below 30%) and 28 of them had 0% attendance. The reason for all the non-attended sessions was documented as "not attended by choice." It is unclear if the individual's choice to not attend was due to schedule conflicts, illness, or any other reason. In addition, it is unclear if these individuals participated in another activity/group at the same time they chose not to attend the exercise/recreational activities.</p> <p>Other Findings: Twenty-seven individuals with BMI =>40 have been targeted for the Winter 2007 exercise/recreational schedule.</p> <p>Recommendation 4, September 2006: Implement corrective action if participation is low.</p>
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		<p>Findings: MSH's progress report noted that the facility is processing the poor/no attendance list to determine reasons for and to take corrective actions. This task is expected to be completed in June 2007.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Establish group exercises and recreational activities for all individuals. 2. Provide training to Mall facilitators to conduct the activities appropriately. 3. Track and review participation of individuals in scheduled group exercise and recreational activities. 4. Implement corrective action if participation is low.
k	<p>Individuals who have an assessed need for family therapy services receive such services in their primary language, as feasible, consistent with generally accepted professional standards of care and that these services, and their effectiveness for addressing the indicated problem, are comprehensively documented in each individual's chart.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Conduct a needs assessment with individuals and/or their families.</p> <p>Recommendation 4, September 2006: Ensure that family therapy needs are fulfilled.</p> <p>Findings: MSH's progress report noted that a needs assessment was conducted for 342 individuals. Of these, 141 (41%) were deemed as fitting the need for family therapy services, and of these 141, 32 (22%) were currently participating in family therapy services. As for the remaining 109 individuals who were not involved in family therapy services, it was documented that the individual was not interested in the services (59), or the family was not interested</p>

		<p>in the services (28).</p> <p>MSH has revised their Family Letter. The newly revised letter to the family includes resources offered at MSH for family participation.</p> <p>Recommendation 2, September 2006: Use individual discharge plan goals as a way to identify families that may need family therapy to help them assist and support their family members upon discharge.</p> <p>Recommendation 3, September 2006: Review pre-admission reports and services/treatments provided to identify the need for family therapy services.</p> <p>Findings: This monitor's review showed that the Social Work Department has included this requirement in their 30-day assessment instructions. The instructions under "Relatives and Significant Others" was for the examiner to "provide an assessment of any need for family therapy and opportunities to engage the family or support system in treatment." MSH is waiting for DMH approval of the new 30-Day Psychosocial Assessment Form.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Conduct a needs assessment with individuals and/or their families. 2. Ensure that family therapy needs are fulfilled.
I	Each individual's therapeutic and rehabilitation service plan identifies general medical diagnoses, the treatments to be employed, the related symptoms to be	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Ensure that staff implements this requirement.</p>

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.

Findings:

MSH submitted the following compliance rates for November 2006, December 2006, and January 2007:

Item	Compliance Rates (%C)			
	Nov	Dec	Jan	Mean
General medical conditions	74	69	73	72
Treatment employees	60	61	69	63
Symptoms monitored by nurse	47	56	49	51
Means for monitoring	44	55	51	50
Frequency of monitoring	36	50	34	40
Staff identified to perform interventions	41	56	47	48
Interventions consistent with standards of care	50	63	51	55
Summation of care, treatment, & follow-up in Present Status of case formulation	30	41	35	35
n	210	108	55	

My findings, based on a review of ten individuals' WRPs (SW, WH, JV, CR, PL, NM, DY, JD, LN, and SF), were comparable to the data presented by MSH.

Recommendation 2, September 2006:

1. Implement this requirement.
2. Continue to monitor this requirement using the Medical Conditions Monitor audit.

Findings:

Same as above.

Compliance:

Partial.

		<p>Current recommendations: Continue to monitor this requirement.</p>
m	The children and adolescents it serves receive, consistent with generally accepted professional standards of care:	<p>Compliance: Partial.</p>
m.i	Therapy relating to traumatic family and other traumatic experiences, as clinically indicated; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Ensure that children and adolescents with traumatic family and other traumatic experiences receive appropriate and timely assessment and treatment services.</p> <p>Findings: This monitor's review of MSH's progress report noted that 23 (100%) of the adolescents with traumatic family and other traumatic experiences were surveyed. Ninety-six percent of them were found to have a history of familial or other forms of trauma. Of these, 82% were provided with individual therapy from Social Work staff or psychologists.</p> <p>Current recommendations: Ensure that children and adolescents with traumatic family and other traumatic experiences receive appropriate and timely assessment and treatment services</p>
m.ii	reasonable, clinically appropriate opportunities to involve their families in treatment and treatment decisions.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Continue to monitor children and families' needs.</p> <p>Findings: This monitor's review showed that MSH offered services to at least some of the 23</p>

		<p>adolescents surveyed. Of these, five were offered family therapy services; two families accepted the offer, two declined, and one lived very far from the facility.</p> <p>Recommendation 2, September 2006: Communicate relevant information to appropriate persons and the WRP team conference.</p> <p>Findings: This monitor's review of documents and interview with the Acting Chief of Social Work showed that MSH developed the "Engagement Curriculum Module" and trained WRP core team members of the new DMH WRP Manual to ensure that the individual was actively engaged in his/her discharge planning.</p> <p>Recommendation 3, September 2006: Actively expand the opportunities for these individuals and their families to receive appropriate services.</p> <p>Findings: This monitor's interview with the Acting Chief of Social Work showed that MSH is utilizing the Family Therapy Database to determine the methods/procedures/activities to engage families with needed services.</p> <p>Recommendation 4, September 2006: Collect outcome and satisfaction data.</p> <p>Findings: This monitor's interview with the Acting Chief of Social Work and review of MSH's progress report showed that MSH had mailed 15 Family Satisfaction Surveys (March 5, 2007 and March 9, 2007). Surveys were also distributed at the NAMI meeting. Three surveys were returned. The outcome showed a satisfaction rate of 67%.</p>
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		<p>Other findings: This monitor reviewed the Family Satisfaction Survey instrument. The surveys were in English and Spanish. The first word in the second sentence of the English version should read "Your" instead of "You". While this is not a monitoring item, it provides an opportunity to reinforce the importance of quality across all individual and family touchpoints. This monitor was not able to review the Spanish version of the Survey for accuracy and typing errors.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to monitor children and families' needs. 2. Communicate relevant information to appropriate persons and the WRP team conference. 3. Actively expand the opportunities for these individuals and their families to receive appropriate services. 4. Collect outcome and satisfaction data.
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.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Revise the screening policy to address the above deficiency.</p> <p>Findings: The facility has revised its Draft Substance Abuse Screening Policy. The Draft policy has been submitted for final approval. The draft adequately addresses the requirement.</p> <p>Recommendation 2, September 2006: Finalize and implement the policy and procedure.</p> <p>Findings: The DMH has yet to approve and implement the draft policy.</p>

		<p>Compliance: Partial.</p> <p>Current recommendations: Finalize and implement the policy and procedure.</p>
o	<p>Individuals who require treatment for substance abuse are provided appropriate therapeutic and rehabilitation services consistent with generally accepted professional standards of care.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Standardize the substance abuse auditing mechanisms across all state facilities.</p> <p>Findings: The clinical Chart Auditing Form includes indicator and operational instructions that are aligned with requirements of the EP (item #13). The facility has developed a specialized Substance Abuse Assessment and Treatment Audit Form that expands the scope of the monitoring.</p> <p>Recommendation 2, September 2006: Develop a formalized substance recovery program with designated administrative and clinical leadership.</p> <p>Findings: The facility has a Substance Abuse Leadership Committee that includes representation by the disciplines of Psychiatry, Psychology, Rehabilitation Therapy, Social Work, Nursing (Psychiatric Technicians) and Administration. Since the baseline evaluation, the facility has appointed a Substance Abuse Coordinator, who is certified in addiction studies and credentialed by the California Association of Alcohol and Drug Educators (CAADE). The team psychiatrist and coordinator provide clinical leadership in the substance abuse program. The facility has identified the most qualified substance abuse providers among all group</p>

		<p>facilitators and developed a core of substance abuse providers based on an evaluation of credentials and experience.</p> <p>Recommendation 3, September 2006: Develop and implement training curriculum and process derived from the trans-theoretical model for substance abuse</p> <p>Findings: MSH has adopted the Napa staged curriculum which is based on the trans-theoretical model for substance abuse. This curriculum is currently developed for the first four stages of change. The facility plans to begin training on March 27, 2007 for the current group of substance abuse providers based on that curriculum. Since the baseline evaluation, the Substance Abuse Leadership Committee provided a three-hour training session to WRPTs regarding Integrating Substance Abuse and Mental illness. The training addressed screening, assessment and planning as well as outcomes of treatment.</p> <p>Recommendation 4, September 2006: The substance recovery program should develop and utilize clinical outcomes for individuals and process outcomes for the program.</p> <p>Findings: The Substance Abuse Leadership Committee has developed a draft process and clinical outcomes and corresponding measurement tools. The facility has yet to implement this mechanism.</p> <p>Recommendation 5, September 2006: Same as in recommendation #4 under C.2.c.</p> <p>Findings: Same as in C.2.c.</p>
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		<p>Other findings: This monitor reviewed five charts of individuals with substance abuse disorders. All charts included substance abuse as a diagnosis, with corresponding objectives and interventions. However, the objectives were not linked to appropriate stages of change in all cases (RTL, TR, VRF, MJA and FEA). In a few cases (RTL and TR), the objectives were not correctly identified as objectives.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. The substance recovery program should utilize clinical outcomes for individuals and process outcomes for the program. 2. Implement the DMH Clinical Chart Auditing Form to monitor this requirement, including the correct identification of the stages of change. 3. Finalize and implement the training curriculum to include the maintenance phase of change. 4. Ensure monitoring of a 20% sample of the target population.
p	<p>Group facilitators and therapists providing therapeutic and rehabilitation services (in groups or individual therapy) are verifiably competent regarding selection and implementation of appropriate approaches and interventions to address therapeutic and rehabilitation services objectives, are verifiably competent in monitoring individuals' responses to therapy and rehabilitation, and receive regular,</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Monitor the competency of group facilitators and therapists in providing rehabilitation services.</p> <p>Findings: MSH used the PSR Mall Facilitator Monitoring Form to assess compliance. The data showed 88% competency for group facilitators and therapists providing rehabilitation services (n=number of facilitator observations conducted). The following is a summary:</p>

	<p>competent supervision.</p>	<table border="1" data-bbox="835 277 1524 394"> <thead> <tr> <th></th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>n</td> <td>30</td> <td>31</td> <td>15</td> <td>10</td> <td>8</td> <td></td> </tr> <tr> <td>%C</td> <td>82</td> <td>84</td> <td>90</td> <td>90</td> <td>95</td> <td>88</td> </tr> </tbody> </table> <p data-bbox="835 435 1990 836">This monitor observed two mall groups: Rational Emotive Behavior Therapy (REBT), and Welcome to Reality. The facilitator in the REBT started on time, followed a lesson plan, appropriately handled irrelevant and digressive conversation and returned to the central theme of the presentation, had handouts, used a variety of teaching modalities, directed questions/asked for opinions of those who were quiet, and used compassionate ways to engage those who were sleeping/inattentive. The facilitator in the Welcome to Reality group was compassionate with respect for the individuals and interacted in an adult-to-adult tone/voice. However, the facilitator did not have a lesson plan, ignored individuals who were repeatedly going in and out of the room, allowed individuals who moved away from the group to engage in their own activities, and did not attempt to engage those who were seated outside the main group.</p> <p data-bbox="835 878 982 943">Compliance: Partial.</p> <p data-bbox="835 987 1913 1092">Current recommendations: Monitor the competency of group facilitators and therapists in providing rehabilitation services.</p>		Oct	Nov	Dec	Jan	Feb	Mean	n	30	31	15	10	8		%C	82	84	90	90	95	88
	Oct	Nov	Dec	Jan	Feb	Mean																	
n	30	31	15	10	8																		
%C	82	84	90	90	95	88																	
q	<p>Group facilitators and therapists providing therapeutic and rehabilitation services in the field of substance abuse should be certified substance abuse counselors.</p>	<p data-bbox="835 1138 1430 1170">Current findings on previous recommendations:</p> <p data-bbox="835 1211 1948 1317">Recommendation 1, September 2006: Ensure that all group facilitators complete the substance abuse training curriculum as per MSH training curriculum.</p>																					

		<p>Findings: This monitor's review of the list of Substance Abuse Group Providers at MSH showed that as of March 6, 2007, MSH had 28 providers across the programs. The SNF unit did not have a Substance Abuse Group Provider. Review of the Staff Training and Competency Record showed that the 28 Substance Abuse Group Providers identified in the Groups Providers are listed under the Training and Competency Record. In addition, there are an additional 13 Substance Abuse providers at MSH who are not assigned to units/programs; of these, two are interns.</p> <p>Recommendation 2, September 2006: Clarify and streamline staff competency criteria to ensure their alignment with the current training curriculum.</p> <p>Findings: This monitor's review showed that MSH has developed Substance Recovery Provider Competency Criteria. The criteria call for a minimum of 80% competency in knowledge, assessment, and behavioral demonstration across 14 domains. A specific set of competency criteria and a competency observation instrument have been developed but not implemented yet.</p> <p>Recommendation 3, September 2006: Ensure that training includes all of the five stages of change.</p> <p>Findings: MSH's progress report stated that MSH was using the Manual from Napa. The Napa manual addresses four of the five stages of change. MSH is awaiting completion of Napa's fifth stage of change to add to the training.</p> <p>Recommendation 4, September 2006: Establish a review system to evaluate the quality of services provided by these trained</p>
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		<p>facilitators.</p> <p>Findings: MSH's progress report showed that MSH has developed the PSR Monitoring Form-- Addendum, as part of the review system to evaluate providers' quality of services. The system has not been implemented.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that all group facilitators complete the substance abuse training curriculum as per MSH training curriculum. 2. Clarify and streamline staff competency criteria to ensure their alignment with the current training curriculum. 3. Ensure that training includes all of the five stages of change. 4. Establish a review system to evaluate the quality of services provided by these trained facilitators.
r	<p>Transportation and staffing issues do not preclude individuals from attending appointments.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Review reasons for cancellations and assess and correct factors contributing to such events.</p> <p>Recommendation 3, September 2006: Assess why individuals refuse medical appointments and find ways to resolve their concerns.</p> <p>Findings: This monitor's review of MSH's documentation and progress report showed that missed/cancelled appointments were significantly high. The main reason for the</p>

		<p>cancellations was stated as individual refusals.</p> <p>Other findings: MSH has hired nine Hospital Police Officers. The hiring of these police officers is expected to reduce missed appointments due to lack of escorts.</p> <p>Recommendation 2, September 2006: Complete and implement the Medical Scheduler.</p> <p>Findings: MSH's progress report noted that MSH had piloted the software used in other state hospitals. Apparently, the software came to MSH without any instructions. MSH found the software incompatible, and their IT department has been working on the problem.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Review reasons for cancellations and assess and correct factors contributing to such events. 2. Assess why individuals refuse medical appointments and find ways to resolve their concerns. 3. Complete and implement the Medical Scheduler.
s	Adequate oversight to treatment, rehabilitation and enrichment groups is provided to ensure that individuals are assigned to groups that are appropriate to their assessed needs, that groups are provided consistently and with appropriate	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Ensure that individuals' cognitive levels, needs, and strengths are utilized when considering groups assignments.</p>

<p>frequency, and that issues particularly relevant for this population, including the use of psychotropic medications and substance abuse, are appropriately addressed, consistent with generally accepted professional standards of care.</p>	<p>Findings: MSH's progress report presented data to show that 40% of the charts reviewed considered the individuals' cognitive levels, needs, and strengths when assigning groups.</p> <p>This monitor's review of nine charts showed that three (MH, JS, and TB) made appropriate considerations prior to assigning the individuals to groups, and six (MC, KR, WW, KM, VR, and AF) did not meet criteria on all elements for this requirement. This is 33% compliance.</p> <p>Recommendation 2, September 2006: Ensure that providers and facilitators are knowledgeable, competent, and motivated to translate course content to individuals' needs to maximize learning.</p> <p>Findings: MSH's progress report showed that training was conducted with providers and facilitators (September 2006 - February 2007). A total of 310 staff has been trained in group leadership.</p> <p>This monitor's review of the 104 competency training scores available (dated March 3, 2007) showed that 101 of them were trained to competency with scores of 80% or better, and three did not meet competency criteria.</p> <p>Recommendation 3, September 2006: Develop and implement monitoring systems that address all of the required elements.</p> <p>Findings: MSH has not put into place a system of monitoring that addresses all of the required elements. MSH's progress report noted that the DMH WRP Clinical Chart Audit Form has been finalized and approved.</p>
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		<p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that individuals' cognitive levels, needs, and strengths are utilized when considering groups assignments. 2. Ensure that providers and facilitators are knowledgeable, competent, and motivated to translate course content to individuals' needs to maximize learning. 3. Develop and implement monitoring systems that address all of the required elements.
†	<p>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;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Continue to develop and implement monitoring tools to ensure the process outcomes of treatment and/or rehabilitation services.</p> <p>Recommendation 2, September 2006: Develop and implement monitoring tools to ensure positive clinical outcomes of treatment and/or rehabilitation services.</p> <p>Findings: This monitor's review of eight charts showed that three of them (DH, QV, and RM) did not have progress notes; the remaining five (MS, JL, CD, JB, and AF) did not meet all the elements of this requirement. In most cases, information from notes was not integrated into the individuals' WRPs.</p> <p>Recommendation 3, September 2006: Develop and implement monitoring tools to ensure that mall activities are properly linked to the foci, objectives and interventions specified in the WRP.</p>

		<p>Findings: MSH's progress report showed that 55% of the charts reviewed had a link between each foci and intervention in the individual's WRP. The data are based on the WRP/Mall Alignment Protocol (n=number of individuals reviewed, with at least a 7-day WRP).</p> <table border="1" data-bbox="835 423 1331 540"> <thead> <tr> <th></th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>n</td> <td>18</td> <td>35</td> <td>6</td> <td></td> </tr> <tr> <td>%</td> <td>72</td> <td>76</td> <td>17</td> <td>55</td> </tr> </tbody> </table> <p>This monitor's review of seven charts (TP, MC, HC, JA, FR, PT, and AA) showed that four of them (AA, TP, HC, and MC) were linked to their foci, objectives, and interventions, and three (JA, FR, and PT) did not.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to develop and implement monitoring tools to ensure the process outcomes of treatment and/or rehabilitation services. 2. Develop and implement monitoring tools to ensure positive clinical outcomes of treatment and/or rehabilitation services. 3. Develop and implement monitoring tools to ensure that mall activities are properly linked to the foci, objectives and interventions specified in the WRP. 		Nov	Dec	Jan	Mean	n	18	35	6		%	72	76	17	55
	Nov	Dec	Jan	Mean													
n	18	35	6														
%	72	76	17	55													
u	Individuals are educated regarding the purposes of their treatment, rehabilitation and enrichment services. They will be provided a copy of their WRP when appropriate based on clinical judgment.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Ensure that the mall group curriculum includes and identifies groups that offer education about the purpose of treatment, rehabilitation and enrichment activities.</p>															

Findings:

The mall director indicates that the facility has implemented this recommendation. However, the facility does not have supporting data in its progress report.

Recommendation 2, September 2006:

Increase the number of mall groups that are provided to address this requirement.

Findings:

The facility does not have data that show an increase in the number of these groups since the baseline evaluation.

The following table outlines MAPP data (October 2006 to February 2007) regarding the current number of groups that provide education about the purpose of treatment, rehabilitation and enrichment, per mall:

Mall	Oct	Nov	Dec	Jan	Feb	Mean
Discovery Bay-Adolescent	2	2	2	3	2	2.2
Discovery Bay-Adult	1	1	1	2	2	1.4
Outward Bound	1	1	1	1	1	1.0
Bridge Recovery	1	1	1	0	0	0.6
New Horizon	5	5	5	5	5	5.0
Inspiration Island	1	1	1	0	2	1.0

Recommendation 3, September 2006:

Develop and implement a monitoring tool to address this requirement.

Findings:

The facility's data are based on a review of MAPP information that is entered into the Monthly Mall Outcome Data Report. The facility does not have monitoring data in their

		<p>progress report.</p> <p>Recommendation 4, September 2006: Ensure that individuals are provided a copy of their WRPs based on clinical judgment.</p> <p>Findings: The facility has added an item to the WRP Observation Monitoring Form that addresses this requirement.</p> <p>The current WRP Engagement Curriculum Module provides instruction regarding this requirement. The facility does not provide data in the progress report to support implementation.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that the mall group curriculum includes and identifies groups that offer education about the purpose of treatment, rehabilitation and enrichment activities. 2. Increase the number of mall groups that are provided to address this requirement. 3. Develop and implement a monitoring tool to address this requirement. 4. Ensure that individuals are provided a copy of their WRPs based on clinical judgment.
v	<p>Staff educates individuals about their medications, the expected results, and the potential common and/or serious side effects of medications, and staff regularly asks individuals about common and/or serious side effects they may experience.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Increase the number of mall groups that offer education regarding medication management.</p> <p>Findings: The facility does not have data to indicate implementation of this recommendation. The</p>

following table outlines MAPP data (October 2006 to February 2007) regarding the current number of groups teaching about medication management.

Mall	Oct	Nov	Dec	Jan	Feb	Mean
Discovery Bay-Adolescent	0	1	1	1	1	0.8
Discovery Bay-Adult	6	3	3	3	3	3.6
Outward Bound	15	17	17	17	12	15.6
Bridge Recovery	4	3	3	3	5	3.6
New Horizon	17	17	17	17	15	16.6
Inspiration Island	3	4	4	4	3	3.6

Recommendation 2, September 2006:

The DMH WRP manual needs to include guidelines to WRPTs regarding the assessment of individuals' needs pursuant to this requirement, and to assist individuals in making choices based on both needs and available services.

Findings:

The current version of the manual is aligned with requirements of the EP.

Other findings:

The facility monitored this requirement (November 2006 to January 2007) using the Integrated Therapeutic and Services Planning Form. The monitoring indicators are aligned with requirements regarding medication education.

	Nov	Dec	Jan	Mean
n	73	33	44	
%C	55	40	38	44

		<p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Increase the number of mall groups that offer education regarding medication management. 2. Continue to monitor this requirement.
w	<p>Interdisciplinary teams review, assess, and develop positive clinical strategies to overcome individual's barriers to participation in therapeutic and rehabilitation services.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Provide key indicator data regarding individuals' non-adherence to interventions in the WRP.</p> <p>Findings: MSH facility has provided these data. In January 2007, 654 individuals reached triggers for non-adherence to WRP for more than 20% of the time in seven consecutive days (adults) and non-attendance at school for more than 20% of the interventions in seven consecutive days (children and adolescents). The facility has yet to develop a notification system for the teams in order to review and develop clinical strategies to identify and overcome barriers to participation.</p> <p>Recommendation 2, September 2006: Assess barriers to individuals' participation in their WRPs and provide strategies to facilitate participation.</p> <p>Findings: Since the baseline evaluation, 147 WRPT members have received training on Motivational Interviewing. The training was provided in four sessions by a doctorate-level social worker who is affiliated with the University of Southern California. The facility does not have information regarding the effectiveness of this training.</p>

		<p>Recommendation 3, September 2006: Ensure that the DMH WRP manual includes guidelines to WRP teams regarding assessment methodology and strategies, including cognitive interventions, to facilitate individuals' participation.</p> <p>Findings: The facility has implemented this recommendation.</p> <p>Recommendation 4, September 2006: Develop and implement monitoring tools to assess compliance with this item.</p> <p>Findings: MSH developed a WRP Tracking Trigger Response Form to be used by the WRPTs to address the needs of individuals that reach triggers for non-adherence to the WRP. The facility has yet to implement this mechanism.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue implementation of mechanisms to track non-adherence to WRPs. 2. Assess barriers to individuals' participation in their WRPs. 3. Provide training to the WRPTs to ensure implementation of: <ol style="list-style-type: none"> a. Appropriate individual therapy to individuals non-adherence to WRP in the Key Indicator; and b. Clinical strategies to help individuals achieve readiness to engage in group activities. 3. Implement tools to assess compliance with this requirement.
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D	Integrated Assessments	
	<p>Each State hospital shall ensure that, consistent with generally accepted professional standards of care, each individual shall receive, promptly after admission to each State hospital, an accurate and comprehensive assessment of the conditions responsible for the individual's admission, to the degree possible given the obtainable information at the time of admission. Thereafter, each individual shall receive an accurate and comprehensive reassessment of the reasons for the individual's continued hospitalization whenever there has been a significant change in the individual's status, or a lack of expected improvement resulting from clinically indicated treatment. The individual's interdisciplinary team shall be responsible for investigating the past and present medical, nursing, psychiatric, and psychosocial factors bearing on the individual's condition, and, when necessary, for revising assessments and therapeutic and rehabilitation plans in accordance with new information that comes to light. Each State hospital shall monitor, and promptly address deficiencies in the quality and timeliness of such assessments.</p>	<p>Summary of Progress:</p> <ol style="list-style-type: none"> 1. In general, the facility has maintained its practice of timely implementation of the admission medical and psychiatric assessments, integrated psychiatric assessments, psychiatric reassessments on the long-term units and the transfer assessments. 2. MSH has made some progress in the quality of the initial psychiatric assessments. 3. MSH has made progress in the finalization of psychiatric diagnoses listed as not otherwise specified (NOS). 4. MSH has a fully operational Forensic Review Panel that provides needed oversight to the WRPTs. This mechanism appears to have improved the structure and quality of many of the court reports submitted for individuals admitted under PC 1026 and PC 1370. 5. MSH has continued the process of internal monitoring using instruments that meet most of the requirements of the EP in the areas of psychiatric assessments and reassessments. The monitor's findings generally corroborate the facility's compliance ratings regarding the timeliness of medical assessments, initial and integrated psychiatric assessments and the content of inter-unit transfer assessments. 6. MSH has developed a Physician Quality Profile that is aligned with requirements of the EP. 7. MSH has revised its Medical Staff Manual to address requirements of the EP.

1	Psychiatric Assessments and Diagnoses	
	<p>Each State hospital shall provide all of the individuals it serves with routine and emergency psychiatric assessments and reassessments consistent with generally accepted professional standards of care; and,</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Michael Barsom, M.D., Acting Medical Director. 2. Nady Hanna, M.D., Acting President of Medical Staff. 3. Bala Gulasekaram, M.D., Chief of Psychiatry Department. 4. Lisa Dieckmann, Ph.D., Standards Compliance Psychologist. <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Charts of 15 individuals (MC, RLT, VRF, HRA, KG, GA, RB, JM, RM, NV, EV, TC, RD, RS and JLB) 2. MSH Medical Services Medical Care Policy and Procedure, revised January 2007. 3. Roster regarding Board Certified medical Staff. 4. Physician Performance Profile Form. 5. Staff Psychiatrist Manual. 6. Admission Psychiatric Assessment Monitoring Form. 7. Admission Psychiatric Assessment Monitoring Form Instructions. 8. Admission Psychiatric Assessment Monitoring summary data (September 2006 to February 2007). 9. Psychiatric Evaluation Monitoring Form. 10. Psychiatric Evaluation Monitoring Form Instructions. 11. Psychiatric Evaluation Monitoring summary data (September 2006 to February 2007). 12. Monthly Progress Notes Monitoring Form. 13. Monthly Progress Notes Monitoring summary data (September 2006 to February 2007). 14. Case Formulation Monitoring Form. 15. Case Formulation Monitoring summary data January and February 2007. 16. Physician Transfer Summary Monitoring Form. 17. Physician Transfer Summary Monitoring Form Instructions. 18. Physician Transfer Summary Monitoring summary data (September 2006 to February 2007).

		<p>2007).</p> <p>19. Department of Medicine Medical Staff Audit Form-Physicians (non-psychiatrists).</p> <p>20. Department of Medicine Medical Staff Audit Form-Physicians (non-psychiatrists) summary data January and February 2007.</p> <p>21. Training material regarding psychiatric diagnosis (provided since baseline evaluation).</p> <p>22. List of CME programs regarding cognitive/neuropsychiatric disorders (provided since baseline evaluation).</p> <p>23. AD #3133.1 Trigger Response.</p>																																																								
a	<p>Each State hospital shall use the diagnostic criteria in the most current Diagnostics and Statistical Manual of Mental Disorders ("DSM") for reaching the most accurate psychiatric diagnoses.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Develop and implement a monitoring instrument to assess accuracy of psychiatric diagnoses.</p> <p>Findings: MSH monitors accuracy of diagnoses based on a combination of items from several monitoring forms. The form instructions are adequate to ensure proper monitoring. The following is an outline of the monitoring indicators, the number of the item on the monitoring form (in parentheses) and compliance data provided by the facility:</p> <table border="1" data-bbox="835 980 1770 1321"> <thead> <tr> <th colspan="8">Admission Psychiatric Assessment</th> </tr> <tr> <th></th> <th>Sep</th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>680</td> <td>675</td> <td>666</td> <td>671</td> <td>60</td> <td>53</td> <td></td> </tr> <tr> <td>n</td> <td>42</td> <td>0</td> <td>9</td> <td>19</td> <td>41</td> <td>43</td> <td></td> </tr> <tr> <td>%S</td> <td>4</td> <td>0</td> <td>1</td> <td>2</td> <td>68</td> <td>81</td> <td></td> </tr> <tr> <td>%C</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>DSM diagnosis consistent with history and presentation (12)</td> <td>98</td> <td>NA</td> <td>89</td> <td>94</td> <td>93</td> <td>79</td> <td>91</td> </tr> </tbody> </table>	Admission Psychiatric Assessment									Sep	Oct	Nov	Dec	Jan	Feb	Mean	N	680	675	666	671	60	53		n	42	0	9	19	41	43		%S	4	0	1	2	68	81		%C								DSM diagnosis consistent with history and presentation (12)	98	NA	89	94	93	79	91
Admission Psychiatric Assessment																																																										
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DSM diagnosis consistent with history and presentation (12)	98	NA	89	94	93	79	91																																																			

Psychiatric Evaluation Monitoring Form							
	Sep	Oct	Nov	Dec	Jan	Feb	Mean
N	680	675	666	671	60	53	
n	31	12	22	31	52	43	
%S	5	2	3	5	8	8	
%C							
Included statements from the individual (4)	61	100	77	84	79	81	80
Included pertinent positive and negative findings (related to differential diagnosis) (5)	94	100	95	97	98	91	96
Included the diagnosis and medications given at previous facilities (6)	71	45	77	81	88	74	73
DSM-IV-TR addresses five axes (39)	97	100	95	97	100	100	98
Diagnostic formulation (40)	77	75	82	87	85	84	82
Included the diagnostic criteria for the given diagnosis (41)	87	75	91	94	92	77	86
Addressed findings which may support other diagnoses (42)	68	24	45	67	81	47	55

Monthly Progress Notes							
	Sep	Oct	Nov	Dec	Jan	Feb	Mean
N	680	675	666	671	673	675	
n	60	39	33	59	74	65	
%S	9	6	5	9	11	10	
%C							
Current diagnosis (changes, if any, with evidence to support) includes resolution of NOS, deferred and rule-out diagnoses , if applicable (20)	83	96	86	85	88	87	88

Case Formulation Monitoring Form*							
	Sep	Oct	Nov	Dec	Jan	Feb	Mean
N	680	675	666	671	673	675	
n	0	0	0	0	7	29	
%S	0	0	0	0	1	4	
%C							
Support the diagnosis by diagnostic formulation, differential diagnosis and Diagnostics and Statistical Manual DSM-IV-TR (or the most current edition) checklists (10)	NA	NA	NA	NA	0	3	2

*(See asterisk in table above) This form will be discontinued in favor of the Clinical Chart Auditing Form. The new form contains an indicator that is aligned with the requirements of the EP.

Average of all items							
	Sep	Oct	Nov	Dec	Jan	Feb	Mean
%C	82	77	82	88	80	72	75

Recommendation 2, September 2006:

Address all recommendations in section D.1.

Findings:

Same as in corresponding sections of D.1.

Recommendation 3, September 2006:

Standardize the monitoring forms, sampling methods and other mechanisms of internal monitoring across state facilities. Ensure that compliance rates derived from internal monitoring are based on a review of at least 20% sample monthly stratified by physician/psychiatrist. This recommendation is relevant to all applicable items in section D.1.

Findings:

The facility has made progress in standardizing the total target populations, subpopulations being reviewed, and sample sizes. As of January 2007, Psychiatry began to monitor at least 20% sample of target populations to assess compliance with EP requirements regarding all psychiatric assessments with the exception of the Physician Transfer Monitoring Form, which will be increased to 20% or 20, whichever is larger.

The following table outlines current expectations regarding sample sizes. The facility anticipates that these expectations will be met by September 1, 2007.

Monitoring Forms	Sampling
Psychiatry Admission	100% of new admissions.
Psychiatry Evaluation (Integrated Assessment)	100% of new admissions
Monthly Progress Notes	20% of individuals
Psychopharmacology	20% of individuals on specified medication
Physician Transfer Summary	20% or 20, which ever is larger

A statewide effort is underway to consolidate and standardize the monitoring indicators in all current forms.

Other findings:

Chart reviews by this monitor indicate that by and large, psychiatric diagnoses are stated in terminology that is consistent with the current version of DSM. However, admission and integrated psychiatric assessments (see D.1.c.i through D.1.c.iii) demonstrate deficiencies in the overall content and quality of the information needed for adequate diagnostic formulations. These deficiencies must be corrected to achieve substantial compliance.

Compliance:

Partial.

Current recommendations:

1. Finalize statewide efforts to consolidate and standardize monitoring indicators in current forms that assess psychiatric assessments.
2. Continue to monitor this requirement and ensure sample sizes of 20% of the total target

		<p>populations.</p> <p>3. Standardize the names of the monitoring instruments statewide and ensure that the facilities' progress reports use these names consistently.</p> <p>4. Address and correct factors related to low compliance.</p>
b	Each State hospital shall ensure that all psychiatrists responsible for performing or reviewing psychiatric assessments:	Please see sub-cells for compliance findings.
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	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Continue current practice and encourage all psychiatrists to obtain board certification.</p> <p>Findings: As of February 28, 100% of psychiatrists at MSH have completed at least three years of psychiatry residency in an Accreditation Council for Graduate Medical Education accreditation program. The facility uses primary source verification to ensure that this requirement is met. At present, 26 psychiatrists (50% of staff) are also certified by the American Board of Psychiatry and Neurology (ABPN).</p> <p>Compliance: In full compliance.</p> <p>Current recommendations: Continue current practice.</p>
b.ii	Are verifiably competent (as defined by privileging at initial appointment and thereafter by reprivileging for continued appointment) in performing	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Finalize the quality indicators to be used in the new format of performance evaluations and</p>

	<p>psychiatric assessments consistent with each State Hospital's standard diagnostic protocols.</p>	<p>ensure that the indicators address the requirements of the EP in the areas of diagnosis, assessment and reassessment.</p> <p>Findings: The facility revised its Physician Performance Profile to improve alignment with requirements of the EP. The new form incorporates information derived from the monitoring instruments that address the admission and integrated psychiatric assessments, annual psychiatric evaluation, monthly progress notes, and transfer notes as well as treatment team leadership.</p> <p>Recommendation 2, September 2006: Ensure that the staff psychiatrist manual includes clear performance expectations regarding the format and the content of all assessments and reassessments.</p> <p>Findings: The facility revised its staff psychiatrist manual. The revised manual includes information regarding the physician performance profile and expectations that are outlined in the various monitoring instruments.</p> <p>Other findings: The facility must correct deficiencies outlined in all sections of D.1. regarding psychiatric diagnosis and assessments in order to achieve substantial compliance with this requirement.</p> <p>Compliance: Partial.</p> <p>Current recommendations: Implement the new system of Physician Quality Profile to ensure that internal monitoring data regarding psychiatric diagnosis and assessments are utilized in the processes of reprivileging and performance improvement.</p>
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c	Each State hospital shall ensure that:	Please see sub-cells for compliance findings.																																																																								
c.i	Within 24 hours of an individual's admission to each State hospital, the individual receives an Admission Medical Assessment that includes:	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Ensure completeness of the admission medical examination within the specified time frame.</p> <p>Findings: The facility has monitoring data based on the Admission Psychiatric Assessment Form. The indicators are aligned with the requirements of the EP. The following is an outline of the monitoring indicators, the item number in the monitoring form (in parentheses), the relevant monitoring report cell if applicable and compliance data provided by the facility:</p> <table border="1" data-bbox="835 760 1906 1328"> <thead> <tr> <th></th> <th>Report cell</th> <th>Sep</th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td></td> <td>680</td> <td>675</td> <td>666</td> <td>671</td> <td>60</td> <td>53</td> <td></td> </tr> <tr> <td>N</td> <td></td> <td>42</td> <td>NA</td> <td>9</td> <td>19</td> <td>41</td> <td>43</td> <td></td> </tr> <tr> <td>%S</td> <td></td> <td>4</td> <td>NA</td> <td>1</td> <td>2</td> <td>68</td> <td>81</td> <td></td> </tr> <tr> <td>%C</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Completed within 24 hours (1)</td> <td></td> <td>100</td> <td>NA</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> </tr> <tr> <td>Admission diagnosis: Axis I-V addressed (11)</td> <td>c.i.4</td> <td>98</td> <td>NA</td> <td>100</td> <td>100</td> <td>100</td> <td>86</td> <td>97</td> </tr> <tr> <td>DSM diagnosis is consistent with history and presentation (12)</td> <td>c.i.4</td> <td>74</td> <td>NA</td> <td>89</td> <td>94</td> <td>93</td> <td>79</td> <td>86</td> </tr> </tbody> </table>		Report cell	Sep	Oct	Nov	Dec	Jan	Feb	Mean	N		680	675	666	671	60	53		N		42	NA	9	19	41	43		%S		4	NA	1	2	68	81		%C									Completed within 24 hours (1)		100	NA	100	100	100	100	100	Admission diagnosis: Axis I-V addressed (11)	c.i.4	98	NA	100	100	100	86	97	DSM diagnosis is consistent with history and presentation (12)	c.i.4	74	NA	89	94	93	79	86
	Report cell	Sep	Oct	Nov	Dec	Jan	Feb	Mean																																																																		
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Admission diagnosis: Axis I-V addressed (11)	c.i.4	98	NA	100	100	100	86	97																																																																		
DSM diagnosis is consistent with history and presentation (12)	c.i.4	74	NA	89	94	93	79	86																																																																		

	Report cell	Sep	Oct	Nov	Dec	Jan	Feb	Mean
Pertinent medical history; medical conditions needed stabilizing identified (23)	c.i.2	100	NA	100	100	100	100	100
Review of systems: pertinent positive and negative noted (24)	c.i.1	100	NA	100	100	100	100	100
Physical examination completed (25)	c.i.3	100	NA	100	100	100	100	100
Adequately detailed neurological examination (26)		100	NA	100	100	100	100	100
AIMS evaluation completed (27)		100	NA	100	100	100	100	100
Management of acute problems (28)	c.i.5	100	NA	100	100	100	100	100
Management of active, chronic problems (29)		100	NA	89	100	97	100	97
<p>Recommendation 2, September 2006: Ensure that there is a rationale for deferral of items on the examination and that deferred items are subsequently addressed to ensure compliance with the intent of this item.</p> <p>Recommendation 3, September 2006: Ensure that monitoring of the admission physical examination addresses completeness of the</p>								

examination and that the overall compliance rate accounts for the content and quality of each item.

Findings:

The medical staff revised the Medical Services Medical Care Policy and Procedures. The revised policy (Section I.B.7, 8 and 9) includes appropriate expectations regarding deferral of any part of the physical examination and follow-up requirements regarding individuals who refuse the admission physical examination. During January and February 2007, the Department of Medicine audited one individual per physician and surgeon per month to determine compliance using the Department of Medicine Medical Staff Audit Form-Physicians (non-psychiatrists). The following table lists the indicators and corresponding compliance rates (January and February 2007). The monitoring is incomplete regarding appropriate follow up when examinations are refused. Furthermore, it does not delineate deferrals of examinations by physicians from refusal by individuals.

Indicator	Jan	Feb	Mean
Neurological exam	100	100	100.0
Breast exam for females	100	97	98.5
Rectal exam	82	75	78.5
Rectal exam reoffer if refused	82	75	78.5
Pap smear	92	NA	92.0
Pap smear reoffer if refused	95	NA	95.0

Other findings:

This monitor reviewed the charts of ten individuals (GA, RB, JM, RM, NV, EV, TC, RD, RS and JLB). The review corroborates the facility's compliance data regarding review of systems, medical history, diagnostic impressions and management plan when acute medical problems

		<p>are identified. However, the monitor found a much lower compliance rate regarding completeness of the examination. The following are examples:</p> <ol style="list-style-type: none"> 1. No documentation of rationale and follow-up regarding deferral of genital/rectal examinations (GA, NV, TC and RS). 2. Inadequate documentation of follow-up regarding the individual's refusal of the parts of the examination, including genital/rectal examination (RB, RD, JLB) and examination of the abdomen (JLB). <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that there is documented rationale for deferral of items on the examination and that deferred items are subsequently addressed to ensure compliance with the intent of this item. 2. Continue to monitor this requirement, and include refusals of the examination and follow up (as per revised Medical Services Medical Care Policy and Procedures).
c.i.1	a review of systems;	100%
c.i.2	medical history;	100%
c.i.3	physical examination;	100%
c.i.4	diagnostic impressions; and	91% (average of 86% and 97%)
c.i.5	management of acute medical conditions	100%
c.ii	within 24 hours of an individual's	Current findings on previous recommendations:

	<p>admission to each State hospital, the individual receives an Admission Psychiatric Assessment that includes:</p>	<p>Recommendation 1, September 2006: Ensure that the mental status examinations are completed on all admission psychiatric assessments. An adequate narrative must be entered whenever indicated to complete the section titled "elaborate on positive mental status examination."</p> <p>Findings: The staff psychiatrist manual has been updated to address completeness of the mental status examination (Section 4.1.3). See findings under recommendation #3 below.</p> <p>Recommendation 2, September 2006: Update the staff psychiatrist manual to include the requirements regarding D.1. c.ii.1 through D.1.c.ii.6.</p> <p>Findings: Staff Psychiatrist Manual, Section 4.1.1, 4.1.2 and 4.1.3 has been updated to address this recommendation.</p> <p>Recommendation 3, September 2006: Ensure that monitoring of the admission psychiatric examination addresses completeness of the examination and that overall compliance rate accounts for the content and quality of each item.</p> <p>Findings: The facility monitored this requirement using the Psychiatric Admission Assessment Form. The following is a list of the monitoring indicators, the item number in the monitoring form (in parentheses) and compliance data provided by the facility, with relevant monitoring report cell noted:</p>
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	Report cell	Sep	Oct	Nov	Dec	Jan	Feb	Mean
N		680	675	666	671	60	53	
N		42	0	9	19	41	43	
%S		4	0	1	2	68	81	
%C								
Pertinent history leading to admission (5)	c.ii.1	100	NA	100	100	100	95	99
Pertinent past history addressed (6)	c.ii.1	95	NA	100	100	98	91	97
Mental status exam completed (9)	c.ii.2	88	NA	100	100	100	95	97
Admission diagnosis - Axis I - V addressed (11)	c.ii.3	98	NA	100	100	100	86	97
Appropriate laboratory and other tests ordered (16)	c.ii.5	100	NA	100	100	100	97	99
Appropriate consultations ordered (if applicable) (17)	c.ii.6	100	NA	100	100	100	100	100
If psychiatrist does the initial AIMS, was it completed? (22)	c.ii.4	100	NA	NA	NS	100	94	98

Source: File "D1 and F1 data.doc "

Other findings:

Chart reviews by this monitor demonstrate improved attention to the documentation of dangerousness (i.e. history of aggression, suicidality and self-abuse). However, there continue to be deficiencies regarding completeness of the mental status examination. The main deficiency is the lack of narrative needed to elaborate on positive mental status findings. This includes auditory hallucinations (RM), persecutory delusions (NV and RD), and

		<p>grandiose and bizarre delusions (EV). There is incomplete assessment of self-abuse and aggression in the case of RD. The assessment of insight and judgment is generic and the initial plans of care are not clearly documented nor sufficiently individualized in most cases. These deficiencies must be corrected to achieve substantial compliance.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that the mental examinations are completed on all admission psychiatric assessments. An adequate narrative must be entered whenever indicated to complete the section titled "elaborate on positive mental status examination." 2. Ensure documentation of a provisional plan of care upon the completion of the initial psychiatric examination. 3. Ensure that monitoring of the admission psychiatric examination addresses completeness of the examination and that overall compliance rate accounts for the completeness of each item. 4. Ensure monitoring of a 20% sample of the target population.
c.ii.1	psychiatric history, including a review of presenting symptoms;	98% (average of 99% and 97%)
c.ii.2	complete mental status examination;	97%
c.ii.3	admission diagnoses;	97%
c.ii.4	completed AIMS;	98%
c.ii.5	laboratory tests ordered; and	99%
c.ii.6	consultations ordered.	100%

c.iii	<p>within seven days (60/72 hrs) of an individual's admission to each State hospital, the individual receives an Integrated Psychiatric Assessment that includes:</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Ensure completeness of the integrated assessment within the specified time frame. The assessment must integrate information that cannot be obtained at the time of admission but becomes available during the first seven days of admission.</p> <p>Findings: The current format of the integrated assessment, if properly completed, meets requirements of the EP. The current time frames for completion are also influenced by CMS requirements. Psychiatric reassessments, as documented in progress notes, capture additional information that becomes available following completion of the integrated assessment.</p> <p>Recommendation 2, September 2006: Update the staff psychiatrist manual to include the requirements regarding D.1. c.iii.1 through D.1.c.iii.10.</p> <p>Findings: MSH revised the staff psychiatrist manual (Sections 4.2.3 and 4.2.4) to address this recommendation.</p> <p>Recommendation 3, September 2006: Ensure that monitoring of the integrated psychiatric examination addresses completeness and quality of the examination and that overall compliance rate accounts for the completeness and quality of each item.</p> <p>Findings: The facility monitored this requirement using the Psychiatric Evaluation Monitoring Form.</p>
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The following is a list of the monitoring indicators, the item number in the monitoring form (in parentheses) and compliance data provided by the facility, with relevant monitoring report cell noted:

	Sep	Oct	Nov	Dec	Jan	Feb	Mean
N	680	675	666	671	60*	53*	
n	31	12	22	31	52	43	
%S	5	2	3	5	86	81	
%C							
Included pertinent positive and negative findings (related to differential diagnosis) (5)	Specific data not provided						
Included the diagnosis and medication(s) given at previous facilities (6)	Specific data not provided						
Included the effectiveness of medication(s) given at previous facilities (7)	Specific data not provided						
Previous psychiatric history (9)	Specific data not provided						
Total cell c.iii.1	83	68	86	85	88	82	82
Psychosocial history (13)	Specific data not provided						
Total cell c.iii.2	97	92	100	100	100	91	97
Attitude/cooperation (16)	Specific data not provided						
General appearance (17)	Specific data not provided						
Motor activity (18)	Specific data not provided						
Speech (19)	Specific data not provided						
Mood/affect (20)	Specific data not provided						
Thought process/content (21)	Specific data not provided						
Perceptual alterations (22)	Specific data not provided						
Alertness (23)	Specific data not provided						

	Sep	Oct	Nov	Dec	Jan	Feb	Mean
Orientation (24)	Specific data not provided						
Memory (recent, remote and recall) (25)	Specific data not provided						
Attention (26)	Specific data not provided						
Fund of general knowledge (27)	Specific data not provided						
Abstraction ability (28)	Specific data not provided						
Judgment (29)	Specific data not provided						
Insight (30)	Specific data not provided						
Folstein, MMSE (if cognitively impaired) (31)	Specific data not provided						
Total cell c.iii.3	91	98	94	92	99	90	94
Patient strengths/ assets (32)	Specific data not provided						
Total cell c.iii.4	81	75	77	87	96	93	85
Risk assessment: addresses relevant demographic risk factors (33)	Specific data not provided						
Addresses history of suicide attempts (34)	Specific data not provided						
Addresses current clinical symptoms, including suicidal ideation, threats, and/or plans to harm self (35)	Specific data not provided						
Addresses psychosocial losses (36)	Specific data not provided						
Risk factors for seclusion/restraint addressed (37)	Specific data not provided						
Risk of aggression, fire setting, elopement, etc. addressed (38)	Specific data not provided						
Total cell c.iii.5	74	89	75	83	84	70	79

	Sep	Oct	Nov	Dec	Jan	Feb	Mean
DSM-IV-TR addresses five axes (39)	Specific data not provided						
Diagnostic formulation (40)	Specific data not provided						
Total cell c.iii.6	87	88	89	92	93	92	90
Included the diagnostic criteria for the given diagnosis (41)	Specific data not provided						
Addressed findings which may support other diagnoses(42)	Specific data not provided						
Total cell c.iii.7	78	5	68	81	87	62	71
DSM-IV-TR addresses five axes (39)	Specific data not provided						
Total cell c.iii.8	97	100	95	97	100	100	98
Reasons for continuing the medication(s) the individual came with (44)	Specific data not provided						
Statement that patient agrees to take medication(s) after explaining the benefits and risks (46)	Specific data not provided						
Total cell c.iii.9	74	28	48	53	72	54	55
Management of identified risks (49)	Specific data not provided						
Total cell c.iii.10	87	100	86	87	88	86	89

Recommendation 4, September 2006:

Ensure that monitoring of the integrated assessment addresses the practice of conducting the assessments so early that the purpose is defeated.

		<p>Findings: The Acting Chief of the Medical Staff states that the current timeline for completion of the integrated assessment is also influenced by requirements of the Center for Medicaid and Medicare Services (CMS). The facility has yet to address the intent of this recommendation.</p> <p>Other findings: In reviewing ten charts (GA, RB, JM, RM, NV, EV, TC, RD, RS and JLB), this monitor found lower compliance due to a pattern of deficiencies as shown in the following examples:</p> <ol style="list-style-type: none"> 1. The integrated assessment is not timely (GA and NV). 2. Important components are missing, including: <ol style="list-style-type: none"> a. Diagnostic formulation (RD); and b. Differential diagnosis (RD). 3. Important components are inadequately assessed, including: <ol style="list-style-type: none"> a. Family history (NV); b. Strengths (GA, RM, NV, JM and RS); c. Diagnostic formulation (NV); and d. Risk assessment (JMR). 4. The assessment of strengths is phrased in a manner that is not respectful of the individual's dignity (EV). 5. Incomplete mental status examinations, including: <ol style="list-style-type: none"> a. Nature of auditory hallucinations (NV); b. Specifics regarding command hallucinations (NV); c. Aspects of cognitive examination (RS); and d. Specifics regarding impaired judgment and insight (GA, JM and RM). <p>These deficiencies must be corrected to achieve substantial compliance.</p>
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		<p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure completeness of the integrated assessment within the specified time frame. The assessment must integrate information that cannot be obtained at the time of admission but becomes available during the first seven days of admission. 2. Ensure that monitoring of the integrated psychiatric examination addresses completeness of the examination and that overall compliance rate accounts for the completeness of each item. 3. Ensure monitoring of a 20% sample of the target population.
c.iii.1	psychiatric history, including a review of present and past history;	82%
c.iii.2	psychosocial history;	97%
c.iii.3	mental status examination;	94%
c.iii.4	strengths;	85%
c.iii.5	psychiatric risk factors;	79%
c.iii.6	diagnostic formulation;	90%
c.iii.7	differential diagnosis;	71%
c.iii.8	current psychiatric diagnoses;	98%
c.iii.9	psychopharmacology treatment plan; and	55%

c.iii.10	management of identified risks.	89%
d	Each State hospital shall ensure that:	Please see sub-cells for compliance findings.
d.i	Clinically justifiable diagnoses are provided for each individual, and all diagnoses that cannot be clinically justified for an individual are discontinued no later than the next review;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Provide continuing medical education to psychiatry staff to improve competency in the area of assessment of cognitive and other neuropsychiatric disorders.</p> <p>Findings: The facility provided two Continuing Medical Education programs (Neuropsychological Testing and Cognitive Rehabilitation for Schizophrenia) to address this recommendation. Both programs were provided by PhD Psychologists with training in neuropsychology. Between February 22 and March 12, 2007, Dr. Hanna, a Senior Psychiatrist, provided training to WRPTs on differential diagnosis; 176 team members were trained and 109 were determined to be competent based on the post-test.</p> <p>Recommendation 2, September 2006: Revise current monitoring tool to address justification of diagnosis, differential diagnosis and updates of diagnosis, as appropriate.</p> <p>Findings: MSH uses a composite of items that address these requirements (see D.1.a). Statewide standardization process is underway.</p> <p>Other findings: Chart reviews by this monitor show an overall decrease in the number of individuals receiving diagnostic categories that are listed as not otherwise specified (NOS). In the charts of individuals currently receiving these diagnoses, there is a pattern of inadequate</p>

		<p>documentation, evaluation and updates in the WRPs of these disorders. Examples include:</p> <ol style="list-style-type: none"> 1. Mood Disorder, NOS (MC); 2. Psychotic Disorder, NOS (RLT); 3. Cognitive Disorder, NOS (VRF); and 4. Impulse Control Disorder, NOS (HRA). 5. Eating Disorder, NOS (KG). <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue medical education programs to improve diagnostic accuracy, including assessment of cognitive and other neuropsychiatric disorders. 2. Ensure that diagnostic formulations and differential diagnoses address the clinically appropriate needs of all individuals and that the diagnostic process includes adequate interventions and follow up to finalize diagnoses. 3. Same as in C.1.a.
d.ii	<p>The documented justification of the diagnoses is in accord with the criteria contained in the most current DSM (as per DSM-IV-TR Checklist);</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Same as D.1.a.</p> <p>Findings: Same as D.1.a.</p> <p>Compliance: Partial.</p>

		<p>Current recommendations: Same as D.1.a.</p>
d.iii	<p>Differential diagnoses, "deferred," or "rule-out" diagnoses, and diagnoses listed as "NOS" ("Not Otherwise Specified") are timely addressed (i.e., within 60 days), through clinically appropriate assessments, and resolved in a clinically justifiable manner; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Same as D.1.d.i.</p> <p>Findings: Same as in D.1.d.i.</p> <p>Other findings: Same as in D.1.d.i.</p> <p>Compliance: Partial.</p> <p>Current recommendations: Same as D.1.d.i.</p>
d.iv	<p>"no diagnosis" is clinically justified and documented.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Continue current practice.</p> <p>Findings: The facility has continued its current practice. At present, no individual has "no diagnosis" listed on Axis I.</p>

		<p>Other findings: Chart reviews by this monitor did not show any Axis I diagnosis listed as "no diagnosis."</p> <p>Compliance: Full.</p> <p>Current recommendations: Continue current practice.</p>																																								
e	<p>Each State hospital shall ensure that psychiatric reassessments are conducted at a frequency that reflects the individual's clinical needs. At a minimum the reassessments are completed weekly for the first 60 days on the admissions units and monthly on other units.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Assess and correct factors related to low compliance with the requirement.</p> <p>Findings: MSH used the Psychiatric Monthly Progress Notes to assess compliance. The following is an outline of the monitoring indicator and the facility's data:</p> <p><i>Weekly note each week if length of stay is less than 60 days:</i></p> <table border="1" data-bbox="835 980 1619 1154"> <thead> <tr> <th></th> <th>Sep</th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>680</td> <td>675</td> <td>666</td> <td>671</td> <td>673</td> <td>675</td> <td></td> </tr> <tr> <td>n</td> <td>60</td> <td>39</td> <td>33</td> <td>59</td> <td>74</td> <td>65</td> <td></td> </tr> <tr> <td>%S</td> <td>9</td> <td>6</td> <td>5</td> <td>9</td> <td>11</td> <td>10</td> <td></td> </tr> <tr> <td>%C</td> <td>48</td> <td>9</td> <td>4</td> <td>29</td> <td>84</td> <td>66</td> <td>40</td> </tr> </tbody> </table> <p>Other findings: This monitor reviewed charts of six individuals on the admissions units (GA, JM, RM, NV, RD and JLB). Of these charts, only two (GA and RM) met compliance.</p>		Sep	Oct	Nov	Dec	Jan	Feb	Mean	N	680	675	666	671	673	675		n	60	39	33	59	74	65		%S	9	6	5	9	11	10		%C	48	9	4	29	84	66	40
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		<p>Compliance: Partial.</p> <p>Current recommendations: Assess and correct factors related to non-compliance with the requirement for weekly progress notes on the admission teams.</p>																																								
f	<p>Each State hospital shall ensure that psychiatric reassessments are documented in progress notes that address the following:</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Develop and implement a format for psychiatric reassessments that addresses and corrects the deficiencies identified above. [Please see baseline report for deficiencies identified.] The format should be standardized for statewide use.</p> <p>Findings: MSH used the Monthly Progress Notes Monitoring Form to assess compliance as well as progress toward correcting a number of the deficiencies. The Form's indicators are aligned with the requirements of the EP. The following is an outline of the previously cited deficiencies, the indicators used to assess compliance/progress, the item number in the monitoring form (in parentheses), the relevant monitoring report cell and compliance data provided by the facility:</p> <table border="1" data-bbox="835 1052 1866 1247"> <thead> <tr> <th></th> <th>Sep</th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>680</td> <td>675</td> <td>666</td> <td>671</td> <td>673</td> <td>675</td> <td></td> </tr> <tr> <td>n</td> <td>60</td> <td>39</td> <td>33</td> <td>59</td> <td>74</td> <td>65</td> <td></td> </tr> <tr> <td>%S</td> <td>9</td> <td>6</td> <td>5</td> <td>9</td> <td>11</td> <td>10</td> <td></td> </tr> <tr> <td>%C</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table> <p>(table continues on next page)</p>		Sep	Oct	Nov	Dec	Jan	Feb	Mean	N	680	675	666	671	673	675		n	60	39	33	59	74	65		%S	9	6	5	9	11	10		%C							
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Relevant deficiency noted in the baseline report:	Assessment of interval events is lacking and does not adequately cover significant clinical developments. Most of the reassessments are cross-sectional and more oriented toward current crisis events.						
Relevant cell in the monitoring report:	f.i						
	Sep	Oct	Nov	Dec	Jan	Feb	Mean
Progress towards objective in the WRP (4)	87	87	97	80	91	69	85
Pharmacologic rationale for continuation of medications or proposed plans (21)	83	82	97	81	86	86	86
Non-pharmacologic (22)	68	77	85	61	77	66	72
Total, cell f.i:	79	82	93	74	85	74	81
Relevant deficiency noted in the baseline report:	The diagnoses are not updated in a timely manner. There is little justification for diagnoses listed as NOS and the diagnostic formulations and differential diagnoses are not adequate when needed. There is little or no documentation to indicate that the psychiatrist has used information regarding the individual's response to specific treatments as data to refine diagnosis.						
Relevant cell in the monitoring report:	f.ii						

(table continues on next page)

	Sep	Oct	Nov	Dec	Jan	Feb	Mean
Current diagnosis (changes, if any, with evidence to support. Includes resolution of NOS, deferred, and rule-out diagnoses, if applicable (20)	86	94	97	78	89	85	88
Relevant deficiency noted in the baseline report:	The risks and benefits of current treatment are not reviewed in a systematic manner.						
Relevant cell in the monitoring report:	f.iii						
	Sep	Oct	Nov	Dec	Jan	Feb	Mean
Benefits and risks of current pharmacologic treatment; includes benzodiazepines, anticholinergics, and polypharmacy, if applicable (14)	68	84	85	68	85	80	78
Relevant deficiency noted in the baseline report:	The assessment of risk factors is limited to some documentation of crises that lead to the use of restrictive interventions. There is no evidence of proactive evaluation of risk factors or timely and appropriate modification of interventions in order to minimize the risk on an ongoing basis.						
Relevant cell in the monitoring report:	f.iv						

(table continues on next page)

	Sep	Oct	Nov	Dec	Jan	Feb	Mean
Risk behaviors - suicide, S.I.B., aggression, elopement, falls, etc. (5)	80	89	94	76	82	83	84
Relevant deficiency noted in the baseline report:	There is limited or no documentation of actual and/or potential side effects of benzodiazepines, anticholinergic medications and/or new-generation antipsychotics. This pattern is noted even when these medications are used in individuals who are particularly vulnerable to the risks.						
Relevant cell in the monitoring report:	f.v						
	Sep	Oct	Nov	Dec	Jan	Feb	Mean
Benefits and risks of current pharmacologic treatment; includes benzodiazepines, anticholinergics and polypharmacy, if applicable (14)	68	84	85	68	85	80	78
Note: see table below for additional monitoring data from the Psychopharmacology Review Monitoring Form.							
(table continues on next page)							

		Relevant deficiency noted in the baseline report:	There is no review of the specific indications for the use of PRN or STAT medications, the circumstances for the administration of these medications or the individual's response to this use. Ultimately, the regular treatment is not modified based on the use of PRN or STAT medications.							
		Relevant cell in the monitoring report:	f.vi							
			Sep	Oct	Nov	Dec	Jan	Feb	Mean	
		Rationale for PRN medications and review of rationale for ongoing PRN/STAT medications used (13)	59	72	83	50	70	64	66	
		Relevant deficiency noted in the baseline report:	When behavioral interventions are provided, there is no documentation to indicate an integration of pharmacological and behavioral modalities.							
		Relevant form:	No monitoring process as of March 2007							
		Relevant cell in the monitoring report:	f.vii							
			Sep	Oct	Nov	Dec	Jan	Feb	Mean	
			No data							
		The compliances rates provided by the facility appear high relative to this monitor's chart reviews. This gap between data and empirical findings raises questions about the accuracy of the facility's findings in these areas.								

The table below summarizes additional monitoring done using the Psychopharmacology Monitoring Form that addresses the requirements in f.v, using mean of all items on this form:
(

Psychopharmacology Review Monitoring Form								
		Sep	Oct	Nov	Dec	Jan	Feb	Mean
N	Varies by subpopulations							
n	Varies by item							
%C								
f.v	Mean of all items	28	4	76	8	18	4	23

Recommendation 2, September 2006:

When the individuals receive both pharmacological and behavioral interventions, the reassessments need to address the following specific items:

- Review of behavioral plans prior to implementation as documented in progress notes and/or behavioral plan;
- Review of individual's progress in behavioral treatment;
- Differentiation, as clinically appropriate, of learned behaviors from behaviors that are targeted for pharmacological treatment; and
- Modification, as clinically appropriate, of diagnosis and/or pharmacological treatment based on above reviews/assessments.

Findings:

MSH used the current Case Formulation Monitoring Form to assess compliance. The indicator is based is on the WRPT's review of the present status section of the case formulation.

Present Status is addressed.

	Jan	Feb	Mean
N	673	675	
n	7	29	
%S	1	4	
%C	0	7	4

Recommendation 3, September 2006:

Update the staff psychiatrist manual to include requirements regarding documentation of psychiatric reassessments.

Findings:

MSH revised its Staff Psychiatrist Manual, Section 4.3 (monthly progress note) and 4.4 (annual psychiatric evaluation) to address this recommendation.

Recommendation 4, September 2006:

Ensure that monitoring instruments are clearly aligned with all of the above expectations.

Findings:

The integration of behavioral and pharmacological treatments is addressed in the present status of the WRP case formulation. Requirements regarding this integration are not specifically addressed in current monitoring tools. MSH will recommend that these be added to the standardized DMH forms.

Other findings:

Chart reviews by this monitor indicate the same pattern of deficiencies that was noted in the baseline evaluation. While the facility has made progress in tailoring the monitoring findings to these deficiencies, this monitor's findings continue to show lower compliance

		<p>rates that those reported by the facility. These deficiencies must be corrected in order to achieve substantial compliance with this recommendation. The current Progress Notes Monitoring Form contains indicators that serve as a standardized format for progress notes that can meet requirements of the EP.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Address and correct factors related to low compliance with this requirement. 2. Continue monitoring to address all above mentioned deficiencies. 3. Ensure that monitoring instructions are aligned with the elements listed in recommendation 2 September 2006. 4. Monitor documentation of the scope and goals of individual psychotherapy and of the individual's progress in treatment when the WRP indicates that the psychiatrist is providing this intervention. 5. Address and correct discrepancies between findings using the Monthly Progress Notes Monitoring Form and the Psychopharmacology Review Monitoring Form.
f.i	significant developments in the individual's clinical status and of appropriate psychiatric follow up;	81%
f.ii	Timely and justifiable updates of diagnosis and treatment, as clinically appropriate;	88%
f.iii	Analyses of risks and benefits of chosen treatment interventions;	78%
f.iv	Assessment of, and attention to, high-risk behaviors (e.g., assaults, self-harm, falls) including appropriate and timely	84%

	monitoring of individuals and interventions to reduce risks;	
f.v	Responses to and side effects of prescribed medications, with particular attention to risks associated with the use of benzodiazepines, anticholinergic medications, polypharmacy (use of multiple drugs to address the same condition), and conventional and atypical antipsychotic medications;	78% using the Monthly Progress Notes Monitoring Form 23% using the Psychopharmacology Review Monitoring Form
f.vi	Timely review of the use of "pro re nata" or "as-needed" ("PRN") and "Stat" (i.e., emergency psychoactive) medications and adjustment of regular treatment, as indicated, based on such use; and	66%
f.vii	Verification in a clinically justifiable manner, that psychiatric and behavioral treatments are properly integrated. The psychiatrist shall review the positive behavior support plan prior to implementation to ensure consistency with psychiatric formulation, document evidence of regular exchange of data or information with psychologists regarding differentiation of learned behaviors and behaviors targeted for psychopharmacological treatments, and document evidence of integration of treatments.	No data

g	<p>When individuals are transferred between treatment teams, a psychiatric transfer note shall be completed addressing: review of medical and psychiatric course of hospitalization, including medication trials; current target symptoms; psychiatric risk assessment; current barriers to discharge; and anticipated benefits of transfer.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Update the staff psychiatrist manual to include requirements regarding content and quality of inter-unit transfer assessments.</p> <p>Findings: The facility revised the Staff Psychiatrist Manual, Section 4.5, to address this requirement.</p> <p>Recommendation 2, September 2006: Continue to monitor using current instrument, but ensure that monitoring is completed by a peer physician or a supervisor and that quality of clinical data is considered in the estimation of compliance.</p> <p>Findings: The facility used the Physician Transfer Summary Monitoring Form to assess compliance. The population reviewed (n) was increased in February 2007 to a minimum of 20 assessments. The following is a summary of the data:</p> <table border="1" data-bbox="835 980 1850 1325"> <thead> <tr> <th></th> <th>Sep</th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>25</td> <td>32</td> <td>27</td> <td>25</td> <td>92</td> <td>50</td> <td></td> </tr> <tr> <td>n</td> <td>5</td> <td>6</td> <td>5</td> <td>5</td> <td>18</td> <td>20</td> <td></td> </tr> <tr> <td>%S</td> <td>20</td> <td>19</td> <td>19</td> <td>20</td> <td>20</td> <td>40</td> <td></td> </tr> <tr> <td>%C</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Reason for transfer (1)</td> <td>80</td> <td>66</td> <td>60</td> <td>80</td> <td>61</td> <td>35</td> <td>64</td> </tr> <tr> <td>Five-axis diagnosis (2)</td> <td>60</td> <td>33</td> <td>80</td> <td>40</td> <td>38</td> <td>25</td> <td>46</td> </tr> <tr> <td>Psychiatric course of hospitalization (3)</td> <td>100</td> <td>66</td> <td>80</td> <td>80</td> <td>50</td> <td>30</td> <td>68</td> </tr> </tbody> </table>		Sep	Oct	Nov	Dec	Jan	Feb	Mean	N	25	32	27	25	92	50		n	5	6	5	5	18	20		%S	20	19	19	20	20	40		%C								Reason for transfer (1)	80	66	60	80	61	35	64	Five-axis diagnosis (2)	60	33	80	40	38	25	46	Psychiatric course of hospitalization (3)	100	66	80	80	50	30	68
	Sep	Oct	Nov	Dec	Jan	Feb	Mean																																																											
N	25	32	27	25	92	50																																																												
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%S	20	19	19	20	20	40																																																												
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Psychiatric course of hospitalization (3)	100	66	80	80	50	30	68																																																											

	Sep	Oct	Nov	Dec	Jan	Feb	Mean
Medical history and current medical conditions (4)	60	50	80	60	38	30	53
Current target symptoms (5)	60	50	80	80	50	30	58
Psychiatric risk factors (6)	60	33	80	40	50	30	49
Review of medications (7)	40	33	80	60	38	25	46
Current barriers to discharge (8)	60	66	80	60	44	10	53
Anticipated benefits of transfer (9)	40	33	60	60	33	5	39
Mean	62	48	76	62	45	24	53

Recommendation 3, September 2006:

Ensure that individuals who present severe management problems and require frequent inter-unit transfers receive PBS plans that are adequately designed and implemented prior to transfers.

Findings:

MSH has taken steps to prevent frequent transfers. The facility has a trigger system to identify individuals who present severe management problems. In this system, the individuals are identified by the WRPT and referred to the PBS team. When the PBS team is not available, the WRPT develops a behavior plan. If an individual is transferred, the transferring and receiving WRPTs review the PBS plan together, and revise it as necessary prior to transfer. This system is included in the WRP Instruction Manual and there is ongoing training by the PBS team of WRPT members regarding the PBS process.

		<p>Other findings: Review by this monitor of a chart sample of individuals that required inter-unit transfer generally corroborates the facility's data regarding content of the inter-unit transfer assessment.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none">1. Continue to monitor using current instrument.2. Address and correct factors related to low compliance.3. Ensure that individuals who present severe management problems and require frequent inter-unit transfers receive PBS plans that are adequately designed and implemented prior to transfers.
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2	Psychological Assessments
	<p>Methodology:</p> <p>Interviewed:</p> <ol style="list-style-type: none"> 1. Wilma Fuentes, R.N 2. Latasha Fields, P.T. 3. Crystal Amey, P.T 4. Eric McMullen, P.T 5. Gretchen Hunt, PT, Unit Supervisor 6. Edwin Poon, Ph.D, Psychologist 7. Sean Johnson, LVN, Assistant BY CHOICE coordinator 8. Swati Roy, Ph.D, Acting Chief of Psychology. 9. Edwin Poon, Ph.D, Psychologist. 10. Brian Hough, Ph.D, Psychologist. 11. Richard Ettelson, Ph.D, Psychologist, 12. Noor Damavandi, Ph.D, Psychologist. 13. Kirk Hartley, Ph.D, Psychologist. 14. Matthew Jogernson, Ph.D, Psychologist. 15. Amy Choi, Ph.D, Psychologist. 16. Cheryl Kempinsky, Ph.D, Psychologist. 17. Walt Sullivan, Ph.D, Psychologist. 18. Larry Ledesma, Ph.D, Psychologist. 19. Yih-Jia Chang, Ph.D, Psychologist. 20. Clark Brickel, Ph.D, Psychologist. 21. H. Feinberg, Ph.D, Psychologist 22. Kelly Cohlberg, Ph.D, Psychologist 23. Kenneth Layman, Program Director. 24. Rachel Potts 25. Five pre-doctoral interns (Susan Shifflett, Alisha Christiane Bent, Ashvind Singh, Erin Lacy and Jan Bestwick)

		<p>Reviewed:</p> <ol style="list-style-type: none"> 1. Assessments of 31 individuals (FR, CC, HC, DY, UN, VT, PT, JM, JS, CG, AF, RM, FJ, DA, ET, TR, TN, DC, LM, GC, AF, BH, AA, KM, NR, CB, DD, SF, AE, RD, and JH) 2. Intervention Plans of 15 individuals (FR, SM, DH, FR, MC, AW, TP, NR, MW, AF, SW, AB, JS, RM, and HC) 3. Charts of 44 individuals (AB, MD, JW, SG, TG, SS, AC, WS, CR, NV, DE, RA, GS, MW, KM, DA, ET, TR, PT, TN, DC, LM, NR, BH, AW, AA, PS, AM, JA, JS, MG, SY, RD, HF, CB, EN, DD, TK, JV, TB, JD, AD, SF, and JM) 4. DMH PBS Manual 5. DMH Psychology Manual 6. Standard Psychological Assessment Protocols 7. List of individuals needing cognitive and academic assessments within 30 days of admission 8. List of psychologists by program by unit by individual assessed 9. List of all individuals who were admitted prior to June 1, 2006 10. List of individuals by program by unit with "rule-out," "deferred," "no diagnosis," and "NOS" diagnoses.
a	<p>Each State hospital shall develop and implement standard psychological assessment protocols, consistent with generally accepted professional standards of care. These protocols shall address, at a minimum, diagnostic neuropsychological assessments, cognitive assessments, and I.Q./achievement assessments, to guide psychoeducational (e.g., instruction regarding the illness or disorder, and the purpose or objectives of treatments for the</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Finalize and implement the revised statewide manual that codifies the requirements of the EP. The manual should include a generic section that applies to all hospitals and orientation information for newly hired psychologists and clinical practices that is specific to each hospital. For the most part, all clinical practices should apply across DMH hospitals.</p> <p>Findings: MSH's progress report showed that the Psychology Manual was completely revised by a statewide committee of Chiefs of Psychology, chaired by Dr. Swati Roy.</p>

<p>same, including medications), educational, rehabilitation, and habilitation interventions, and behavioral assessments (including functional assessment of behavior in schools and other settings), and personality assessments, to inform positive behavior support plans and psychiatric diagnoses.</p>	<p>The Psychology Manual has been revised, but not approved. In a separate document, this monitor provided feedback to the DMH to ensure proper alignment of the manual with requirements of the EP.</p> <p>Recommendation 2, September 2006: Develop and implement practice-based protocols for inclusion in the DMH Psychology Manual (August 2006).</p> <p>Findings: MSH's progress report indicated that practice-based protocols have been developed and included in the DMH Psychology Manual.</p> <p>This monitor reviewed MSH's draft manual (March 2007 draft). Eight practice-based protocols were included in the draft manual (DMH Integrated Assessment Psychology Section, DMH Focused Psychological Assessments, DMH Suicide Risk Assessment Protocol, Cognitive Screening Protocol, Diagnostic Clarification Protocol, Cognitive and Academic Assessment Protocol, Behavior Guideline Protocol, and Personality Assessment Protocol). According to the Acting Chief of Psychology, these protocols were being implemented.</p> <p>Recommendation 3, September 2006: Conduct orientation to the new manual for current psychologists and all future hires.</p> <p>Findings: MSH's progress report indicated that this recommendation was not completed.</p> <p>This monitor's interview with the Acting Chief of Psychology revealed that training on the new manual has begun and was to continue until all the psychologists have been trained.</p> <p>Compliance: Partial.</p>
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		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Finalize and implement approved version of the DMH Psychology Manual. 2. Fully implement the protocols and procedures in the DMH Psychology Manual. 3. Continue the practice of orienting new staff to the manual.
b	<p>Each State hospital shall require the completion of cognitive and academic assessments within 30 days of admission of all school-age and other individuals, as required by law, unless comparable testing has been performed within one year of admission and is available to the interdisciplinary team.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Ensure that all individuals admitted to the facility have their academic and cognitive assessments conducted within 30 days, unless comparable testing has been performed within one year of admission and is available for review by the interdisciplinary team.</p> <p>Recommendation 2, September 2006: Get an accurate count of the individuals that should have academic and cognitive assessments conducted within 30 days.</p> <p>Recommendation 3, September 2006: Develop and implement monitoring and tracking instruments to assess the key elements of this requirement.</p> <p>Findings: MSH used the Psychology Monitoring form to assess compliance. The following table outlines the facility's data (the monitoring procedure was modified in November 2006; months prior to November 2006 were not used in calculating the mean):</p> <p><i>Completion of cognitive 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.</i></p>

	Oct	Nov	Dec	Jan	Feb	Mean
N	7	7	9	11	7	
n	7	7	9	11	7	
%S	100	100	100	100	100	
%C	29	29	100	73	100	91

This monitor's review of new admissions for the three months (December, 2006 - February, 2007) surveyed by MSH showed a total of 144 admissions. Of these, 27 needed academic and cognitive assessments, and 24 had their cognitive and academic assessments completed on time (91%).

Other findings:

According to Dr. Edwin Poon, Psychologist, Senior Psychologists have undertaken testing of all outstanding assessments. Psychology interns were said to test new admissions. The DMH Psychology Monitoring Form contains the key elements of this requirement.

Compliance:

Partial.

Current recommendations:

Complete academic and cognitive assessments of new admissions on a timely basis.

c Each State hospital shall ensure that all clinicians responsible for performing or reviewing psychological assessments and evaluations are verifiably competent in the methodology required to conduct the assessment.

Current findings on previous recommendations:

Recommendation 1, September 2006:

Ensure that the Chief of Psychology has the administrative authority for conducting annual reviews and exit debriefing of psychologists who resign their positions.

		<p>Recommendation 2, September 2006: Ensure that Chief of Psychology is the primary person authorized to determine staffing needs and appropriate hiring for those needs.</p> <p>Recommendation 3, September 2006: Ensure that the Chief of Psychology has the administrative and clinical authority for directly supervising the senior psychologists who monitor and mentor line psychologists in the implementation of the EP.</p> <p>Findings: MSH's progress report stated that the Acting Chief of Psychology is involved in the process of annual reviews, conducts exit debriefing when psychologists resign their positions, determines staffing needs, and involved in the hiring process for all new psychologists</p> <p>This monitor reviewed MSH's Organizational Chart, Psychology Manual, and AD #0151, and interviewed the Acting Chief of Psychology. The documents and the information from the Acting Chief of Psychology were verified and are in agreement with MSH's progress report. The recommendations were fully addressed through AD#0151 as outlined under Policy (2.0, from 2.3 through 2.9). Furthermore, the recommendations are also addressed in the Psychology Manual (March 2007), Pages 10 (2.4.4, Chief of Psychology) and 11 (2.4.5, Orientation and Exit of Psychology staff).</p> <p>Other findings: The organizational chart does not list the Behavioral Consultation Committee (BCC) under the Chief of Psychology.</p> <p>Compliance: Partial.</p>
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		<p>Current recommendations: Continue current practices.</p>																																			
d	Each State hospital shall ensure that all psychological assessments, consistent with generally accepted professional standards of care, shall:	<p>Compliance: Partial.</p>																																			
d.i	expressly state the clinical question(s) for the assessment;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Ensure that all psychological assessments have a statement of the reasons for referral and ensure that the statement is concise and clear.</p> <p>Findings: Using the Psychology Monitoring Form, MSH reported 20% compliance. The following table summarizes the facility's data:</p> <p><i>All psychological assessments, consistent with generally accepted professional standards of care, shall expressly state the clinical question(s) for the assessment.</i></p> <table border="1"> <thead> <tr> <th></th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>700</td> <td>700</td> <td>700</td> <td>700</td> <td>700</td> <td></td> </tr> <tr> <td>n</td> <td>11</td> <td>52</td> <td>86</td> <td>140</td> <td>140</td> <td></td> </tr> <tr> <td>%S</td> <td>2</td> <td>7</td> <td>12</td> <td>20</td> <td>20</td> <td></td> </tr> <tr> <td>%C</td> <td>100</td> <td>23</td> <td>19</td> <td>20</td> <td>16</td> <td>20</td> </tr> </tbody> </table> <p>This monitor's review of 17 assessments showed that 11 (HF, NR, RM, TK, JV, TB, AT, SF, RD, JH, and EN) expressly stated the clinical question(s), and six did not (KM, DD, CD, AA, CB, and JD).</p>		Oct	Nov	Dec	Jan	Feb	Mean	N	700	700	700	700	700		n	11	52	86	140	140		%S	2	7	12	20	20		%C	100	23	19	20	16	20
	Oct	Nov	Dec	Jan	Feb	Mean																															
N	700	700	700	700	700																																
n	11	52	86	140	140																																
%S	2	7	12	20	20																																
%C	100	23	19	20	16	20																															

		<p>Recommendation 2, September 2006: Ensure that there is continuity amongst the various sections that address referral questions to appropriate conclusions, recommendations and therapies available within MSH.</p> <p>Recommendation 3, September 2006: Ensure that all psychological assessments meet at least generally acceptable professional standards.</p> <p>Findings: MSH's self report indicated that two senior psychologists (Drs. Ettelson and Hough) monitor and mentor other psychologists.</p> <p>This monitor's review of 12 assessments showed that seven (RM, JV, TB, KM, HF, DD, and TB) assessments evidenced continuity among the various sections, and five did not (DD, NR, TK, JD, and ED).</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that all psychological assessments have a statement of the reasons for referral and ensure that the statement is concise and clear. 2. Ensure that there is continuity amongst the various sections that address referral questions to appropriate conclusions, recommendations and therapies available at MSH.
d.ii	include findings specifically addressing the clinical question(s), but not limited to diagnoses and treatment recommendations;	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Continue and improve on current practice.</p> <p>Findings: MSH used the Psychology Monitoring Form and reported 20% compliance. The following is a summary of the data:</p>

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

	Oct	Nov	Dec	Jan	Feb	Mean
N	700	700	700	700	700	
n	11	52	86	140	140	
%S	2	7	12	20	20	
%C	100	23	20	19	16	20

This monitor's review of 13 assessments showed that nine (HF, NR, DD, JV, TB, JD, AE, SF, and RD) fully addressed the clinical question beyond the diagnoses and treatment, and four did not (KM, CB, TK and EN).

Current recommendations:

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

d.iii

Specify whether the individual would benefit from individual therapy or group therapy in addition to attendance at mall groups;

Current findings on previous recommendation:

Recommendation, September 2006:

Ensure that all psychological assessments specify whether the individual would benefit from individual therapy or group therapy.

Findings:

MSH used the Psychology Monitoring form to assess compliance. The following is an outline of the data:

All psychological assessments, consistent with generally accepted professional standards of

care, shall specify whether the individual would benefit from individual therapy or group therapy in addition to attendance at mall group.

	Oct	Nov	Dec	Jan	Feb	Mean
N	700	700	700	700	700	
n	11	52	86	140	140	
%S	2	7	12	20	20	
%C	64	6	16	9	15	12

This monitor's review of 16 assessments showed that eight (KM, NR, JV, TB, JD, RD, RL, and NR) specified whether or not individuals would benefit from individual therapy or group therapy, and eight (HF, CB, RM, DD, TK, AE, SF, and EN) did not. This is 50% compliance.

Other findings:

In some cases, recommendations were not followed up. For example, RL was recommended for behavioral intervention, but there was no indication in the chart that this was addressed.

Current recommendations:

Ensure that all psychological assessments specify whether the individual would benefit from individual therapy or group therapy.

d.iv

be based on current, accurate, and complete data;

Current findings on previous recommendation:

Recommendation, September 2006:

Continue and improve on current practice.

Findings:

Using the Psychology Monitoring Form, the facility has compliance data that are summarized as follows:

		<p><i>All psychological assessments, consistent with generally accepted professional standards of care, shall be based on current, accurate, and complete data.</i></p> <table border="1" data-bbox="835 349 1453 544"> <thead> <tr> <th></th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>700</td> <td>700</td> <td>700</td> <td>700</td> <td>700</td> <td></td> </tr> <tr> <td>n</td> <td>11</td> <td>52</td> <td>86</td> <td>140</td> <td>140</td> <td></td> </tr> <tr> <td>%S</td> <td>2</td> <td>7</td> <td>12</td> <td>20</td> <td>20</td> <td></td> </tr> <tr> <td>%C</td> <td>50</td> <td>8</td> <td>18</td> <td>20</td> <td>17</td> <td>16</td> </tr> </tbody> </table> <p>This monitor's review of 13 assessments showed that ten (HF, CB, DD, JV, TB, JD, AE, SF, RD, and RL) of them were based on current, accurate and complete data, and 3 were not (KM, NR, and TK). This is 77% compliance.</p> <p>Current recommendation: Ensure that assessments are based on current, accurate, and complete data.</p>		Oct	Nov	Dec	Jan	Feb	Mean	N	700	700	700	700	700		n	11	52	86	140	140		%S	2	7	12	20	20		%C	50	8	18	20	17	16
	Oct	Nov	Dec	Jan	Feb	Mean																															
N	700	700	700	700	700																																
n	11	52	86	140	140																																
%S	2	7	12	20	20																																
%C	50	8	18	20	17	16																															
d.v	determine whether behavioral supports or interventions (e.g., behavior guidelines or mini behavior plans) are warranted or whether a full positive behavior support plan is required;	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Ensure that all psychological assessments of individuals with maladaptive behavior meet this requirement.</p> <p>Findings: The following is a summary of MSH's data based on the psychology Monitoring Form:</p> <p><i>All psychological assessments, consistent with generally accepted professional standards of care, shall determine whether behavioral supports or interventions (e.g., behavior guidelines or mini behavior plans) are warranted or whether a full positive behavior support plan is required.</i></p>																																			

		<table border="1"> <thead> <tr> <th></th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>700</td> <td>700</td> <td>700</td> <td>700</td> <td>700</td> <td></td> </tr> <tr> <td>n</td> <td>11</td> <td>52</td> <td>86</td> <td>140</td> <td>140</td> <td></td> </tr> <tr> <td>%S</td> <td>2</td> <td>7</td> <td>12</td> <td>20</td> <td>20</td> <td></td> </tr> <tr> <td>%C</td> <td>36</td> <td>6</td> <td>13</td> <td>8</td> <td>3</td> <td>8</td> </tr> </tbody> </table> <p>This monitor's review of 14 assessments showed that four (RM, EN, RD, and RL) specified whether Behavior Guidelines or PBS plans were recommended, and ten did not (KM, HF, CB, NR, TK, JB, TB, JD, AE, and SF).</p> <p>Current recommendation: Ensure that all psychological assessments of individuals with maladaptive behaviors determine whether behavioral supports or interventions are warranted or whether a full positive behavior support plan is required.</p>		Oct	Nov	Dec	Jan	Feb	Mean	N	700	700	700	700	700		n	11	52	86	140	140		%S	2	7	12	20	20		%C	36	6	13	8	3	8
	Oct	Nov	Dec	Jan	Feb	Mean																															
N	700	700	700	700	700																																
n	11	52	86	140	140																																
%S	2	7	12	20	20																																
%C	36	6	13	8	3	8																															
d.vi	include the implications of the findings for interventions;	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Ensure that all focused psychological assessments include the implications of the findings for interventions, especially psychosocial rehabilitation.</p> <p>Findings: MSH's has monitoring data based on the Psychology Monitoring Form. The following is a summary:</p> <p><i>All psychological assessments, consistent with generally accepted professional standards of care, shall include the implications of the findings for interventions.</i></p>																																			

		<table border="1" data-bbox="835 277 1451 469"> <thead> <tr> <th></th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>700</td> <td>700</td> <td>700</td> <td>700</td> <td>700</td> <td></td> </tr> <tr> <td>n</td> <td>11</td> <td>52</td> <td>86</td> <td>140</td> <td>140</td> <td></td> </tr> <tr> <td>%S</td> <td>2</td> <td>7</td> <td>12</td> <td>20</td> <td>20</td> <td></td> </tr> <tr> <td>%C</td> <td>91</td> <td>21</td> <td>20</td> <td>19</td> <td>15</td> <td>19</td> </tr> </tbody> </table> <p data-bbox="835 513 1976 613">This monitor's review of 12 assessments showed that seven (NR, RM, EN, AE, SF, RD, and RL) included the implications of the findings for interventions, and five did not (HF, CB, DD, TK, and TB)</p> <p data-bbox="835 662 1944 764">Current recommendation: Ensure that all focused psychological assessments include the implications of the findings for interventions, especially psychosocial rehabilitation.</p>		Oct	Nov	Dec	Jan	Feb	Mean	N	700	700	700	700	700		n	11	52	86	140	140		%S	2	7	12	20	20		%C	91	21	20	19	15	19
	Oct	Nov	Dec	Jan	Feb	Mean																															
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n	11	52	86	140	140																																
%S	2	7	12	20	20																																
%C	91	21	20	19	15	19																															
d.vii	<p data-bbox="312 813 785 1057">identify any unresolved issues encompassed by the assessment and, where appropriate, specify further observations, records review, interviews, or re-evaluations that should be performed or considered to resolve such issues; and</p>	<p data-bbox="835 813 1419 837">Current findings on previous recommendation:</p> <p data-bbox="835 886 1745 951">Recommendation, September 2006: Ensure that all focused psychological assessments meet this requirement.</p> <p data-bbox="835 1000 1990 1097">Findings: MSH's data showed that 14% of the focused psychological assessments identified unresolved issues and specified further evaluations to resolve such issues. The following is a summary:</p> <p data-bbox="835 1146 1986 1276"><i>All psychological assessments, consistent with generally accepted professional standards of care, shall 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.</i></p>																																			

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	Oct	Nov	Dec	Jan	Feb	Mean																															
N	700	700	700	700	700																																
n	11	52	86	140	140																																
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%C	27	14	14	15	11	14																															
d.viii	Use assessment tools and techniques appropriate for the individuals assessed and in accordance with the American Psychological Association Ethical Standards and Guidelines for testing.	<p data-bbox="835 849 1434 878">Current findings on previous recommendations:</p> <p data-bbox="835 922 1381 989">Recommendation 1, September 2006: Continue and improve upon current practice.</p> <p data-bbox="835 1032 1982 1279">Findings: MSH has data derived from the Psychology Monitoring Form. The following is a summary: <i>All psychological assessments, consistent with generally accepted professional standards of care, shall use assessment tools and techniques appropriate for the individuals assessed and in accordance with the American Psychological Association Ethical Standards and Guidelines for testing.</i></p>																																			

	Oct	Nov	Dec	Jan	Feb	Mean
N	700	700	700	700	700	
n	11	52	86	140	140	
%S	2	7	12	20	20	
%C	0	13	16	10	13	13

This monitor's review of 16 assessments showed that 11 (RM, JV, JS, SM, AE, SF, CB, DD, JD, EN, and RD) used assessment tools and techniques appropriate for the individuals assessed in accordance with the American Psychological Association Ethical Standards and Guidelines for testing, and five (JM, NR, GC, AF, and DY) did not.

Recommendation 2, September 2006:

Abide by the American Psychological Association Ethical Standards and Guidelines for testing.

Findings:

This monitor's interview with the Acting Chief of Psychology showed that two senior psychologists monitor and review psychological assessments. An interview with the two senior psychologists (Drs. Ettelson and Hough) revealed that they observe instructions during psychological assessments, and rescore 20% of the assessments.

The psychological assessments reviewed by this monitor included statements on confidentiality and the APA ethical standards and guidelines.

The DMH focused psychological assessment instructions include aspects of culture and ethnicity and religious preference. Furthermore, the DMH psychology monitoring form instruction sheet identifies the elements that should be addressed to fulfill the requirements of this cell.

		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Use assessment tools and techniques appropriate for the individuals assessed and in accordance with the American Psychological Association Ethical Standards and Guidelines for testing. 2. Abide by the American Psychological Association Ethical Standards and Guidelines for testing.
e	<p>Each State hospital shall ensure that all psychological assessments of all individuals residing at each State hospital who were admitted there before the Effective Date hereof shall be reviewed by qualified clinicians with demonstrated current competency in psychological testing and, as indicated, revised to meet the criteria in § [IV.B.1 and IV.B.2], above.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Ensure that psychological tests are completed in a timely manner, as specified in the EP.</p> <p>Findings: MSH's progress report showed 706 admissions as of February 1, 2007. Of these, 639 (90%) integrated psychological assessments were reviewed and revised as needed on individuals who were admitted before June 1, 2006.</p> <p>This monitor reviewed MSH's admission log. The log (Census 5-30-06) contained 706 admissions. Of these, 631 assessments were listed as completed and 75 assessments as not completed.</p> <p>Compliance: Partial.</p> <p>Current recommendations: Ensure that all psychological assessments of all individuals residing at MSH admitted before the effective date hereof be reviewed, by qualified clinicians in psychological testing, and revised as needed to meet EP requirements.</p>

f	Each State hospital shall ensure that all appropriate psychological assessments shall be provided in a timely manner whenever clinically indicated, consistent with generally accepted professional standards of care, including whenever there has been a significant change in condition, a lack of expected improvement resulting from treatment, or an individual's behavior poses a significant barrier to treatment, therapeutic programming, safety to self or others, or school programming, and, in particular:	<p>Compliance: Partial.</p>
f.i	before an individual's therapeutic and rehabilitation service plan is developed, a psychological assessment of the individual shall be performed that will:	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Ensure that integrated psychological assessments are conducted in a timely manner as required.</p> <p>Findings: MSH did not provide progress report data for this requirement. However, it was indicated that an Access data base was being set up, which when completed will address this requirement.</p> <p>This monitor's review of 28 charts showed that 12 (RK, WH, JM, TP, EM, RM, DA, ET, TR, TN, AW, and JM) had integrated assessments that were conducted in a timely manner; eight (PT, DC, LM, NR, BH, AA, PS, and JS) were not timely; and eight (RW, KH, GV, HK, SL, EJ, CY, and DW) did not have Integrated Psychological Assessments.</p>

		<p>Current recommendations: Ensure that integrated psychological assessments are conducted in a timely manner as required.</p>																																			
f.i.1	address the nature of the individual's impairments to inform the psychiatric diagnosis; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Ensure that integrated psychological assessments address the nature of the individual's impairments to inform the psychiatric diagnosis.</p> <p>Findings: MSH used the Psychology Monitoring Form to assess compliance. The data are summarized as follows:</p> <p><i>Address the nature of the individual's impairments to inform the psychiatric diagnosis:</i></p> <table border="1" data-bbox="835 833 1451 1024"> <thead> <tr> <th></th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>700</td> <td>700</td> <td>700</td> <td>700</td> <td>700</td> <td></td> </tr> <tr> <td>n</td> <td>11</td> <td>52</td> <td>86</td> <td>140</td> <td>140</td> <td></td> </tr> <tr> <td>%S</td> <td>2</td> <td>7</td> <td>12</td> <td>20</td> <td>20</td> <td></td> </tr> <tr> <td>%C</td> <td>0</td> <td>0</td> <td>10</td> <td>19</td> <td>17</td> <td>12</td> </tr> </tbody> </table> <p>This monitor's review of 20 assessments showed that 13 (DA, ET, TR, PT, TN, DC, LM, NR, BH, AW, AA, JS, and PS) addressed the nature of the individual's impairments and seven (RW, KH, GV, HK, SL, EJ, JS, and CY) did not.</p> <p>Current recommendations: Ensure that integrated psychological assessments address the nature of the individual's impairments to inform the psychiatric diagnosis.</p>		Oct	Nov	Dec	Jan	Feb	Mean	N	700	700	700	700	700		n	11	52	86	140	140		%S	2	7	12	20	20		%C	0	0	10	19	17	12
	Oct	Nov	Dec	Jan	Feb	Mean																															
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%C	0	0	10	19	17	12																															

f.i.2	provide an accurate evaluation of the individual's psychological functioning to inform the therapeutic and rehabilitation service planning process;	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Ensure accurate evaluation of psychological functioning that informs that WRP team of the individual's rehabilitation service needs.</p> <p>Findings: MSH presented data based on the Psychology Monitoring form. The following is a summary:</p> <p><i>Provide an accurate evaluation of the individual's psychological functioning to inform the therapeutic and rehabilitation service planning process;</i></p> <table border="1" data-bbox="835 678 1451 873"> <thead> <tr> <th></th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>700</td> <td>700</td> <td>700</td> <td>700</td> <td>700</td> <td></td> </tr> <tr> <td>n</td> <td>11</td> <td>52</td> <td>86</td> <td>140</td> <td>140</td> <td></td> </tr> <tr> <td>%S</td> <td>2</td> <td>7</td> <td>12</td> <td>20</td> <td>20</td> <td></td> </tr> <tr> <td>%C</td> <td>0</td> <td>58</td> <td>10</td> <td>10</td> <td>10</td> <td>22</td> </tr> </tbody> </table> <p>This monitor reviewed nine Integrated Psychological Assessments (JS, PS, JM, BH, NR, LM, DC, PT, and DA). Seven of them (JS, PS, AW, NR, LM, DC, and DA) addressed the individual's rehabilitation service needs, and two (PT and JM) did not.</p> <p>Current recommendations: Ensure accurate evaluation of psychological functioning that informs that WRP team of the individual's rehabilitation service needs.</p>		Oct	Nov	Dec	Jan	Feb	Mean	N	700	700	700	700	700		n	11	52	86	140	140		%S	2	7	12	20	20		%C	0	58	10	10	10	22
	Oct	Nov	Dec	Jan	Feb	Mean																															
N	700	700	700	700	700																																
n	11	52	86	140	140																																
%S	2	7	12	20	20																																
%C	0	58	10	10	10	22																															
f.ii	if behavioral interventions are indicated, a structural and functional assessment shall be performed, consistent with generally accepted	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Ensure appropriate structural and functional assessments are undertaken by a qualified</p>																																			

	<p>professional standards of care, by a professional having demonstrated competency in positive behavior supports; and</p>	<p>psychologist when an individual has learned maladaptive behavior.</p> <p>Findings: MSH's progress report did not provide data for this requirement.</p> <p>This monitor reviewed the list of individuals in need of behavioral interventions and individuals with reoccurrence of triggers from the Key Indicators. The vast majority did not have either a Behavior Guideline or a referral to PBS. For those that did have a Behavior Guideline, there was not always a referral to PBS when the Behavior Guideline was not working. Although the ten Structural and Functional Assessments reviewed (HC, FJ, RM, FR, DY, AF, SM, JS, GC, AF) showed a vast improvement from the baseline visit, none (0%) met all the criteria of being developed at generally accepted professional standards.</p> <p>Current recommendations: Ensure appropriate structural and functional assessments are undertaken by a qualified psychologist when an individual has learned maladaptive behavior.</p>
f.iii	<p>additional psychological assessments shall be performed, as appropriate, where clinical information is otherwise insufficient, and to address unresolved clinical or diagnostic questions, including differential diagnosis, "rule-out," "deferred," "no-diagnosis" and "NOS" diagnoses.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Ensure that additional psychological assessments are performed, as appropriate, where clinical information is otherwise insufficient, and address unresolved clinical or diagnostic questions, including differential diagnosis, "rule-out," "deferred," "no-diagnosis," and "NOS" diagnoses.</p> <p>Recommendation 2, September 2006: Ensure that the facility's monitoring instrument that address "no diagnosis" are aligned with the key requirement, i.e. that "no diagnosis" is backed up by clinical data, especially in individuals with forensic issues.</p>

Findings:

The following outlines the facility's monitoring indicators and compliance data based on the Psychology Monitoring Form:

	Oct	Nov	Dec	Jan	Feb	Mean
N	700	700	700	700	700	
n	11	52	86	140	140	
%S	2	7	12	20	20	
%C						
1. Additional psychological assessments are performed, as appropriate, where psychological information is otherwise insufficient.	0	27	25	4	8	16
2. Additional psychological assessments are performed, as appropriate for diagnostic questions, specifically "differential diagnosis.	0	27	25	4	3	15
3. Additional psychological assessments are performed, as appropriate for diagnostic questions, specifically "rule-out."	0	27	25	4	0	14
4. Additional psychological assessments are performed, as appropriate for diagnostic questions, specifically "deferred."	0	27	25	4	0	14

	Oct	Nov	Dec	Jan	Feb	Mean
5. Additional psychological assessments are performed, as appropriate for diagnostic questions, specifically "no-diagnosis."	0	27	25	4	0	14
6. Additional psychological assessments are performed, as appropriate for diagnostic questions, specifically "NOS" diagnoses.	0	27	25	4	0	14

This monitor's review of 24 assessments showed that five (AB, MD, JM, CR, JS) assessments addressed the diagnostic uncertainties with recommendations for follow-up psychological assessments, and 19 (AC, JW, SG, TG, SS, WS, NV, JA, DE, RA, MW, KM, DA, ET, NR, BH, AW, AA, and PS) did not. This is 21% compliance.

Other findings:

This monitor's review of the DMH Psychology Monitoring Form showed that the form specified (in items #15 through 20) that additional assessments be conducted for the various diagnostic uncertainties. Instruction for the monitoring form was also included.

This monitor's review of the DMH Psychology Monitoring Form Instructions showed a conflict in the instruction. There are two statements in the instructions, one reads, Score as **Yes**, if the following conditions are **not** met; and the other reads, Score as **No**, if (a), (b), (c) are **not** met.

Current recommendations:

1. Ensure that additional psychological assessments are performed, as appropriate, where

		<p>clinical information is otherwise insufficient, and address unresolved clinical or diagnostic questions, including differential diagnosis, "rule-out," "deferred," "no-diagnosis," and "NOS" diagnoses.</p> <p>2. Ensure that the facility's monitoring instrument that address "no diagnosis" are aligned with the key requirement, i.e. that "no diagnosis" is backed up by clinical data, especially in individuals with forensic issues.</p>																																										
g	<p>For individuals whose primary language is not English, each State hospital shall endeavor to assess them in their own language; if this is not possible, each State hospital will develop and implement a plan to meet the individuals' assessment needs, including, but not limited to the use of interpreters in the individual's primary language and dialect, if feasible.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Ensure that examiners consider cultural aspects when choosing assessment instruments with individuals whose preferred language is not English.</p> <p>Recommendation 2, September 2006: Ensure that psychological assessments are provided in the individual's preferred language using interpreters.</p> <p>Findings: MSH used the Psychology Monitoring Form to assess compliance. The monitoring indicators and compliance data are outlined as follows:</p> <table border="1" data-bbox="844 1015 1974 1367"> <thead> <tr> <th></th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>700</td> <td>700</td> <td>700</td> <td>700</td> <td>700</td> <td></td> </tr> <tr> <td>n</td> <td>11</td> <td>52</td> <td>86</td> <td>140</td> <td>140</td> <td></td> </tr> <tr> <td>%S</td> <td>2</td> <td>7</td> <td>12</td> <td>20</td> <td>20</td> <td></td> </tr> <tr> <td>%C</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>1. For individuals whose primary/preferred language is not English, there is documentation that the psychologist has endeavored to assess them in their own language.</td> <td>0</td> <td>82</td> <td>72</td> <td>36</td> <td>0</td> <td>48</td> </tr> </tbody> </table>		Oct	Nov	Dec	Jan	Feb	Mean	N	700	700	700	700	700		n	11	52	86	140	140		%S	2	7	12	20	20		%C							1. For individuals whose primary/preferred language is not English, there is documentation that the psychologist has endeavored to assess them in their own language.	0	82	72	36	0	48
	Oct	Nov	Dec	Jan	Feb	Mean																																						
N	700	700	700	700	700																																							
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1. For individuals whose primary/preferred language is not English, there is documentation that the psychologist has endeavored to assess them in their own language.	0	82	72	36	0	48																																						

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	Oct	Nov	Dec	Jan	Feb	Mean										
2. If this is not possible, there is 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.	0	0	70	36	2	27										

3	Nursing Assessments	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Carmen Fayloga, RN/HSS. 2. Joellyn Arce, Acting NC in Central Nursing Services. 3. Aurora Hendricks, CNS. 4. Kanya Sitanggang, RN, Psychiatric Nurse Education Director. <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Nursing Assessment Competency Validation tool and instructions and training rosters 2. Statewide Admission Nursing Assessment Monitoring data 3. Revised Nursing Admission Assessment form 4. CA Department of Mental Health Wellness and Recovery Model Support System, Admission Assessment Training Document 5. NP 101, Nursing Assessment and Plan of Care; NP 102, Nursing Assessment Guidelines; NP 110, Documentation: Frequency and Guidelines 6. MSH Nursing Education lesson plan for Nursing Assessment, Plan of Care and Wellness and Recovery Plan 7. WRP Knowledge Assessment 8. Nursing Process post-test 9. Statewide Integrated Nursing Assessment (5 or seven day) monitoring data 10. DMH WRPC CET Team Attendance and Nursing Participation Monitoring form, instructions, and data 11. Statewide Integrated Nursing Assessment (Quarterly) monitoring data 12. Annual and Quarterly Nursing Assessment monitoring form, instructions, and data
a	Each State hospital shall develop standard nursing assessment protocols, consistent with generally accepted professional	<p>Compliance: Partial.</p>

	standards of care. These protocols shall address, at a minimum:																									
a.i	a description of presenting conditions;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Ensure that nursing staff is competent in the protocols addressing this requirement.</p> <p>Findings: MSH reported that the Nursing Assessment Competency Validation has been revised in February 2007 and that auditors (all program Health Service Supervisors (HSSs) and Supervising Registered Nurses (SRNs) are assigned to monitor RNs' performance to ensure their competency. The Auditor Training started March 1, 2007 and will be completed by the Assistant Clinical Nurse Supervisor (ACNS) on March 25, 2007.</p> <p>Recommendation 2, September 2006: Ensure that nursing staff adequately tracks, documents and monitors this requirement.</p> <p>Findings: MSH reported the following monitoring data for this item. The mean compliance rates regarding D.3.a.ii through D.3.a.ix are entered for each corresponding cell below.</p> <table border="1" data-bbox="835 1019 1619 1133"> <thead> <tr> <th></th> <th>Sep</th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>n</td> <td>2</td> <td>3</td> <td>21</td> <td>20</td> <td>55</td> <td>58</td> <td></td> </tr> <tr> <td>%C</td> <td>50</td> <td>0</td> <td>87</td> <td>75</td> <td>85</td> <td>100</td> <td>89-66</td> </tr> </tbody> </table> <p>NOTE: The monitoring process has been changed since January 2007 with regard to Population and sample size as follows:</p> <ul style="list-style-type: none"> • Population: All admitted Individuals for the month. • Sample size: 100% 		Sep	Oct	Nov	Dec	Jan	Feb	Mean	n	2	3	21	20	55	58		%C	50	0	87	75	85	100	89-66
	Sep	Oct	Nov	Dec	Jan	Feb	Mean																			
n	2	3	21	20	55	58																				
%C	50	0	87	75	85	100	89-66																			

		<p>Recommendation 3, September 2006: Revise the Admission Nursing Assessment to reflect this requirement.</p> <p>Findings: The facility indicated that the Admission Nursing Assessment has been revised and approved by Medical Record and Medical Executive Committees and is awaiting final approval from the HQ. However, the discussion during my interviews indicated that the revised Admission Nursing Assessment was not adequate. There is a statewide nursing committee that has been working to address such issues. The status of the Admission Nursing Assessment needs to be addressed.</p> <p>Recommendation 4, September 2006: Revise the Admission Nursing Assessment Monitoring form to adequately measure compliance with this requirement.</p> <p>Findings: MSH reported that the Admission, Integrated and Annual Nursing Assessment Monitoring forms have been revised twice (9/06 and 2/07) to align with the EP.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that the Admission Nursing Assessment is reflective of the Wellness and Recovery Model and aligned with the EP. 2. Continue to monitor this requirement.
a.ii	current prescribed medications;	39%
a.iii	vital signs;	83%
a.iv	allergies;	93%

a.v	pain;	91%
a.vi	use of assistive devices;	97%
a.vii	activities of daily living;	98%
a.viii	immediate alerts (e.g., escape risk, physical assault, choking risk, suicidal risk, homicide risk, fall risk, sexual assault, self-injurious behavior, arson, or fire setting); and	89%
a.ix	conditions needing immediate nursing interventions.	86%
b	Nursing may use a systems model (e.g., Johnson Behavioral System Model) for the nursing evaluation.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Replace the Johnson Behavioral System Model with a psychiatric rehabilitation and recovery model for consistency.</p> <p>Findings: MSH is no longer using the Johnson Behavioral System Model. The state has hired a Nurse Consultant (Dr. Lynn DeLacy) to help the Nurse Administrator develop a psychiatric rehabilitation and recovery model for the nursing evaluation.</p> <p>Recommendation 2, September 2006: Revise policies and procedures to include WRP language.</p> <p>Findings: MSH reported that NPP #101 & 102 have been revised to incorporate the Recovery Model in</p>

		<p>practice.</p> <p>Recommendation 3, September 2006: Revise Nursing Assessments, Integrated Nursing Assessments and documentation in the IDNs to reflect Wellness and Recovery principles.</p> <p>Findings: The facility has reported that it is in the process of revising Statewide Nursing Assessment forms to reflect Wellness and Recovery principles. At the current time, MSH is using the old Nursing Assessment forms until revisions are finalized and approved.</p> <p>Recommendation 4, September 2006: Discontinue the use of nursing diagnoses.</p> <p>Findings: MSH reported that the use of nursing diagnoses has been discontinued since 9/06.</p> <p>Recommendation 5, September 2006: Align current training of nurses with the psychiatric rehabilitation and recovery models used in the WRP system.</p> <p>Findings: The facility reported that revised curriculum, all lesson plans and WRP trainings will be aligned with psychiatric rehabilitation and recovery models (not in medical model format) and that ongoing WRP training will be provided during Hospital Orientation and Update classes.</p> <p>Other findings: From my observations while on the units as well as from interviews with various nursing staff members, I noted that most of the nursing staff were usually in the nursing stations and not out on the units interacting with the individuals. There are a number of nurses at MSH that</p>
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		<p>have medical backgrounds and experience, but little to no psychiatric nursing experience. Consequently, many nurses do not have adequate training in developing therapeutic relationships with the individuals they serve. This is a significant barrier in the transition to the Wellness and Recovery Model for the Nursing Department.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to integrate the Wellness and Recovery principles and language into nursing practice at MSH. 2. Provide training regarding psychiatric nursing principles and practice to nurses who do not have a psychiatric background. 3. Develop and implement strategies and interventions to assist the nursing staff in developing therapeutic relationships with the individuals in order to effectively execute Wellness and Recovery.
c	<p>Each State hospital shall ensure that all nurses responsible for performing or reviewing nursing assessments are verifiably competent in performing the assessments for which they are responsible. All nurses who are employed at Metropolitan State Hospital shall have graduated from an approved nursing program, shall have passed the NCLEX-RN and shall have a license to practice in the state of California.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Develop and implement a monitoring system to adequately address this requirement.</p> <p>Findings: MSH developed the Nursing Assessment Competency Validation form 2/07. The training of auditors (HSSs and SRNs) started 3/1/07 and will be completed by 3/25/07.</p> <p>However, there is no reliable monitoring and tracking system for license renewals.</p> <p>Recommendation 2, September 2006: Initiate and document regular monitoring, at least quarterly, of nursing assessment</p>

competency.

Findings:

MSH presented the following data related to this recommendation for March 2007:

Nursing Assessment Competency Validation

Month	3/07
N	5
Timely Completed	100%
Presenting Conditions	100%
Prescribed Medications	100%
Vital Signs	100%
Allergies	100%
Pain Assessment	100%
Assistive Devices	100%
ADLs	100%
Alerts Addressed	100%
Immediate Nursing Interventions	100%

Compliance:

Partial.

Current recommendations:

1. Continue to develop and implement a monitoring system to address this requirement.
2. Ensure that there is a reliable system for monitoring and tracking nursing licenses and renewals.
3. Continue to monitor this requirement.

d	Each State hospital shall ensure that nursing assessments are undertaken on a timely basis, and in particular, that:	Compliance: Partial.																																
d.i	Initial nursing assessments are completed within 24 hours of the individual's admission;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Review data to ensure accuracy in reporting.</p> <p>Findings: MSH reported that Inter-Rater Reliability Testing for Admission Nursing Assessment in January 2007 is 76% agreement between seven pairs of raters:</p> <table border="1" data-bbox="835 699 1646 776"> <thead> <tr> <th>Month</th> <th>N</th> <th>Range</th> <th>Mean % Agreement</th> </tr> </thead> <tbody> <tr> <td>1/07</td> <td>7</td> <td>60-100%</td> <td>76%</td> </tr> </tbody> </table> <p>Recommendation 2, September 2006: Ensure that initial nursing assessments are completed within 24 hours of each individual's admission.</p> <p>Findings: MSH presented the following data regarding this recommendation: Admission Nursing Assessment Data for past 6 months:</p> <table border="1" data-bbox="835 1105 1619 1219"> <thead> <tr> <th></th> <th>Sep</th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>2</td> <td>3</td> <td>24</td> <td>20</td> <td>55</td> <td>58</td> <td></td> </tr> <tr> <td>%C</td> <td>100</td> <td>100</td> <td>100</td> <td>85</td> <td>96</td> <td>98</td> <td>97</td> </tr> </tbody> </table> <p>From my review of eight Admission Nursing Assessments, I found all were completed within 24 hours.</p>	Month	N	Range	Mean % Agreement	1/07	7	60-100%	76%		Sep	Oct	Nov	Dec	Jan	Feb	Mean	N	2	3	24	20	55	58		%C	100	100	100	85	96	98	97
Month	N	Range	Mean % Agreement																															
1/07	7	60-100%	76%																															
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N	2	3	24	20	55	58																												
%C	100	100	100	85	96	98	97																											

		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue testing for reliability until acceptable percentage of agreement (85% or higher) is achieved. 2. Continue to monitor this requirement. 																								
d.ii	<p>Further nursing assessments are completed and integrated into the individual's therapeutic and rehabilitation service plan within seven days of admission; and</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Include total number of charts reviewed per month in the monitoring data.</p> <p>Findings: MSH provided the following data: Seven-Day Nursing Assessment Data for past six months:</p> <table border="1" data-bbox="835 756 1619 873"> <thead> <tr> <th></th> <th>Sep</th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>43</td> <td>33</td> <td>29</td> <td>27</td> <td>25</td> <td>78</td> <td></td> </tr> <tr> <td>%</td> <td>51</td> <td>55</td> <td>93</td> <td>70</td> <td>76</td> <td>54</td> <td>67</td> </tr> </tbody> </table> <p>NOTE: The monitoring process has been changed since February 2007 with regard to Population and sample size.</p> <ul style="list-style-type: none"> • Population: All admitted Individuals for the month, with exclusion of last seven days. • Sample size: 100% <p>Recommendation 2, September 2006: Ensure that further nursing assessments are completed and integrated into the individual's WRP within seven days of admission.</p> <p>Findings: MSH provided the following data addressing this recommendation:</p>		Sep	Oct	Nov	Dec	Jan	Feb	Mean	N	43	33	29	27	25	78		%	51	55	93	70	76	54	67
	Sep	Oct	Nov	Dec	Jan	Feb	Mean																			
N	43	33	29	27	25	78																				
%	51	55	93	70	76	54	67																			

		<p>WRPC CET team attendance and Nursing participation for the past two months:</p> <table border="1" data-bbox="835 315 1556 691"> <thead> <tr> <th></th> <th>Jan</th> <th>Feb</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>7</td> <td>12</td> <td></td> </tr> <tr> <td>Assessments reviewed at WRP</td> <td>85</td> <td>83</td> <td>84</td> </tr> <tr> <td>Interventions based on Assessment</td> <td>28</td> <td>50</td> <td>39</td> </tr> <tr> <td>RN reports status at WRP</td> <td>57</td> <td>50</td> <td>54</td> </tr> <tr> <td>Observations reported by PT/LVN</td> <td>16</td> <td>8</td> <td>12</td> </tr> </tbody> </table> <p>Current recommendations: Continue to monitor this requirement.</p>		Jan	Feb	Mean	N	7	12		Assessments reviewed at WRP	85	83	84	Interventions based on Assessment	28	50	39	RN reports status at WRP	57	50	54	Observations reported by PT/LVN	16	8	12
	Jan	Feb	Mean																							
N	7	12																								
Assessments reviewed at WRP	85	83	84																							
Interventions based on Assessment	28	50	39																							
RN reports status at WRP	57	50	54																							
Observations reported by PT/LVN	16	8	12																							
d.iii	<p>Nursing assessments are reviewed every 14 days during the first 60 days of admission and every 30 days thereafter and updated as appropriate. The third monthly review shall be a quarterly review and the 12th monthly review shall be the annual review.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Develop and implement a monitoring system to address the key elements of this requirement.</p> <p>Findings: MSH reported that a monitoring system has been developed. The Statewide Committee developed a monitoring form "DMH WRPC CET Team Attendance and Nursing Participation Monitoring."</p> <p>MSH submitted the following compliance data addressing completion of assessment within required time frames:</p> <p>Quarterly Nursing Assessment Data for past six months:</p>																								

	Sep	Oct	Nov	Dec	Jan	Feb	Mean
N	131	80	71	83	84	77	
%	59	68	83	66	70	70	69

Annual Nursing Assessment Data for past 6 months:

	Sep	Oct	Nov	Dec	Jan	Feb	Mean
N	13	18	21	26	18	17	
%	85	83	81	77	61	76	77

NOTE: Monitoring process has been changed since February 2007, regarding Population to include all individuals who were admitted for a year in a given month.

Current recommendations:

Continue to monitor this requirement.

4 Rehabilitation Therapy Assessments

Methodology:

Interviewed:

1. Aurora Hendricks, CNS.
2. Adella Davis-Sterling, Acting SRN.
3. Edward Arguijo, Speech Pathologist.
4. Rebecca Arguijo, Speech Pathologist.
5. Julie Duane, CNS, PMHNP.
6. Portia Salvacion, Assistant Director of Dietetics.
7. Chris Elder-Marshall, Director of Dietetics.
8. Mari Cobb, Rehabilitation Therapy Services Chief.

		<p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. DMH Integrated Rehabilitation Therapy Assessment form. 2. Dining Plan form. 3. Rehabilitation policy #2.11, Rehabilitation Therapy Integration. 4. Training rosters for Rehabilitation Therapy Integration dated 3/6/07 and 3/14/07, Mealtime Competency Training Checklist dated 3/8/07, Rehab Therapy Training to PT/OT/ST/RD dated 3/8/07, Functional IRTA Revisions dared 3/6/07, Bed/Wheelchair positioning for EB/JP dated 3/14/07, Rehab Monitoring dated 11/16/06, 5. Policy # 2.21, Rehabilitation Therapy Assessment. 6. Rehabilitation Therapy Audit data. 7. MSH Monitoring Data report form and raw data. 8. Rehabilitation Therapy Competency monitoring data. 9. Criteria Based Performance Appraisal forms for Speech Pathology, Physical Therapy. and Occupational Therapy. 10. MSH Rehabilitation Therapy Audit tool. 11. MSH AD 1052, Physical, Occupational and Speech Therapy. 12. Nursing Policy/Procedure 419, Gastrostomy Tube Feeding. 13. WRP for EG and JP. 14. MSH Dysphagia Level list. 15. MSH Daily Care Flow Sheet form. 16. Audit data for Program VI, Adaptive Equipment Monitor/Audit. 17. List of individuals who had wheelchair assessments. 18. MSH Initial/Annual Nursing Summary/Identification/Assessment form. 19. Training roster for Comprehensive Dysphagia and Wheelchair management. 20. Roster for Nursing Inservice: Dysphagia Training dated 1/18/06, 6/14/06. 21. Nursing Orientation Program schedule. 22. New Employee Orientation curriculum. 23. Purchasing Authority Purchase Order for a wheelchair. 24. Physical Therapy roster of purchased equipment.
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		<p>25. List of individuals with significant vision problems.</p> <p>26. List of individuals who use a hearing aid.</p> <p>27. MSH Program 6 Manual, Wheelchair Cleaning/Maintenance policy.</p> <p>28. MSH Wheelchair Cleaning/Maintenance Schedule form.</p> <p>29. Augmentative & Alternative Communication Evaluations for SP.</p> <p>30. Training roster for Medical Services Update dated 2/14/07.</p> <p>31. MSH procedure # 4101.002, Nutrition Care.</p> <p>32. Nursing Policy/Procedure 101, Nursing Assessment and Plan of Care; 102.2, Dysphagia/Choking Assessment; 1605, Occupational Therapy; 1606, Physical Therapy; and 1608, Speech Pathology.</p> <p>33. Speech Pathology Assessment and Treatment Plan Dysphagia.</p> <p>34. Unit 419 Seating Plan.</p> <p>35. Dysphagia Risk Levels.</p> <p>36. Swallowing Evaluation Form and data for EG.</p> <p>37. MSH AD # 3414, Physical and Nutritional Management of Dysphagia.</p> <p>38. List of individuals not on SNF with Assistive Device.</p> <p>39. Consolidated List of individuals by Dysphagia level, Vision issues, hearing issues, Speech issues, mobility issues, requiring side rails, and assistive devices.</p> <p>40. List of individuals who may benefit from Speech Evaluation for Augmentative Communication Devices.</p> <p>41. Reviewed PT assessments, weekly progress notes, and WRPs for KL and PS.</p> <p>42. PT/OT Database information.</p> <p>43. Competency-Based Training for Unit Staff form.</p> <p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. Exercise group on unit 419. 2. Units 418, 419 and 420. 3. Positioning for JP.
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a	<p>Each State hospital shall develop standard rehabilitation therapy assessment protocols, consistent with generally accepted professional standards of care, for satisfying the necessary components of a comprehensive rehabilitation therapy assessment.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Integrate OT, PT, and Speech Therapy into the Rehabilitation Therapy Services.</p> <p>Findings: The facility has integrated OT, PT, and Speech Therapy into the Rehabilitation Therapy Services Department.</p> <p>Recommendation 2, September 2006: Revise the Comprehensive Rehabilitation Assessment to include functional abilities that would indicate a need for OT, PT and/or Speech Therapy.</p> <p>Findings: MSH has developed and recently implemented a new Integrated Rehabilitation Therapy Assessment with input from the specialty therapies, OT, PT, and Speech Therapy.</p> <p>These assessments need to be reviewed to ensure that they are comprehensive and yield meaningful outcomes related to the individuals' Wellness and Recovery goals and objectives.</p> <p>Recommendation 3, September 2006: Revise, update, and implement policies, procedures, operations manuals and ADs to address this requirement.</p> <p>Findings: MSH reported that the Rehabilitation Manual assessment policy # 2.21 has been revised to address the new Integrated Rehabilitation Therapy Assessment (IRTA). In addition, a new policy, #2.11 Rehabilitation Therapy Integration has been developed and implemented. This issue will be ongoing as systems continue to be developed and implemented.</p>
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		<p>Recommendation 4, September 2006: Develop and implement a monitoring system to address the key elements of this requirement.</p> <p>Findings: MSH has developed and implemented a new auditing instrument to address the revisions made to the Integrated Rehabilitation Therapy Assessment.</p> <p>From my review of the instrument, I noted that the element of assessment protocols as designated by the EP was not included on this instrument or any others that Rehabilitation Therapy presented.</p> <p>Recommendation 5, September 2006: Review and revise OT, PT, and Speech Pathology Manuals to include Wellness and Recovery language.</p> <p>Findings: MSH reported this recommendation as completed stating that the PT, OT and ST have attended Wellness and Recovery training to prepare for the policy revisions and that the policy manuals were revised.</p> <p>From my review, I found that the OT and PT manuals did not include the language of Wellness and Recovery. In addition, none of the manuals addressed the integration with Rehabilitation Therapy Services.</p> <p>Compliance: Partial.</p>
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		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue the process of integrating OT, PT, and Speech Therapy into the Rehabilitation Therapy Services. 2. Review completed Integrated Rehabilitation Therapy Assessments to ensure that they are comprehensive and yield meaningful outcomes related to the individuals' Wellness and Recovery goals and objectives. 3. Continue to revise, update, and implement policies, procedures, operations manuals and ADs to address this requirement. 4. Ensure that the monitoring system addresses all of the elements of this requirement. 5. Review and revise OT, PT, and Speech Pathology Manuals to include Wellness and Recovery language and departmental, administrative, and system changes.
b	Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:	<p>Compliance: Partial.</p>
b.i	Is accurate and comprehensive as to the individual's functional abilities;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Revise appropriate policies, procedures and manuals to be aligned with this requirement.</p> <p>Findings: Same as D.4.a., under Findings for Recommendation 3.</p> <p>Recommendation 2, September 2006: Train RT staff regarding changes implemented.</p> <p>Findings: MSH reported that training has been provided to all Rehabilitation Therapy staff as well</p>

		<p>as to PT, OT, ST, RD, and nursing supervisors. Training rosters submitted by MSH supports compliance with this issue.</p> <p>Recommendation 3, September 2006: Develop and implement a system for monitoring and tracking the key elements of this requirement.</p> <p>Findings: MSH has revised and implemented a monitoring instrument in alignment with this requirement.</p> <p>Recommendation 4, September 2006: Include indicators related to OT, PT, and Speech Therapy in the Rehabilitation Assessments to trigger referrals to these therapy specialties.</p> <p>Findings: MSH reported that OT, PT, and ST provided input into the assessment tool to trigger referrals to these specialty therapies when appropriate. In addition, MSH reported that triggers for dietary, Optometry, and Audiology are also integrated into the assessment.</p> <p>Recommendation 5, September 2006: Identify, assess, develop and implement proactive interventions for individuals with OT, PT, and/or Speech Therapy needs.</p> <p>Findings: The MSH progress report indicated the following for this recommendation:</p> <ol style="list-style-type: none"> 1. Proactive screening is done by the RT for physical functioning. Individuals needing assessment are referred to PT, OT, and ST. 2. Proactive screening is done by the RD for high-risk individuals within the first 24 hours of admission. This includes tube feeding and dysphagia.
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		<ol style="list-style-type: none"> 3. Proactive screening is completed by the RN and referrals for assessment and interventions are made to the RD and ST. 4. If conditions/systems are present, the RN will refer to the physician for an ST evaluation. 5. A bedside swallowing evaluation is done by ST. 6. Based upon the ST assessment, the ST develops a plan utilizing proactive treatment interventions. 7. Training for the comprehensive assessment by Bailey and assoc, consultants, is scheduled for May 2007. <p>Although the above interventions are noteworthy, no data regarding this recommendation was provided.</p> <p>Recommendation 6, September 2006: Integrate OT, PT, and Speech Therapy assessments and interventions into the individual WRPs.</p> <p>Findings: MSH provided the following progress report regarding this recommendation:</p> <ol style="list-style-type: none"> 1. All OT, PT, and ST assessments and interventions are now reviewed and reported at the WRP by the Rehabilitation Therapist assigned to that caseload. 2. The new Rehabilitation Services policy number 2.11 addresses this responsibility. 3. The Rehabilitation Therapy Monitoring tool has been revised to monitor compliance with this new policy. 4. All Rehabilitation Therapy Staff have been trained on the new procedures. <p>No data was provided regarding this recommendation. However, from my review of two individuals (KL and PS) receiving PT services, I found no mention of the PT goals or</p>
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		<p>objectives in the WRPs.</p> <p>Recommendation 7, September 2006: Assess and develop 24-hour, proactive interventions for individuals at-risk and high-risk for choking and aspiration.</p> <p>Findings: MSH reported the following in response to this recommendation:</p> <ol style="list-style-type: none"> 1. Proactive screening is done by the RT for physical functioning. Individuals needing assessment are referred to PT, OT, and ST. 2. Proactive screening is done by the RD for high-risk individuals within the first 24 hours of admission. This includes tube feeding and dysphagia. 3. Proactive screening is completed by the RN and referrals for assessment and interventions are made to the RD and ST. 4. If conditions/systems are present, the RN will refer to the physician for an ST evaluation. 5. Based upon the ST assessment, the ST develops a plan utilizing proactive treatment interventions. 6. Training for the comprehensive assessment by Bailey & Associates, consultants, is scheduled for May 2007. <p>From my review, the Dysphagia system continues to be in the beginning stages of development and implementation. As the system develops and staff knowledge increases, I would expect to see a significant increase in the implementation of proactive interventions. See section F.5.c, Findings under recommendation 3, September 2006.</p> <p>Recommendation 8, September 2006: Provide ongoing training to all team members regarding dysphagia.</p>
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		<p>Findings: MSH reported that hospital-wide didactic Dysphagia Training has been provided to all disciplines by Julie Duane, PNP. Hospital-wide Dysphagia training has been provided by Bailey & Associates, Speech Therapy and Occupational Therapy consultants. Dysphagia training has been added to the Nursing Orientation Program and the Nursing Annual Update Program. In addition, dysphagia training has been added to the Rehabilitation Therapy New Employee Orientation Program. Bailey & Associates are scheduled to provide additional Dysphagia training the MSH PNMP team in May, 2007.</p> <p>The training curriculum, schedule, and rosters provided by MSH support the continued training the facility plans to provide.</p> <p>Recommendation 9, September 2006: Assess the mobility needs and fabricating individual wheelchairs that promote appropriate body alignment for individuals who depend on the use of wheelchairs for the majority of their mobility.</p> <p>Findings: MSH submitted a list of 20 individuals who have had wheelchair assessments (MG, EF, ERB, LB, JA, PC, DC, JC, RF, MW, RM, SR, DE, CC, DR, KM, HN, GF, DS, and EL).</p> <p>Although these individuals received wheelchair assessments, from my interviews it was indicated that the process was conducted by a community vendor and not in collaboration with an integrated team from MSH. Without this collaboration, significant issues can be missed, such as tendency for skin breakdowns or frequent weight fluctuations, since the vender has little to no knowledge about the individuals. To ensure adequate assessments, this process should be conducted in collaboration with members of the individual's team.</p> <p>Recommendation 10, September 2006: Streamline the process of obtaining adaptive equipment.</p>
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		<p>Findings: MSH reported that meetings have occurred to discuss the process, but no outcome data is currently available. In addition, consultation has occurred with vendors on how to streamline the process of obtaining adaptive equipment. One adaptive wheelchair has been ordered.</p> <p>Recommendation 11, September 2006: Provide and document training to individuals and staff regarding the appropriate use of adaptive equipment.</p> <p>Findings: MSH reported that this recommendation was completed since positioning training was provided by the OT and PT.</p> <p>This training was a good beginning to the process. However, it needs to be ongoing addressing all types of adaptive equipment. In addition, the training needs to include staff and the individuals who require the equipment.</p> <p>Recommendation 12, September 2006: Develop a monitoring system to ensure that individuals have access to their adaptive equipment and that it is in proper working condition, and that it is being used appropriately.</p> <p>Findings: MSH has initiated the use of the Nursing Daily Care Flow Sheet for tracking. In addition, an audit was completed on the SNF units evaluating adaptive equipment. The results are listed below:</p>
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n =	9
Compliance with MD orders for equipment	100%
Specialty department evaluations	100%
Timeliness and corresponding with WRP	77%
Progress notes reflect equipment use and response	55%

Although the audit provided significant information, a system needs to be developed addressing the additional issues noted in this recommendation.

Recommendation 13, September 2006:

Re-evaluate the adaptive equipment at least annually or in response to individuals' status changes to ensure that it is meeting the individuals' needs.

Findings:

MSH reported that the PT/OT will reassess the individuals' adaptive equipment needs in the monthly progress report. In addition, the RT will observe the physical functioning of the individual and make referrals. Also, the IRTA has been revised to include change of condition. However, there was no data presented regarding this recommendation.

Recommendation 14, September 2006:

Develop and implement a system to identify, assess, monitor, track, document, and provide ongoing services to individuals who have significant vision and hearing problems and the need for augmentative/adaptive communication devices.

Findings:

The facility's progress report indicated the following:

1. Screening for vision and hearing problems occur within 24 hours of admission.
2. Ongoing screening is done by Nursing.

		<p>3. The new IRTA, completed by the RTs, now includes physical observations for vision and hearing. These observations will be forwarded to Optometry and Audiology when appropriate.</p> <p>However, these interventions do not adequately address this recommendation.</p> <p>Recommendation 15, September 2006: Provide augmentative/adaptive communication devices for individuals with communications issues.</p> <p>Findings: MSH reported that Typing Telephone Communication Devices (TTY) are located on Units 104 and Unit 419 and a list of all individuals that have received evaluations for Augmentative Communication plan has been developed by ST. Training is scheduled for the Program 6 staff on 3/21/07.</p> <p>From my review, I noted that more individuals were referred for communication evaluations. From the evaluations I reviewed for SP, DC, LB, AND JL, I noted that each individual had a recommendation for further assessment for possible use of augmentative devices. However, there was no indication when this assessment would be conducted.</p> <p>Recommendation 16, September 2006: Develop and implement a system to monitor and track the regular cleaning and sanitizing of adaptive equipment and wheelchairs.</p> <p>Findings: The facility's progress reported that a policy has been developed and implemented for the cleaning of wheelchairs on Program 6 and there is a tracking log for monitoring cleaning. Also, Nutrition Services policy 4101.001 is in place for the cleaning of adaptive equipment. No data was presented regarding this recommendation.</p>
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		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement proactive interventions for individuals with OT, PT, and/or Speech Therapy needs. 2. Ensure that OT, PT, and Speech Therapy assessments and interventions are integrated into the individual WRPs. 3. Continue to assess and develop 24-hour, proactive interventions for individuals who are at risk or are high-risk for choking and aspiration. 4. Continue to provide ongoing training to all team members regarding dysphagia. 5. Ensure that mobility assessments and fabrication of wheelchairs to promote appropriate body alignment for individuals are conducted in collaboration with members of the WRP team. 6. Continue to work on streamlining the process of obtaining adaptive equipment. 7. Continue to provide and document training to individuals and staff regarding the appropriate use of adaptive equipment. 8. Develop a monitoring system to ensure that individuals have access to their adaptive equipment and that it is in proper working condition, and that it is being used appropriately. 9. Continue to re-evaluate the adaptive equipment at least annually or in response to individuals' status changes to ensure that it is meeting the individuals' needs. 10. Develop and implement a system to identify, assess, monitor, track, document, and provide ongoing services to individuals who have significant vision and hearing problems and the need for augmentative/adaptive communication devices. 11. Provide augmentative/adaptive communication assessments and the needed devices for individuals with communications issues. 12. Monitor and track the regular cleaning and sanitizing of adaptive equipment and wheelchairs.
b.ii	Identifies the individual's current functional status and the skills and	The facility reported the following on the progress report for this requirement:

	<p>supports needed to facilitate transfer to the next level of care; and</p>	<ol style="list-style-type: none"> 1. Six months of data reflecting skills and current functional status has been collected. 2. The sample size has increased from 10% to 20%. 3. Two full-time RT monitors/Mentors have been assigned the task of monitoring RT assessments. 4. An inter-rater reliability analysis has been completed for the current functional status audit. 5. A new IRTA has been developed and implemented to better address functional status and skills/supports needed to facilitate transfer to the next level. 6. New guidelines have been established for this area. 7. A new monitoring tool has been developed and implemented for this area. <p>The data presented had variability issues that were not specified or accounted for on the Rehabilitation Therapy Monitoring form data.</p>
<p>b.iii</p>	<p>Identifies the individual's life goals, strengths, and motivation for engaging in wellness activities.</p>	<p>The facility reported the following on the progress report for this requirement:</p> <ol style="list-style-type: none"> 1. Six months of data reflecting life goals, strengths, and motivation for engaging in wellness activities has been collected. 2. The sample size has increased from 10% to 20%. 3. Two full-time RT monitors/mentors have been assigned the task of monitoring RT assessments. 4. An inter-rater reliability analysis has been completed for the life goals, strengths, and motivation for engaging in wellness activities to facilitate transfer to the next level. 5. A new IRTA has been developed and implemented to better address life goals, strengths, and motivation for engaging in wellness activities to facilitate transfer to the next level. 6. New guidelines have been established for this area. 7. A new monitoring tool has been developed and implemented for this area.

		<p>As noted above, the data presented had variability issues that were not specified or accounted for on the Rehabilitation Therapy Monitoring form data.</p>
c	<p>Each State hospital shall ensure that all clinicians responsible for performing or reviewing rehabilitation therapy assessments are verifiably competent in performing the assessments for which they are responsible</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Develop and implement a system to ensure that OT, PT and Speech therapists are verifiably competent in performing the assessments for which they are responsible.</p> <p>Recommendation 2, September 2006: Develop and implement a monitoring system to adequately address this requirement.</p> <p>Findings: The facility progress report indicated that six months of clinical competency data is available for Rehabilitation Therapy. In addition, the PTs, OTs, and STs are evaluated by the Medical Supervisor for competence on an annual basis and state license verification is obtained. However, there is no system in place verifying competency for PT, OT, and ST by these respective disciplines. The facility reported that a cross check peer review with other DMH hospitals is being explored but no outcome data is available.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a system to ensure that OT, PT and Speech therapists are verifiably competent in performing the assessments for which they are responsible. 2. Develop and implement a monitoring system to adequately address this requirement.

d	<p>Each State hospital shall ensure that all rehabilitation therapy assessments of all individuals who were admitted to each State hospital before the Effective Date hereof shall be reviewed by qualified clinicians and, as indicated, revised to meet the criteria in § [IV.D.2], above.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: See recommendations in section 4a.</p> <p>Findings: The facility provided the following progress report:</p> <ol style="list-style-type: none"> 1. A new integrated Rehabilitation Therapy Assessment has been developed and fully implemented. 2. Comprehensive Dysphagia assessment has been implemented jointly by PT, OT, ST, RD, RN. 3. A new policy 2.11 "Rehabilitation Therapy Assessment" has been developed and implemented. 4. Training has been provided for all disciplines by ST on Mealtime competency. 5. Training has been provided by PT/OT on wheelchair positioning. <p>My discussion with the Chief of Rehabilitation Therapy indicated that at this time 98% of the required review/reassessments have been conducted. However, these review/reassessments were conducted using the old Rehabilitation Therapy Assessment tool which was inadequate. It is reasonable at this time to first evaluate the utility of the new Integrated Rehabilitation Therapy Assessment before implementing the review/reassessment process as required by the EP.</p> <p>Compliance: Partial.</p> <p>Current recommendations: Evaluate the utility of the new Integrated Rehabilitation Therapy Assessment before implementing this requirement.</p>
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5	Nutrition Assessments	
	<p>Each State hospital shall provide nutrition assessments, reassessments, and interventions consistent with generally accepted professional standards of care. A comprehensive nutrition assessment will include the following:</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Mary Christina Marshall, Director of Dietetics. 2. Portia Salvacion, Assistant Director of Dietetics. 3. Ninfa Guzman, RD, Hospital Administration Resident. <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Reviewed the charts of 21 individuals (SW, WH, JV, CR, PL, NM, DY, JD, MG, LN, LB, KA, LH, DP, HF, QV, PS, PT, MW, CM and SF). 2. MSH monitoring data reports. 3. MSH procedure #4101.002, Nutrition Care. 4. MSH policy #4101, Nutritional Care Standards. 5. High-risk Referral draft. 6. Nutrition Care Monitoring Tool (NCMT) revised instructions. 7. Department of Dietetics Clinical Section Meeting Reports dated October 18, 2006, January 9 and 23, 2007 and March 13, 2007 and attendance sign-in sheets. 8. Memorandum dated March 6, 2007 regarding Recommendations/January 2007 Nutrition Assessment Review. 9. Initial data presented by the Dietetic Department and the revised data.
a	<p>For new admissions with high-risk referral (e.g., type I diabetes mellitus, enteral/parenteral feeding, dysphagia/recent choking episode), or upon request by physician, a comprehensive Admission Nutrition Assessment will be completed within 24 hours of notification to the dietitian.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Develop and implement a high-risk referral monitoring and tracking system to identify individuals who meet this criterion to ensure that they receive adequate and timely nutrition assessments.</p>

Findings:

The facility reports full implementation of the Department of Dietetics policy and procedure #4101 Nutrition Care Standards and #4101.002 Nutrition Screening/High Risk Individuals addressing this recommendation.

MSH presented the following data:

Month	Sep	Oct	Nov	Dec	Jan	Feb
Total assessments (N)	2	3	3	2	7	2
Assessments reviewed (n)	2	3	3	2	7	2
Sample size	100%	100%	100%	100%	100%	100%
Timeliness	100%	33%	100%	100%	100%	100%
Total score	98%	94%	100%	100%	97%	100%
Compliance level	Full	Partial	Full	Full	Full	Full

MSH reported that the total score section of all data tables submitted reflect the overall averaged compliance rates for all indicators included on the NCMT for assessments monitored for each month.

Presenting the averaged compliance rate for each indicator on the NCMT would provide more meaningful data in alignment with the EP as well as for clinical issues.

From my review of nutrition assessments of three individuals meeting this criteria, LB, KA, and LH, I found all three were completed within the appropriate time frame.

Other findings:

Initially, the Dietetics Department presented data that did not consistently include the requirement elements of each cell regarding the timeliness of Nutrition Assessments.

		<p>However, during the review, the department re-ran their data to provide the required compliance rates.</p> <p>The department has made significant progress in the development and implementation of its Nutrition Care Monitoring Tool (NCMT). The department has found the data that it is collecting valuable both administratively and clinically. In addition, the Dietetic Department has begun to incorporate their findings into the performance evaluations of the staff dietitians to identify areas of needed improvement and/or clinical expertise. This process will enhance the dietetic services provided to the individuals at MSH.</p> <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Provide compliance rates in alignment with the requirements of the EP. 2. Continue to monitor this requirement.
b	For new admissions directly into the medical-surgical unit, a comprehensive Admission Nutrition Assessment will be completed within 3 days of admission.	Not applicable—MSH does not have a medical/surgical unit.
c	For new admissions directly into the skilled nursing facility unit, a comprehensive Admission Nutrition Assessment will be completed within seven days of admission.	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Ensure that new admissions directly admitted into the skilled nursing facility unit have a comprehensive Admission Nutrition Assessment completed within seven days of admission</p> <p>Findings: MSH submitted the following data:</p>

		<table border="1" data-bbox="869 277 1793 618"> <thead> <tr> <th></th> <th>Sep</th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> </tr> </thead> <tbody> <tr> <td>Total assessments (N)</td> <td>1</td> <td>1</td> <td>4</td> <td>3</td> <td>1</td> <td>1</td> </tr> <tr> <td>Assessments reviewed (n)</td> <td>1</td> <td>1</td> <td>4</td> <td>3</td> <td>1</td> <td>1</td> </tr> <tr> <td>Sample size</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> </tr> <tr> <td>Timeliness</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> </tr> <tr> <td>Total score</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>94%</td> </tr> <tr> <td>Compliance level</td> <td>Full</td> <td>Partial</td> <td>Full</td> <td>Full</td> <td>Full</td> <td>Full</td> </tr> </tbody> </table> <p data-bbox="869 662 1953 727">From my review of one individual who met this criterion, MG, I found that the nutrition assessment was obtained within the required time frame.</p> <p data-bbox="869 776 1018 841">Compliance: Full.</p> <p data-bbox="869 889 1333 954">Current recommendations: Continue to monitor this requirement.</p>		Sep	Oct	Nov	Dec	Jan	Feb	Total assessments (N)	1	1	4	3	1	1	Assessments reviewed (n)	1	1	4	3	1	1	Sample size	100%	100%	100%	100%	100%	100%	Timeliness	100%	100%	100%	100%	100%	100%	Total score	100%	100%	100%	100%	100%	94%	Compliance level	Full	Partial	Full	Full	Full	Full
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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 seven days of admission.	<p data-bbox="869 997 1465 1029">Current findings on previous recommendations:</p> <p data-bbox="869 1068 1354 1101">Recommendation 1, September 2006:</p> <p data-bbox="869 1107 1984 1286">Ensure that 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), are provided a comprehensive Admission Nutrition Assessment.</p>																																																	

Findings:

The following is a summary of MSH's monitoring data:

Month	Sep	Oct	Nov	Dec	Jan	Feb
Total assessments (N)	10	15	17	23	33	11
Assessments reviewed (n)	6	4	5	7	9	8
Sample size	60%	27%	29%	30%	27%	73%
Timeliness	100%	100%	100%	100%	100%	88%
Total score	93%	98%	99%	99%	96%	98%
Compliance level	Partial	Full	Full	Full	Full	Full

From my review of two individuals who met this criteria (DP, and HF), I found that both assessments were completed within seven days of their admission.

Recommendation 2, September 2006:

Ensure staff competency regarding deficiencies and appropriate procedures for Admission Nutrition Assessments.

Findings:

MSH reported that clinical knowledge based updates in the areas of concern from the last review were provided via Literature/Journal Review and peer reviews/case presentations. Inservice sheets dated Oct 18, 2006, Jan 9, 2007, Jan 23, 2007, and March 13, 2007 supported the implementation of this recommendation.

In addition, MSH reviewed the quality indicators of areas of concern from the previous review's findings.

		<table border="1" data-bbox="869 277 1755 506"> <thead> <tr> <th>Areas of Concern</th> <th>Sept</th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> </tr> </thead> <tbody> <tr> <td>Nutrition Education</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> </tr> <tr> <td>Response to MNT</td> <td>100%</td> <td>75%</td> <td>83%</td> <td>100%</td> <td>89%</td> <td>88%</td> </tr> <tr> <td>Nutrition Goals</td> <td>95%</td> <td>100%</td> <td>100%</td> <td>96%</td> <td>89%</td> <td>100%</td> </tr> <tr> <td>Complete/appropriate recommendation</td> <td>100%</td> <td>94%</td> <td>100%</td> <td>96%</td> <td>89%</td> <td>100%</td> </tr> </tbody> </table> <p data-bbox="869 548 1016 578">Compliance:</p> <p data-bbox="869 586 957 615">Partial.</p> <p data-bbox="869 659 1201 688">Current recommendations:</p> <p data-bbox="869 696 1335 725">Continue to monitor this requirement.</p>	Areas of Concern	Sept	Oct	Nov	Dec	Jan	Feb	Nutrition Education	100%	100%	100%	100%	100%	100%	Response to MNT	100%	75%	83%	100%	89%	88%	Nutrition Goals	95%	100%	100%	96%	89%	100%	Complete/appropriate recommendation	100%	94%	100%	96%	89%	100%
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e	For new admissions with therapeutic diet orders for medical reasons, a comprehensive Admission Nutrition Assessment will be completed within seven days of admission.	<p data-bbox="869 773 1465 802">Current findings on previous recommendations:</p> <p data-bbox="869 846 1352 875">Recommendation 1, September 2006:</p> <p data-bbox="869 883 1944 951">Ensure that new admissions with therapeutic diet orders for medical reasons receive a comprehensive Admission Nutrition Assessment.</p> <p data-bbox="869 995 982 1024">Findings:</p> <p data-bbox="869 1068 1734 1097">The following is a summary of the monitoring data submitted by MSH:</p> <table border="1" data-bbox="869 1138 1797 1362"> <thead> <tr> <th></th> <th>Sep</th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> </tr> </thead> <tbody> <tr> <td>Total assessments (N)</td> <td>2</td> <td>2</td> <td>3</td> <td>2</td> <td>5</td> <td>2</td> </tr> <tr> <td>Assessments reviewed (n)</td> <td>2</td> <td>2</td> <td>3</td> <td>2</td> <td>5</td> <td>2</td> </tr> <tr> <td>Sample size</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> </tr> </tbody> </table>		Sep	Oct	Nov	Dec	Jan	Feb	Total assessments (N)	2	2	3	2	5	2	Assessments reviewed (n)	2	2	3	2	5	2	Sample size	100%	100%	100%	100%	100%	100%							
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	Sep	Oct	Nov	Dec	Jan	Feb
Timeliness	100%	100%	100%	100%	100%	100%
Total score	100%	97%	99%	99%	100%	100%
Compliance	Full	Full	Full	Full	Full	Full

From my review of two individuals' nutrition assessment who met this criteria (LB and QV), I found the assessments were completed within seven days of admission.

Recommendation 2, September 2006:

Ensure staff competency regarding deficiencies and appropriate procedures for Admission Nutrition Assessments.

Findings:

MSH provided the following compliance data regarding quality areas of concerns found during the previous review:

Areas of Concern	Sep	Oct	Nov	Dec	Jan	Feb
Nutrition diagnosis	100%	80%	83%	100%	100%	100%
Nutrition Education	100%	100%	100%	100%	100%	100%
Complete/appropriate recommendation	100%	100%	100%	84%	100%	100%

Compliance:

Partial.

Current recommendations:

Continue to monitor this requirement.

f	<p>For individuals with therapeutic diet orders for medical reason after admission, a comprehensive Admission Nutrition Assessment will be completed within seven days of the therapeutic diet order but no later than 30 days of admission.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Complete nutritional assessments within the time frames indicated in the EP to ensure proper integration of data regarding changes that may occur after the fifth day of admission.</p> <p>Findings: MSH reported that a comprehensive Admission Nutrition Assessment is completed within five days of admit for all non-high-risk individuals regardless of type of diet order. For new admissions with therapeutic diet orders after the completion of the Admission Nutrition Assessment, a reassessment is completed via the diet confirmation process per the department's policy and procedure #4101.</p> <p>Recommendation 2, September 2006: Develop and implement monitoring system to ensure compliance with this requirement.</p> <p>Findings: MSH reported that compliance with this requirement is being monitored via the Reassessment Task Section of the Nutrition Care Monitoring Tool (NCMT). If after five days a change in the diet occurs, the time frame for completion of the assessment will determine by status and by the acuity of the Nutrition Status Type (NST).</p> <p>Compliance: Partial.</p> <p>Current recommendations: Continue to monitor this requirement.</p>
g	<p>For all other individuals, a comprehensive</p>	<p>Current findings on previous recommendations:</p>

Admission Nutrition Assessment will be completed within 30 days of admission.

Recommendation 1, September 2006:

Continue to monitor Admission Nutrition Assessments to ensure that they are completed in a timely manner.

Findings:

The following table summarizes MSH's monitoring data:

	Sep	Oct	Nov	Dec	Jan	Feb
Total assessments (N)	13	8	8	7	6	6
Assessments reviewed (n)	13	8	8	7	6	6
Sample size	100%	100%	100%	100%	100%	100%
Timeliness	100%	100%	100%	100%	100%	100%
Total score	98%	98%	99%	98%	99%	100%
Compliance level	Full	Full	Full	Full	Full	Full

From my review of five individuals who met this criteria (PS, PT, MW, NM, and CM), I found that all nutritional assessments were completed within 30 days of admission.

Recommendation 2, September 2006:

Ensure staff competency regarding deficiencies and appropriate procedures for Admission Nutrition Assessments.

Findings:

MSH provided the following compliance data from Sept 2006 through Feb 2007 regarding quality areas of concerns found during the previous review:

		<table border="1" data-bbox="869 277 1575 467"> <thead> <tr> <th>Areas of Concern</th> <th>Average Score</th> <th>Compliance Level</th> </tr> </thead> <tbody> <tr> <td>Nutrition diagnosis</td> <td>99%</td> <td>Full compliance</td> </tr> <tr> <td>Response to MNT</td> <td>93%</td> <td>Partial compliance</td> </tr> <tr> <td>Nutrition Goals</td> <td>93%</td> <td>Partial compliance</td> </tr> </tbody> </table> <p data-bbox="869 509 1016 574">Compliance: Partial.</p> <p data-bbox="869 623 1335 688">Current recommendations: Continue to monitor this requirement.</p>	Areas of Concern	Average Score	Compliance Level	Nutrition diagnosis	99%	Full compliance	Response to MNT	93%	Partial compliance	Nutrition Goals	93%	Partial compliance		
Areas of Concern	Average Score	Compliance Level														
Nutrition diagnosis	99%	Full compliance														
Response to MNT	93%	Partial compliance														
Nutrition Goals	93%	Partial compliance														
h	Acuity level of an individual at nutritional risk will be determined by Nutritional Status Type ("NST") which defines minimum services provided by a registered dietitian.	<p data-bbox="869 737 1465 769">Current findings on previous recommendations:</p> <p data-bbox="869 808 1869 915">Recommendation 1, September 2006: Utilize the NCMT, item 12 to determine compliance with the key element of this requirement.</p> <p data-bbox="869 954 1352 1029">Recommendation 2, September 2006: Provide consistent data findings.</p> <p data-bbox="869 1068 1944 1247">Findings: Using the NCMT, MSH used the NCMT to assess its compliance with this requirement. The following is a summary of the data regarding the assignment of the Nutritional Status Type (NST) (N= all newly admitted individuals with nutritional triggers, therapeutic diet orders etc.):</p> <table border="1" data-bbox="869 1282 1919 1359"> <thead> <tr> <th></th> <th>Sep</th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> </tr> </thead> <tbody> <tr> <td>Total target population (N)</td> <td>46</td> <td>46</td> <td>34</td> <td>60</td> <td>60</td> <td>28</td> </tr> </tbody> </table>		Sep	Oct	Nov	Dec	Jan	Feb	Total target population (N)	46	46	34	60	60	28
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NST	100%	100%	100%	100%	100%	100%																																													
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i	<p>The frequency of a comprehensive Nutrition Assessment Update will be determined by the NST. Updates should include, but not be limited to: subjective data, weight, body-mass index ("BMI"), waist circumference, appropriate weight range, diet order, changes in pertinent medication, changes in pertinent medical/psychiatric problems, changes in nutritional problem(s), progress toward goals/objectives, effectiveness of interventions, changes in goals/plan, recommendations, and follow-up as needed.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Develop and implement tracking and monitoring systems related to the key elements of this requirement.</p> <p>Findings: MSH presented data that are summarized in the following table:</p> <table border="1"> <thead> <tr> <th></th> <th>Sep</th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> </tr> </thead> <tbody> <tr> <td>Total assessment updates due for completion (N)</td> <td>153</td> <td>134</td> <td>180</td> <td>146</td> <td>145</td> <td>164</td> </tr> <tr> <td>Assessment updates reviewed (n)</td> <td>56</td> <td>45</td> <td>54</td> <td>35</td> <td>41</td> <td>32</td> </tr> <tr> <td>Sample size</td> <td>37%</td> <td>34%</td> <td>30%</td> <td>24%</td> <td>28%</td> <td>20%</td> </tr> <tr> <td>Timeliness</td> <td>95%</td> <td>100%</td> <td>96%</td> <td>97%</td> <td>98%</td> <td>100%</td> </tr> <tr> <td>Total score</td> <td>99%</td> <td>98%</td> <td>93%</td> <td>98%</td> <td>98%</td> <td>99%</td> </tr> <tr> <td>Compliance level</td> <td>Full</td> <td>Full</td> <td>Partial</td> <td>Full</td> <td>Full</td> <td>Full</td> </tr> </tbody> </table>		Sep	Oct	Nov	Dec	Jan	Feb	Total assessment updates due for completion (N)	153	134	180	146	145	164	Assessment updates reviewed (n)	56	45	54	35	41	32	Sample size	37%	34%	30%	24%	28%	20%	Timeliness	95%	100%	96%	97%	98%	100%	Total score	99%	98%	93%	98%	98%	99%	Compliance level	Full	Full	Partial	Full	Full	Full
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The above data do not adequately indicate if all the elements of this requirement were met. In January 2007, the elements of this requirement were separated out in the data. The following are the data for January and February 2007:

January 2007 (N=145, n=41):

Pertinent objective information	Yes	No	Na	%
Diet/supplement order	41	0	0	100%
Age	0	0	41	--
Height	41	0	0	100%
Weight	41	0	0	100%
BMI	41	0	0	100%
Adjusted weight	0	0	41	--
Appropriate weight range	29	12	0	71%
Weight trend	40	0	1	100%
Waist circumference	21	3	17	88%
Food allergy/intolerance	1	0	40	100%
Labs	32	0	9	100%
Medical condition	31	0	10	100%
Changes in medical/psych condition				
Changes in nutritional problems	15	0	26	100%
Medication	38	1	2	97%
Changes in medication				
Potential food/drug side effects	2	0	39	100%
Meal intake	41	0	0	100%

		<p>February 2007 (N=174, n=32):</p> <table border="1"> <thead> <tr> <th>Pertinent objective information</th> <th>Yes</th> <th>No</th> <th>Na</th> <th>%</th> </tr> </thead> <tbody> <tr> <td>Diet/supplement order</td> <td>32</td> <td>0</td> <td>0</td> <td>100%</td> </tr> <tr> <td>Age</td> <td>0</td> <td>0</td> <td>32</td> <td>--</td> </tr> <tr> <td>Height</td> <td>32</td> <td>0</td> <td>0</td> <td>100%</td> </tr> <tr> <td>Weight</td> <td>32</td> <td>0</td> <td>0</td> <td>100%</td> </tr> <tr> <td>BMI</td> <td>32</td> <td>0</td> <td>0</td> <td>100%</td> </tr> <tr> <td>Adjusted weight</td> <td>0</td> <td>0</td> <td>32</td> <td>--</td> </tr> <tr> <td>Appropriate weight range</td> <td>25</td> <td>0</td> <td>7</td> <td>100%</td> </tr> <tr> <td>Weight trend</td> <td>32</td> <td>0</td> <td>0</td> <td>100%</td> </tr> <tr> <td>Waist circumference</td> <td>20</td> <td>3</td> <td>9</td> <td>87%</td> </tr> <tr> <td>Food allergy/intolerance</td> <td>0</td> <td>0</td> <td>32</td> <td>100%</td> </tr> <tr> <td>Labs</td> <td>22</td> <td>0</td> <td>10</td> <td>100%</td> </tr> <tr> <td>Medical condition</td> <td>12</td> <td>0</td> <td>20</td> <td>100%</td> </tr> <tr> <td>Changes in medical/psych condition</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Changes in nutritional problems</td> <td>12</td> <td>0</td> <td>20</td> <td>100%</td> </tr> <tr> <td>Medication</td> <td>23</td> <td>0</td> <td>9</td> <td>100%</td> </tr> <tr> <td>Changes in medication</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Potential food/drug side effects</td> <td>7</td> <td>0</td> <td>25</td> <td>100%</td> </tr> <tr> <td>Meal intake</td> <td>26</td> <td>3</td> <td>3</td> <td>90%</td> </tr> </tbody> </table> <p>Compliance: Partial.</p> <p>Current recommendations: Continue to monitor the elements of this requirement.</p>	Pertinent objective information	Yes	No	Na	%	Diet/supplement order	32	0	0	100%	Age	0	0	32	--	Height	32	0	0	100%	Weight	32	0	0	100%	BMI	32	0	0	100%	Adjusted weight	0	0	32	--	Appropriate weight range	25	0	7	100%	Weight trend	32	0	0	100%	Waist circumference	20	3	9	87%	Food allergy/intolerance	0	0	32	100%	Labs	22	0	10	100%	Medical condition	12	0	20	100%	Changes in medical/psych condition					Changes in nutritional problems	12	0	20	100%	Medication	23	0	9	100%	Changes in medication					Potential food/drug side effects	7	0	25	100%	Meal intake	26	3	3	90%
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j.i	Individuals will be reassessed when there is a significant change in condition.	Current findings on previous recommendations:																																																																																															

Recommendation 1, September 2006:

Develop and implement a system to ensure that individuals who have a significant change in condition will be reassessed.

Recommendation 2, September 2006:

Develop and implement monitoring system to ensure that these individuals are adequately reassessed in a timely manner.

Findings:

MSH reported that the NCMT has been modified to include the following criteria in the identification of individuals who have had a significant change in condition thus requiring a reassessment:

1. Non-administrative transfer to skilled nursing units;
2. High-risk referrals/consults; and
3. Diet change to a therapeutic diet order

Although the NCMT has been modified, data need to be specific regarding the timeliness of reassessments from consults and high-risk referrals since the timelines can differ from 24 hours, seven days, 14 days or other. The following outlines the facility's data:

Non-administrative transfer to skilled unit (within seven days).

	Sep	Oct	Nov	Dec	Jan	Feb
Total target population (N)	1	3	1	N/A	4	1
Population reviewed (n)	1	3	1	N/A	4	1
Sample size	100%	100%	100%	N/A	100%	100%
Timeliness	100%	100%	100%	N/A	100%	100%
Total score	100%	98%	100%	N/A	98%	100%
Compliance level	Full	Full	Full	N/A	Full	Full

Reassessment per high-risk referral/consult..

	Sep	Oct	Nov	Dec	Jan
Total target population (N)	2	2	2	2	6
Population reviewed (n)	2	2	2	2	6
Sample size	100%	100%	100%	100%	100%
Timeliness	100%	100%	100%	100%	100%
Total score	97%	92%	97%	97%	96%
Compliance level	Full	Full	Full	Full	Full

MSH submitted compliance data for February 2007 with the designated timelines for this category. Although the data were not clearly presented, it did indicate that there was 100% compliance for five reassessments requiring 24-hour and seven-day timelines.

From my review of two individuals who met this criteria (SB and DH), I found both reassessments were completed within the required seven-day timeline.

Recommendation 3, September 2006:

Provide training on components of an adequate assessment for changes in conditions.

Findings:

MSH reported that at the January 31, 2007 Clinical Section Meeting, the updated NCMT was presented.

Compliance:

Partial.

Current recommendations:

1. Clarify data regarding the timelines of reassessments.

		2. Continue to monitor this requirement.																																																	
j.ii	Every individual will be assessed annually.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Continue monitoring and tracking the key element of this requirement.</p> <p>Recommendation 2, September 2006: Ensure staff competency regarding deficiencies and appropriate procedures for annual Nutrition Assessments.</p> <p>Findings: The following table summarizes the facility's data regarding individuals assessments due for the reporting month:</p> <table border="1" data-bbox="869 797 1755 1138"> <thead> <tr> <th></th> <th>Sep</th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> </tr> </thead> <tbody> <tr> <td>Total target population (N)</td> <td>27</td> <td>37</td> <td>50</td> <td>41</td> <td>35</td> <td>27</td> </tr> <tr> <td>Population reviewed (n)</td> <td>12</td> <td>15</td> <td>22</td> <td>14</td> <td>14</td> <td>15</td> </tr> <tr> <td>Sample size (%)</td> <td>44%</td> <td>40%</td> <td>44%</td> <td>34%</td> <td>40%</td> <td>56%%</td> </tr> <tr> <td>Timeliness</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> </tr> <tr> <td>Total score</td> <td>99%</td> <td>98%</td> <td>99%</td> <td>98%</td> <td>99%</td> <td>99%</td> </tr> <tr> <td>Compliance level</td> <td>Full</td> <td>Full</td> <td>Full</td> <td>Full</td> <td>Full</td> <td>Full</td> </tr> </tbody> </table> <p>From my review of ten individuals' annual nutrition assessments (SW, WH, JV, CR, PL, NM, DY, JD, LN, and SF), I noted that all had been timely completed.</p> <p>In addition, MSH provided the following compliance data from Sept 06 through Feb 07 regarding quality areas of concerns found during the previous review:</p>		Sep	Oct	Nov	Dec	Jan	Feb	Total target population (N)	27	37	50	41	35	27	Population reviewed (n)	12	15	22	14	14	15	Sample size (%)	44%	40%	44%	34%	40%	56%%	Timeliness	100%	100%	100%	100%	100%	100%	Total score	99%	98%	99%	98%	99%	99%	Compliance level	Full	Full	Full	Full	Full	Full
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Complete/appropriate recommendation	98%	Full																		
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:	<p>Methodology:</p> <p>Interviewed:</p> <ol style="list-style-type: none"> 1. Shirin Karimi, Clinical Social Worker, Acting Chief of Social Work. <p>Reviewed:</p> <ol style="list-style-type: none"> 1. Charts of 22 Individuals (CY, ET, PT, DA, JO, RC, DC, GB, TN, AW, RW, PS, AA, B-HA, SL, MR, DW, EJ, RT, SJ, ML, and HK). 2. WRP Chart Auditing Monitoring Form. 3. Psychosocial Assessment Instruction Form (30 day). 4. Social Work Monthly Note Monitoring Tool. 																		
a	Is, to the extent reasonably possible, accurate, current and comprehensive;	Current findings on previous recommendations:																		

		<p>Recommendation 1, September 2006: Implement the 30-day social history reviews.</p> <p>Findings: This monitor's interview with the Acting Chief of Social Work indicated that the Statewide Committee was finalizing the 30-day social history monitoring form. Meanwhile, MSH had conducted training on the draft form. Training was conducted on January 10, 17, and 24, 2007. Thirty-one of the 37 (84%) have received training.</p> <p>Recommendation 2, September 2006: Include quality indicators in the Social Work monitoring instruments.</p> <p>Findings: The facility has yet to implement this recommendation. This monitor's interview with the Acting Chief of Social Work revealed that Chiefs of Social Work from State Hospitals met on January 22, 2007 and February 16, 2007 for discussion of quality indicators.</p> <p>Recommendation 3, September 2006: Develop, finalize and implement statewide annual social history evaluations.</p> <p>Findings: This item has been developed, but is not finalized and implemented. This monitor's interview with the Acting Chief of Social Work indicated that the Statewide Annual Social History Evaluations were approved by the Statewide Hospitals. The evaluations are being reviewed by the DMH Statewide Committee.</p> <p>Recommendation 4, September 2006: Align monitoring tools with the Evaluation Plan.</p>
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		<p>Findings: The monitoring tools have not been finalized.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Implement the 30-day social history reviews. 2. Include quality indicators in the Social Work monitoring instruments. 3. Develop, finalize and implement statewide annual social history evaluations. 4. Align monitoring tools with the Evaluation Plan.
b	Expressly identifies factual inconsistencies among sources, resolves or attempts to resolve inconsistencies, and explains the rationale for the resolution offered;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Ensure that social workers identify and address the inconsistencies in current assessments.</p> <p>Recommendation 2, September 2006: Monitor factual inconsistencies in social histories.</p> <p>Findings: MSH's progress report noted that factual inconsistencies were identified and resolved in seven of the 10 assessments reviewed.</p> <p>This monitor's review of five charts (ET, DA, GB, AA, and TN) did not evidence any discernible factual inconsistencies from the information contained in the social history assessments.</p>

		<p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that social workers identify and address the inconsistencies in current assessments. 2. Monitor factual inconsistencies in social histories.
c	Is included in the 7-day integrated assessment and fully documented by the 30 th day of an individual's admission; and	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Ensure all SW Integrated assessments are completed and available to the WRP team before the seven-day WRP conference.</p> <p>Findings: MSH's progress report showed that 88% of the 119 Social Work Integrated Assessments reviewed were completed and made available to the WRP teams before the seven-day WRPCs.</p> <p>This monitor's review of nine (PT, AA, ET, DA, GB, RC, TN, PS, and ET) Integrated Assessments showed that eight of them (PT, AA, ET, DA, GB, TN, PS, and ET) were completed in a timely manner.</p> <p>Recommendation 2, September 2006: Ensure that all 30-day social histories are completed and available to the individual's WRPT members by the 30th day of admission.</p> <p>Findings: MSH's progress report indicated that eight of ten (80%) of the 30-day social history assessments reviewed were completed on time and made available to the individual's</p>

		<p>WRPT.</p> <p>This monitor's review of 22 cases showed that four of them had the 30-day assessments (ET, DA, AA, PT), fourteen did not have the 30-day assessments (SJ, ML, HK, RT, PS, DC, SL, RW, AW, TN, GB, CY, B-HA, and JO), three were very recent assessments and not applicable for the 30-day assessments (RC, DW, EJ), and one (MR) was a recent transfer from Patton State Hospital and did not require a new 30-day assessment.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure all SW Integrated assessments are completed and available to the WRP team before the seven-day WRP conference. 2. Ensure that all 30-day social histories are completed and available to the individual's WRP team members by the 30th day of admission.
d	Reliably informs the individual's interdisciplinary team about the individual's relevant social factors and educational status.	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Ensure that social histories reliably inform the individual's WRP team about the individual's relevant social factors and educational status.</p> <p>Findings: MSH did not present any data for this requirement. The progress report indicated that the statewide committee is in the process of finalizing the form.</p> <p>This monitor's review of seven assessments (ET, DA, RC, GB, TN, PS, and AA) showed that one (ET) had both the social factors and educational status, and the remaining six (DA, RC, GB, TN, PS, and AA) failed to include either the social factor or educational status.</p>

		<p>This is 14% compliance.</p> <p>Compliance: Partial.</p> <p>Current recommendations: Ensure that social histories reliably inform the individual's WRP team about the individual's relevant social factors and educational status.</p>
7	Court Assessments	
		<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Jasmine Wynn, M.D., 2. Michael Barsom, M.D., Acting Medical Director. <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Charts of six individuals under PC 1026 (OCG, BJL, TEK, JC, JD and RN). 2. Charts of six individuals under PC 1370 (JB, BTL, LRD, MR, KL and CD). 3. Draft AD #3462 Penal Code commitments. 4. Forensic Monitoring Form 1026. 5. Forensic Monitoring 1026 summary data October 2006 to February 2007. 6. Inter-Rater Reliability Check Audit 1026 (February 2007). 7. Forensic Monitoring Form 1370. 8. Forensic Monitoring 1370 summary data September 2006 to February 2007. 9. Inter-Rater Reliability Check Audit 1370 (February 2007). 10. Written feedback letters by the chair of the FRP to WRPTs regarding 1026 reports (#3) and 1370 (#8). 11. Minutes of Forensic Panel meetings (October 19, November 2 and 14 and December 12 and January 23, February 4 and February 27, 2007).

a	Each State hospital shall develop and implement policies and procedures to ensure an interdisciplinary approach to the development of court submissions for individuals adjudicated "not guilty by reason of insanity" ("NGI") pursuant to Penal Code Section 1026, based on accurate information, and individualized risk assessments. The forensic reports should include the following, as clinically indicated:	Compliance: Partial.
a.i	clinical progress and achievement of stabilization of signs and symptoms of mental illness that were the cause, or contributing factor in the commission of the crime (i.e., instant offense);	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Ensure that the facility's AD codifies all plan requirements regarding the content of 1026 court submissions.</p> <p>Findings: The facility revised AD #3462 Penal Code Commitments in order to meet requirements of the EP. The draft revision is aligned with these requirements. It has yet to be finalized and approved.</p> <p>Recommendation 2, September 2006: Implement an internal monitoring process utilizing the current tool.</p> <p>Findings: MSH used the Forensic Monitoring Form for PC 1026 to assess compliance with items D.7.a.i through D.7.a.ix. The facility's indicators are aligned with the requirements of each cell below. The monitoring data are based on a review by the Chairman or a member of the Forensic Review Panel (FRP) of all 1026 court submissions during the reporting</p>

month. Inter-rater reliability was established and ranged from 83% to 100% (February 2007). The following table is a summary of the facility's data for this cell.

	Oct	Nov	Dec	Jan	Feb	Mean
n	18	10	23	18	21	
%C	57	60	87	94	81	76

Recommendation 3, September 2006:

Ensure that the FRP reviews all PC 1026 reports and provide feedback to the WRP teams to achieve compliance.

Findings:

Since October 2006, the FRP has been reviewing all 1026 reports and providing written feedback to the WRPTs.

Other findings:

This monitor reviewed the charts of six individuals (OCG, BJL, TEK, JC, JD and RN). The Chair of the FRP, Dr. Wynn, participated in this review and concurred with the monitor's determinations of compliance regarding all items in this section. The monitor found lower rates than those reported by the facility in almost all cells in this section. Regarding this requirement, the monitor found non-compliance in four charts (OCG, TEK, JC and JD), partial compliance in one (RN) and compliance in one (BJL).

The facility's data are summarized in tables and presented under other findings for each cell below.

Current recommendations:

1. Continue to monitor this requirement.
2. Address and correct factors related to low compliance.

a.ii	acts of both verbal and physical aggression and property destruction during the past year of hospitalization and, if relevant, past acts of aggression and dangerous criminal behavior;	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Same as above.</p> <p>Findings: As above.</p> <p>Other findings:</p> <table border="1" data-bbox="869 610 1556 724"> <thead> <tr> <th></th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>n</td> <td>18</td> <td>10</td> <td>23</td> <td>18</td> <td>21</td> <td></td> </tr> <tr> <td>%C</td> <td>76</td> <td>90</td> <td>96</td> <td>78</td> <td>90</td> <td>86</td> </tr> </tbody> </table> <p>This monitor's reviews show compliance in four charts (OCG, BJL, TEK and JD), partial in one (JC) and non-compliance in one (RN).</p> <p>Current recommendations: Same as above.</p>		Oct	Nov	Dec	Jan	Feb	Mean	n	18	10	23	18	21		%C	76	90	96	78	90	86
	Oct	Nov	Dec	Jan	Feb	Mean																	
n	18	10	23	18	21																		
%C	76	90	96	78	90	86																	
a.iii	understanding of potential for danger and precursors of dangerous/criminal behavior, including instant offense;	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Same as above.</p> <p>Findings: Same as above.</p>																					

		<p>Other findings:</p> <table border="1" data-bbox="869 315 1556 428"> <thead> <tr> <th></th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>n</td> <td>18</td> <td>10</td> <td>23</td> <td>18</td> <td>21</td> <td></td> </tr> <tr> <td>%C</td> <td>65</td> <td>60</td> <td>83</td> <td>67</td> <td>86</td> <td>72</td> </tr> </tbody> </table> <p>This monitor found non-compliance in three charts (JC, JD and RN), compliance in two (OCG and BJL) and partial compliance in one (TEK).</p> <p>Current recommendations: Same as above.</p>		Oct	Nov	Dec	Jan	Feb	Mean	n	18	10	23	18	21		%C	65	60	83	67	86	72
	Oct	Nov	Dec	Jan	Feb	Mean																	
n	18	10	23	18	21																		
%C	65	60	83	67	86	72																	
a.iv	acceptance of mental illness and understanding of the need for treatment, both psychosocial and biological, and the need to adhere to treatment;	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Same as above.</p> <p>Findings: As above.</p> <p>Other findings:</p> <table border="1" data-bbox="869 1062 1556 1175"> <thead> <tr> <th></th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>n</td> <td>18</td> <td>10</td> <td>23</td> <td>18</td> <td>21</td> <td></td> </tr> <tr> <td>%C</td> <td>76</td> <td>90</td> <td>91</td> <td>100</td> <td>100</td> <td>91</td> </tr> </tbody> </table> <p>This monitor's reviews show compliance in three charts (OCG, BJL and TEK), partial compliance in two (JC and RN) and non-compliance in one (JD)</p>		Oct	Nov	Dec	Jan	Feb	Mean	n	18	10	23	18	21		%C	76	90	91	100	100	91
	Oct	Nov	Dec	Jan	Feb	Mean																	
n	18	10	23	18	21																		
%C	76	90	91	100	100	91																	

		<p>Current recommendations: Same as above.</p>																								
a.v	<p>development of relapse prevention plan (i.e., Personal Wellness Recovery Plan or Wellness Recovery Action Plan) for mental illness symptoms, including the individual's recognition of precursors and warning signs and symptoms and precursors for dangerous acts;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Same as above.</p> <p>Findings: Same as above.</p> <p>Other findings:</p> <table border="1"> <thead> <tr> <th></th> <th>Sep</th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>n</td> <td></td> <td>18</td> <td>10</td> <td>23</td> <td>18</td> <td>21</td> <td></td> </tr> <tr> <td>%C</td> <td></td> <td>78</td> <td>70</td> <td>87</td> <td>100</td> <td>100</td> <td>87</td> </tr> </tbody> </table> <p>This monitor found non-compliance in three charts (TEK, JD and RN), compliance in two (BJL and JD) and partial compliance in one (JC).</p> <p>Current recommendations: Same as above.</p>		Sep	Oct	Nov	Dec	Jan	Feb	Mean	n		18	10	23	18	21		%C		78	70	87	100	100	87
	Sep	Oct	Nov	Dec	Jan	Feb	Mean																			
n		18	10	23	18	21																				
%C		78	70	87	100	100	87																			
a.vi	<p>willingness to achieve understanding of substance abuse issues and to develop an effective relapse prevention plan (as defined above);</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Same as above.</p> <p>Findings: Same as above.</p>																								

		<p>Other findings:</p> <table border="1" data-bbox="869 350 1556 467"> <thead> <tr> <th></th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>n</td> <td>18</td> <td>10</td> <td>23</td> <td>18</td> <td>16</td> <td></td> </tr> <tr> <td>%C</td> <td>67</td> <td>67</td> <td>84</td> <td>100</td> <td>93</td> <td>82</td> </tr> </tbody> </table> <p>This monitor found compliance in one chart (BJL), non-compliance in one (OCG) and partial compliance in one (JC). This requirement does not apply to three individuals (TEK, JD and RN).</p> <p>Current recommendations: Same as above.</p>		Oct	Nov	Dec	Jan	Feb	Mean	n	18	10	23	18	16		%C	67	67	84	100	93	82
	Oct	Nov	Dec	Jan	Feb	Mean																	
n	18	10	23	18	16																		
%C	67	67	84	100	93	82																	
a.vii	previous community releases, if the individual has had previous CONREP revocations;	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Same as above.</p> <p>Findings: Same as above.</p> <p>Other findings:</p> <table border="1" data-bbox="869 1133 1556 1250"> <thead> <tr> <th></th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>n</td> <td>18</td> <td>10</td> <td>23</td> <td>18</td> <td>21</td> <td></td> </tr> <tr> <td>%C</td> <td>36</td> <td>75</td> <td>100</td> <td>100</td> <td>100</td> <td>82</td> </tr> </tbody> </table> <p>This monitor found compliance in two charts (OCG and TEK) and non-compliance in one (JD). This requirement does not apply to three individuals (BJL, JC and RN).</p>		Oct	Nov	Dec	Jan	Feb	Mean	n	18	10	23	18	21		%C	36	75	100	100	100	82
	Oct	Nov	Dec	Jan	Feb	Mean																	
n	18	10	23	18	21																		
%C	36	75	100	100	100	82																	

		<p>Current recommendations: Same as above.</p>																								
a.viii	<p>social support, financial resources, family conflicts, cultural marginalization, and history of sexual and emotional abuse, if applicable; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Same as above.</p> <p>Findings: Same as above.</p> <p>Other findings:</p> <table border="1"> <thead> <tr> <th></th> <th>Sep</th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>n</td> <td>NA</td> <td>18</td> <td>10</td> <td>23</td> <td>18</td> <td>21</td> <td></td> </tr> <tr> <td>%</td> <td>NA</td> <td>60</td> <td>100</td> <td>78</td> <td>93</td> <td>94</td> <td>85</td> </tr> </tbody> </table> <p>This monitor found non-compliance in three charts (TEK, JD and RN) and partial compliance in three (OCG, BJL and JC).</p> <p>Current recommendations: Same as above.</p>		Sep	Oct	Nov	Dec	Jan	Feb	Mean	n	NA	18	10	23	18	21		%	NA	60	100	78	93	94	85
	Sep	Oct	Nov	Dec	Jan	Feb	Mean																			
n	NA	18	10	23	18	21																				
%	NA	60	100	78	93	94	85																			
a.ix	<p>relevant medical issues, all self-harm behaviors, risks for self harm and risk of harm to others, to inform the courts and the facility where the individual will be housed after discharge.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Same as above.</p>																								

		<p>Findings: Same as above.</p> <p>Other findings:</p> <table border="1" data-bbox="869 425 1556 540"> <thead> <tr> <th></th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>n</td> <td>18</td> <td>10</td> <td>23</td> <td>18</td> <td>21</td> <td></td> </tr> <tr> <td>%C</td> <td>100</td> <td>100</td> <td>100</td> <td>0</td> <td>100</td> <td>80</td> </tr> </tbody> </table> <p>This monitor found non-compliance in three charts (JC, JD and RN), partial compliance in two (OCG and BJL) and compliance in one (OCG).</p> <p>Current recommendations: Same as above.</p>		Oct	Nov	Dec	Jan	Feb	Mean	n	18	10	23	18	21		%C	100	100	100	0	100	80
	Oct	Nov	Dec	Jan	Feb	Mean																	
n	18	10	23	18	21																		
%C	100	100	100	0	100	80																	
b	<p>Each State hospital shall develop and implement policies and procedures to ensure an interdisciplinary approach to the development of court submissions for individuals admitted to the hospital pursuant to Penal Code Section 1370, "incompetent to stand trial" ("IST"), based on accurate information and individualized risk assessments. Consistent with the right of an individual accused of a crime to a speedy trial, the focus of the IST hospitalization shall be the stabilization of the symptoms of mental illness so as to enable the individual to understand the legal proceedings and to assist his or her attorney in the preparation of the defense. The forensic</p>	<p>Compliance: Partial.</p>																					

	reports should include the following:																						
b.i	relevant clinical description of initial presentation, if available, which caused the individual to be deemed incompetent to stand trial by the court;	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Same as D.7.a.i (as applicable to PC 1370).</p> <p>Findings: MSH used the Forensic Monitoring Form for PC 1370 to assess compliance with items D.7. b.i through D.7.b.iv. The form has indicators that are aligned with the requirements of each cell below. The monitoring data are based on a review by the Chair or a member of the Forensic Review Panel (FRP) of all 1370 court submissions during the reporting month. Inter-rater reliability was established and ranged from 86% to 100% (February 2007). The following table is a summary of the facility's data for this cell.</p> <table border="1"> <thead> <tr> <th></th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>n</td> <td>54</td> <td>35</td> <td>61</td> <td>28</td> <td>41</td> <td></td> </tr> <tr> <td>%C</td> <td>94</td> <td>100</td> <td>98</td> <td>100</td> <td>100</td> <td>98</td> </tr> </tbody> </table> <p>Other findings: This monitor reviewed the charts of six individuals (JB, BTL, LRD, MR, KL and CD). The Chair of the FRP, Dr. Wynn, participated in this review and concurred with the monitor's determinations of compliance regarding all items in this section. The monitor found lower rates than those reported by the facility in almost all cells in this section. In the chart of KL, the court report was missing and could not be retrieved by staff from the HIMD. As a result, this monitor's review resulted in a determination of non-compliance in all items. Regarding this item, this monitor found non-compliance in four charts (JB, BTL, KL and CD) and compliance in two (LRD and MR).</p> <p>The facility's data are summarized in tables and presented under other findings for each</p>		Oct	Nov	Dec	Jan	Feb	Mean	n	54	35	61	28	41		%C	94	100	98	100	100	98
	Oct	Nov	Dec	Jan	Feb	Mean																	
n	54	35	61	28	41																		
%C	94	100	98	100	100	98																	

		<p>cell below.</p> <p>Current recommendations: Same as D.7.a.i (as applicable to PC 1370).</p>																					
b.ii	<p>clinical description of the individual at the time of admission to the hospital;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Same as above.</p> <p>Findings: Same as above.</p> <p>Other findings:</p> <table border="1"> <thead> <tr> <th></th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>n</td> <td>54</td> <td>35</td> <td>61</td> <td>27</td> <td>41</td> <td></td> </tr> <tr> <td>%C</td> <td>57</td> <td>71</td> <td>95</td> <td>96</td> <td>93</td> <td>82</td> </tr> </tbody> </table> <p>This monitor found non-compliance in three charts (LRD, KL and CD), partial compliance in two (BTL and MR) and compliance in one (JB).</p> <p>Current recommendations: Same as above.</p>		Oct	Nov	Dec	Jan	Feb	Mean	n	54	35	61	27	41		%C	57	71	95	96	93	82
	Oct	Nov	Dec	Jan	Feb	Mean																	
n	54	35	61	27	41																		
%C	57	71	95	96	93	82																	
b.iii	<p>course of hospital stay, describing any progress or lack of progress, response to treatment, current relevant mental status, and reasoning to support the recommendation; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Same as above.</p>																					

		<p>Findings: Same as above.</p> <p>Other findings:</p> <table border="1" data-bbox="869 425 1581 732"> <thead> <tr> <th></th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>n</td> <td>54</td> <td>35</td> <td>61</td> <td>28</td> <td>41</td> <td></td> </tr> <tr> <td>%C</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>1</td> <td>85</td> <td>94</td> <td>98</td> <td>100</td> <td>100</td> <td>95</td> </tr> <tr> <td>2</td> <td>80</td> <td>94</td> <td>97</td> <td>100</td> <td>100</td> <td>94</td> </tr> <tr> <td>3</td> <td>80</td> <td>86</td> <td>93</td> <td>100</td> <td>100</td> <td>92</td> </tr> <tr> <td>4</td> <td>96</td> <td>100</td> <td>63</td> <td>100</td> <td>50</td> <td>82</td> </tr> <tr> <td>Mean</td> <td>85</td> <td>94</td> <td>88</td> <td>83</td> <td>88</td> <td>87</td> </tr> </tbody> </table> <p>The above table contains separate compliance rates for each of the four components of this requirement.</p> <p>This monitor found partial compliance in four charts (JB, LRD, MR and CD) ad non-compliance in two (BTL and KL).</p> <p>Current recommendations: Same as above.</p>		Oct	Nov	Dec	Jan	Feb	Mean	n	54	35	61	28	41		%C							1	85	94	98	100	100	95	2	80	94	97	100	100	94	3	80	86	93	100	100	92	4	96	100	63	100	50	82	Mean	85	94	88	83	88	87
	Oct	Nov	Dec	Jan	Feb	Mean																																																				
n	54	35	61	28	41																																																					
%C																																																										
1	85	94	98	100	100	95																																																				
2	80	94	97	100	100	94																																																				
3	80	86	93	100	100	92																																																				
4	96	100	63	100	50	82																																																				
Mean	85	94	88	83	88	87																																																				
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.	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Same as above.</p> <p>Findings: Same as above.</p>																																																								

		<p>Other findings:</p> <table border="1" data-bbox="867 349 1556 467"> <thead> <tr> <th></th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>n</td> <td>54</td> <td>34</td> <td>61</td> <td>28</td> <td>41</td> <td></td> </tr> <tr> <td>%C</td> <td>0</td> <td>6</td> <td>63</td> <td>50</td> <td>50</td> <td>34</td> </tr> </tbody> </table> <p>This monitor found non-compliance in five charts (JB, BTL, MR, KL and CD) and compliance in one (LRD).</p> <p>Current recommendations: Same as above.</p>		Oct	Nov	Dec	Jan	Feb	Mean	n	54	34	61	28	41		%C	0	6	63	50	50	34
	Oct	Nov	Dec	Jan	Feb	Mean																	
n	54	34	61	28	41																		
%C	0	6	63	50	50	34																	
c	<p>Each State hospital shall establish a Forensic Review Panel (FRP) to serve as the internal body that reviews and provides oversight of facility practices and procedures regarding the forensic status of all individuals admitted pursuant to Penal Code 1026 and 1370. The FRP shall review and approve all forensic court submissions by the Wellness and Recovery Teams and ensure that individuals receive timely and adequate assessments by the teams to evaluate changes in their psychiatric condition, behavior and/or risk factors that may warrant modifications in their forensic status and/or level of restriction</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Develop and implement a procedure that specifies the duties and responsibilities of the FRP.</p> <p>Findings: MSH has yet to implement this recommendation.</p> <p>Recommendation 2, September 2006: Ensure that the panel performs the primary function of reviewing all court reports for individuals admitted under penal codes 1026 and 1370. The panel must provide feedback to WRP teams to ensure compliance with all above requirements.</p> <p>Findings: The facility has implemented this recommendation.</p>																					

		<p>Compliance: Partial.</p> <p>Current recommendations: Develop and implement a procedure that specifies the duties and responsibilities of the FRP.</p>
c.i	<p>The membership of the FRP shall include Director of Forensic Psychiatry, Facility Director or designee, Medical Director or designee, Chief of Psychology or designee, Chief of Social Services or designee, Chief of Nursing Services or designee, and Chief of Rehabilitation Services or designee. The Director of Forensic Psychiatry shall serve as the chair and shall be a board certified forensic psychiatrist. A quorum shall consist of a minimum of four FRP members or their designee.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Continue current practice and ensure that the panel performs its specified duties and responsibilities.</p> <p>Findings: The current membership of the FRP is in accord with this requirement. As mentioned earlier, the facility has yet to develop and implement a procedure that specifies the duties and responsibilities of the FRP. In general, minutes of the FRP meetings contain inadequate documentation of the panel's activities during the meetings.</p> <p>Other findings: The minutes of the FRP meetings do not adequately document activities of the panel.</p> <p>Compliance: Partial.</p> <p>Current recommendations: Ensure that minutes of the FRP meetings adequately document activities of the panel.</p>

E	Discharge Planning and Community Integration	
	<p>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.</p>	<p>Methodology:</p> <p>Interviewed: Shirin Karimi, Clinical Social Worker, Acting Chief of Social Work</p> <p>Reviewed: Charts of 24 individuals (DT, CK, CG, JL, MC, FR, MM, TP, PT, HC, AA, MH, NW, JE, VC, SW, PC, RG, EF, JM, MR, MO JA, and CH) WRP Chart Auditing Monitoring Form Psychosocial Assessment Instruction Form (30-day) Social Work Monthly Note Monitoring Tool Performance Improvement Checklist (VC and AF) Group Change Request Form Level of Care List List of Individuals Still in MSH after Six Months Program Management Meeting Minutes DMH Wellness and Recovery Plan Manual, Version 2.0, March 2007</p>
1	<p>Each State hospital shall identify at the 7-day therapeutic and rehabilitation service planning conference, and address at all subsequent planning conferences, the particular considerations for each individual bearing on discharge, including:</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Achieve continuity of the discharge process from admission to discharge through the WRP and WRP team process.</p> <p>Findings: MSH's progress report showed that 25 of the 40 Clinical Social Workers (63%) were provided with discharge training on December 13, 2006, specific to continuity between the discharge expectations and WRP.</p>

		<p>This monitor's review of six charts (AF, DS, RA, DR, JS, and ES) showed that five of them (DS, RA, DR, JS, and ES) did not address discharge issues properly to show evidence of continuity. These five individuals had issues related to discharge in the Social Work monthly progress notes yet the issues were not discussed or included in the individuals' WRPs. This is compliance of 17%.</p> <p>Other findings: Acting Chief of Social Work has made changes to inform community agency about intrafacility transfer. Furthermore, the Acting Chief of Social Work has revised the referral packet to include legal documentation for Penal Code individuals, revised family letters to include a list of available MSH support services, and revised the Intra Hospital Transfer acceptance to include contact of community agency.</p> <p>Recommendation 2, September 2006: Involve the individual in the discharge process through discussion of discharge criteria and how to meet them by attending relevant PSR Mall groups, individual therapy (as needed), and by practicing newly acquired skills in the therapeutic milieu.</p> <p>Findings: MSH's progress report indicated that all programs provide discharge, life skills, and/or CONREP groups in their PSR Malls. The Mall groups include Individual Living Skills, Discharge Planning, Discharge and Resource Planning, CONREP Beginning, CONREP Advanced, Independent Living Skills, and Life Skills.</p> <p>This monitor's review of Mall groups showed significant group participation, with groups averaging 20 to 22 participants. An increase in</p>
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		<p>the number of groups is necessary to reduce the groups to 8-10 participants.</p> <p>Recommendation 3, September 2006: Social workers must review discharge status with the WRP team and the individual at all scheduled WRP conferences involving the individual.</p> <p>Findings: MSH's progress report showed that social workers reviewed the discharge status of individuals with the WRPT at 61% of the WRPCs between September 2006 and February 2007. The data are based on the WRP Observation Monitoring Form.</p> <p>This monitor observed a WRPC (MW). The WRPT social worker (Justin Weber, CSW) presented a comprehensive set of information to the WRPT and the individual on what the individual had to do to get discharged, what was keeping the individual from meeting the discharge goals, why the individual kept returning to State Hospitals, and the skills and support systems the individual needed, including Alcohol Anonymous groups in the community and defensive driving course.</p> <p>This monitor's review of 11 WRPs for discharge criteria (DC, CG, CK, VC, SW, PC, RG, EF, JM, MR, and MO) revealed that discharge criteria progress is not updated at the WRP.</p> <p>Compliance: Partial.</p> <p>Current recommendations: 1. Ensure that discharge setting and relevant skills for that setting are</p>
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		<p>developed at the first seven-day WRP.</p> <ol style="list-style-type: none"> 2. Ensure appropriate linkage between each discharge criteria, focus of hospitalization and relevant PSR Mall groups or individual therapy (as needed) to achieve that discharge criteria. 3. Ensure that the discharge criteria and discharge status are reviewed and documented at each WRPC. 4. Ensure that the discharge criteria and discharge status are reviewed with the individual at each WRPC. 5. Develop a tool to monitor these requirements.
1a	<p>those factors that likely would foster successful discharge, including the individual's strengths, preferences, and personal life goals;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: 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.</p> <p>Findings: MSH's progress report showed that 10% of the charts reviewed (September 2006 to February 2007) utilized the individual's strengths and preferences to achieve discharge goals. The data are based on the Chart Audit Form.</p> <p>This monitor's review of five charts (ES, DT, CK, CG, and JL) showed that none of them utilized the individual's strengths and preferences to achieve discharge goals or linked them to the interventions that impacted the individual's discharge criteria.</p> <p>Recommendation 2, September 2006: The individual's life goals should be linked to one or more focus of</p>

		<p>hospitalization, with associated objectives and interventions.</p> <p>Findings: MSH's progress report showed that none of the 25 charts (0%) reviewed met this requirement. However, 10 charts linked the life goals to foci, and 10 charts had linked the life goals to objectives.</p> <p>This monitor's review of nine charts (MC, FR, MM, TP, PT, HC, AA, MH, and JL) showed that none of them linked the individuals' life goals to foci and/or the objectives and interventions. Some of the individuals' life goals were very meaningful and would have been of tremendous motivation for the individual to work towards their recovery, hope, and community integration (e.g. MC).</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that the individual's strengths and preferences are utilized to achieve discharge goals. These should be linked to the interventions that impact the individual's discharge criteria. 2. The individual's life goals should be linked to one or more foci of hospitalization, with associated objectives and interventions.
1b	the individual's level of psychosocial functioning;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Ensure that the level of psychosocial functioning (functional status) is</p>

		<p>included in the individual's present status section of the case formulation section of the WRP.</p> <p>Findings: This monitor's review of ten charts showed that four of them (PT, MC, HC, and FR) discussed the individuals' psychosocial functioning and six did not (CK, CG, MM, TP, AA, and MH).</p> <p>Recommendation 2, September 2006: Use the DMH WRP Manual in developing and updating the case formulation.</p> <p>Findings: This monitor's review of MSH's progress report showed that MSH developed and implemented a WRP tool and conducted staff training on February 2, 2007 and March 7, 2007 to teach WRP core team members the new DMH WRP Manual pertaining to engaging the individual in providing substantive input into discharge planning.</p> <p>Compliance: Partial.</p> <p>Current recommendation: 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.</p>
1c	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:

		<p>Recommendation 1, September 2006: Ensure that discharge barriers, especially difficulties in previously unsuccessful placements, are discussed with the individual at scheduled WRP conferences.</p> <p>Findings: MSH's progress report showed that 92% of the charts reviewed had documented a discussion of the individual's barriers to transitioning to a more integrated environment. The data are based on the Monthly Progress Notes Monitoring Form from September 2006 to February 2007 (the data do not identify the number of charts reviewed in September 2006 and January 2007).</p> <p>This monitor's review of 13 charts (DT, AA, CK, NW, JE, VC, SW, PC, RG, EF, JM, MR, and MO) showed that one (AA) had an entry on discharge issues. This is 7% compliance.</p> <p>An exception to this finding in the charts is the observation of a WRPC for MW. The Social Worker, Justin Webber, fully and clearly discussed the individual's previous difficulties with discharge, his current barriers to discharge, and the factors that contributed to his repeated returns to state hospitals. The individual's input was acknowledged, but did not appear to be fully documented in the WRP.</p> <p>Other findings: According to the Acting Chief of Social Work, the statewide committee was finalizing the Five-Day Integrated Social Work Assessment and 30-Day Assessment, both of which address an individual's unsuccessful placement issues.</p>
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		<p>Recommendation 2, September 2006: Include all skills training and supports in the WRP so that the individual can overcome the stated barriers.</p> <p>Findings: MSH's progress report presented data using the Chart Audit Form. However, the monitoring indicator is not specific to this requirement.</p> <p>This monitor's review of eight charts showed that five of them (PT, FR, AA, MM, and HC) included some of the skills training and support the individual needed to overcome barriers, and three (TP, MH, and JA) did not include any.</p> <p>Recommendation 3, September 2006: Report to the WRP team, on a monthly basis, the individual's progress in overcoming the barriers to discharge.</p> <p>Findings: This monitor's review of seven charts (AA, AF, DS, RA, DR, JS, and ES) showed that none of the individuals' WRPs included updates on the individual's barriers to discharge or progress in overcoming any barriers to discharge.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that discharge barriers, especially difficulties in previously unsuccessful placements, are discussed with the individual at scheduled WRP conferences.
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		<ol style="list-style-type: none"> 2. Include all skills training and supports in the WRP so that the individual can overcome the stated barriers. 3. Report to the WRP team, on a monthly basis, the individual's progress in overcoming the barriers to discharge.
1d	the skills and supports necessary to live in the setting in which the individual will be placed.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Assess skills and supports deficits the individual may have for the intended placement.</p> <p>Findings: This monitor's review of 11 charts (DC, CG, CK, VC, SW, PC, RG, EF, JM, MR, and MO) showed that none of them addressed the individual's skills and supports deficits relevant to the intended placement.</p> <p>Recommendation 2, September 2006: Assess the skills and supports that will be needed by the individual for a successful transition to the identified setting.</p> <p>Recommendation 3, September 2006: Include these skills and supports in the individual's WRP at the next scheduled conference.</p> <p>Findings: This monitor's review of 11 charts (DC, CG, CK, VC, SW, PC, RG, EF, JM, MR, and MO) showed that none of them assessed the skills and supports that the individual will need for a successful transition to the identified setting.</p>

		<p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Assess skills and supports deficits the individual may have for the intended placement. 2. Assess the skills and supports that will be needed by the individual for a successful transition to the identified setting. 3. Include these skills and supports in the individual's WRP at the next scheduled conference.
2	<p>Each State hospital shall ensure that, beginning at the time of admission and continuously throughout the individual's stay, the individual is an active participant in the discharge planning process, to the fullest extent possible, given the individual's level of functioning and legal status.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Ensure that the individual is an active participant in the discharge planning process.</p> <p>Findings: MSH presented data on the frequency of individuals' participation in the discharge planning process. The data are based on the WRP Observation Monitoring Form. This audit showed 85% compliance with this requirement (September 2006 to February 2007).</p> <p>This monitor's review of 11 charts (DC, CG, CK, VC, SW, PC, RG, EF, JM, MR, and MO) did not show any evidence that the individuals were active participants in the discharge planning process. There was no documentation that the individual's input into matters pertaining to discharge was discussed, or indications that such was not possible due to the individual's psychosocial status. This is 0% compliance.</p>

		<p>Recommendation 2, September 2006: Implement the DMH WRP Manual on discharge process</p> <p>Findings: MSH's progress report noted that MSH developed and implemented a WRP audit tool to teach WRP core team members the new DMH WRP Manual pertaining to engaging the individual in providing substantive input and discharge planning. Training was conducted on February and March 2007.</p> <p>This monitor reviewed the DMH WRP Manual, page 10, section 1.4. The Manual outlines a series of steps and stages moving the individual's recovery from admission to discharge. MSH, under its current practice, does not fully meet all the elements set forth in the Manual.</p> <p>Recommendation 3, September 2006: Prioritize objectives and interventions related to the discharge processes</p> <p>Findings: MSH's progress report noted that 17 of the 25 charts (68%) reviewed included prioritized objectives and interventions related to the discharge process.</p> <p>This monitor's review of 11 charts (DC, CG, CK, VC, SW, PC, RG, EF, JM, MR, and MO) showed that none of the charts included well-developed discharge criteria, making it difficult to determine when an objective or intervention was related to that discharge criteria. This is 0% compliance.</p>
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		<p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that the individual is an active participant in the discharge planning process. 2. Develop individualized and measurable discharge criteria. 3. Prioritize objectives and interventions related to the discharge processes.
3	<p>Each State hospital shall ensure that, consistent with generally accepted professional standards of care, each individual has a professionally developed discharge plan that is integrated within the individual's therapeutic and rehabilitation service plan, that addresses his or her particular discharge considerations, and that includes:</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Follow the established DMH WRP process for discharge planning to ensure that each individual has a professionally developed discharge plan that is integrated within the individual's WRP.</p> <p>Findings: This monitor interviewed the Acting Chief of Social Work and reviewed MSH's progress report. MSH recently developed and implemented the WRP audit tool to teach WRP core team members the new DMH WRP Manual pertaining to engaging individuals in providing input into their discharge planning.</p> <p>Compliance: Partial.</p> <p>Current recommendations: Follow the established DMH WRP process for discharge planning to ensure that each individual has a professionally developed discharge plan</p>

		that is integrated within the individual's WRP.
3a	measurable interventions regarding these discharge considerations;	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Write all interventions, including those dealing with discharge criteria, in behavioral and measurable terms as outlined in the DMH WRP Manual.</p> <p>Findings: MSH used the Chart Audit Form to assess compliance (September 2006 to February 2007). The data show 26% compliance (rate represents how many interventions, specific to discharge, were stated in behavioral and measurable terms).</p> <p>This monitor's review of ten charts (JA, MH, MC, MM, AA, HC, FR, PT, TP, and DT) showed that none of them had all the interventions written in behavioral and measurable terms.</p> <p>Other findings: In certain cases, individuals' goals are subjective and arbitrary. This can mean that the individual has no clear idea on the criteria or how to achieve it. For example, MP is held back due to, as explained to this monitor, one or two WRPT members' belief that his response to questions was slow and he did not actively participate in groups. However, MP's BY CHOICE point data did not reflect this view; and he was said to speak when he wants/has to.</p> <p>Compliance: Partial.</p>

		<p>Current recommendations: Write all interventions, including those dealing with discharge criteria, in behavioral and measurable terms.</p>
3b	the staff responsible for implement the interventions; and	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Ensure that for each intervention in the Mall or for individual therapy, clearly state the name of the staff member responsible.</p> <p>Findings: MSH's progress report noted 10% compliance, using the Chart Audit Form (September 2006 to February 2007). The compliance rate represents how often the WRPs specified the interventions, the staff providing the interventions and the frequency of the interventions.</p> <p>This monitor's review of ten charts (JA, MH, MC, MM, AA, HC, FR, PT, TP, and DT) showed that none of them had identified the name of the professional responsible for implementing the interventions for all the interventions for that individual. This is 0% compliance.</p> <p>Recommendation 2, September 2006: Confirm that the staff to be listed in the WRP is actually involved in facilitating the activity, group, or intervention.</p> <p>Findings: MSH's progress report noted that 17 of the 25 charts reviewed (68%) identified the staff members providing listed groups at the time the WRP was written.</p>

		<p>This monitor's review of nine charts (JA, MH, MC, MM, AA, HC, FR, PT, and TP) showed that five of them (JA, MC, PT, AA, FR,) did not identify the staff responsible for providing listed groups, and four of them (MH, MM, HC, and TP) correctly identified the staff responsible for providing the group. This is 44% compliance.</p> <p>Recommendation 3, September 2006: Ensure that the individual does not fall through the cracks if a staff member is no longer responsible for the individual's assigned group.</p> <p>Findings: MSH's progress report noted that treatment team and/or mall coordinator can reassign individuals to a new group using the Group Change Request if the scheduled group was no longer provided. This does not adequately reflect the requirements of this item.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that for each intervention in the Mall or for individual therapy, the name of the staff member responsible is noted. 2. Confirm that the staff to be listed in the WRP are actually involved in facilitating the activity, group, or intervention. 3. Ensure that there is a system for identifying when a staff member is no longer responsible for the individual's assigned group and that the WRPT is alerted.
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3c	The time frames for completion of the interventions.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: For each intervention in the Mall or for individual therapy, clearly state the time frame for the next scheduled review. This review should be the same as the individual's scheduled WRP conference.</p> <p>Recommendation 2, September 2006: Ensure that target dates for completion of intervention take into account the difficulty of the intervention and previous interventions, if any.</p> <p>Findings: MSH has monitoring data based on the Chart Audit form (September 2006 to February 2007). The data showed that 51% of the charts reviewed specified target dates for the achievement of each objective.</p> <p>This monitor reviewed 13 charts (DT, CK, CG, NW, JE, VC, SW, PC, RG, EF, JM, MR, and MO) showed that only six of them (DT, CG, RG, JM, MR, and NW) clearly stated the time frame for each intervention in the Mall or for individual therapy.</p> <p>Compliance: Partial.</p> <p>Current recommendations: For each intervention in the Mall or for individual therapy, clearly state the time frame for the next scheduled review. This review should be the same as the individual's scheduled WRP conference.</p>
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4	Each State hospital shall provide transition supports and services consistent with generally accepted professional standards of care. In particular, each State hospital shall ensure that:	Compliance: Partial.
4a	individuals who have met discharge criteria are discharged expeditiously, subject to the availability of suitable placements; and	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Reduce the overall number of individuals still hospitalized after referral for discharge has been made.</p> <p>Findings: This monitor's review of information from MSH's progress report data, and documents (e.g. list of individuals who met discharge criteria but are still hospitalized) and interview with the Acting Chief of Social Work, revealed that as of March 2007, there were 38 individuals who have met discharge criteria but were still awaiting placement. Those awaiting discharge include 5 adolescents on the ALOC list, 24 LPS Adults, and 9 with CONREP referrals.</p> <p>Recommendation 2, September 2006: Identify and resolve system factors that act as barriers to timely discharge.</p> <p>Findings: MSH's progress report noted that the Acting Chief of Social Work had taken a number of steps to address this requirement. She had revised the referral packets to include necessary legal documentation for Penal Code individuals and the Intra Hospital Transfer acceptance was revised to include contact of community agency. The Acting Chief of Social Work reported that reasons for delays in discharge were limited</p>

		<p>communication, charges pending, and medical issues. She also has established a process of review for adolescents beyond 60 days of referral.</p> <p>Recommendation 3, September 2006: Develop and implement a tracking and monitoring system for obtaining data on all individuals delayed from their discharge.</p> <p>Findings: A system has not been developed at this time. The Acting Chief of Social Work holds an ongoing monthly meeting with Los Angeles County. Meeting minutes suggested that delays occur due to limited communication, pending charges, and medical issues. In addition, monitoring is also conducted through the Performance Improvement Checklist for adolescents at MSH beyond 180 days. The Performance Improvement Checklists are completed by the 190th day and every 60 days until the individual is discharged.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Reduce the overall number of individuals still hospitalized after referral for discharge has been made. 2. Identify and resolve system factors that act as barriers to timely discharge. 3. Develop and implement a tracking and monitoring system for obtaining data on all individuals delayed from their discharge.
4b	Individuals receive adequate assistance in transitioning to the new setting.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Develop and implement a monitoring and tracking system to address the</p>

		<p>key elements of this requirement.</p> <p>Findings: MSH's progress report indicated that there is no monitoring and tracking system at this time to address the key elements of this requirement.</p> <p>Recommendation 2, September 2006: Ensure and document that individuals receive adequate assistance when they transition to the new setting.</p> <p>Findings: MSH's progress report noted that social workers from program III, V, and VI were to visit CONREP Los Angeles facilities to increase understanding of community needs and expectations.</p> <p>This monitor's review of five charts (DT, CK, CG, NW, and JE) showed that none of the charts identified any support system that the individual may need for transitioning upon discharge. This is 0% compliance.</p> <p>Recommendation 3, September 2006: Continue with and improve upon the current activities to aid in the transition of individuals upon discharge.</p> <p>Findings: This monitor's interview with the Acting Chief of Social Work and review of Mall group activity lists showed that programs related to discharge and related matters including Life Skills groups, Individual Living Skills groups, Discharge Planning and Resource planning groups, CONREP beginning and advanced groups, were provided in the PSR Malls.</p>
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		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure and document that individuals receive adequate assistance when they transition to the new setting. 2. Continue with current practices.
5	For all children and adolescents it serves, each State hospital shall:	<p>Compliance: Partial.</p>
5a	develop and implement policies and protocols that identify individuals with lengths of stay exceeding six months; and	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Train staff in the new policy.</p> <p>Recommendation 2, September 2006: Ensure that timely meetings and reviews are conducted to clarify delays in discharge of all children and adolescents.</p> <p>Findings: MSH's progress report noted that Program I developed and implemented the Performance Improvement Checklist for adolescents at MSH beyond 180 days. The Performance Improvement Checklist was completed by the 190th day and every 60 Days until discharge. Staff training was conducted in September 2006.</p> <p>MSH's Program Assistant maintains and tracks adolescents on the "180 Day Spreadsheet." The Performance Improvement Checklist triggers were discussed at the weekly Adolescent Program Management Meeting.</p> <p>This monitor's interview with the Acting Chief of Social Work revealed that she had set up a review system to address this recommendation.</p>

		<p>This monitor reviewed the Performance Improvement Checklist and minutes of meetings from October 2006 - March 2007. The performance checklist and meeting minutes suggested that discharge rates have improved since this system was implemented in September 2006 (as per memo from Lindsay Yeakel to Sharin Kirimi, Acting Chief of Social Work, March 22, 2007).</p> <p>Compliance: In substantial compliance.</p> <p>Current recommendations: Continue current practice.</p>
5b	<p>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.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Ensure that a review committee is established, functioning, and monitored.</p> <p>Findings: MSH's progress report noted that the Performance Improvement Checklist triggers discussion at the weekly Adolescent Program Management Meeting. The Program Director and Program Assistant attend this meeting.</p> <p>The Acting Chief of Social Work reported that review meetings established since September 2006 address discharge related issues.</p> <p>Recommendation 2, September 2006: Provide minutes of the meeting as evidence of the process.</p>

		<p>Findings: This monitor received and reviewed the minutes of meetings from Ms. Sharin Kirimi, Acting Chief of Social Work. The minutes from October 2006 - October 2007, showed that Performance Improvement Checklist were completed and discussed at these meetings.</p> <p>Recommendation 3, September 2006: Develop individualized action plan for each child or adolescent that address obstacles to discharge.</p> <p>Findings: This monitor's review showed that Program I developed and implemented the Performance Improvement Checklist for adolescents at MSH beyond 180 days. The checklist is completed by the 190th day and every 60 days until discharge. The checklist specifies discharge barriers and actions taken by the team.</p> <p>Current recommendations: Continue current practice.</p>
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F	Specific Therapeutic and Rehabilitation Services	<p>Summary of Progress:</p> <ol style="list-style-type: none"> 1. MSH has decreased the unjustified high-risk uses of benzodiazepines and anticholinergic medications. 2. MSH has reactivated the specialized clinic for management of individuals suffering from involuntary movement disorders. 3. The DMH has developed draft individualized medications guidelines regarding the use of several classes of psychoactive medications. The guidelines comport with current generally accepted professional standards. 4. MSH has maintained its practice of using appropriate instruments to monitor high-risk medication uses, uses, including PRN and STAT medications, benzodiazepines, anticholinergics and polypharmacy.
1	Psychiatric Services	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Michael Barsom, M.D., Acting Medical Director 2. Nady Hanna, M.D., Acting President of Medical Staff 3. Bala Gulasekaram, M.D., Chief of Psychiatry Department 4. Harold Plon, Pharm D, Assistant director of the Pharmacy Department 5. Michael Nunley, Standards Compliance Director 6. Arora Hendricks, RN, Director of Nursing 7. Lisa Dieckmann, Ph.D., Standards Compliance Psychologist <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Charts of 39 individuals (BKW, JC, DTP, CDR, SH, LLW, CG, JLM,

		<p>REG, MS, GAG, RS, DLK, DM, JL, GCA, DAS, VF, SM, MP, TAO, GP, MCF, JS, DTJ, OM, MCL, KL, DR, EV, JL, EV, NB, BRS, RM, NV, EW, DAS and JGH)</p> <ol style="list-style-type: none"> 2. Psychiatric Evaluation Monitoring Form 3. Psychiatric Evaluation Monitoring summary data (September 2006 to February 2007) 4. Monthly Progress Notes Monitoring Form 5. Monthly Progress Notes Monitoring summary data (September 2006 to February 2007) 6. Psychopharmacology Monitoring Form 7. Psychopharmacology Monitoring summary data (December 2006 to February 2007) 8. STAT Psychiatric Medication Auditing Form 9. DMH STAT Psychiatric Medication Auditing Form Instructions 10. TD Monitoring Form 11. TD Monitoring summary data (September 2006 to February 2007) 12. Tardive Dyskinesia Screening Monitoring Form 13. Staff Psychiatrist Manual 14. AD #3133.1 Trigger Response 15. Trigger Response WRP Conference Tracking Form 16. WRPT Responses to Activated PRN & STAT triggers 17. Minutes of the Pharmacy and Therapeutics Committee (September 14, October 9 and November 9, 2006 and January 11, 2007) 18. Adverse Drug reaction (ADR) data since September 2006 19. Last ten completed ADR reports 20. MSH ADR Process 21. Draft Drug Utilization Evaluation (DUE) Policy 22. Last ten completed medication Error Reports
1a	Each State hospital shall develop and implement policies	Current findings on previous recommendations:

	<p>and procedures to ensure system-wide monitoring of the safety, efficacy, and appropriateness of all psychotropic medication use, consistent with generally accepted professional standards of care. In particular, policies and procedures shall require monitoring of the use of psychotropic medications to ensure that they are:</p>	<p>Recommendation 1, September 2006: Develop individualized medication guidelines that include specific information regarding indications, contraindications, clinical and laboratory monitoring and adverse effects for all psychotropic and anticonvulsant medications in the formulary. The guidelines must be derived from current literature, relevant clinical experience and current generally accepted professional practice guidelines.</p> <p>Findings: The facility has yet to implement this recommendation. The DMH is in the process of finalizing individualized medication guidelines regarding the use of new-generation antipsychotic medications, some mood stabilizers (e.g. lamotrigine and divalproex) and some antidepressants (e.g. serotonin-specific reuptake inhibitors). The draft guidelines are in accord with current generally accepted professional standards.</p> <p>Recommendation 2, September 2006: Implement recommendations listed in F.1.g.</p> <p>Findings: Same as in F.1.g.</p> <p>Recommendation 3, September 2006: Implement recommendations listed in D.1.c, D.1.d and D.1.e.</p> <p>Findings: Same as in D.1.c, D.1.d and D.1.e.</p>
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		<p>Recommendation 4, September 2006: Standardize the monitoring forms and other mechanisms of review across state facilities. Ensure that compliance rates derived from internal monitoring are based on a monthly review of a stratified 20% sample. This recommendation applies to all relevant items in section F.</p> <p>Findings: Same as in D.1.a.</p> <p>Statewide efforts to consolidate and standardize all psychiatric and psychopharmacological review monitoring forms are underway. The facility has yet to achieve 20% sample sizes in this section.</p> <p>Other findings: To assess its compliance with requirements F.1.a.i through F.1.a.viii, the facility utilized the Psychiatric Evaluation Monitoring and Monthly Progress Notes Monitoring Forms. The following is an outline of the monitoring indicators that address each cell below, with item numbers as listed on each form.</p> <p>Psychiatric Evaluation Monitoring Form: <i>40. Diagnostic formulation</i> <i>41. Included the diagnostic criteria for the given diagnoses</i> <i>43. Identified target symptoms</i> <i>44. Reasons for continuing the medications individual came with</i> <i>45. Rationale for PRN</i></p> <p>Monthly Progress Notes Monitoring Form: <i>12. Rationale for current psychopharmacology plan.</i> <i>14. Benefits and risks of current psychopharmacologic treatment;</i></p>
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includes benzodiazepines, anticholinergics, and polypharmacy, if applicable.

15. Response to pharmacologic treatments.

16. Monitoring of side effects, including sedation.

19. Response to non-pharmacologic treatments, including PBS plans, if applicable.

21. Pharmacologic (Rationale for continuation of medications or proposed plans.

22. Non-pharmacologic.

23. Consultations, if applicable.

The following tables summarize the facility's monitoring data. Each table outlines the total target population (N), target population reviewed (n), sample size (%S) and compliance rate (%C). The data are aligned with the requirements of each cell (and entered for each cell) below.

		Sep	Oct	Nov	Dec	Jan	Feb	Mean
Psychiatric Evaluation Monitoring Form								
	N	680	675	666	671	60	53	
	n	31	12	22	31	52	43	
	%S	5	2	3	5	86	81	
	%C							
F1a.i	40,41, 43, 44,45	79	60	67	76	83	69	73
F1a.ii	no item	x	x	x	x	x	x	x
F1a.iii	43	84	83	64	97	90	65	81
Monthly Progress Notes								
	N	680	675	666	671	673	675	
	n	60	39	33	59	74	65	
	%S	9	6	5	9	11	10	
	%C							

	target variables and time frames;	
1a.v	monitored appropriately for side effects;	84%
1a.vi	modified based on clinical rationales;	82%
1a.vii	are not inhibiting individuals from meaningfully participating in treatment, rehabilitation, or enrichment and educational services as a result of excessive sedation; and	77%
1a.viii	Properly documented.	82%
b	Each State hospital shall monitor the use of PRN and Stat medications to ensure that these medications are administered in a manner that is clinically justified and are not used as a substitute for appropriate long-term treatment of the individual's condition.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Update the medical staff manual to include all requirements in the EP regarding high-risk medication uses, including PRN and/or STAT medications.</p> <p>Findings: The Staff Psychiatrist Manual has been updated (Sections 3.0, 3.1, 3.2 and 3.7.4) to address this recommendation.</p> <p>Recommendation 2, September 2006: Continue to monitor the use of PRN and STAT medications to ensure correction of the above deficiencies.</p> <p>Findings: The facility used the Monthly Progress Notes Monitoring Form to address this recommendation. The following is a summary of the data.</p>

Rationale for PRN medications and review of rationale for ongoing PRN/STAT medications.

	Sep	Oct	Nov	Dec	Jan	Feb	Mean
N	680	675	666	671	673	675	
n	60	39	33	59	74	65	
%S	9	6	5	9	11	10	
%C	59	72	83	50	70	64	66

During the baseline evaluation, the monitor noted six deficiencies regarding the use of PRN/STAT at MSH. The facility has developed a variety of mechanisms to address these deficiencies. The following is an outline of each deficiency followed by a summary of the facility's processes.

- There is inadequate review of the administration of PRN and/or STAT medications, including the circumstances that required the administration of drugs, the type and dose of drugs administered or the individual's response to the drugs.
- There is no evidence of a face-to-face assessment by the psychiatrist within one hour of the STAT medication.

A STAT Psychiatric Medication Auditing Form was developed to address these deficiencies as they pertain to the use of STAT medications. The facility has yet to fully implement this mechanism.

- There is no evidence of a critical review of the use of PRN medication and/or STAT medications in order to modify scheduled treatment and/or diagnosis based on this use.

		<p>The Trigger Response process is currently used to address this deficiency. In this process, the Standards Compliance Department issues a notice when a trigger occurs. The program is required to reply, using the Trigger Response Form developed by MSH. The response from the program is reviewed by the senior psychiatrist, and tracked using the Trigger Response WRP Conference Tracking Form. Data are entered into an Access database and compiled by Standards Compliance. From January 4, 2007 through February 28, 2007, 36 WRPT action responses to PRN triggers and eight WRPT action responses to STAT medication use triggers were received by Standards Compliance.</p> <ul style="list-style-type: none">• PRN medications are frequently ordered when the individual's condition, as documented in psychiatric progress notes, no longer requires this intervention. <p>To ensure adequate physician review of the use of PRN medications, the Psychiatry Department has decided to revise its procedures to have all PRN medication orders expire automatically after 14 days. This will be in effect by June 2007.</p> <ul style="list-style-type: none">• At times, more than one drug is ordered on a PRN basis without specification of the circumstances that require the administration of each drug.• PRN medications are prescribed for generic indications, typically "agitation" without specific information on the nature of behaviors that require the drug administration. <p>At present, MSH does not mechanisms to address these deficiencies.</p>
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		<p>Recommendation 3, September 2006: Consolidate the monitoring processes for PRN and/or STAT medications and for psychiatric reassessments (progress notes).</p> <p>Findings: The facility has yet to address this recommendation.</p> <p>Other findings: Chart reviews by this monitor show that, in general, the deficiencies mentioned above still exist in practice.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to monitor the use of PRN and STAT medications to ensure correction of the deficiencies noted by this monitor. 2. Consolidate the monitoring processes for PRN and/or STAT medications and for psychiatric reassessments (progress notes). 3. Ensure monitoring of a sample of 20% of the target population.
c	Each State hospital shall monitor the psychiatric use of benzodiazepines, anticholinergics, and polypharmacy to ensure clinical justification and attention to associated risks.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Update the Staff Psychiatrist Manual to include all requirements regarding high-risk medication uses, including benzodiazepines, anticholinergics and polypharmacy.</p>

		<p>Findings: The Staff Psychiatrist Manual, Section 3.2 (Psychopharmacology Reviews) currently contains requirements regarding the use of benzodiazepines, anticholinergics and polypharmacy that address this recommendation.</p> <p>Recommendation 2, September 2006: Continue to use current monitoring instruments regarding the use of benzodiazepines, anticholinergics and polypharmacy. Ensure that the justification of use is consistent with current generally accepted standards.</p> <p>Findings: The facility developed a new form, the Psychopharmacology Monitoring Form, to meet monitoring requirements. Monthly progress notes are monitored to determine acceptable justification for long-term anticholinergic and benzodiazepine use as well as justification for use of more than three routine psychotropics or more than one routine neuroleptic/antipsychotic. Monitoring is conducted by the Pharmacy department and senior psychiatrists. Data are aggregated to assess compliance and also used for the individual Physician Performance Reports. The Chief of Psychiatry sends out feedback letters based on review of the data. The following is an outline of the monitoring indicators, with item numbers as listed on the forms.</p> <p><i>Anticholinergics:</i></p> <ol style="list-style-type: none"> 1. <i>Justification for the short-term routine use of the anticholinergic;</i> 2. <i>Risks posed by the short-term routine use of the anticholinergic;</i> 3. <i>Justification for the long-term routine use (greater than 60</i>
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		<p><i>days) of the anticholinergic;</i></p> <ol style="list-style-type: none"> 4. <i>Risks posed by the long-term (greater than 60 days) routine use of the anticholinergic;</i> 5. <i>Justification for the use of the anticholinergic (regardless of the duration of treatment) for individuals with cognitive impairment, dementia, mental retardation or substance abuse;</i> 6. <i>Risks posed by the use of the anticholinergic (regardless of the duration of treatment) for individuals with cognitive impairment, dementia, mental retardation or substance abuse; and</i> 7. <i>The Mini Mental Status Examination every three months is completed for individuals who have dementia.</i> <p><i>Benzodiazepines:</i></p> <ol style="list-style-type: none"> 1. <i>Justification for the short-term routine use of the benzodiazepine;</i> 2. <i>Risks posed by the short-term routine use of the benzodiazepine;</i> 3. <i>Justification for the long-term routine use (greater than 60 days) of the benzodiazepine;</i> 4. <i>Risks posed by the long-term (greater than 60 days) routine use of the benzodiazepine;</i> 5. <i>Justification for the use of the benzodiazepine (regardless of the duration of treatment) for individuals with cognitive impairment, dementia, mental retardation or substance abuse;</i> 6. <i>Risks posed by the use of the benzodiazepine (regardless of the duration of treatment) for individuals with cognitive impairment, dementia, mental retardation or substance abuse; and</i> 7. <i>The Mini Mental Status Examination every three months is completed for individuals who have dementia.</i>
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Polypharmacy:

1. *Justification for the polypharmacy-more than three routine psychotropics.*
2. *Risks posed by the polypharmacy-more than three routine psychotropics.*
3. *Justification for the polypharmacy-more than one routine antipsychotic; and*
4. *Risks posed by the polypharmacy-more than one routine antipsychotic.*

The following table summarizes the monitoring data (N=total target population; n= number of charts reviewed that contain medication uses relevant to the monitoring indicator and %C=compliance rates).

	Dec		Jan		Feb		
I. ANTICHOLINERGICS							
N	79		80		88		
	%C	n	%C	n	%C	n	Mean
1.	39	18	67	3	80	5	62
2.	0	4	33	3	20	5	18
3.	0	4	NA	11	50	6	25
4.	0	4	0	11	25	4	8
5.	46	13	100	1	0	3	49
6.	31	13	0	1	0	3	10
7.	15	13	NA	0	NA	0	15
II. BENZODIAZEPINES							
N	66		76		169		
	%C	n	%C	n	%C	n	Mean
1.	50	2	100	1	0	2	50
2.	50	2	100	1	0	2	50
3.	33	3	100	3	0	2	44
4.	0	3	33	3	0	2	11
5.	38	8	100	8	25	8	54

	Dec		Jan		Feb		
6.	12	8	62	8	12	8	29
7.	0	2	NA	0	NA	8	0
III. POLYPHARMACY							
N	174		143		169		
	%C	n	%C	n	%C	n	Mean
1.	NA	NA	61	23	NA	NA	61
2.	NA	NA	48	23	NA	NA	48
3.	70	30	NA	NA	50	32	60
4.	63	30	NA	NA	41	32	52

Recommendation 3, September 2006:

Consolidate the process of monitoring of all individual medications within the Drug Utilization Evaluation (DUE) Process.

Findings:

The facility has yet to implement this recommendation.

Recommendation 4, September 2006:

Identify patterns and trends regarding high-risk medication uses and implement corrective and educational actions.

Findings:

The facility has yet to implement this recommendation.

Other findings:

Chart reviews by this monitor show a general decrease in the number of individuals diagnosed with polysubstance dependence who are receiving long-term treatment with lorazepam. This represents improved practice since the baseline evaluation. However, this monitor found several chart examples indicating that a number of individuals with this

		<p>diagnosis are still receiving treatment with either lorazepam (e.g. BKW and JC) or clonazepam (DTP, CDR and SH) without documented justification or appropriate analysis of risks and benefits of treatment.</p> <p>This monitor also found an overall decrease in the number of individuals with diagnoses of cognitive disorders who are receiving unjustified long-term treatment with anticholinergic agents. However, examples of unjustified long-term use were found in several charts (e.g. LLW, CG, JLM, REG, MS, RS and GAG), including individuals suffering from cognitive impairments (LLW, CG and RS).</p> <p>In reviewing the charts of individuals receiving polypharmacy, this monitor found examples of inadequate documentation of justified treatment (e.g. DLK, DM, JL, GCA, DAS and VF).</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none">1. Continue to monitor the use of benzodiazepines, anticholinergics and polypharmacy, based on DMH medication guidelines (yet to be finalized). Ensure that the justification of use is consistent with current generally accepted standards.2. Ensure monitoring of a 20% sample.3. Address and correct factors related to low compliance.4. Consolidate the process of monitoring of all drug uses within the Drug Utilization Evaluation (DUE) Process.5. Identify patterns and trends regarding high-risk medication uses and implement corrective and educational actions.
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d	<p>Each State hospital shall ensure the monitoring of the metabolic and endocrine risks associated with the use of new generation antipsychotic medications.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Same as in recommendation #1 in F.1.a</p> <p>Findings: Same as in F.1.a.</p> <p>Recommendation 2, September 2006: Same as in C.1.g.</p> <p>Findings: This recommendation is in error.</p> <p>Recommendation 3, September 2006: Same as in F.1.g.</p> <p>Findings: Same as in F.1.g.</p> <p>Other findings: This monitor reviewed the charts of individuals receiving new-generation antipsychotic agents, either as single agents or in polypharmacy. Examples include clozapine (SM and MP), clozapine and risperidone (TAO), clozapine and quetiapine (GP), olanzapine (MCF), olanzapine and quetiapine (MS and JS), ziprasidone (JS), quetiapine (DTJ), risperidone (OM, MCL, KL: and DR) and quetiapine (EV and JL). Some of these individuals are diagnosed with diabetes mellitus (MCF, JS, MS and GP), obesity (EV, DTJ, JS) or disorders of lipid metabolism (JL, JS and MP). The reviews indicate that, in general, the facility</p>
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		<p>ensures adequate laboratory monitoring of the metabolic indicators, blood counts and vital signs in individuals at risk. However, deficiencies exist in the laboratory and clinical monitoring of the risk of endocrine disorders and in the documentation of the risks and benefits of treatment and of attempts to use safer treatment alternatives.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Same as in F.1.a. 2. Same as in F.1.g.
e	<p>Each State hospital shall ensure regular monitoring, using a validated rating instrument (such as AIMS or DISCUS), of tardive dyskinesia (TD); a baseline assessment shall be performed for each individual at admission with subsequent monitoring of the individual every 12 months while he/she is receiving antipsychotic medication, and every 3 months if the test is positive, TD is present, or the individual has a history of TD.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Ensure that the Staff Psychiatrist Manual includes required criteria for monitoring of individuals with TD.</p> <p>Findings: The Staff Psychiatrist Manual (Section 3.7.3) has been revised to outline the process of management of individuals suffering from TD.</p> <p>Recommendation 2, September 2006: Ensure that the diagnoses listed on the WRP are aligned with those listed in psychiatric documentation.</p> <p>Recommendation 3, September 2006: Ensure that TD is recognized as one of the foci of hospitalization and that appropriate objectives and interventions are identified for</p>

treatment and/or rehabilitation.

Findings:

MSH revised the TD Monitoring Form to ensure that TD is included as a focus in domain #6 of the WRP. Since the baseline evaluation, the facility has developed a database that identifies individuals in the facility suffering from involuntary movement disorders, including TD. The HIMD monitored the alignment of diagnosis of TD between WRP and Psychiatric Assessments. The following is a summary of the data.

	Sep	Oct	Nov	Dec	Jan	Feb	Mean
N	Not available						
n	34	77	76	87	77	51	
%S	Not available						
%C	88	65	60	80	74	53	70

Other findings:

MSH developed a new form, the Tardive Dyskinesia Screening Monitoring Form, to identify individuals with a history of tardive dyskinesia. The form has yet to be implemented.

The facility used the Psychiatric Monthly Progress Notes to assess compliance with the required schedule of AIMS monitoring. The following is a summary of the data.

AIMS - Quarterly, if applicable (positive AIMS)

	Sep	Oct	Nov	Dec	Jan	Feb	Mean
N	680	675	666	671	673	675	
n	60	39	33	59	74	65	
%S	9	6	5	9	11	10	

	Sep	Oct	Nov	Dec	Jan	Feb	Mean
%C	21	67	8	16	80	11	34

This monitor reviewed the charts of all individuals identified on the TD list (NB, BRS, RM, NV and EW) as well as two individuals with diagnosis of TD but not identified on the list (DAS and JGH). The reviews show the following deficiencies:

1. The WRPs do not identify the disorder despite documentation in the last annual psychiatric assessment of TD as a current diagnosis (NB).
2. TD is identified as a diagnosis (NV) or rule out diagnosis (EW), but the psychiatric notes indicate inadequate clinical monitoring.
3. There is documented history of positive AIMS, without evidence of any clinical monitoring in the past six months (BRS).
4. The required schedule of quarterly AIMS is not implemented (NB, BRS, RM, NV, EW, DAS and JGH)

Compliance:

Partial.

Current recommendations:

1. Ensure accuracy of the TD database.
2. Address (and correct) factors related to low compliance.
3. Ensure that the diagnoses listed on the WRP are aligned with those listed in psychiatric documentation.
4. Ensure that TD is recognized as one of the foci of hospitalization and that appropriate objectives and interventions are identified for treatment and/or rehabilitation.
5. Continue to monitor this requirement.

f	<p>Each State hospital shall ensure timely identification, reporting, data analyses, and follow up remedial action regarding all adverse drug reactions ("ADR").</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Revise the data collection tool to include the newly adopted Naranjo algorithm.</p> <p>Recommendation 2, September 2006: Increase reporting of ADRs and provide instruction to all clinicians regarding significance of and proper methods in reporting ADRs.</p> <p>Recommendation 3, September 2006: Develop a policy and procedure regarding ADRs that includes an updated data collection tool. The procedure and the tool must correct the deficiencies identified above.</p> <p>Recommendation 4, September 2006: Improve current tracking log and data analysis systems to provide adequate basis for identification of patterns and trends of ADRs.</p> <p>Recommendation 5, September 2006: Develop and implement an intensive case analysis procedure based on established severity/outcome thresholds. The analysis must include proper discussion of history/circumstances, preventability, contributing factors and recommendations.</p> <p>Findings: MSH has yet to implement these recommendations. The projected date for implementation is June 2007.</p>

		<p>Other findings: The monitor found the same deficiencies identified in the baseline assessment.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Revise the data collection tool to include the newly adopted Naranjo algorithm. 2. Increase reporting of ADRs and provide instruction to all clinicians regarding significance of and proper methods in reporting ADRs. 3. Develop a policy and procedure regarding ADRs that includes an updated data collection tool. The procedure and the tool must correct the deficiencies identified in the baseline assessment. 4. Improve current tracking log and data analysis systems to provide adequate basis for identification of patterns and trends of ADRs. 5. Develop and implement an intensive case analysis procedure based on established severity/outcome thresholds. The analysis must include proper discussion of history/circumstances, preventability, contributing factors and recommendations.
g	<p>Each State hospital shall ensure drug utilization evaluation ("DUE") occurs in accord with established, up-to-date medication guidelines that shall specify indications, contraindications, and screening and monitoring requirements for all psychotropic medications; the guidelines shall be in accord with current professional literature.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Same as recommendation #1 in F.1.a.</p> <p>Findings: Same as in F.1.a.</p>

	<p>A verifiably competent psychopharmacology consultant shall approve the guidelines and ensure adherence to the guidelines.</p>	<p>Recommendation 2, September 2006: Develop and implement a policy and procedure to codify a DUE system based on established individualized medication guidelines.</p> <p>Findings: The facility developed a draft DUE policy and procedure. The draft DUE policy provides guidelines regarding the method of evaluation of medication or devices that are high volume, high cost, high-risk of toxicity or adverse events.</p> <p>Recommendation 3, September 2006: Ensure systematic review of all medications, with priority given to high-risk, high-volume uses.</p> <p>Findings: According to the draft Drug Utilization Evaluation Policy (developed in February 2007), one DUE will be completed monthly. Since the baseline evaluation, MSH has conducted three reviews (anticholinergics, polypharmacy and TD management). The facility reports these reviews as meeting criteria for DUEs. However, the reviews fall short in that they do not include analysis and conclusions regarding problematic trends/patterns and follow up corrective actions.</p> <p>Recommendation 4, September 2006: Determine the criteria by which the medications are evaluated, the frequency of evaluation, the indicators to be measured, the DUE data collection form, acceptable sample size, and acceptable thresholds of compliance.</p>
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		<p>Findings: The facility has yet to implement this recommendation. The current procedure regarding DUE does not address the recommendation.</p> <p>Recommendation 5, September 2006: Ensure proper aggregation and analysis of DUE data to determine practitioner and group patterns and trends.</p> <p>Findings: MSH has yet to implement this recommendation.</p> <p>Recommendation 6, September 2006: Ensure that the individualized medication guidelines are continually updated to reflect current literature, relevant clinical experience and current professional practice guidelines.</p> <p>Findings: The facility has yet to implement this recommendation.</p> <p>Recommendation 7, September 2006: Develop and implement a mechanism to ensure that the psychopharmacology consultant is utilized to satisfy the requirements of the EP.</p> <p>Findings: The facility has contracts with two part-time consultants who are university-affiliated. All Therapeutic Review Committee (TRC) consults are initially screened by MSH's senior psychiatrists. The senior psychiatrists complete consultations in the following situations:</p>
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		<ol style="list-style-type: none"> 1. When doses specified in the guidelines are exceeded; and 2. Use of polypharmacy and long-term use of benzodiazepines and anticholinergics. <p>Senior psychiatrists refer more complex consultations to the psychopharmacology consultants, including:</p> <ol style="list-style-type: none"> 1. Refractory conditions; 2. Individuals with severe management behaviors not responding to medication; 3. ECT referrals; and 4. Use of psychopharmacology during pregnancy <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Same as recommendation #1 in F.1.a. 2. Develop and implement a DUE system based on established individualized medication guidelines. 3. Ensure systematic review of all medications, with priority given to high-risk, high-volume uses. 4. Determine the criteria by which the medications are evaluated, the frequency of evaluation, the indicators to be measured, the DUE data collection form, the sample size, and acceptable thresholds of compliance. 5. Ensure that the individualized medication guidelines are continually updated to reflect current literature, relevant clinical experience and current professional practice guidelines.
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h	<p>Each State hospital shall ensure documentation, reporting, data analyses, and follow up remedial action regarding actual and potential medication variances ("MVR") consistent with generally accepted professional standards of care.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Develop and implement a data collection tool to assist staff in reporting potential and actual variances in all possible categories of variances.</p> <p>Findings: The facility has not implemented this recommendation. Instead, the facility has a tool that is completed by nursing regarding actual variances and another mechanism completed by pharmacy regarding three categories of potential variances (prescribing variances, variances identified by pharmacy and variances identified by nursing). These tools are not integrated and they represent fragments of a system that ignores many potential variances and has little utility for performance improvement purposes. In general, the tools do not adequately address the deficiencies that were identified by the monitor in the baseline report.</p> <p>Recommendation 2, September 2006: Provide instruction to all clinicians regarding the significance of and proper methods in MVR.</p> <p>Findings: The medical staff indicates that verbal instructions were provided at the Physician Department Meeting (March 7, 2007). The facility does not have written guidelines that adequately address this recommendation.</p> <p>Recommendation 3, September 2006: Develop a policy and procedure regarding MVR that includes a data</p>
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		<p>collection tool. The procedure and the tool must correct the deficiencies identified above.</p> <p>Recommendation 4, September 2006: Develop and implement adequate tracking log and data analysis systems to provide the basis for identification of patterns and trends related to medication variances.</p> <p>Recommendation 5, September 2006: Develop and implement an intensive case analysis procedure based on established severity/outcome thresholds. The analysis must include proper discussion of history/ circumstances, preventability, contributing factors and recommendations.</p> <p>Recommendation 6, September 2006: Ensure that MVR is a non-punitive process.</p> <p>Findings: The facility has yet to implement these recommendations.</p> <p>Other findings: The monitor's findings are unchanged from the baseline assessment.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a policy and procedure regarding MVR that includes a revised data collection tool. The procedure and the revised tool must address the deficiencies identified in the baseline
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		<p>assessment report.</p> <ol style="list-style-type: none"> 2. Provide instruction to all clinicians regarding significance of and proper methods in MVR. 3. Develop and implement tracking log and data analysis systems. 4. Provide educational programs to address trends in the occurrence of ADRs. 5. Develop and implement an intensive case analysis procedure based on established severity/outcome thresholds. The analysis must include proper discussion of history/ circumstances, preventability, contributing factors and recommendations.
i	<p>Each State hospital shall ensure tracking of individual and group practitioner trends, including data derived from monitoring of the use of PRNs, Stat medications, benzodiazepines, anticholinergics, and polypharmacy, and of ADRs, DUE, and MVR consistent with generally accepted professional standards of care.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Same as in F.1.a. through F.1.h.</p> <p>Findings: Same as in F.1.a through F.1.h.</p> <p>Recommendation 2, September 2006: Improve IT resources to the pharmacy department to facilitate the development of databases regarding medication use.</p> <p>Findings: The facility has yet to implement this recommendation.</p> <p>Compliance: Partial.</p>

		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Same as in F.1.a through F.1.h. 2. Improve IT resources to the pharmacy to facilitate the development of databases regarding medication use.
j	Each State hospital shall ensure feedback to the practitioner and educational/corrective actions in response to identified trends consistent with generally accepted professional standards of care.	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Same as above.</p> <p>Findings: Same as above.</p> <p>Compliance: Non-compliance.</p> <p>Current recommendations: Same as above.</p>
k	Each State hospital shall ensure integration of information derived from ADRs, DUE, MVR, and the Pharmacy & Therapeutics, Therapeutics Review, and Mortality and Morbidity Committees consistent with generally accepted professional standards of care.	<p>Current findings on previous recommendations:</p> <p>Recommendation, September 2006: Same as above.</p> <p>Findings: Same as above.</p> <p>Compliance: Non-compliance.</p>

		<p>Current recommendations: Same as above.</p>
I	<p>Each State hospital shall ensure that all physicians and clinicians are verifiably competent, consistent with generally accepted professional standards of care, in appropriate medication management, interdisciplinary team functioning, and the integration of behavioral and pharmacological treatments.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Finalize the physician's performance profile and ensure that the quality indicators address and integrate all the medication management requirements outlined in section F.</p> <p>Findings: The Physician Performance Profile contains indicators for DUE, benzodiazepines, anticholinergics and polypharmacy. These changes are intended to incorporate requirements of the EP.</p> <p>Recommendation 2, September 2006: Ensure that the Staff Psychiatrist Manual includes clear expectations regarding medication management that are aligned with all the requirements in section F.</p> <p>Findings: The facility has yet to comply with this recommendation pending finalization and implementation of the DMH individualized medication guidelines.</p> <p>Recommendation 3, September 2006: Same as in D.1.b, D.1.c, D1.f. and F.1.a through F.1.h.</p> <p>Findings: Same as in D.1.b, D.1.c, D1.f. and F.1.a through F.1.h.</p>

		<p>Compliance: Partial.</p> <p>Current recommendations: Same as in D.1.b., D.1.c., D.1.f.viii. and F.1.a. through F.1.h.</p>
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:	<p>Compliance: Partial.</p>
m.i	all individuals prescribed continuous anticholinergic treatment for more than two months;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Same as in F.1.c.</p> <p>Findings: The facility used the Psychopharmacology Monitoring Form (Anticholinergics) to assess its compliance. The following is an outline of the indicators (with numbers as listed on the form) and compliance data (N=total target population, n=number of charts reviewed that include documentation applicable to the indicator, %C=compliance rate):</p> <p><i>3. Justification for the long term routine use (greater than 60 days) of the anticholinergic.</i></p> <p><i>4. Risks posed by the long term routine use (greater than 60 days) of the anticholinergic.</i></p>

	Dec		Jan		Feb		Mean
N	79		80		88		
Indicator #	%C	n	%C	n	%C	n	
3	0	4	NA	11	50	6	25
4	0	4	0	11	25	4	8

Recommendation 2, September 2006:

Ensure that this practice is triggered for review by the facility's psychopharmacology consultant, with corrective follow-up actions by the psychiatry department.

Findings:

Recently, MSH began a process to implement this recommendation. The facility aggregates data derived from the Psychopharmacology Monitoring Form. The data are used to develop practitioner profile. The senior psychiatrist sends out a letter to all psychiatrists who have not adhered to the most current guidelines. The facility has yet to implement performance improvement/educational measures.

Other findings:

The monitor's findings are the same as in F.1.c

Current recommendations:

1. Same as in F.1.c.
2. Ensure that this practice is triggered for review by the facility's psychopharmacology consultant, with corrective follow-up actions by the psychiatry department.

m.ii all elderly individuals and individuals with cognitive disorders who are prescribed continuous

The facility has data based on the Psychopharmacology Monitoring Form. The following is a summary:

	<p>anticholinergic treatment regardless of duration of treatment;</p>	<p>5. Justification for the use of the anticholinergic (regardless of the duration of treatment) for individuals with cognitive impairment, dementia, mental retardation, or substance abuse</p> <p>6. Risks posed by the use of the anticholinergic (regardless of the duration of treatment) for individuals with cognitive impairment, dementia, mental retardation, or substance abuse</p> <p>7. The Mini Mental Status Exam q three months is completed for individuals who have dementia.</p> <table border="1" data-bbox="1014 610 1906 857"> <thead> <tr> <th></th> <th colspan="2">Dec</th> <th colspan="2">Jan</th> <th colspan="2">Feb</th> <th></th> </tr> <tr> <th colspan="8">I. ANTICHOLINERGIC</th> </tr> <tr> <th>N</th> <th colspan="2">79</th> <th colspan="2">80</th> <th colspan="2">88</th> <th></th> </tr> <tr> <th>Indicator</th> <th>%C</th> <th>n</th> <th>%C</th> <th>n</th> <th>%C</th> <th>n</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>5</td> <td>46</td> <td>13</td> <td>100</td> <td>1</td> <td>0</td> <td>3</td> <td>49</td> </tr> <tr> <td>6</td> <td>31</td> <td>13</td> <td>0</td> <td>1</td> <td>0</td> <td>3</td> <td>10</td> </tr> <tr> <td>7</td> <td>15</td> <td>13</td> <td>NA</td> <td>0</td> <td>NA</td> <td>0</td> <td>15</td> </tr> </tbody> </table> <p>Other findings: Same as above.</p> <p>Current recommendations: Same as above.</p>		Dec		Jan		Feb			I. ANTICHOLINERGIC								N	79		80		88			Indicator	%C	n	%C	n	%C	n	Mean	5	46	13	100	1	0	3	49	6	31	13	0	1	0	3	10	7	15	13	NA	0	NA	0	15
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7	15	13	NA	0	NA	0	15																																																			
m.iii	<p>all individuals prescribed benzodiazepines as a scheduled modality for more than two months;</p>	<p>The facility used the Psychopharmacology Monitoring Form (Benzodiazepines) to report data that are summarized as follows:</p> <p>3. Justification for the long term routine use (greater than 60 days) of the benzodiazepine</p> <p>4. Risks posed by the long term routine use (greater than 60 days) of the benzodiazepine</p>																																																								

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m.iv	all individuals prescribed benzodiazepines with diagnoses of substance abuse or cognitive impairments, regardless of duration of treatment; and	<p data-bbox="1010 678 1822 743">The facility used the Psychopharmacology Monitoring Form (Benzodiazepines) to report data that are summarized as follows:</p> <p data-bbox="1010 789 1871 889"><i>5. Justification for the use of the benzodiazepine (regardless of the duration of treatment) for individuals with cognitive impairment, dementia, mental retardation, or substance abuse</i></p> <p data-bbox="1010 902 1850 1003"><i>6. Risks posed by the use of the benzodiazepine (regardless of the duration of treatment) for individuals with cognitive impairment, dementia, mental retardation, or substance abuse</i></p> <p data-bbox="1010 1016 1822 1081"><i>7. The Mini Mental Status Exam q three months is completed for individual who have dementia.</i></p> <table border="1" data-bbox="1010 1117 1902 1360"> <thead> <tr> <th colspan="9">II. BENZODIAZEPINE</th> </tr> <tr> <th></th> <th></th> <th colspan="2">Dec</th> <th colspan="2">Jan</th> <th colspan="2">Feb</th> <th></th> </tr> <tr> <th>N</th> <th></th> <th colspan="2">66</th> <th colspan="2">76</th> <th colspan="2">169</th> <th></th> </tr> <tr> <th>Indicator</th> <th>%C</th> <th>n</th> <th>%C</th> <th>n</th> <th>%C</th> <th>n</th> <th>Mean</th> <th></th> </tr> </thead> <tbody> <tr> <td>5</td> <td>38</td> <td>8</td> <td>100</td> <td>8</td> <td>25</td> <td>8</td> <td>54</td> <td></td> </tr> <tr> <td>6</td> <td>12</td> <td>8</td> <td>62</td> <td>8</td> <td>12</td> <td>8</td> <td>29</td> <td></td> </tr> <tr> <td>7</td> <td>0</td> <td>2</td> <td>NA</td> <td>0</td> <td>NA</td> <td>8</td> <td>0</td> <td></td> </tr> </tbody> </table>	II. BENZODIAZEPINE											Dec		Jan		Feb			N		66		76		169			Indicator	%C	n	%C	n	%C	n	Mean		5	38	8	100	8	25	8	54		6	12	8	62	8	12	8	29		7	0	2	NA	0	NA	8	0	
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		<p>Other findings: Same as above.</p> <p>Current recommendations: Same as above.</p>
m.v	all individuals with a diagnosis or evidencing symptoms of tardive dyskinesia.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Same as in F.1.e.</p> <p>Findings: Same as in F.1.e.</p> <p>Recommendation 2, September 2006: Ensure the proper identification and management of TD as well as proper frequency of clinical assessments. The management should include follow-up at a specialized movement disorders clinic run by a neurologist with relevant training and experience.</p> <p>Findings: MSH has a system for the identification of individuals suffering from TD or other movement disorders. Newly admitted individuals are to receive AIMS examination at admission. All individuals with positive AIMS should be followed quarterly if they have diagnoses of TD or positive AIMS. The facility has developed a database for individuals suffering from TD or other involuntary disorders. The main purpose of the database is to refer these individuals to the TD clinic. The clinic was recently reactivated after approximately one year hiatus. The</p>

		<p>clinic is run by psychiatric and neurology consultants with expertise in the identification and management of involuntary movement disorders.</p> <p>Recommendation 3, September 2006: Ensure that the facility's monitoring data are based on a review of all individuals diagnosed with TD.</p> <p>Findings: The facility uses the TD Monitoring Form to screen all individuals and develop a TD database. See above and findings in F.1.e.</p> <p>Other findings: As mentioned in F.1.e, this monitor found examples of individuals suffering from TD but not identified on the database and individuals with current or history of TD who are not receiving the required monitoring using AIMS.</p> <p>Current recommendations: Same as F.1.e.</p>
m.vi	all individuals diagnosed with dyslipidemia, and/or obesity, and/or diabetes mellitus who are prescribed new generation antipsychotic medications	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Same as in F.1.d. and F.1.g.</p> <p>Findings: Same as in F.1.d. and F.1.g.</p> <p>Other findings: Same as in F.1.d. and F.1.g.</p>

		<p>Current recommendations: Same as in F.1.d. and F.1.g.</p>
n	<p>Each State hospital shall ensure that the medication management of individuals with substance abuse disorders is provided consistent with generally accepted professional standards of care.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Same as in C.2.o and F.1.c.</p> <p>Findings: Same as in C.2.o and F.1.c.</p> <p>Other findings: Same as in C.2.o and F.1.c.</p> <p>Compliance: Partial.</p> <p>Current recommendations: Same as in C.2.o, F.1.c and F.1.m.iii.</p>
o	<p>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.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Develop a formalized mechanism to track and ensure consistent and sufficient participation by all psychiatrists in the facility in order to comply with this requirement.</p> <p>Findings: Review of the facility's records show that 38 psychiatrists (89% of</p>

		<p>current staff) have completed the requirement during the past year (March 1, 2006 to February 28, 2007).</p> <p>Compliance: Partial.</p> <p>Current recommendations: Ensure full and consistent compliance with this requirement.</p>
2	Psychological Services	
	<p>Each State hospital shall provide adequate and appropriate psychological supports and services that are derived from evidence-based practice or practice-based evidence and are consistent with generally accepted professional standards of care, to individuals who require such services; and:</p>	<p>Methodology:</p> <p>Interviewed:</p> <ol style="list-style-type: none"> 1. Wilma Fuentes, RN 2. Latasha Fields, PT 3. Crystal Amey, PT 4. Eric McMullen, PT 5. Gretchen Hunt, PT, Unit Supervisor 6. Edwin Poon, Ph.D., psychologist 7. Sean Johnson, LVN, Assistant BY CHOICE coordinator 8. Swati Roy, Ph.D., Acting Chief of Psychology 9. Edwin Poon, Ph.D., Psychologist 10. Brian Hough, Ph.D., Psychologist 11. Richard Ettelson, Ph.D., Psychologist 12. Noor Damavandi, Ph.D., Psychologist 13. Kirk Hartley, Ph.D., Psychologist 14. Matthew Jogernson, Ph.D., Psychologist 15. Amy Choi, Ph.D., Psychologist 16. Cheryl Kempinsky, Ph.D., Psychologist 17. Walt Sullivan, Ph.D., Psychologist

18. Larry Ledesma, Ph.D., Psychologist
19. Yih-Jia Chang, Ph.D., Psychologist
20. Clark Brickel, Ph.D., Psychologist
21. H. Feinberg, Ph.D, Psychologist
22. Kelly Cohlberg, Ph.D., Psychologist
23. Kenneth Layman, Program Director
24. Rachel Potts
25. Five Pre-Doctoral Interns (Susan Shifflett, Alisha Christiane Bent, Ashvind Singh, Erin Lacy and Jan Bestwick)

Reviewed:

1. Charts of 57 individuals (FP, AA, PT, MM, CH, JC, GC, MC, HC, AF, JG, DH, JL, SM, RM, LM, TP, KS, RS, JS, CW, AW, PW, DY, RG, LP, VR, WF, NM, WW, MH, CD, SW, AL, PD, SO, CS, SB, ML, JD, SJ, CG, FR, AB, MW, RH, KR, NR, and MP)
2. DMH WRP observation monitoring form instructions
3. DMH Psychology Manual (March 2007)
4. DMH Wellness and Recovery Plan Manual, V2, March 2007
5. Neuropsychology Service Referral Tracking Database
6. List of individuals by program by unit needing behavioral interventions
7. List of individuals on Positive Behavioral Support Plan
8. List of individuals needing cognitive and academic assessments within 30 days of admission
9. List of individuals admitted prior to June 1, 2006
10. List of individuals by program by unit with "rule-out," "deferred," "no diagnosis," and "NOS" diagnoses
11. List of individuals who met discharge criteria and are still hospitalized
12. List of membership to BCC

		<p>13. List of individuals referred/need neuropsychological services 14. List of individuals on PBS plans 15. List of individuals by program by unit by scheduled hours of Mall. groups/individual therapy by actual hours attended 16. List of individuals under 1:1 monitoring and/or restraints and seclusions 17. List of DCAT training record 18. List of Seclusion and Restraint Users 19. MSH PBS manual 20. Standard Psychological Assessment Protocols 21. Missed appointment list 22. Survey of BY CHOICE Staff Competency 23. BY CHOICE Manual-Revised (March 2007) 24. MSH BY CHOICE Staff Competency Evaluation 25. Individuals' BY CHOICE satisfaction survey 26. Curriculum Committee Meeting Minutes 27. Neuropsychology Service Referral Tracking Database 28. Psychologist by Program by Unit by Individual Assessed 29. Service Order # 129.1, Psychological Services</p> <p>Observed:</p> <ol style="list-style-type: none"> 1. Four individuals (MW, JK, HC, and FR) 2. Wellness and Recovery Planning Conferences (MW and JK) 3. Mall Groups (DBT, Welcome to Reality, and Rational Emotive Behavioral Therapy)
a	Each State hospital shall ensure that it has positive behavior support teams (with 1 team for each 300 individuals, consisting of 1 clinical psychologist, 1 registered nurse, 2 psychiatric technicians (1 of whom may	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Revise the statewide PBS manual to include clear guidelines on the</p>

	<p>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:</p>	<p>referral process (i.e., what triggers a referral, who is responsible for making the referral and what is expected once a referral is made, timelines).</p> <p>Findings: This monitor's review of the draft Statewide PBS manual (March 2007), showed that clear guidelines have been identified on the referral process (page 12).</p> <p>Recommendation 2, September 2006: Include in the PBS manual clear guidelines on how structural and functional assessments are to be performed.</p> <p>Recommendation 3, September 2006: Identify in the manual specific evidence-based tools to use for each type of assessment.</p> <p>Findings: This monitor's review of the Statewide PBS manual (March 2007) showed that the manual included clear guidelines on how structural and functional assessments were to be performed (page 13), with evidence-based tools for each type of assessment. Furthermore, ways to gather information and factors to consider in conducting these assessments were also included.</p> <p>Recommendation 4, September 2006: Use the terms Behavior Guidelines and PBS plans instead of Type A and Type B plans, which are not meaningful to staff or the individuals.</p>
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		<p>Findings: This monitor's review of documents showed that the terms Type A and Type B plans are no longer in use. Documentation of the usage of the term behavior guidelines are found in PBS Special Order 129.1, PBS-BCC Checklist, and in MSH AD: Positive Behavior Support # 3131. The PBS-BCC checklist still includes the identifier as Type-A and Type-B.</p> <p>This monitor's interview with psychologists showed they used the term behavior guidelines without exception.</p> <p>This monitor's review of DMH Psychology Manual under Behavior Guidelines (page 20, 4.1.1.) revealed a conflict in the way the section reads. The section reads to suggest that behavior guidelines are indicated when b) The maladaptive behaviors have responded positively to the efforts of the Wellness and Recovery Team (e.g. reallocation of BY CHOICE points, modifying mall group enrollment, individual therapy).</p> <p>Recommendation 5, September 2006: Recruit an additional PBS team.</p> <p>Findings: This monitor's review of documentation and interviews with staff showed MSH has two PBS teams. However, the teams are not fully operational. One team lacks a data analyst, and the other lacks a nurse and a data analyst. The nurse in the second team is out due to injury.</p> <p>Other Findings: This monitor's interview with MSH's PBS teams revealed that Nurses and Psychiatric Technicians perform mandatory overtime work. The overtime work negatively affects both the staff who have to work</p>
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overtime and the PBS teams. The staff members who work overtime are treated as "PBS team members" by the unit staff during their overtime duties and placed in front as "crisis teams" putting them in harms-way. The PBS team finds that the staff who work overtime are often unable to attend training and leave meetings early for their overtime work.

Recommendation 6, September 2006:

Ensure that all PBS psychologists use the PBS model as currently identified in the literature.

Findings:

MSH's progress report showed that 44% of the psychologists use the PBS model as currently identified in the literature. Using the Psychology Monitoring form, the facility has data summarized as follows (The monitoring procedure was modified in November 2006. Months prior to November 2006 were not used in calculating the mean):

Behavioral interventions, which include positive behavior support plans, are based on a positive behavior supports model and do not include the use of aversive or punishment contingencies.

	Oct	Nov	Dec	Jan	Feb	Mean
N	-	-	17	27	24	
n	-	-	11	27	24	
%S	-	-	65	100	100	
%C	-	-	63	25	44	44

This monitor's review of the PBS models with the PBS team members showed that four of the seven had a good working knowledge of the PBS models. This is 57% compliance. A number of PBS team members

		<p>requested additional training especially in understanding when, why, and how to design intervention plans; collect and analyze data, and case conferencing.</p> <p>Recommendation 7, September 2006: Provide Positive Behavior Supports training to all PBS team members. Specifically, train these members on the reliable use of evidence-based tools.</p> <p>Findings: This monitor's review of PBS training showed that the Chief CRIPA Consultant provided training on December 13 and 14, 2006; January 9 and 10, 2007; and February 13, 2007. Additional training was provided by consultant Angela Adkins.</p> <p>Recommendation 8, September 2006: Standardize the referral system and the format for developing PBS structural and functional assessments across all facilities.</p> <p>Findings: This monitor's review of the draft Statewide PBS manual (March 2007), showed that guidelines for referrals and format for developing PBS structural and functional assessments were standardized (page 13).</p> <p>Recommendation 9, September 2006: Recruit data analysts for all PBS teams.</p> <p>Findings: MSH's progress report indicated that the position "Data Analyst" is not a DMH civil service classification. MSH has worked to hire data analyst</p>
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		<p>support through other civil service positions similar to a Data Analysts.</p> <p>This monitor's review of the status of MSH's PBS teams with the Chief of Psychology and PBS team members revealed that MSH still does not have data analysts for its PBS teams.</p> <p>This monitor's review of the PBS manual showed that one of the psychiatric technicians and data analyst can be a behavior specialist. Thus, MSH can hire a behavior specialist if the title 'data analyst' is not recognized by the civil service job code.</p> <p>Recommendation 10, September 2006: Ensure senior psychologists' primary duties involve monitoring and mentoring psychology staff and specialist team members.</p> <p>Findings: This monitor interviewed the Acting Chief of Psychology who reported that two senior psychologists (Richard Ettelson, Ph.D., and Brian Hough, Ph.D.), were responsible to train and mentor unit psychologists. A review of the senior psychologists' training and mentoring logs showed that they regularly met with the psychologists they train and mentor. Sample topics listed in their logs included discussion on assessments, DSM-IV checklists, Integrated Psychology Assessments, and neuropsychological and cognitive assessments. Psychological services AD#0151 Addresses this requirement.</p> <p>Recommendation 11, September 2006: Ensure that the Chief of Psychology is given the necessary responsibility in hiring psychologists with specific education, training, and experience to suit departmental needs.</p>
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		<p>Recommendation 12, September 2006: Ensure that the Chief of Psychology is given the necessary clinical and administrative authority to supervise all senior psychologists involved in monitoring and mentoring psychologists.</p> <p>Findings: This monitor's interview with the Acting Chief of Psychology revealed that the Chief of Psychology is granted the duty and privilege of participating in the hiring process along with the Human Resource Department, with authority to determine the appropriate candidate based on departmental needs.</p> <p>This monitor's review of MSH's organizational chart, psychology manual, and AD#1051 showed evidence that the Chief of Psychology was given the clinical and administrative authority to supervise psychologists.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that all PBS psychologists use the PBS model as currently identified in the literature. 2. Provide Positive Behavior Supports training to all PBS team members. Specifically, train these members on the reliable use of evidence-based tools. 3. Recruit data analysts for all PBS teams. 4. Ensure that PBS team members do not have other duties that conflict with their full participation in PBS activities. 5. Ensure that the need for Behavior Guidelines statement in the DMH Psychology Manual is written correctly.
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		6. Revise the PBS-BCC Checklist to remove the Type-A and Type-B identifiers.
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	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Ensure that all PBS staff members receive systematic training in all aspects of the PBS plans, including the relationship between PBS and recovery principles.</p> <p>Findings: MSH's progress report revealed that the Chief CRIPA Consultant provided training on December 13 and 14, 2006; January 9 and 10, 2007; and February 13, 2007. Training was also provided by consultant Angela Adkins during the week of January 22-26, 2007. PBS staff also participated in the University of Kansas Online PBS Training (initiated December 2006).</p> <p>This monitor's interview with PBS team members showed that many do not have a comprehensive understanding of PBS principles and methodology. A number of staff requested further training.</p> <p>Recommendation 2, September 2006: Conduct treatment implementation fidelity checks regularly.</p> <p>Findings: MSH's progress report showed that fidelity checks were conducted for only 3% of the total opportunities.</p> <p>This monitor's review of fidelity checks with PBS team members</p>

		<p>showed that fidelity checks were rare, and a number of them did not fully comprehend the methodology and analysis of the fidelity data.</p> <p>Recommendation 3, September 2006: Senior Psychologists should be assigned to review treatment plans and Crisis Intervention plans for content and appropriateness.</p> <p>Findings: MSH's progress report indicated that senior psychologists receive S&R data from Standards Compliance, review Wellness and Recovery Plans and review the Crisis Intervention plans for content and appropriateness.</p> <p>This monitor's review of five intervention plans (AF, AB, MW, HC, and SW), showed the following deficiencies:</p> <ol style="list-style-type: none"> 1. AF's interventions were stated as what AF will "learn" and "think" and not what the providers or AF would do. 2. Verbal reinforcement for AB was not specific as to the strategy AB utilized to calm down. 3. SW's intervention was not well developed. One of S's objectives was to increase S's participation in treatment/school, and yet there was no mention of this in any of the subsequent sections. 4. MW's target behaviors were not operationalized. 5. HC's plan was incomplete. <p>Recommendation 4, September 2006: PBS team leaders need to develop a systematic way of evaluating treatment outcomes and reporting those outcomes.</p>
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Recommendation 5, September 2006:

Revision of treatment plans should be directly related to the outcome data and reported at all scheduled WRP conferences of the individual. Data should be reviewed regularly to determine treatment effectiveness and to decide if plans should be revised, terminated, or if further training of unit staff is necessary to improve treatment implementation.

Findings:

Using the Psychology Monitoring Form (MSH PBS Monthly Case Audit Form), the facility assessed its compliance. The following is a summary of the data:

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.

	Dec	Jan	Feb	Mean
N	17	27	24	
n	12	27	24	
%S	71	100	100	
%C	42	44	50	45

MSH's progress report also indicated that PBS teams review and graph frequency of target behaviors, PRN, S&R, and Special Incident Reports, and document in the WRPs. The PBS teams include adaptive behaviors (e.g. social skills, communications skills, coping skills) in evaluating outcome data and report them in the WRPs. PBS teams attend all WRPCs that occur as scheduled. PBS plans are revised based on outcome data and are reported at all scheduled WRPCs. Data are reviewed monthly, or more frequently as necessary.

		<p>This monitor's review of six (DH, TP, RH, KR, NR, and RM) intervention plans showed that none of their plans were implemented consistently with a minimum of 80% fidelity, or updated in a timely manner, and the outcome data updated in their WRPs.</p> <p>Other findings: This monitor's interview with PBS teams revealed that PBS team members have difficulty with participation in WRPCs because the WRPTs fail to inform the PBS team members about meeting times or changes in meeting days and times.</p> <p>Staff has difficulty understanding PBS principles and behavior functions as evidenced in the Summary/Conclusions section of DY's functional assessment.</p> <p>Recommendation 6, September 2006: PBS teams and WRP teams need to follow the PBS-BCC checklist for all referrals to the BCC.</p> <p>Findings: This monitor's review of PBS referrals and relevant PBS-BCC Checklist (JC, GC, MC, HC, AF, JG, RH, DH, JL, SM, NM, RM, LM, TP, KR, N'R, KS, RS, JS, CW, AW, PW, and DY) showed that all referrals indicated in the BCC list and PBS list have accompanying PBS-BCC Checklists. Ten of them (RS, NR, KR, RM, TP, NM, DH, RH, JC, and PW) were undated.</p> <p>Recommendation 7, September 2006: The PBS teams, WRP teams and the BCC require further training to fully understand their roles, agenda at the BCC and tracking of referrals made to the BCC.</p>
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		<p>Recommendation 8, September 2006: Ensure that all PBS team leaders receive training in the development of structural assessment, functional assessment and functional analysis, and the development and implementation of PBS plans.</p> <p>Findings: MSH's progress report showed that training has been provided to all PBS team members by their Chief CRIPA Consultant on December 13 and 14, 2006; January 9 and 10, 2007; and February 13, 2006. Training was also provided by consultant Angela Adkins during the week of January 22-26, 2007.</p> <p>This monitor's review of the PBS-BCC checklist, PBS Support Manual, and DMH Psychology Monitoring Tool showed that process and procedures for PBS, BCC, and WRPTs have been outlined to assist these groups in understanding their role and appropriate actions.</p> <p>Recommendation 9, September 2006: Ensure that all RNs, PTs and data analysts on the PBS teams receive guidelines for using evidence-based tools for referrals, training on evidence-based tools for data collection and that a team leader performs reliability checks in this area.</p> <p>Findings: MSH PBS teams do not have data analysts at this time. MSH is in the process of hiring for this position. This monitor's review with RNs and PTs in the PBS teams showed that they are not fully trained in using evidence-based tools for referrals and for data collection. Team leaders have not regularly performed reliability checks.</p>
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		<p>Recommendation 10, September 2006: Develop a training protocol for all PBS plans to ensure that all staff who will be responsible for implementing the plan are consistently and appropriately trained prior to implementation of the plan (i.e., behavioral rehearsals, demonstrations, role plays, modeling).</p> <p>Findings: This monitor's review of the PBS Draft Manual, March 2007, page 26, showed that a PBS Team Staff Training Protocol has been developed with guidelines on procedures and criteria for training staff before they implement the PBS plans. However, staff is not always trained to competency, as in the case of MC.</p> <p>Recommendation 11, September 2006: Integrate a response to triggers in the referral process.</p> <p>Findings: This monitor's review of the PBS Draft Manual, March 2007, Page 12, showed that a guideline for a referral process in response to triggers has been developed and implemented.</p> <p>Recommendation 12, September 2006: Ensure that team psychologists and PBS psychologists are trained in the WRP process.</p> <p>Findings: MSH's progress report showed that Wellness and Recovery Plan Training was provided to psychologists by DMH's Chief CRIPA Consultant on February 14, 2007.</p>
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		<p>This monitor's review of PBS teams' understanding of the WRP process indicated that PBS team members attend WRP conferences and have an understanding of the WRP team and referral processes. Furthermore, the WRPT' responsibilities are included in the SO#129.01. (Effective date, February1, 2007).</p> <p>This monitor's review of the Psychology Manual, March 2007, showed that WRP procedures are outlined in pages 23 and 24, section 5.1. Furthermore, section 5.2 outlines specific requirements of the WRPT psychologist. The DMH WRP manual outlines the requirements for including PBS programs in the Objectives and Interventions of an individual's WRP.</p> <p>Other findings:</p> <p>This monitor reviewed individual care with staff and individuals, based on information on CG (see below). In a number of instances it was pointed out that unit staff was mean, sarcastic, and demeaning to individuals. For example, one of CG's identified antecedents was staff using authoritarian approach (making demands, harsh tone of voice). This was similar to the information obtained for MP, TP, MC, and HC. Examples of staff comments included, "Hurry up, I do not have all day to wait for you," "You are too proud," and "Your behavior is intolerable." Unfortunately, at least in some occasions, individuals' maladaptive behaviors could be a result of such provocation rather than the antecedents and consequences identified in the assessments, thereby making the intervention plans irrelevant and ineffective. Staff should be educated on how their behaviors act as "triggers" for individuals to display maladaptive behaviors. Staff should refer to 5.3.6 and 5.4.3, page 23, in the PBS Manual.</p>
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		<p>There are numerous problems with the application of PBS at MSH. Difficulties in staff understanding of PBS principles and procedures, quality of PBS plans, difficulty in training unit staff, difficulty in implementing the plans, and poor cooperation and support from unit staff to the PBS teams, to name a few. It appears to this monitor that establishing a system-wide PBS plan would be in the best interest of all.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue current practices of training of PBS staff members. 2. Conduct treatment implementation fidelity checks regularly. 3. PBS team leaders should come up with specific criteria to revise treatment plans, conduct further assessments, and to make referrals to BCC. 4. Ensure that all PBS team leaders receive training in the development of structural assessment, functional assessment and functional analysis, and the development and implementation of PBS plans. 5. Ensure that all RNs, PTs and data analysts on the PBS teams receive guidelines for using evidence-based tools for referrals, training on evidence-based tools for data collection and that a team leader performs reliability checks in this area.
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.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Train all staff in correctly implementing the BY CHOICE program.</p>

		<p>Findings: MSH's progress report showed that all staff is trained annually and during orientation of new employees.</p> <p>This monitor's review of the BY CHOICE status showed that BY CHOICE has been rolled out facility-wide. A review of the training log (September 2006 and February 2007) showed that 528 staff have undergone training. A review of the BY CHOICE Post-Test document shows that this document is used to evaluate training outcome. The document includes 20 true/false questions</p> <p>Recommendation 2, September 2006: Implement the program as per the manual.</p> <p>Findings: MSH's progress report indicated that the BY CHOICE program is implemented facility wide following the Manual aligned with the EP.</p> <p>This monitor's review of the status of BY CHOICE program at MSH with the BY CHOICE coordinator and document review (training logs, BY CHOICE administrative manual, SO#130, and Psychology Manual) showed that the BY CHOICE program is designed and implemented per the manual.</p> <p>Recommendation 3, September 2006: Ensure that the program has additional resources, including computers and software that will assist in running the systems monthly.</p> <p>Findings: MSH's progress report stated that both the BY CHOICE Coordinator</p>
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		<p>and Assistant have computers and software that assist them in running the system monthly.</p> <p>This monitor's review with the BY CHOICE coordinator showed that the BY CHOICE team now has the necessary resources. According to the BY CHOICE coordinator everyone in her program has computers and software.</p> <p>Recommendation 4, September 2006: Hire dedicated staff to the BY CHOICE program to assist with management of the data and program matters.</p> <p>Findings: This monitor's review of staffing for the BY CHOICE program with the BY CHOICE coordinator indicated that the BY CHOICE program has the necessary staffing to manage the program as intended. A review of documents including MSH's BY CHOICE staffing list and the Incentive System Implementation list showed that every unit has a BY CHOICE program coordinator.</p> <p>Recommendation 5, September 2006: Assure that the individuals have the final choice in allocating points per cycle, ranging from 0 to 100 per cycle.</p> <p>Recommendation 6, September 2006: BY CHOICE point allocation should be determined by the individual at the WRP conference, with facilitation by the staff.</p> <p>Findings: MSH's progress report found that 1% of the cases reviewed showed</p>
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		<p>evidence where the individual determined point allocation at the WRP conference.</p> <p>This monitor reviewed eight charts (HC, MC, TP, FR, MH, AA, PT, and MM) and found compliance in one (AA) and partial or non-compliance in seven.</p> <p>Other findings: This monitor's review showed that the individuals' right to allocate points as they choose and to be able to do it during WRP conferences is documented in the BY CHOICE manual. The BY CHOICE Coordinator stated that BY CHOICE training includes the policy emphasizing that individuals have the choice on allocation of points.</p> <p>Recommendation 7, September 2006: Report BY CHOICE point allocation in the Present Status section of the individual's case formation and update at every scheduled WRP conference.</p> <p>Findings: The facility has monitoring data based on the Psychology Monitoring Form. The data are summarized as follows (the monitoring criteria were modified in January 2007; months prior to January 2007 were not used in calculating the mean):</p> <p><i>The BY CHOICE point allocation is updated monthly in the individual's Wellness and Recovery Plan.</i></p>
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	Oct	Nov	Dec	Jan	Feb	Mean
N	700	700	700	700	700	
n	111	101	86	133	88	
%S	16	14	12	19	13	
%C	77	75	81	1	1	1

This monitor's review of 19 charts showed that none of the WRPs had a comprehensive documentation of the individual's BY CHOICE point allocation. Three of the WRPs (WW, MH, CD) did not have any mention of the individual's BY CHOICE status, and the remaining 16 (SW, AL, JL, PD, SO, AF, CS, SB, MC, ML, RG, LP, VR, WF, JD, NM) had mentioned the individual's BY CHOICE participation, however, they were not comprehensive. None of them followed the sample documentation format prepared by the BY CHOICE Coordinator. This is 0% compliance.

Other findings:

This monitor's observation of providers signing off on BY CHOICE point cards showed that providers did not pair the awarding of points with social reinforcement as required in the BY CHOICE Manual under section 3.5., Earning and Awarding of Points (page 12).

Compliance:

Partial.

Current recommendations:

1. Continue with competency based training of all staff in correctly implementing the BY CHOICE program.
2. Implement the program as per the manual.
3. Continue to train WRPTs and individuals on the individuals' final choices in allocating points per cycle, ranging from 0 to 100 per

		<p>cycle.</p> <p>4. Report BY CHOICE point allocation statement in the Present Status section of the individual's case formation and update at every scheduled WRP conference.</p>
b	<p>Each State Hospital shall ensure that the Chief of Psychology has the clinical and administrative responsibility for the Positive Behavior Supports Team and the By CHOICE incentive program.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Use the Special Order as the MSH AD.</p> <p>Recommendation 2, September 2006: Implement the AD.</p> <p>Recommendation 3, September 2006: Follow the requirements of the EP.</p> <p>Findings: This monitor's review of documents (MSH organizational structure, PBS Special Order 129.1, AD# 3131, BY CHOICE AD (no#), page 2, F) showed that the Chief of Psychology has the clinical and administrative responsibility for the PBS and BY CHOICE incentive program. Furthermore, interview of MSH's Acting Chief of Psychology verified the intent and meaning of the documents cited.</p> <p>Compliance: Substantial.</p> <p>Current recommendations: Continue current practice.</p>

c	Each State Hospital shall ensure that:	Compliance: Partial.
c.i	behavioral assessments include structural and functional assessments and, as necessary, functional analysis;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Train all PBS team members in functional assessment, data collection, data analysis, graphing, plan implementation and data interpretation.</p> <p>Findings: MSH's progress report noted that training was provided to PBS team members in functional assessment, and PBS by the Chief CRIPA Consultant and their other consultant, Angela Adkins, on December 13 and 14, 2006; January 9 and 10, 2007; January 22-26, 2007; and February 13, 2007.</p> <p>This monitor's review of the competency of PBS team members through interviews showed that nursing and psychiatric technicians were in need of additional training on designing treatment plans and collecting and analyzing data.</p> <p>Recommendation 2, September 2006: Develop a system for identifying and tracking individuals in the hospital who are in need of behavioral interventions.</p> <p>Findings: This monitor's review of the list of individuals by program by unit needing behavioral interventions showed that MSH has its unit psychologists track all individuals on their caseloads in need of behavioral interventions. A review of the list showed that 46 of the</p>

		<p>486 individuals were in need of behavioral interventions. However, this list is incomplete. Six psychologists failed to submit their data on time for analysis.</p> <p>Recommendation 3, September 2006: Use the PBS-BCC checklist for all consultations.</p> <p>Findings: MSH's progress report noted 28 referrals, all having PBS-BCC checklists.</p> <p>This monitor's review of the completed PBS-BCC Checklists is in agreement with MSH's report.</p> <p>Recommendation 4, September 2006: Senior Psychologists should be utilized to monitor the appropriateness of Behavior Guidelines, Crisis Intervention Plans and the need for a referral to PBS teams.</p> <p>Findings: MSH's progress report noted that senior psychologists receive S&R data from Standards Compliance, and review Wellness and Recovery Plans and Crisis Intervention plans for content and appropriateness.</p> <p>This monitor's review showed that MSH has assigned two senior psychologists to train and mentor as well as review behavior guidelines and Crisis Intervention plans. Review of the senior psychologists training and mentoring log showed that each of them regularly meet with unit psychologists and review assessments and treatment plans.</p>
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		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Train all PBS team members in functional assessment, data collection, data analysis, graphing, plan implementation and data interpretation. 2. Develop a system for identifying and tracking individuals in the hospital who are in need of behavioral interventions. 3. Ensure that senior Psychologists monitor the appropriateness of Behavior Guidelines, Crisis Intervention Plans and the need for a referral to PBS teams. 																									
c.ii	<p>hypotheses of the maladaptive behavior are based on structural and functional assessments;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Ensure that hypotheses of the maladaptive behaviors are based on structural and functional assessments and clearly stated in the PBS documentation.</p> <p>Findings: The facility has monitoring data based on the Psychology Monitoring Form (DMH PBS Monitoring Form). The data are summarized as follows:</p> <p><i>The hypotheses of the maladaptive behavior are based on structural and functional assessments:</i></p> <table border="1" data-bbox="1165 1156 1690 1331"> <thead> <tr> <th></th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>17</td> <td>27</td> <td>24</td> <td></td> </tr> <tr> <td>n</td> <td>12</td> <td>27</td> <td>24</td> <td></td> </tr> <tr> <td>%S</td> <td>71</td> <td>100</td> <td>100</td> <td></td> </tr> <tr> <td>%C</td> <td>50</td> <td>50</td> <td>60</td> <td>53</td> </tr> </tbody> </table>		Dec	Jan	Feb	Mean	N	17	27	24		n	12	27	24		%S	71	100	100		%C	50	50	60	53
	Dec	Jan	Feb	Mean																							
N	17	27	24																								
n	12	27	24																								
%S	71	100	100																								
%C	50	50	60	53																							

		<p>Current recommendations: Ensure that hypotheses of the maladaptive behaviors are based on structural and functional assessments and clearly stated in the PBS documentation.</p>																																			
c.iii	There is documentation of previous behavioral interventions and their effects;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Document previous behavioral interventions.</p> <p>Recommendation 2, September 2006: Document effectiveness of previous interventions.</p> <p>Findings: MSH reported that 2% of the behavioral assessments documented previous behavioral interventions. The following summarizes the data based on the Psychology Monitoring Form:</p> <p><i>There is documentation of previous behavioral interventions and their effects.</i></p> <table border="1" data-bbox="1163 971 1793 1146"> <thead> <tr> <th></th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>700</td> <td>700</td> <td>700</td> <td>700</td> <td>700</td> <td></td> </tr> <tr> <td>n</td> <td>140</td> <td>140</td> <td>140</td> <td>140</td> <td>140</td> <td></td> </tr> <tr> <td>%S</td> <td>20</td> <td>20</td> <td>20</td> <td>20</td> <td>20</td> <td></td> </tr> <tr> <td>%C</td> <td>0</td> <td>0</td> <td>2</td> <td>2</td> <td>3</td> <td>2</td> </tr> </tbody> </table> <p>This monitor's review of nine assessments (FR, CC, HC, DY, JS, CG, AF, RM, and FJ) showed that one of them (FJ) had a fairly good discussion of previous treatment and effects. Three (JS, AF, CG) had mentioned previous treatment without any indication of their effects, and the rest did not discuss previous treatments and or their effectiveness.</p>		Oct	Nov	Dec	Jan	Feb	Mean	N	700	700	700	700	700		n	140	140	140	140	140		%S	20	20	20	20	20		%C	0	0	2	2	3	2
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N	700	700	700	700	700																																
n	140	140	140	140	140																																
%S	20	20	20	20	20																																
%C	0	0	2	2	3	2																															

		<p>Current recommendations: Ensure that previous interventions and their effectiveness are documented in the behavioral assessments.</p>																									
c.iv	<p>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;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Ensure that all behavioral interventions are based on a positive behavioral supports model without any use of aversive or punishment contingencies.</p> <p>Findings: The facility has monitoring data based on the Psychology Monitoring Form (DMH PBS Monitoring Form). The data show 44% compliance, which indicate that 56% of the interventions reviewed included some form of aversive or punishment contingencies.</p> <p><i>Behavioral interventions, which include positive behavior support plans, are based on a positive behavior supports model and do not include the use of aversive or punishment contingencies:</i></p> <table border="1" data-bbox="1163 1042 1688 1218"> <thead> <tr> <th></th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>17</td> <td>27</td> <td>24</td> <td></td> </tr> <tr> <td>n</td> <td>11</td> <td>27</td> <td>24</td> <td></td> </tr> <tr> <td>%S</td> <td>20</td> <td>100</td> <td>100</td> <td></td> </tr> <tr> <td>%C</td> <td>63</td> <td>25</td> <td>44</td> <td>44</td> </tr> </tbody> </table> <p>Current recommendations: Ensure that all behavioral interventions are based on a positive</p>		Dec	Jan	Feb	Mean	N	17	27	24		n	11	27	24		%S	20	100	100		%C	63	25	44	44
	Dec	Jan	Feb	Mean																							
N	17	27	24																								
n	11	27	24																								
%S	20	100	100																								
%C	63	25	44	44																							

		behavioral supports model without any use of aversive or punishment contingencies.																									
c.v	behavioral interventions are consistently implemented across all settings, including school settings;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Ensure that staff across settings is aware of individual's behavioral plan, and that they receive written plans and training.</p> <p>Recommendation 2, September 2006: Ensure that all behavioral interventions are consistently implemented across all settings, including mall, vocational and education settings.</p> <p>Findings: MSH used the Psychology Monitoring Form (Fidelity Checks/MSH PBS Monthly Case Audit Form) and reports compliance data summarized as follows:</p> <p><i>Behavioral interventions are consistently implemented across all settings, including school settings:</i></p> <table border="1" data-bbox="1163 956 1703 1133"> <thead> <tr> <th></th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>17</td> <td>27</td> <td>24</td> <td></td> </tr> <tr> <td>n</td> <td>5</td> <td>27</td> <td>24</td> <td></td> </tr> <tr> <td>%S</td> <td>29</td> <td>100</td> <td>100</td> <td></td> </tr> <tr> <td>%C</td> <td>0</td> <td>0</td> <td>10</td> <td>3</td> </tr> </tbody> </table> <p>This monitor's review of six (MC, FJ, SW, NR, and TP) cases showed that none of these six behavioral interventions were consistently implemented across settings, as evidenced through Mall observations, documentation, and staff report..</p>		Dec	Jan	Feb	Mean	N	17	27	24		n	5	27	24		%S	29	100	100		%C	0	0	10	3
	Dec	Jan	Feb	Mean																							
N	17	27	24																								
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%S	29	100	100																								
%C	0	0	10	3																							

		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that staff across settings is aware of individual's behavioral plan, and that they receive written plans and training. 2. Ensure that all behavioral interventions are consistently implemented across all settings, including mall, vocational and education settings.
c.vi	<p>triggers for instituting individualized behavioral interventions are specified and utilized, and that these triggers include excessive use of seclusion, restraint, or psychiatric PRN and Stat medication for behavior control;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: The hospital should have a system for using the trigger data to obtain PBS consultation for appropriate individuals.</p> <p>Findings: MSH's progress report points to the PBS Manual (draft) Section "Referrals from Trigger Meeting". A review of this section indicates that PBS team leaders attend trigger meetings to review individuals with triggers. PBS team leaders will then contact WRT psychologists (or other WRT member if the WRT does not have a psychologist) to complete a PBS-BCC checklist and follow the procedure established from thereof.</p> <p>This monitor's review of this recommendation with the Acting Chief of Psychology and Dr. Edwin Poon (psychologist) indicated that in addition to the system described above, they look at trigger data received from Central Support Services and take appropriate steps.</p> <p>This monitor's review of 10 WRPs of individual's with S&R showed that three (ML,DY, and JD) of them had mentioned and had a response to the S&R, whereas seven others (SW, JL, DW, RS, CG, DH, and SJ) did</p>

		<p>not have an addendum or have an attachment to the S&R. This is 30% compliance.</p> <p>Current recommendations: The hospital should have a system for using the trigger data to obtain PBS consultation for appropriate individuals.</p>																									
c.vii	<p>positive behavior support teams and team psychologists integrate their therapies with other treatment modalities, including drug therapy;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Integrate all behavioral interventions with other treatment modalities, including drug therapy.</p> <p>Findings: MSH used the Psychology Monitoring Form (MSH PBS Monthly Case Audit Form) to assess its compliance. The data are summarized as follows:</p> <p><i>Positive Behavior Support teams and team psychologists integrate their therapies with other treatment modalities, including drug therapy.</i></p> <table border="1" data-bbox="1163 1003 1688 1214"> <thead> <tr> <th></th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>17</td> <td>27</td> <td>24</td> <td></td> </tr> <tr> <td>n</td> <td>17</td> <td>27</td> <td>24</td> <td></td> </tr> <tr> <td>%S</td> <td>100</td> <td>100</td> <td>100</td> <td></td> </tr> <tr> <td>%C #34</td> <td>0</td> <td>8</td> <td>21</td> <td>15</td> </tr> </tbody> </table> <p>This monitor's review of seven intervention plans (AH, SW, AF, HC, JS, AB, and MW) showed that non-compliance in all cases, even though many of the intervention plans targeted suicide, self-injurious behaviors, and</p>		Dec	Jan	Feb	Mean	N	17	27	24		n	17	27	24		%S	100	100	100		%C #34	0	8	21	15
	Dec	Jan	Feb	Mean																							
N	17	27	24																								
n	17	27	24																								
%S	100	100	100																								
%C #34	0	8	21	15																							

		<p>aggression.</p> <p>Current recommendations: Integrate all behavioral interventions with other treatment modalities, including drug therapy.</p>																									
c.viii	<p>all positive behavior support plans are specified in the objectives and interventions sections of the individual's Wellness and Recovery Plan;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Specify PBS plans in the objectives and interventions sections of the individual's WRP Plan as outlined in the DMH WRP Manual.</p> <p>Findings: MSH has monitoring data based on the Psychology Monitoring Form (MSH PBS Monthly Case Audit Form). The following is a summary:</p> <p><i>All positive behavior support plans are specified in the objectives and interventions section of the Wellness and Recovery Plan:</i></p> <table border="1" data-bbox="1163 932 1688 1105"> <thead> <tr> <th></th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>17</td> <td>27</td> <td>24</td> <td></td> </tr> <tr> <td>n</td> <td>12</td> <td>27</td> <td>24</td> <td></td> </tr> <tr> <td>%S</td> <td>71</td> <td>100</td> <td>100</td> <td></td> </tr> <tr> <td>%C</td> <td>66</td> <td>81</td> <td>84</td> <td>77</td> </tr> </tbody> </table> <p>This monitor's review of eight WRPs (FR, TP, MC, DH, RH, KR, and NR) showed compliance in five (FR, TP, MC, KR, and NR) and non-compliance in three.</p> <p>Current recommendations: Specify PBS plans in the objectives and interventions sections of the</p>		Dec	Jan	Feb	Mean	N	17	27	24		n	12	27	24		%S	71	100	100		%C	66	81	84	77
	Dec	Jan	Feb	Mean																							
N	17	27	24																								
n	12	27	24																								
%S	71	100	100																								
%C	66	81	84	77																							

		individual's WRP Plan as outlined in the DMH WRP Manual.																									
c.ix	all positive behavior support plans are updated as indicated by outcome data and reported at least quarterly in the Present Status section of the case formulation in the individual's Wellness and Recovery Plan	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Update all PBS plans as indicated by outcome data and document it at every scheduled WRP conference in the Present Status section of the individual's case formulation.</p> <p>Findings: MSH used the Psychology Monitoring Form (MSH PBS Monthly Case Audit Form) to report the following monitoring data:</p> <p><i>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:</i></p> <table border="1" data-bbox="1163 862 1688 1053"> <thead> <tr> <th></th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>17</td> <td>27</td> <td>24</td> <td></td> </tr> <tr> <td>n</td> <td>12</td> <td>27</td> <td>24</td> <td></td> </tr> <tr> <td>%S</td> <td>71</td> <td>100</td> <td>100</td> <td></td> </tr> <tr> <td>%C</td> <td>42</td> <td>44</td> <td>50</td> <td>45</td> </tr> </tbody> </table> <p>This monitor's review of five WRPs (DH, TP, DY and MC, and RM) showed compliance in three (TP, MC, and RM) and non-compliance in two.</p> <p>Current recommendations: Update all PBS plans as indicated by outcome data and document it at every scheduled WRP conference in the Present Status section of the individual's case formulation.</p>		Dec	Jan	Feb	Mean	N	17	27	24		n	12	27	24		%S	71	100	100		%C	42	44	50	45
	Dec	Jan	Feb	Mean																							
N	17	27	24																								
n	12	27	24																								
%S	71	100	100																								
%C	42	44	50	45																							

c.x	<p>all staff has received competency-based training on implementing the specific behavioral interventions for which they are responsible, and performance improvement measures are in place for monitoring the implementation of such interventions.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Provide competency-based training to appropriate staff on implementing specific behavioral interventions for which they are responsible, and have performance improvement measures in place for monitoring the implementation of such interventions.</p> <p>Findings: MSH has monitoring data based on the Psychology Monitoring Form (MSH PBS Monthly Case Audit Form). The following is a summary of the data:</p> <p><i>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:</i></p> <table border="1" data-bbox="1165 943 1633 1135"> <thead> <tr> <th></th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>17</td> <td>27</td> <td>24</td> <td></td> </tr> <tr> <td>n</td> <td>5</td> <td>27</td> <td>24</td> <td></td> </tr> <tr> <td>%S</td> <td>29</td> <td>100</td> <td>100</td> <td></td> </tr> <tr> <td>%C</td> <td>0</td> <td>38</td> <td>42</td> <td>40</td> </tr> </tbody> </table> <p>Interview with unit teams and PBS teams showed that a number of individuals were not progressing due to poor implementation of the intervention plans (HC, MW, SW, AF, MC and AB). For example, in the case of MC, Unit (413), the staff and the PBS team serving MC had difficulty getting together and carrying out the plan. There has been a</p>		Dec	Jan	Feb	Mean	N	17	27	24		n	5	27	24		%S	29	100	100		%C	0	38	42	40
	Dec	Jan	Feb	Mean																							
N	17	27	24																								
n	5	27	24																								
%S	29	100	100																								
%C	0	38	42	40																							

		<p>continuous back and forth discussion for months on who should do what without any resolution. Meanwhile, MC received 13 PRNs and was on S&R five times in February. FJ (Structural Behavioral Assessment, February 6, 2007), is another case that showed lack of progress due to poor implementation of the intervention plan. Page 6 (the document has no pagination), paragraph 2, line 8, stated, "when this plan was initially implemented, it was initially successful and reduced his ability to barter. However, due to inconsistent staffing, this plan was not fully implemented".</p> <p>Other findings: A review of Special Order Number 129.01 (February 1, 2007), page 6, under section V (B, C, and D) clearly states the roles of the various staff and when and who is responsible for staff training and data collection.</p> <p>Current recommendations: Provide competency-based training to appropriate staff on implementing specific behavioral interventions for which they are responsible, and have performance improvement measures in place for monitoring the implementation of such interventions.</p>
c.xi	all positive behavior support team members shall have as their primary responsibility the provision of behavioral interventions;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Ensure that all PBS team members provide PBS services fulltime until the needs of all individuals requiring behavioral interventions is met.</p> <p>Findings: MSH's progress report indicated that all PBS Team members provide</p>

		<p>PBS services during the 40-hour workweek.</p> <p>This monitor's reviewed PBS team members' duties through interviews with the Acting Chief of Psychology and the PBS team members. Information gathered showed that PBS team members perform fulltime in PBS activities. However, it appears that the nursing and psychiatric technician staff is required to perform mandatory overtime duties. These staff often had to leave early from PBS-related training sessions and meetings to get to their overtime work. Furthermore, they are treated as "PBS team members" and "crisis intervention" staff during their overtime duties. One of the PBS team nurses was injured and on medical leave.</p> <p>Recommendation 2, September 2006: Ensure that the Chief of Psychology has responsibility to determine PBS team members' duties.</p> <p>Findings: This monitor's review of documents (PBS Special Order 129.1 and MSH AD: Positive Behavior Support # 3131.) to address this recommendations showed that the Chief of Psychology has been given the responsibility to determine PBS team members' duties.</p> <p>Current recommendations: Ensure that all PBS team members provide PBS services fulltime until the needs of all individuals requiring behavioral interventions is met.</p>
c.xii	the By CHOICE point allocation is updated monthly in the individual's Wellness and Recovery Plan.	Current findings on previous recommendations:

Recommendation 1, September 2006:

Ensure that By CHOICE point allocation is updated monthly in the individual's Wellness and Recovery Plan.

Findings:

Using the Psychology Monitoring Form, the facility has monitoring data that are summarized as follows:

The BY CHOICE point allocation is updated monthly in the individual's Wellness and Recovery Plan:

	Oct	Nov	Dec	Jan	Feb	Mean
N	700	700	700	700	700	
n	111	101	86	133	88	
%S	16	14	12	19	13	
%C	77	75	81	1	1	1

This monitor's review of eight WRPs showed non-compliance in one (HC) and marginal compliance in the other seven.

Recommendation 2, September 2006:

Ensure that individuals who are bed-bound and individuals whose primary language is not English are fully included in the plan.

Findings:

MSH's progress report noted that a bed-bound individual has been identified on Unit 419, and has provided consultation to the staff on inclusion of the individual in the BY CHOICE system. The report also noted that Spanish version of the BY CHOICE Point card has been developed and implemented on Unit 415 and 420. A Spanish interpreter

		<p>was at hand to interpret at the December 2006 "Individual BY-CHOICE" training (on Unit 415),</p> <p>This monitor's review on BY CHOICE program for bed-bound individuals and non-English speaking individuals showed that the BY CHOICE program was not tailored to the bed-bound individual. Interview of Spanish-speaking individuals showed that they are familiar with the BY CHOICE program and are participating in the program. Observation of Mall group activities also revealed that non-English speaking individuals were carrying BY CHOICE cards.</p> <p>Other findings: This monitor reviewed the BY CHOICE Manual (March 2007). In Appendix B, under Incentive Store Roles and Responsibilities, #6 (page 23) reads, 'After the individual has selected his/her items, assure s/he <u>did not go over</u> the total available.' This statement appears to be incorrect.</p> <p>The BY CHOICE coordinator has produced points cards in Korean and Chinese.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that By CHOICE point allocation is updated monthly in the individual's Wellness and Recovery Plan. 2. Ensure that individuals who are bed-bound and individuals whose primary language is not English are fully included in the plan.
d	Each State hospital shall ensure that it has at least one developmental and cognitive abilities team (DCAT;	Current findings on previous recommendations:

	<p>consisting of 1 clinical psychologist, 1 registered nurse, 1 social worker, 1 psychiatric technician, and 1 data analyst (who may be a behavior specialist) who have a demonstrated competence, consistent with generally accepted professional standards of care, in assessing individuals with cognitive disorders/challenges; developing therapeutic interventions (including positive behavior supports); advising therapy and rehabilitation providers on the implementation of interventions at the cognitive level of the individuals; and managing discharge processes for individuals with developmental disabilities and cognitive disorders/challenges,. This team shall assume some of the functions of the positive behavior support teams if the individuals they serve also need positive behavioral supports.</p>	<p>Recommendation 1, September 2006: Hire all members of the DCAT team.</p> <p>Findings: MSH's progress report indicated that DCAT Social Worker Nancy White, LCSW, has left the position, and Jennifer Escude, LCSW is the interim DCAT Social Worker.</p> <p>This monitor's review of the DCAT membership showed that the team lacked a Data Analyst.</p> <p>Recommendation 2, September 2006: Ensure that DCAT team members' primary responsibility is consistent with EP.</p> <p>Findings: This monitor's review of the DCAT membership showed that their primary responsibility is consistent with the EP requirements. The DCAT members primarily conduct cognitive screening, participate in cognitive related Mall group activities, PBS teams, and ensure that placement of individuals within and outside the facility consider the individuals cognitive status. These activities are consistent with EP.</p> <p>Recommendation 3, September 2006: Ensure that all DCAT team members receive appropriate training.</p> <p>Findings: MSH's progress report showed that DCAT team members have received extensive training including training provided by the Chief CRIPA Consultant (on December 13 and 14, 2006 and January 9th and 10th</p>
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		<p>2007, and February 13, 2007), and by their other consultant, Ms. Angela Adkins (from January 22-26, 2007).</p> <p>This monitor's review of training received by the DCAT members showed that the DCAT members have received additional training in addition to the training received from their consultants. For example, Dr. Amy Choi attended the National Association for the Dually Diagnosed conference on Promoting Mental Health in Children and Adults with Intellectual Disabilities, and a seminar by Susan McPherson, Ph.D. on Aging and Cognition. Other DCAT staff attended conferences/ workshops/ presentations including seminar by John Ortiz, PhD, on Neuro-Developmental Disorders, by Nancy White, LCSW on case management and discharge planning,</p> <p>This monitor's review of the DCAT training record showed that there were 10 training sessions between October and November 2006. Topics covered in these training sessions included: Promoting Mental Health in Children and Adults with Intellectual Disabilities, Neuro-Developmental Disorders, Aging and Cognition, PBS, Discharge Planning and Regional Centers, and Writing Behavior Guidelines.</p> <p>This monitor's interview with DCAT members showed that a few members were still not proficient in discussing PBS procedures and plans as well as design and implement of intervention plans.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Hire all members of the DCAT team.
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		2. Ensure that all DCAT team members receive appropriate training.						
e	<p>Each State Hospital shall develop and implement a Behavioral Consultation Committee (BCC), chaired by the Chief of Psychology, and co-chaired by the Chief of Psychiatry, to review the Wellness and Recovery Plan and maladaptive behavior(s) of the individuals who have not made timely progress on positive behavior support plans. The Chief of Psychology is responsible for the functions of this committee, together with members of the positive behavior support team (in functions of the committee that relate to individuals under the care of those team members). The committee membership shall include all clinical discipline heads, including the medical director, as well as the clinical administrator of the facility.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Use the PBS-BCC checklist to define the sequence of steps for referrals to the BCC.</p> <p>Findings: MSH's progress report stated that all individuals currently use PBS-BCC checklist.</p> <p>This monitor's review of the PBS-BCC checklist showed that all referrals to PBS and BCC had used the PBS-BCC checklist.</p> <p>Recommendation 2, September 2006: Ensure that all standing members of the BCC attend every meeting.</p> <p>Findings: This monitor's review of BCC membership list showed 14 core members, 12 "other members", and a list of WRPT disciplines whose members are requested to attend when their feedback was needed. PBS, DCAT, and BY CHOICE program members are included in this list.</p> <p>This monitor's review of BCC attendance summary of five meetings over the last six months showed that attendance ranged from 0% to 100%. A breakdown of the attendance summary showed the following pattern:</p> <table border="1" data-bbox="1010 1276 1906 1351"> <tr> <td>0% attendance</td> <td>80% attendance</td> <td>100% attendance</td> </tr> <tr> <td>15%</td> <td>18%</td> <td>67%</td> </tr> </table>	0% attendance	80% attendance	100% attendance	15%	18%	67%
0% attendance	80% attendance	100% attendance						
15%	18%	67%						

		<p>Recommendation 3, September 2006: Include PBS team members and WRPT members at BCC team meetings periodically to problem solve as to why plans are not fully implemented.</p> <p>Findings: This monitor's review of the BCC membership and attendance list showed that PBS team leaders regularly attend BCC meetings. Furthermore WRPT psychologists are included in BCC meetings when needing them to report on a referral. .</p> <p>Recommendation 4, September 2006: Set up a system of accountability to ensure that BCC plans are properly implemented when indicated.</p> <p>Findings: MSH's progress report noted that BCC recommendations are provided to the PBS teams who provide them to the WRPT and track the progress/completion of the recommendations on a monthly basis.</p> <p>This monitor's interview with PBS and the BCC team members showed that PBS team members and the unit psychologist monitor and track the BCC plans to ensure that the plans are properly implemented.</p> <p>Compliance: In partial compliance.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Use the PBS-BCC checklist to define the sequence of steps for referrals to the BCC.
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		<p>2. Ensure that all standing members of the BCC attend every meeting.</p> <p>3. Set up a system of accountability to ensure that BCC plans are properly implemented when indicated.</p>
f	<p>Each State Hospital shall ensure that it has sufficient neuropsychological services for the provision of adequate neuropsychological assessment of individuals with persistent mental illness.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Ensure that WRP teams, especially psychologists, make referrals that are appropriate for neuropsychological assessments.</p> <p>Findings: MSH's progress report noted that Cognitive screening follow-up training was provided to staff psychologists during the November 2006 Staff Meeting. It was also reported that between October 2006 and February 2007, a total number of 16 referrals were received, a 60% increase compared to the prior five months (May 06 to Sept 06, 10 referrals).</p> <p>This monitor's review showed that WRPT psychologists have been assigned to track and refer individuals who may be in need of neuropsychological assessments. The WRPT psychologists were to monitor all individuals in their caseloads. The number of referrals has significantly increased since this system was implemented.</p> <p>This monitor's review of the Neuropsychology Service Referral Tracking Database showed a total of 110 referrals since 2004. This appears to be a low number of referrals for more than a three-year period, given the nature of individuals admitted at MSH.</p>

		<p>Other findings: Program III did not have a psychologist. More than likely a number of individuals in need of neuropsychological evaluation from this program may not have been referred.</p> <p>Recommendation 2, September 2006: Ensure that neuropsychologists provide cognitive remediation and cognitive retraining groups in the PSR Mall.</p> <p>Findings: MSH's progress report noted that lesson plans have been developed and implemented for cognitive rehabilitation groups based on Braintrain Captain's Log. The DCAT team members (PhD, RN, and PT) and the PBS RN provide the Captain's Log groups in Program III PSR Mall.</p> <p>This monitor's review of neuropsychologists offerings of cognitive remediation and cognitive retraining groups in the PSR Mall showed that neuropsychologists are providing the Braintrain Captain's Log group and the Attention and Memory modules in programs 2,3, and 5 four days a week. Furthermore, the Acting Chief of Psychology and the neuropsychology intern in the DCAT team are providing the Cognitive Skills Enhancement groups,</p> <p>Recommendation 3, September 2006: Increase the number of neuropsychologists to meet the anticipated demand for neuropsychological services.</p> <p>Findings: MSH's progress report did not specifically address this recommendation.</p>
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		<p>This monitor's review with the Acting Chief of Psychology indicated that there were two neuropsychologists in the department. The Acting Chief of Psychology would like to add a Spanish-speaking neuropsychologist given the large number of Spanish-speaking individuals at MSH. At the moment the plan is to contract with a Spanish-speaking neuropsychologist. A review of the Neuropsychology Service Referral Tracking Database showed that DH, who is Spanish-speaking, referred on September 7, 2005, still was waiting for the evaluation.</p> <p>This monitor's review of the Neuropsychology Service Referral Tracking Database showed a total of 110 referrals since 2004. This appears to be a low number of referrals over a three year period, given the nature of individuals admitted at MSH. Furthermore, there has been an increase in the number of referrals since the new tracking system.</p> <p>This monitor's review of the Neuropsychology Service Referral Tracking Database showed that on average it took almost three months for evaluations to be completed, and in some cases it took as many as five (DK), six (CK) and nine (FL) months. Delay in completing assessments can potentially affect WRPT's decision making, assignment of the individuals to proper services, and the individual's discharge planning.</p> <p>This monitor's review of the list of individuals in need of behavioral interventions showed that 44 individuals also needed neuropsychological assessments. However, this number is underrepresented because the list did not include data from six psychologists who failed to submit</p>
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		<p>their data in a timely manner.</p> <p>This monitor's review and findings for this recommendations shows that MSH does not have a sufficient number of neuropsychologists to address all referrals in a timely manner and to fully participate in all aspects of the EP.</p> <p>Compliance: Partial.</p> <p>Current recommendations: Increase the number of neuropsychologists to meet the anticipated demand for neuropsychological services and to fully participate in EP requirements.</p>
g	<p>All clinical psychologists with privileges at any State Hospital shall have the authority to write orders for the implementation of positive behavior support plans, consultation for educational or other testing, and positive behavior support plan updates.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: The hospital and/or state must provide psychologists the authority to write orders as specified in the EP.</p> <p>Findings: MSH's progress report noted that psychologists have the authority to write orders as specified in the EP.</p> <p>This monitor's review showed that this requirement is addressed in the psychology manual, SO # 129.01, and the PBS manual. The findings from these documents indicated that psychologists at MSH have the authority to write orders for the implementation of positive behavior support plans, consultation for educational or other testing and positive</p>

		<p>behavior support plan updates as specified in the EP. For example, section 2.2 (scope of practice), page 9, of the Psychology Manual states that Psychologists have limited order-writing privileges for a) one-to-one observation, b) home visit and ground passes, and c) the implementation of PBS plans, consultation for educational or other testing, and PBS updates. Page 5 of the SO#129.01, section IV, (Team Responsibilities), item E reads, 'The PBS team psychologist will write the order for implementing the PBS Plan by all staff'.</p> <p>Compliance: Substantial.</p> <p>Current recommendations: Continue current practice.</p>
3	Nursing Services	
	<p>Each State hospital shall provide adequate and appropriate nursing care and services consistent with generally accepted professional standards of care to individuals who require such services.</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Carmen Fayloga, RN/HSS 2. Joellyn Arce, Acting NC in Central Nursing Services 3. Aurora Hendricks, CNS 4. Kanya Sitanggang, RN, Psychiatric Nurse Education Director <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. DMH Nursing Services: Shift Change Monitoring Form 2. Curriculum for Diagnostic and Statistical Manual IV-TR (DSM-IV-TR) and Comorbid Conditions 3. Compliance list for Nursing Orientation 4. NP 500, Medication Administration; NP 528, PRN Orders; NP

		<p>530, STAT Orders ;NP 510, Security of Narcotics and Controlled Medications; NP 304, Care Of The Individual With Impaired Mobility</p> <ol style="list-style-type: none"> 5. PRN and STAT Medications Monitoring Form and data 6. Statewide Medication Administration Monitoring form and data 7. MSH Nursing Education lesson plan for Medication Administration and annual update 8. Medication Administration Competency Validation Monitoring form and data 9. DMH Nursing Services PRN/STAT Medication Monitoring Form 10. Medication Administration Monitoring Form 11. List of out of compliance medication certification report 12. 24-Hour Medication Audit 13. PRN/STAT Medication monitoring instrument 14. In-Service training rosters 15. WRP Knowledge Assessment 16. DMH Nursing Interventions Monitoring data 17. WRP Attendance by discipline data 18. DMH Nursing Staff Working with an Individual Shall Be Familiar with Goals, Objectives, and Interventions for that Individual Monitoring form and data 19. Nursing Mandated Training form 20. Inter-Rater Reliability-Nursing data 21. CNS/NC Minutes dated 2/28/07 22. Unit specific 2007 Medication Audit 23. DMH Bedbound Individuals Monitoring Form and data 24. DMH Therapeutic Milieu Observation Monitoring data 25. List of staff not current for Positive Management of Assaultive Behavior (PMAB) 26. PBS Training rosters for 2007
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		<p>27. Nursing Education Department course outlines</p> <p>28. April, May, and June 2007 Nursing Education/Professional Education & Training calendar</p>
a	<p>Each State hospital shall develop and implement policies and protocols regarding the administration of medication, including pro re nata ("PRN") and "Stat" medication (i.e., emergency use of psychoactive medication), consistent with generally accepted professional standards of care, to ensure:</p>	<p>Compliance: Partial.</p>
a.i	<p>safe administration of PRN medications and Stat medications;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Continue to develop and implement policies and procedures that ensure the safe administration of PRN medications and STAT medications.</p> <p>Findings: MSH reported that the following policies had been revised to address this recommendation: NP #500 (Medication Administration), NP #528 (PRN Orders), NP #530 (STAT Orders) and NP #510 (Security of Narcotics and Controlled Medications).</p> <p>Recommendation 2, September 2006: Continue to monitor the administration and documentation of medication administration, including PRN and STAT medications.</p> <p>Findings: MSH presented monitoring data based on the PRN Medication Monitoring Form, STAT Medication Monitoring Form and Medication</p>

		<p>Administration Monitoring. The data can not be accurately interpreted. The data need to be presented by monitoring indicator, with specifics regarding target populations, to reflect accurate compliance rates.</p> <p>Recommendation 3, September 2006: Report PRN medication data and STAT medication data separately.</p> <p>Findings: MSH reported that the PRN/STAT medication data are reported separately in the database.</p> <p>Recommendation 4, September 2006: Ensure staff competency regarding deficiencies and appropriate procedures for safe administration of PRN medications and STAT medications.</p> <p>Findings: The data submitted by MSH cannot be accurately interpreted.</p> <p>Recommendation 5, September 2006: Revise Statewide Medication Administration Monitoring Tool to reflect PRN medication and STAT medication data separately.</p> <p>Findings: MSH has revised the Medication Administration Monitoring Form 9/2006 to address this recommendation.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Report data by item to ensure accurate interpretation. 2. Continue to monitor this requirement.
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a.ii	documentation of the circumstances requiring PRN and Stat administration of medications;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Revise proposed PRN/STAT Medication Monitoring Form to report PRN and STAT data separately.</p> <p>Findings: See F.3.a.i, under Findings for recommendation #5.</p> <p>Recommendation 2, September 2006: Revise 24-hour Medication Audit Form to include STAT medications.</p> <p>Findings: MSH reported that the 24-hour Medication Audit Form was revised to include STAT medications. (Number's 14 and 15)</p> <p>Recommendation 3, September 2006: Revise language in NP #528 and #530 to include the "circumstances" requiring PRN and STAT administration of medications.</p> <p>Findings: The NP #528 and #530 have been revised to address this recommendation.</p> <p>Recommendation 4, September 2006: Revise all monitoring forms to reflect PRN and STAT data separately.</p> <p>Findings: MSH reports that monitoring forms have been revised to reflect PRN</p>
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and STAT data separately.

Recommendation 5, September 2006:

Provide staff training on policy and procedure revisions.

Findings:

MSH reported the following regarding this recommendation:

1. Training completed of 96% of the Health Service Specialists on PRN/STAT medication monitoring and related policies and procedures (NP #528 PRN Orders revised December 2006 and NP #530 STAT Orders revised December 2006) on January 12, 18 and 24, 2007.
2. Health Service Specialists trained 44% of level of care nursing staff (February 10, 2007).
3. Nursing Education is providing competency based curriculum on Medication Administration which includes PRN and STAT medications during Nursing.

Recommendation 6, September 2006:

Ensure staff competency regarding deficiencies and appropriate procedures for safe administration of PRN medications and STAT medications.

Findings:

The following is a list of the facility's indicators followed by a table including number of reviews conducted (n) and compliance rates for each indicator per reporting month:

Medication Administration Form:

1. *Assesses Individual prior to PRN/STAT*
2. *Correct medication*
3. *Correct dose*
4. *Correct individual*
5. *Correct route*
6. *Correct time/date*
7. *Provides medication education*
8. *Applies principles of asepsis*
9. *Prepares no more than 1 hour*
10. *IDs by name and photo*
11. *Checks allergies*
12. *BP/Pulse*
13. *Opens/Pours meds in front of individual*
14. *Correctly administers crushed/liquids*
15. *Checks med with MTR 3 times*
16. *Ensures meds swallowed*
17. *Proper technique with syringes*
18. *Ensures privacy/confidentiality*
19. *Properly administers eye/ear drops, inhalers/sprays*

Month	Sep	Oct	Nov	Dec	Jan	Feb	Mean
n	21	19	21	23	22	36	24
Indicator							
1	73	100	100	100	100	100	96%
2	100	100	100	100	100	100	100%
3	95	100	100	100	100	100	99%
4	100	100	100	100	100	100	100%
5	100	100	100	100	100	100	100%
6	100	94	100	95	100	100	98%

Month	Sep	Oct	Nov	Dec	Jan	Feb	Mean
7	81	75	85	81	76	79	80%
8	86	63	90	86	82	89	83%
9	100	95	95	100	100	100	98%
10	95	95	95	100	100	100	98%
11	95	89	95	95	100	100	96%
12	87	79	93	95	94	91	90%
13	95	95	95	95	100	97	96%
14	100	79	93	94	100	97	94%
15	67	89	89	71	82	91	70%
16	100	100	100	90	100	97	98%
17	70	100	75	100	100	100	91%
18	85	84	90	86	77	86	71%
19	60	78	73	85	62	96	76%

Competency Validation Monitoring Form:

1. *Safe administration of PRN*
2. *Safe administration of STAT*
3. *Educates individuals during med time*
4. *Follows med administration protocol*

Indicator	Jan	Feb	Mean
n	27	29	28
1	100	100	100%

Indicator	Jan	Feb	Mean
2	100	100	100%
3	74	83	79%
4	85	93	89%

		<p>In addition, MSH's Nursing Education Department is providing competency-based curriculum on Medication Administration which includes PRN and STAT medications during Nursing orientation and Nursing Annual Update.</p> <p>Recommendation 7, September 2006: Same as in D.1.f. and F.1.b.</p> <p>Findings: Same as in D.1.f. and F.1.b.</p> <p>Other findings: This monitor did not conduct reviews through which the accuracy of the facility's data could be generally corroborated.</p> <p>Current recommendations: Continue to monitor this requirement.</p>
a.iii	documentation of the individual's response to PRN and Stat medication.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Ensure staff competency regarding the documentation of specific indicators describing an individual's response to PRN and STAT medications.</p> <p>Findings: The following is an outline of the facility's monitoring indicators and compliance data:</p>

a)PRN Monitoring Form:

Documents individuals' response to PRN

	Sep	Oct	Nov	Dec	Jan	Feb	Mean
n	235	183	183	166	160	289	
%	63	57	75	86	82	61	71%

b)STAT Medication Monitoring Form:

Documents individuals' response to STAT

	Sep	Oct	Nov	Dec	Jan	Feb	Mean
n	79	88	82	81	87	220	
%	66	79	83	85	69	59	74%

From my review of 12 individuals (SW, WH, JV, CR, PL, PZ, NM, DY, JD, NMA, LN, and SF) who received PRN and/or STAT medication, my findings were similar to those presented by MSH regarding the documentation of the individual' response to PRN and STAT medications.

Recommendation 2, September 2006:

Clarify and specify criteria regarding what should be documented regarding an individual's response to PRN and STAT medications to ensure consistent data.

Findings:

MSH took the following actions to address this recommendation:

1. Revised NP 528 (PRN Orders) Documentation.

		<ol style="list-style-type: none"> 2. Revised NP 530 (STAT Orders) 3. Revised MSH PRN/STAT Medication Monitoring Form. 4. Revised MSH PRN/STAT Medication Monitoring Form Instructions to ensure consistent data collections from the auditors. 5. Inter-rater Reliability among 20% of the auditors (HSSs) doing the PRN/STAT Medication Monitoring Tool was completed in February 2007. The outcome reliability is at 78% <p>Recommendation 3, September 2006: Revise 24 Hour Medication Audit tool to include response to STAT medications.</p> <p>Findings: MSH revised the 24 Hour Medication Audit tool to include response to STAT medications. (Number's 11 and 14)</p> <p>Recommendation 4, September 2006: Ensure staff competency regarding deficiencies and appropriate procedures for safe administration of PRN medications and STAT medications.</p> <p>Findings: The data presented by MSH could not be accurately interpreted. The data needs to be presented by item to reflect accurate and meaningful compliance rates.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Report data by item to ensure accurate interpretation. 2. Continue to monitor this requirement.
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b	<p>Each State hospital shall ensure that all failures to properly sign the Medication Treatment Record (MTR) or the controlled medication log are treated as medication variances, and that appropriate follow-up occurs to prevent recurrence of such variances.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Revise monitoring tools to include this requirement.</p> <p>Findings: MSH reported that the 24-Hour Noc Audit (MSH 1109) had been revised to address this recommendation.</p> <p>Recommendation 2, September 2006: Revise policies and procedures regarding medication variances to include failures to properly sign the Medication Treatment Record (MTR) or the controlled medication log as a reportable medication variance.</p> <p>Findings: MSH reported that it had revised NP 546 (Medication Variance Report) to address this recommendation.</p> <p>Recommendation 3, September 2006: Develop and implement a system to monitor that appropriate follow-up occurs to prevent recurrence of such variances.</p> <p>Findings: The facility reported the following addressing this recommendation:</p> <ol style="list-style-type: none"> 1. New tool was created for follow up monitoring on Medication Variances March 9, 2007. 2. Training was provided to 92 % of the Unit Supervisor's and Nursing Coordinators on March 14, 2007.
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		<p>3. Tool is to be implemented following training by April 1, 2007. 4. Data are to be presented to the Nursing Coordinator group monthly.</p> <p>Recommendation 4, September 2006: Provide training to staff regarding the above.</p> <p>Findings: As above in Finding under recommendation 3.</p> <p>Other findings: No data was presented addressing this requirement.</p> <p>Compliance: Partial.</p> <p>Current recommendations: Continue to monitor this requirement.</p>
c	<p>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.</p>	<p>Current findings on previous recommendations:</p> <p>(NOTE: Recommendations were inadvertently numbered 1, 3, 4, 5 and 6 in the MSH baseline evaluation. That numbering has been retained here to avoid confusion.)</p> <p>Recommendation 1, September 2006: Revise policies and procedures to reflect this requirement.</p> <p>Findings: MSH has revised NP 103 (Wellness and Recovery Plan - Plan of Care)</p>

Recommendation 3, September 2006:

Ensure that all nursing and psychiatric technicians are competent with regard to the WRP and the Recovery Model.

Findings:

MSH presented monitoring data that cannot be interpreted to determine compliance regarding implementation of this recommendation.

Recommendation 4, September 2006:

Ensure that interventions are written in observable, behavioral, and/or measurable terms.

Findings:

The following is an outline of the facility's monitoring indicators and compliance data:

Nursing Interventions Monitoring Form:

Interventions are written in observable (1), behavioral (2) and/or measurable (3) terms.

Month	Sep	Oct	Nov	Dec	Jan	Feb	Mean
n	86	86	135	117	99	161	
Indicator							
1	87	86	95	89	94	82	89
2	87	77	79	84	86	81	82
3	78	74	73	71	79	72	75

Recommendation 5, September 2006:

Develop and implement proactive interventions related to the

		<p>individuals needs.</p> <p>Findings: The data presented by MSH did not address this recommendation.</p> <p>Recommendation 6, September 2006: Revise appropriate monitoring and tracking instruments to ensure accuracy of data collected.</p> <p>Findings: MSH reported that the Nursing Interventions Monitoring Form and Instructions were revised. In addition, a database was created 12/06 for accurate data collection as well as the new Plato system to be implemented following training. First training to master trainers was provided 3/14/07. On 2/20/07 Cross-checking was completed on 10% of January Nursing Interventions audits.</p> <p>Compliance: Partial.</p> <p>Other findings: This monitor did not conduct reviews through which the accuracy of the facility's data could be generally corroborated.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Restructure data regarding competency for all nursing and psychiatric technicians with regard to the WRP and the Recovery Model. 2. Develop and implement proactive interventions related to the individuals needs.
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		3. Continue to monitor this requirement.																																																
d	All nursing staff working with an individual shall be familiar with the goals, objectives and interventions for that individual.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Fully integrate nursing into the WRP process for individuals.</p> <p>Findings:</p> <p>MSH reported that the DMH WRPC Consistent Enduring Team (CET) Attendance and Nursing Participation Monitoring Form, which requires participation of both RNs and PTs/LVNs in the WRP, was implemented January 2007. The following is a summary of the facility's data (n=number of WRPs each month):</p> <p><i>Nursing (RN) Attendance in the WRP</i></p> <table border="1" data-bbox="1012 868 1602 974"> <thead> <tr> <th></th> <th>Sep</th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>n</td> <td>60</td> <td>47</td> <td>35</td> <td>44</td> <td>37</td> <td>23</td> <td></td> </tr> <tr> <td>%C</td> <td>98</td> <td>98</td> <td>78</td> <td>98</td> <td>89</td> <td>96</td> <td>92%</td> </tr> </tbody> </table> <p><i>Nursing (PT/LVN) Attendance in the WRP</i></p> <table border="1" data-bbox="1012 1084 1602 1190"> <thead> <tr> <th></th> <th>Sep</th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>n</td> <td>60</td> <td>47</td> <td>35</td> <td>44</td> <td>37</td> <td>23</td> <td></td> </tr> <tr> <td>%C</td> <td>13</td> <td>0</td> <td>6</td> <td>9</td> <td>16</td> <td>39</td> <td>9%</td> </tr> </tbody> </table> <p>Recommendation 2, September 2006: Ensure staff competency in developing, reviewing, revising and implementing the WRP.</p>		Sep	Oct	Nov	Dec	Jan	Feb	Mean	n	60	47	35	44	37	23		%C	98	98	78	98	89	96	92%		Sep	Oct	Nov	Dec	Jan	Feb	Mean	n	60	47	35	44	37	23		%C	13	0	6	9	16	39	9%
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		<p>Findings: MSH implemented the DMH Nursing Staff Working With an Individual Shall Be Familiar With the Goals, Objectives and Interventions Form. Monitoring began in October 2006 and is ongoing. However, the data presented by MSH could not be interpreted to reflect accurate compliance rates. The data need to be separated out by monitoring indicator.</p> <p>Recommendation 3, September 2006: Evaluate staffing patterns to promote continuity of care.</p> <p>Findings: MSH reported that this recommendation is in development by Dr. DeLacy, DMH Nurse Consultant in conjunction with the nurse administrators.</p> <p>Recommendation 4, September 2006: Continue to monitor and track this requirement.</p> <p>Findings: Data presented by MSH need to be restructured for accurate interpretation.</p> <p>Recommendation 5, September 2006: Develop and implement a statewide monitoring tool for the key elements of this requirement.</p> <p>Findings: See d, under Findings for recommendation 2.</p>
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		<p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Restructure data to ensure accurate interpretation. 2. Continue to evaluate staffing patterns to promote continuity of care. 3. Continue to monitor this requirement.
e	<p>Each State hospital shall ensure that nursing staff timely monitor, document and report the status of symptoms, target variables, health, and mental health status, of individuals in a manner that enables interdisciplinary teams to assess each individual's status, and response to interventions, and to modify, as appropriate, individuals' therapeutic and rehabilitation service plans. Each State Hospital shall ensure that all nursing shift changes include a review of changes in status of individuals on the unit.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Develop and implement a system for monitoring and tracking the key elements of this requirement.</p> <p>Findings: The facility has yet to implement this recommendation.</p> <p>Recommendation 2, September 2006: Develop and implement policies and procedures addressing criteria for shift change reports.</p> <p>Findings: MSH reported that the NP #710 (Change of Shift Report) was revised in February 2007/07 and that a Shift Change Monitoring Form was developed and implemented December 2006. The data presented by MSH could not be accurately interpreted. Data need to be separated out by monitoring indicator to accurately assess the compliance rates.</p>

		<p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a system for monitoring and tracking all elements of this requirement. 2. Restructured data for accurate interpretation. 3. Continue to monitor this requirement.
f	Each State hospital shall develop and implement a system to monitor nursing staff while administering medication to ensure that:	<p>Compliance: Partial.</p>
f.i	nursing staff are knowledgeable regarding each individual's prescribed medications;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Develop and implement a monitoring and tracking system to ensure nursing staff are knowledgeable regarding each individual's prescribed medications, including medical and psychiatric medications.</p> <p>Findings: MSH presented monitoring data that are summarized as follows:</p> <p>Medication Administration Monitoring Form:</p> <ol style="list-style-type: none"> 1. <i>Verbalized generic & trade names</i> 2. <i>Describes effects, doses, and routes</i> 3. <i>Side effects vs adverse effects</i> 4. <i>Sliding scale for Insulin</i> 4. <i>Symptoms/interventions of hypo/hyperglycemia</i>

	Sep	Oct	Nov	Dec	Jan	Feb	Mean
n	21	19	21	23	22	36	
%S	57	78	76	83	82	92	78
%C							
1	86	79	90	91	86	97	88
2	76	89	90	82	91	100	88
3	100	100	100	95	95	100	98
4	86	94	86	100	86	97	78

The facility presented data based on the Medication Administration Competency Validation Form. These data can not be accurately interpreted. The data needs to be presented by indicator to reflect accurate compliance rates.

MSH has assigned Nursing Coordinators to track mandatory training records (Nursing Annual Update) on February 28, 2007 to begin April 1, 2007.

Recommendation 2, September 2006:

Include unit supervisors in the process of observing medication administration.

Findings:

MSH reported that Unit Supervisors are now included in the process of observing medication administration. In addition, NP #500 (Medication Administration) was revised to include unit supervisors in the process of observing. The following is a summary of the facility's monitoring data (

N= Total Number of Unit Supervisors in the Hospital):

1. *Unit Supervisors Who Had Inter-rater Reliability Testing with Nursing Instructors.*
- 2.. *Unit Supervisors Who Conducted Medication Administration Monitoring.*

	Jan	Feb	Mean
N	17	17	
%C			
1	41%	47%	44%
2	12%	53%	34%

Recommendation 3, September 2006:

Develop and implement system to ensure that every nurse that administers medication is observed on a quarterly basis.

Findings:

The facility reported that the following steps have been taken addressing this recommendation:

Other findings:

This monitor did not conduct reviews through which the accuracy of the facility's data could be generally corroborated.

1. Nursing Coordinators were assigned to track mandatory medication certifications of all licensed staff assigned to administer medications (February 28, 2007) and instructed to send tracking data to CNS monthly.
2. Nursing Coordinators were assigned to track and monitor all licensed nursing staff assigned to administer medications every five months.
3. Nursing Coordinator in Central Nursing Services are to aggregate

		<p>data monthly and report deficiencies to Nursing Coordinators.</p> <ol style="list-style-type: none"> 4. Tracking forms were created and will be implemented April 1, 2007. 5. Provided training to 92% of all Unit Supervisors and Nursing Coordinator's March 14, 2007. <p>Due to the medication pass rotation at MSH, this recommendation will be changed to; ensure that every nurse that administers medication is observed every five months rather than on a quarterly basis.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Restructure data for accurate interpretation. 2. Ensure that every nurse that administers medication is observed every five months. 3. Continue to monitor this requirement.
f.ii	education is provided to individuals during medication administration;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Ensure staff competency regarding the implementation of this requirement.</p> <p>Findings: The facility reported that the systems that are in place addressing this recommendation including:</p> <ol style="list-style-type: none"> 1. Statewide Medication Administration Monitoring Form (indicator # 8); 2. Medication Administration Competency Validation Form (indicator # 4), implemented January 2007; and 3. Assigned Nursing Coordinators to track mandatory training records

(Nursing Annual Update) on February 28, 2007 to begin April 1, 2007.

Recommendation 2, September 2006:

Continue to monitor and track this requirement.

Findings:

The following is an outline of the facility's monitoring forms, indicators and compliance data:

Statewide Medication Administration Monitoring Form:

Educates the individual regarding medications.

	Sep	Oct	Nov	Dec	Jan	Feb	Mean
n	21	19	21	23	22	36	
%C	81	75	85	81	76	79	80

Medication Administration Competency Validation Form:

Educates the individual regarding medications.

	Jan	Feb	Mean
n	27	29	
%C	74	83	79

Other findings:

This monitor did not conduct reviews through which the accuracy of the facility's data could be generally corroborated.

		<p>Current recommendations: Continue to monitor this requirement.</p>
f.iii	nursing staff are following the appropriate medication administration protocol; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Revise monitoring instrument to reflect the complete medication administration protocol to ensure appropriate medication administration practices.</p> <p>Findings: MSH has revised the Medication Administration Monitoring Form and the Medication Administration Competency Validation Form to address this recommendation.</p> <p>Other findings: This monitor did not conduct reviews through which the accuracy of the facility's data could be generally corroborated.</p> <p>Current recommendations: Continue to monitor this requirement.</p>
f.iv	medication administration is documented in accordance with the appropriate medication administration protocol.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Continue to monitor this requirement.</p> <p>Recommendation 2, September 2006: Ensure staff competency regarding documentation of medication administration in accordance with the appropriate medication</p>

administration protocol.

Findings:

The following is an outline of the facility's monitoring data that address these recommendations:

Statewide Medication Administration Monitoring Form:

Documentation/Completion of MTR:

- 1. Reasons for PRN/STAT*
- 2. Involuntary/Emergency PRN/STAT*
- 3. Effects of PRN/STAT within 1 hour*
- 4. Signs controlled med log*
- 5. Documents on MTR immediately after med admin.*
- 6. Documents MTR med not taken & notifies physician*
- 7. Documents telephone orders*

Month	Sep	Oct	Nov	Dec	Jan	Feb	Mean
n	21	19	21	23	22	36	
%C							
1	91	100	100	87	100	94	95
2	91	83	100	100	100	92	94
3	83	83	80	89	93	88	86
4	59	75	88	82	93	84	80
5	84	95	89	95	91	97	92
6	93	71	86	92	77	100	87
7	82	100	89	92	100	100	94

		<p>Medication Administration Competency Validation Form:</p> <p><i>Documentation/Completion of the MTR.</i></p> <ol style="list-style-type: none"> 1. Reason for PRN/STAT med 2. Effects of PRN/STAT within 1 hour 3. Signs MTR & controlled med log 4. Documents med administration per protocol <table border="1" data-bbox="1014 537 1675 805"> <thead> <tr> <th></th> <th>Jan</th> <th>Feb</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>n</td> <td>27</td> <td>29</td> <td></td> </tr> <tr> <td>%C</td> <td></td> <td></td> <td></td> </tr> <tr> <td>1</td> <td>100</td> <td>100</td> <td>100</td> </tr> <tr> <td>2</td> <td>94</td> <td>100</td> <td>97</td> </tr> <tr> <td>3</td> <td>89</td> <td>86</td> <td>88</td> </tr> <tr> <td>4</td> <td>92</td> <td>96</td> <td>94</td> </tr> </tbody> </table> <p>Other findings: This monitor did not conduct reviews through which the accuracy of the facility's data could be generally corroborated.</p> <p>Current recommendations: Continue to monitor this requirement.</p>		Jan	Feb	Mean	n	27	29		%C				1	100	100	100	2	94	100	97	3	89	86	88	4	92	96	94
	Jan	Feb	Mean																											
n	27	29																												
%C																														
1	100	100	100																											
2	94	100	97																											
3	89	86	88																											
4	92	96	94																											
g	Each State hospital shall ensure that individuals remain in a "bed-bound" status only for clinically justified reasons.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Revise policies and procedures to address the key element in this requirement.</p>																												

Findings:

MSH has revised NP 304 (Care of the Individual with Impaired Mobility).

Recommendation 2, September 2006:

Revise monitoring and tracking system to address the key element of this requirement and the specific criteria for documentation to ensure accurate data.

Findings:

MSH has revised Bed-bound Individuals Monitoring Form (and Instructions). In addition, on February 15, 2007 cross-checking was completed on 45% of the Bed Bound Individuals audits. The facility audited all individuals deemed bed bound for that month. The following are the monitoring indicators and compliance rates for each indicator:

1. *Physician order identifies clinical reason for bed bound status.*
2. *WRP includes interventions for integration into milieu activities in and out of room.*
3. *Physician notes reflect clinical justification, period of containment, and ongoing progress.*
4. *Number of hours out in milieu recorded on Daily Flow Sheet*

Indicator	Mean %C
1	20
2	97
3	40
4	20

		<p>Other findings: This monitor did not conduct reviews through which the accuracy of the facility's data could be generally corroborated.</p> <p>Compliance: Partial.</p> <p>Current recommendations: 1. Separate data for Item #3 on DMH Bed-bound Individuals Monitoring Form. xxx 2. Continue to monitor this requirement.</p>
h	Each State hospital shall ensure that, before they work directly with individuals, all nursing and psychiatric technicians have successfully completed competency-based training regarding:	<p>Compliance: Partial.</p>
h.i	mental health diagnoses, related symptoms, psychotropic medications and their side effects, monitoring of symptoms and target variables, and documenting and reporting of the individual's status;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Develop and implement a reliable system to monitor and track staff that has not completed orientation and annual mandatory training.</p> <p>Findings: MSH reported the following regarding this recommendation:</p> <ul style="list-style-type: none"> • Competency Validation has been awarded after completion of class and skill demonstration during Nursing Orientation, Nursing Annual Updates and PMAB. • Nursing Coordinators were assigned to track this requirement using the Nursing Mandated Training Tracking Form.

		<ul style="list-style-type: none"> • Nursing Education has maintained database of Attendance Roster re: non-compliance of all initial and annual mandatory training including Nursing Annual Update <p>Recommendation 2, September 2006: Assign responsibility for follow-up for attendance at orientation and other required training.</p> <p>Findings: MSH reported that Nursing Coordinators have been assigned to track orientation and mandatory training records (Nursing Annual Update) on February 28, 2007.</p> <p>Recommendation 3, September 2006: Ensure completion of classes and skill demonstration prior to competency validation.</p> <p>Findings: MSH reported that Competency Validation is awarded after completion of class and skill demonstration during Nursing Orientation, Nursing Annual Updates and PMAB training.</p> <p>Current recommendations: Continue to monitor this requirement.</p>
h.ii	the provision of a therapeutic milieu on the units and proactive, positive interventions to prevent and de-escalate crises; and	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Ensure that there are training classes to specifically address therapeutic milieu on the units and proactive, positive interventions to</p>

		<p>prevent and de-escalate crises.</p> <p>Findings: The facility reported that Therapeutic Milieu Training is included in New Employee Orientation as well as in Nursing Education's New Curriculum (Lessons 3 & 4). PMAB Class is provided in New Employee Orientation and in Annual Updates. This training is ongoing.</p> <p>Recommendation 2, September 2006: Develop and implement a system to adequately monitor and track this requirement.</p> <p>Findings: MSH reported that Nursing Education maintains database of Attendance Roster regarding Therapeutic Milieu Training provided. Professional Education and Training maintains database of Attendance Roster regarding PMAB Training provided during orientation and in annual mandated update classes.</p> <p>MSH presented monitoring data from the Therapeutic Milieu Observation Monitoring Tool. However, the data are collected for all staff interventions with the Individual's, do not capture the specific requirement regarding nursing and are not delineated based on specific monitoring indicators.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Separate the Therapeutic Milieu Observation Monitoring data to reflect nursing to ensure nursing is promoting a therapeutic milieu and to identify training needs. 2. Continue to monitor this requirement.
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h.iii	positive behavior support principles.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Ensure that Program Directors are held responsible for any nursing staff, including psychiatric technicians, who do not attend scheduled PBS training.</p> <p>Findings: MHS reported that outcome of training data and % trained presented to the Nursing Coordinators, Program Directors and Clinical Administrator monthly. No data was provided to assess effectiveness of this process.</p> <p>Recommendation 2, September 2006: Develop and implement a system to ensure that nursing staff attend PBS training.</p> <p>Findings: The facility reported that PBS is now offered monthly in new employee orientation for all Employees' and that Nursing Education maintains database of Attendance Roster regarding PBS class attendance.</p> <p>Recommendation 3, September 2006: Continue to monitor and track attendance at PBS training.</p> <p>Findings: MSH reported that in January and February 2007, 66% of all nursing staff was trained on PBS.</p>
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		<p>Current recommendations: Continue to monitor this requirement.</p>
i	<p>Each State hospital shall ensure that, prior to assuming their duties and on a regular basis thereafter, all staff responsible for the administration of medication has successfully completed competency-based training on the completion of the MTR and the controlled medication log.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Assign responsibility and accountability at the program level for tracking and ensuring mandatory training and competency validation.</p> <p>Findings: MSH reported the following actions that address this recommendation:</p> <ul style="list-style-type: none"> • Assigned Nursing Coordinators to track orientation and mandatory training records (Nursing Annual Update) on February 28, 2007. • Nursing Education maintains database of Attendance Roster for all mandated classes. • Outcome of training data and % trained presented to the Nursing Coordinators, Program Directors and Clinical Administrator monthly <p>Compliance: Partial.</p> <p>Current recommendations: Continue to monitor this requirement.</p>

4	Rehabilitation Therapy Services
	<p>Each State hospital shall provide adequate, appropriate, and timely rehabilitation therapy services to each individual in need of such services, consistent with generally accepted professional standards of care.</p> <p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Aurora Hendricks, CNS 2. Adella Davis-Sterling, Acting SRN 3. Edward Arguijo, Speech Pathologist 4. Rebecca Arguijo, Speech Pathologist 5. Julie Duane, CNS, PMHNP 6. Portia Salvacion, Assistant Director of Dietetics 7. Mary Christina Marshall, Director of Dietetics 8. Mari Cobb, Rehabilitation Therapy Services Chief <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. DMH Integrated Rehabilitation Therapy Assessment form 2. MSH AD # 3414, Physical and Nutritional Management of Dysphagia. 3. Training rosters for Rehabilitation Therapy Integration dated 3/6/07 and 3/14/07, Mealtime Competency Training Checklist dated 3/8/07, Rehab Therapy Training to PT/OT/ST/RD dated 3/8/07, Functional IRTA Revisions dated 3/6/07, Bed/Wheelchair positioning for EB/JP dated 3/14/07. 4. Rehabilitation Therapy Manual. 5. Competency Report of MSH Staff after PT/OT Training. 6. Scope of Work draft for Occupational Therapist. 7. List of Dysphagia levels per individual. 8. Consolidated List of individuals by Dysphagia level, Vision issues, hearing issues, Speech issues, mobility issues, requiring side rails, and assistive devices. 9. List of individuals not on SNF with Assistive Device.

		<p>10. Physical Therapy roster of purchased equipment.</p> <p>11. Purchasing Authority Purchase Order for a wheelchair</p> <p>12. Nursing Policy/Procedure 102.2, Dysphagia/Choking Assessment.</p> <p>13. List of individuals with Care form Wheelchairs.</p>
a	Each State hospital shall develop and implement policies and procedures, consistent with generally accepted professional standards of care, related to the provision of rehabilitation therapy services that address, at a minimum:	<p>Compliance: Partial.</p>
a.i	the provision of direct services by rehabilitation therapy services staff; and	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Revise policies and procedures to include principles and language of the Wellness and Recovery Model, psychiatric rehabilitation, and recovery principles.</p> <p>Findings: The facility reported that the Rehabilitation Manual has been revised to include more principles and language of the Wellness and Recovery Model.</p> <p>Recommendation 2, September 2006: Integrate OT, PT, and Speech Therapy into the Rehabilitation Department as well as into the WRP and team process.</p> <p>Findings: The facility reported the following from its progress report:</p> <ol style="list-style-type: none"> 1. A new integrated Rehabilitation Therapy Assessment has been developed and fully implemented.

		<ol style="list-style-type: none"> 2. A new AD #3414 Physical Nutritional Management of Dysphagia, has been implemented. 3. Comprehensive dining plans have been implemented jointly by PT, OT, ST, RD, RN for level 1 Dysphagia. 4. A new policy 2.11 "Rehabilitation Therapy Integration" has been developed and implemented. 5. Training has been provided for RTs on their role in integrating services. 6. Training has been provided for all disciplines by ST on Mealtime competency. 7. Training has been provided for PT, OT ST, RD and nursing supervisors on the IRTA. 8. Training has been provided by PT/OT on wheelchair positioning. 9. Training for the comprehensive assessment by Bailey & Associates, consultants, is scheduled for May 2007. <p>Although OT, PT, and Speech Therapy have been integrated into the Rehabilitation Therapy Department, these therapies have not been fully integrated into the WRP process. I reviewed two individuals (KL and PS) receiving PT services and noted that there was no mention in the WRPs regarding the goals or objectives from their PT services.</p> <p>Current recommendations: Continue to integrate OT, PT, and Speech Therapy into the Rehabilitation Department and the WRPT process.</p>
a.ii	the oversight by rehabilitation therapists of individualized physical therapy programs implemented by nursing staff.	Current findings on previous recommendations:

		<p>Recommendation 1, September 2006: Develop and implement a system to provide regular oversight by rehabilitation therapists to nursing staff implementing individualized PT programs.</p> <p>Findings: There is currently no system in place addressing this recommendation.</p> <p>Recommendation 2, September 2006: Develop and implement a monitoring system to ensure that oversight by rehabilitation therapists of individualized physical therapy programs implemented by nursing staff is occurring.</p> <p>Findings: There is currently no system in place addressing this recommendation.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a system to provide regular oversight by rehabilitation therapists to nursing staff implementing individualized PT programs. 2. Develop and implement a monitoring system to ensure that oversight by rehabilitation therapists of individualized physical therapy programs implemented by nursing staff is occurring.
b	Each State hospital shall provide competency-based training to nursing staff, as appropriate, on the use and care of adaptive equipment, transferring, and positioning, as well as the need to promote individuals' independence.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Develop and implement a system to provide and document competency-based training on this requirement.</p>

Findings:

MSH reported that training has been provided by PT, OT to nursing services thus far. (See table below) However, there has not been a system developed and implemented addressing this requirement.

Month Trained	# Trained (n)	# Passed (95% threshold)	% Compliance
September	0	0	NA
October	3	3	100%
November	26	26	100%
December	2	2	100%
January	0	0	NA
February	6	2	33%

Recommendation 2, September 2006:

Develop and implement a monitoring system to ensure that competency-based training is provided for this requirement.

Findings:

MSH reported that in April 2007 it will begin to maintain a training database addressing this recommendation.

Compliance:

Partial.

Current recommendations:

1. Develop and implement a system to provide and document competency-based training on this requirement.
2. Develop and implement a monitoring system to ensure that competency-based training is provided for this requirement.

c	<p>Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Develop and implement a system to adequately monitor this requirement.</p> <p>Findings: The facility reported the following actions:</p> <ol style="list-style-type: none"> 1. A database has been established by the ST to assess and track all Dysphagia levels 1,2,3 and 4. 2. Proactive screening is done by the RT for physical functioning. Individuals needing assessment are referred to PT, OT, and ST. 3. Proactive screening is done by the RD for high-risk individuals within the first 24 hours of admission. This includes tube feeding and Dysphagia. 4. Proactive screening is completed by the RN during the 1st 8 hours and referrals for assessment and interventions are made to the RD and ST. 5. OT PT has trained the physician group on the referral process in order to increase referrals. <p>A system needs to be developed and implemented to address this recommendation.</p> <p>Recommendation 2, September 2006: See Recommendations for Rehabilitation Therapy Assessments.</p>

		<p>Findings: A system needs to be developed and implemented to address this recommendation.</p> <p>Compliance: Partial.</p> <p>Current recommendations: Develop and implement a system to adequately monitor this requirement.</p>
d	<p>Each State hospital, consistent with generally accepted professional standards of care, shall ensure that each individual who requires adaptive equipment is provided with equipment that meets his/her assessed needs and promotes his/her independence, and shall provide individuals with training and support to use such equipment.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Develop and implement a system to monitor the key elements of this requirement.</p> <p>Findings: MSH reported that Meetings have occurred to discuss the process of acquiring adaptive equipment, but no outcome data is available. Consultation has occurred with vendors on how to streamline the process of obtaining adaptive equipment and one adaptive wheelchair has been ordered.</p> <p>Compliance: Partial.</p> <p>Current recommendations: Develop and implement a system to adequately monitor this requirement.</p>

5	Nutrition Services	<p>Each State hospital shall provide the individuals it serves, particularly those experiencing weight-related problems, adequate and appropriate dietary services consistent with generally accepted professional standards of care.</p> <p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Mary Christina Marshall, Director of Dietetics 2. Portia Salvacion, Assistant Director of Dietetics 3. Ninfa Guzman, RD, Hospital Administration Resident 4. Briefly spoke with Gloria Figueroa, Unit Supervisor for Unit 420 5. Briefly spoke with Josie Agtarap, Supervising Registered Nurse Unit 419 <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Nutrition Care Process, goals objectives, and activities 2. F5 Monitoring Tool draft 3. MSH Monitoring Data Report, F5 Nutrition Services Monitoring tool and data 4. MSH AD # 3133, Wellness and Recovery Plan 5. MSH AD #3204, Individual Meal Service and Nutrition Care revised draft 6. MSH AD # 3413, Clinical Nutrition- Weight Management Protocol 7. Risk Assessment by WRPT instrument and data sheets 8. Dietetic Service Clinical Dietitian Monthly Report form 9. Study B Department for Dietetics Clinician Audit: Axis III and Focus 6 and data summary 10. Wellness and Recovery Plan Conference audit tool 11. Study C MSH Monitoring Data Report, WRP Chart audit/SNF data 12. Roster of employees trained on BMI and Weight Management Protocol
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		<ol style="list-style-type: none"> 13. MSH AD # 3414, Physical and Nutritional Management of Dysphagia 14. MSH Procedure # 4109.00, Guidelines for the Physical and Nutritional Management of Dysphagia/At Risk for Choking and /or Aspiration/Aspiration Pneumonia/Gastroesophageal Disorder 15. Nursing Policy 102.2, Physical and Nutritional Management Plan (PNMP) For Dysphagia 16. Dysphagia/Choking Screening tool 17. Management of Dysphagia/High Risk for Choking In-Service Lesson Plan 18. Managing Dysphagia post test 19. Dysphagia Risk Levels form 20. WRPs and associated Dysphagia documentation, dinning plans and assessments for JP and EG 21. Augmentative & Alternative Communication Evaluations for SP, DC, LB, and JL 22. Unit 419 seating plan for meals 23. Daily Tracking Sheet for Aspiration/Choking Triggers form 24. The "PT-OT-ST action plan" dated 1/22/07 25. DMH Integrated Rehabilitation Therapy Assessment and guidelines 26. Training Needs for Enhancement Plan report 27. Training roster for Bed and W/C positioning and Mealtime Competency training for EG and JP 28. Mealtime Competency-Based Training Checklist 29. Enhancement Training Grid Worksheet 30. MSH Dysphagia Level list 31. Training curriculum and pre-/post-tests for Nutrition Management of Diabetes Mellitus/Weight-Health Issues,
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		<p>Nutrition Assessment and Incorporation into the Wellness and Recovery Plan (WRP), RN/Nursing Training Orientation Annual Update, and Weight Management</p> <p>32. MSH Nursing Education/Professional Education & Training calendar for February 2007</p> <p><u>Toured:</u> Units 418, 419, and 420.</p>
a	<p>Each State hospital shall modify policies and procedures to require that the therapeutic and rehabilitation service plans of individuals who experience weight problems and/or related health concerns include adequate strategies and methodologies to address the identified problems and that such strategies and methodologies are implemented in a timely manner, monitored appropriately, and revised, as warranted, consistent with generally accepted professional standards of care.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Develop and implement a system to monitor this requirement.</p> <p>Findings: MSH reported that the Statewide Nutrition Care Monitoring tool draft for these cells was implemented for the January/February 2007 monitoring. The instructions have not yet been completed. The Weight Management Protocol has been converted to an AD, #3413. In addition, MSH reported that they conducted studies to monitor the implementation and the opening of the Axis III, Focus 6 weight-related health concerns and methodologies to address the identified problems.</p> <p>MSH reported that from a review of 28 individuals with a BMI of 40 or greater, 23 had Obesity opened under Axis III, Focus 6. In addition, MSH reviewed a sample of 28 individuals' WRPT conferences held in January 2007 that were attended by the registered dietician/dietetic technician, registered. Of these 28 charts reviewed, 19 had a medical nutrition problem for weight opened in the Axis III, Focus 6 and six</p>

		<p>who were identified individuals with Obesity or Overweight issues, did not have these problems opened.</p> <p>It appears that MSH is actively reviewing individuals who have weight problems and/or related health concerns. The process needs to continue to include plans of correction for those individuals who have not had the appropriate Axis III, Focus 6 initiated as well as reviewing the timeliness and adequacy of the strategies and methodologies implemented by the WRPTs.</p> <p>The facility is in the process of developing and implementing a monitoring instrument addressing the elements of this requirement. The F5 Monitoring Tool draft is currently being evaluated by the facility.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Develop and initiate plans of correction for those individuals who have not had the appropriate Axis III, Focus 6 initiated. 2. Implement monitoring instrument for this requirement when approved. 3. Continue to monitor the elements of this requirement.
b	Each State hospital shall ensure that one or more treatment team members demonstrate competence in the dietary and nutritional issues affecting the individuals they serve and the development and implementation of strategies and methodologies to address such issues.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Develop and implement a monitoring system to ensure that one or more treatment team members demonstrate competence in the dietary and</p>

		<p>nutritional issues affecting the individuals they serve and the development and implementation of strategies and methodologies to address such issues.</p> <p>Findings: MSH reported that the Nutrition Care Monitoring Tool (NCMT) F.5 cell draft has been implemented.</p> <p>Recommendation 2, September 2006: Develop and implement a statewide tool for the training of staff regarding this requirement.</p> <p>Findings: MSH reported that training of the WRPT members is currently being conducted for Weight Management Protocol, Nutrition Management of Diabetes Mellitus and Weight Related Issues, Management of Dysphagia and High Risk of Choking, and statewide approved class for WRP Representation.</p> <p>The training modules, PowerPoint presentations, and post-tests were submitted to and approved by DMH Statewide Nutrition Group. MSH reported that the training started in January 2007 for new nursing staff as part of the Nursing Orientation Program.</p> <p>In addition, MSH has increased the attendance of the Registered Dietician and Dietetic Technician, Registered at the WRPT meetings.</p> <p>MSH submitted data regarding this recommendation. However, the data are unclear as to what they reflected. In addition, the data submitted regarding training do not indicate how many treatment team</p>
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		<p>members have been trained and demonstrated competence in the dietary and nutritional issues, how many have been trained and did not demonstrate competence, and how many have not yet received the training.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Restructure data to clarify what information is being presented in alignment with the EP. 2. Continue to monitor the elements of this requirement.
c	<p>Each State hospital shall develop and implement policies and procedures to address the needs of individuals who are at risk for aspiration or dysphagia, including but not limited to, the development and implementation of assessments and interventions for mealtimes and other activities involving swallowing.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Ensure that this requirement is met.</p> <p>Findings: MSH reported that the Rehabilitation Services Department and Chief has taken the lead in this process.</p> <p>Recommendation 2, September 2006: Revise policies and procedures in accordance with generally accepted standards of practice regarding risk of aspiration/ dysphagia.</p> <p>Findings: MSH reported that the Department of Dietetics Policy/Procedure/ Protocol 4109.001 was revised to meet this requirement and has been converted to AD #3414.</p>

		<p>This needs to be an ongoing process as the system for Dysphagia continues to be developed and implemented.</p> <p>Recommendation 3, September 2006: Develop and implement 24-hour, individualized dysphagia care plans.</p> <p>Findings: Thus far, MSH has developed plans and meal plans for the Level 1 (highest-risk) individuals. From my review of the charts for the two individuals (JP and EG) who have been identified as Level 1 and my conversation with the Supervising Registered Nurse (SRN) on unit 419, there is a significant increase in both awareness and knowledge regarding Dysphagia.</p> <p>Although the WRPs for these individuals listed proactive interventions such as regular monitoring and documenting of lung sounds, oxygen saturations, and individual trigger symptoms, I did not consistently find this documentation in the charts.</p> <p>Recommendation 4, September 2006: Provide competency-based training to staff regarding risk of aspiration/dysphagia.</p> <p>Findings: MSH reported that competency-based training was been conducted on November 6-7, 2006, January 24, and February 22 2007 in Nursing Orientation. This should be an ongoing process.</p> <p>Recommendation 5, September 2006: Provide competency-based training on individualized, 24-hour dysphagia</p>
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		<p>care plans to staff working with individuals at risk of aspiration/dysphagia.</p> <p>Findings: MSH reported that competency-based training was provided on March 8 & 14 2007 by the Speech Therapist, OT and PT. As noted above, this should be an ongoing process.</p> <p>Recommendation 6, September 2006: Develop and implement a monitoring system for this requirement.</p> <p>Findings: MSH reported that the NCMT for this requirement has been developed by the DMH Nutrition Care Task Force. However, the data that were provided cannot be interpreted.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Restructure data to clarify what information is being presented in alignment with the EP. 2. Continue to revise policies and procedures in accordance with generally accepted standards of practice regarding risk of aspiration/ dysphagia. 3. Continue to develop and implement 24-hour, individualized dysphagia care plans. 4. Continue to provide competency-based training to staff regarding risk of aspiration/dysphagia. 5. Provide competency-based training on individualized, 24-hour
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		<p>dysphagia care plans to staff working with individuals at risk of aspiration/dysphagia.</p> <p>6. Continue to develop and implement a monitoring system for this requirement.</p>
d	<p>Each State hospital shall ensure that staff with responsibilities for assessments and interventions regarding aspiration and dysphagia has successfully completed competency-based training commensurate with their responsibilities.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Ensure staff competency-based training regarding the implementation of this requirement.</p> <p>Findings: Same as F.5.c, under Findings for Recommendation 4.</p> <p>Recommendation 2, September 2006: Develop and implement a monitoring system regarding this requirement.</p> <p>Findings: Same as F.5.c, under Findings for Recommendation 6.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Restructure data to clarify what information is being presented in alignment with the EP. 2. Continue to ensure staff competency-based training regarding the implementation of this requirement. 3. Continue to develop and implement a monitoring system regarding this requirement.

e	<p>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.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Revise policies and procedures to reflect key elements of this requirement.</p> <p>Findings: The MSH Department of Dietetics Policy #4109, Enteral Nutrition Support addressing this requirement was completed.</p> <p>Recommendation 2, September 2006: Develop and implement a system to monitor this requirement.</p> <p>Findings: Same as F.5.c, under Findings for Recommendation 6.</p> <p>Other findings: No data was submitted specific to individuals who are enterally fed regarding the elements of this requirement.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Restructure data to clarify what information is being presented in alignment with the EP. 2. Continue to develop and implement a monitoring system regarding this requirement.
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6	Pharmacy Services	
	<p>Each State hospital shall provide adequate and appropriate pharmacy services consistent with generally accepted professional standards of care. Each State hospital shall develop and implement policies and procedures that require:</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Harold Plon, PharmD 2. Glen Itow, Director of Pharmacy 3. Quydh-NGA Ton-Nu, PharmD <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Pharmacy New Medication Review data collection instrument 2. In-service training sheets for Clinical Pharmacy Application Updates and In-service for November 15, 2006 and February 6, 2007 3. The Pharmacy Department policy; Medication Orders-Inpatient 4. The Pharmacy Department policy; Clinical Drug Review 5. Pharmacy compliance data for recommendations followed and new medication reviews from October 2006 to February 2007
a	<p>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</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Complete and implement an electronic system for documentation.</p> <p>Findings: MSH reported that the completion and implementation of an electronic documentation system for pharmacy has been completed as of October 2006.</p> <p>Recommendation 2, September 2006: Provide IT assistance to pharmacy regarding electronic database and</p>

data collection systems.

Findings:

IT assistance has been provided to the pharmacy to automate needed data. However, the pharmacy reports that problems continue to exist with the state's POH system, making it difficult to isolate new medications orders from any new order written. During this review, the state IT department was notified of the issue and has begun to address the problem in collaboration with the pharmacy department.

Recommendation 3, September 2006:

Ensure pharmacy staff competency regarding this requirement.

Findings:

The facility submitted in-service sheets indicating that training was conducted on November 11, 2006 and February 6, 2007.

Other findings:

Reviewed new physician orders, MSH has monitoring orders that are summarized as follows:

Month	Oct	Nov	Dec	Jan	Feb
Total new physician orders (N)	NA	NA	131	199	156
New physician orders reviewed (n)	30	64	97	117	80
%S	NA	NA	74	59	51
Drug interaction	100%	100%	100%	98.3%	96.3%
Side Effects	100%	100%	100%	100%	100%
Labs	100%	100%	100%	99.1%	99.8%

		<p>Compliance: Substantial compliance.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to provide the needed IT support in collaboration with the pharmacy department. 2. Continue to monitor the elements of this requirement.
b	Physicians to consider pharmacists' recommendations, and for any recommendations not followed, document in the individual's medical record an adequate clinical justification.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Develop and implement policies and procedures in collaboration with pharmacy and medical/psychiatry to address this requirement.</p> <p>Findings: MSH submitted a pharmacy policy regarding Medication Orders that requires physicians to consider pharmacists' recommendations and for any recommendations not followed, adequate clinical justification will be documented in the individual's medical record and monitored for such by pharmacy. The facility reported that this policy was accepted by the Pharmacy & Therapeutics Committee on 2/8/07. However, there is currently not a corresponding medical/psychiatric policy addressing the responsibility and actions required by the medical staff.</p> <p>Recommendation 2, September 2006: Assign responsibility and accountability to medical/psychiatry for plans of corrections for problems identified.</p> <p>Findings: Although MSH reported this recommendation as completed, my</p>

interviews with the pharmacy staff indicated that this issue has not been formally addressed.

Recommendation 3, September 2006:

Develop and implement a monitoring system for this requirement.

Findings:

A monitoring instrument has been developed and implemented to track pharmacy recommendations and physician responses. However, as mentioned above, a process for follow-up by the medical department has not yet been developed and implemented.

Other findings:

To assess compliance, MSH reviewed all instances of pharmacists' recommendations to physicians to determine physicians' responses. The following is a summary of the facility's compliance data:

Month	Oct	Nov	Dec	Jan	Feb
n	200	191	189	186	155
%C					
Recommendations followed	61	64.4	60.8	44.6	60.6
Not followed with justification	0	5.2	2.1	3.2	5.8
Not followed without justification	3.5	5.8	1.6	1.1	6.5
Non-response	35.5	24.6	35.4	51.1	27.1

Compliance:

Partial.

		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a policy addressing the responsibility and required actions by the medical staff regarding pharmacy recommendations. 2. Assign responsibility and accountability to medical/psychiatry for plans of corrections for problems identified. 3. Continue to monitor this requirement.
7	General Medical Services	
		<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Vinh Bach, M.D., Director of Medical Services 2. Adale Davis-Sterling, RN, Supervising Nurse 3. Niza Uy-Uyan, MD, Staff Physician and Surgeon 4. Thai Vu, DO, Staff Physician and Surgeon 5. Murni Lubis, M.D., Staff Physician and Surgeon 6. Quynh Pham, DO, Staff Physician and Surgeon 7. Raymond Flores, MD, Staff Physician and Surgeon <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Charts of six individuals (JS, EB, PW, DR, TR and RS) who were hospitalized at a general medical facility during the past year 2. Medical Services Medical Care Policy and Procedure (January 16, 2007) 3. AD #3304 Emergency Medical Response System 4. Drill Medical Emergency Response Work Sheet 5. Duty Statement Physician and Surgeon 6. Consultation Referral and Report

		<ol style="list-style-type: none"> 7. Medical Director's memorandum regarding Physical Examination Deferred/Refused 8. Admission Psychiatrist Assessment Monitoring Form 9. Admission Medical Assessment summary data (September 2006 to February 2007) 10. Ongoing Medical Care Monitoring Form 11. Ongoing Medical Care Monitoring summary data November 2006 to January 2007 12. Non-emergent Medical Care Monitor 13. Non-emergent Medical Care Monitoring summary data (November 2006 to January 2006) 14. Medical Emergency Response Monitoring Form 15. Medical Emergency Response Monitoring Data (September 2006 to February 2007) 16. Quality of Care (Diabetes) Monitoring Form 17. Quality of Care (Diabetes) Monitoring summary data November 2006 and January and February 2007 18. Quality of Care (Hypertension) Monitoring Form 19. Quality of Care (Hypertension) Monitoring summary data (October and December 2006 and January and February 2007) 20. Quality of Care (Asthma/COPD) Monitoring Form 21. Quality of Care (Asthma/COPD) Monitoring summary data (September and December 2006 to February 2007) 22. STAT/Accuracy of X-ray Monitoring Form 23. STAT/Accuracy of X-ray Monitoring summary data (October 2006 to February 2007) 24. STAT/Routine EKG Monitoring Form 25. STAT/Routine EKG Monitoring summary data (October 2006 to February 2007) 26. STAT/Critical Laboratory Monitoring Form
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		<p>27. STAT/Critical Laboratory Monitoring summary data (October 2006 to February 2007)</p> <p>28. Training curriculum for non-psychiatric physicians, including pre and post-tests (and test scores) regarding psychiatric emergencies</p> <p>29. AD #2004 Physicians of the Day (P.O.D)</p> <p>30. MSH Tracking System For Retrieving Medical Records From Outside Facilities After Individual Returns With No Records</p> <p>31. Outside Appointments and Hospitalization Monitoring Form</p> <p>32. Outside Appointments and Hospitalization Monitoring summary data (October 2006 to February 2007).</p> <p>33. Medical Conditions Focus 6 Monitoring Form</p> <p>34. Medical Conditions Focus 6 Monitoring summary data (February 2006)</p> <p>35. Medical Staff Audit form-Physicians (non-psychiatrists)</p> <p>36. MSH overview data regarding individuals with Metabolic Syndrome</p> <p>37. Medical Director's memorandum regarding Laboratory Information System (LIS)</p>
a	<p>Each State hospital shall provide adequate, appropriate, and timely preventive, routine, specialized, and emergency medical care to all individuals in need of such services, consistent with generally accepted professional standards of care. Each State hospital shall ensure that individuals with medical problems are promptly identified, assessed, diagnosed, treated, monitored and, as monitoring indicates is necessary, reassessed, diagnosed, and treated, consistent with generally accepted professional standards of care.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Develop and implement policy and procedure to codify facility's standards and expectations regarding the areas outlined above.</p> <p>Findings: MSH has revised its Medical Services Medical Care Policy and Procedure (January 16, 2007). The revised policy and the current duty statement address the standards and expectations outlined in the baseline report. However, the policy has yet to meet the following requirements:</p>

		<ol style="list-style-type: none"> 1. Definitions of routine, urgent and emergent medical conditions and corresponding time frames for physicians' responses; 2. Formalized mechanisms for review and follow up corrective actions regarding medical emergency response and drill practice; 3. Formalized mechanisms for physician-nurse communications and documentation of these communications to ensure timely recognition by nursing of the change in the medical condition and notification of the physician of this change; 4. Formalized mechanisms for review, filing and physician follow up regarding laboratory reports and consultations; and 5. Physician's review of various medical risks, including contributing factors and recommendations for interdisciplinary interventions. <p>Recommendation 2, September 2006: Ensure that monitoring instruments are aligned with the policy and procedure and that the data address not only timeliness and completeness of medical assessments but also quality of assessments and management interventions.</p> <p>Findings: The facility used the following monitoring mechanisms to assess compliance with EP requirements regarding medical services:</p> <ol style="list-style-type: none"> 1. Admission Psychiatric Assessment Form: MSH used this form to assess compliance with EP requirements regarding the timeliness and content of the initial medical assessment. The monitoring data are outlined in D.1.c.i. The facility does not have a formalized mechanism, to ensure that a physician and surgeon is responsible for the data regarding the initial medical examination.
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2. **Ongoing Medical Care Monitoring:** Cases were randomly selected from the total population (approximately 700) to find 40 charts of individuals requiring ongoing medical care (for chronic conditions). The actual number of individuals requiring ongoing medical care was not determined, so the total target population (N) and % sample size were only estimates. The following is an outline of the monitoring indicators and a table containing summary of the monitoring data ((N=total target population; n=target population reviewed; % S=sample size and %C=compliance rate):

1. *Was an appropriate medical (acute/chronic) conditions and treatment been addressed and documented?*
2. *If applicable, was an appropriate medical work up (lab, X-ray, consultation etc...) done?*
3. *If yes on # 2, has the physician reviewed and followed up on the test results and/or the recommendations of the consultants?*
4. *If the individual's condition is required to be managed by the outside facility, has the individual been transferred for continuing care in a timely manner and documented in the chart?*
5. *Was medical care adequate and appropriate as recommended by the medical society/hospital policy?*
6. *Has the annual physical exam been completed in a timely manner?*
7. *Have all the chronic medical conditions been addressed and integrated into the WRP?*

	Nov	Dec	Jan	Feb	Mean
N*	350	350	350	350	
n	40	40	40	40	

%S	11	11	11	11	
%C					
1	95	100	97	100	98
2	93	97	92	95	94
3	95	97	82	87	90
4	100	100	100	100	100
5	100	95	100	88	96
6	91	NA	92	90	91
7	100	100	92	97	97
Mean	96	98	94	94	95

3. **Non-emergent Medical Care Monitoring:** The medical service reviewed the care provided for individuals that required non-emergent medical interventions (for acute conditions) during the period of November 2006 to January 2007. The following are the monitoring indicators and a table that summarizes the data:

1. *Was the patient seen in a timely fashion (within one hour for non-life-threatening emergencies)?*
2. *Was an appropriate history documented?*
3. *Was an appropriate physical examination performed and documented?*
4. *Was an appropriate differential diagnosis generated?*
5. *If there was tissue damage, was tetanus status ascertained?*
6. *If patient suffered a human bite or exposure to blood/body fluid, was HIV & hepatitis screening performed?*
7. *Were appropriate diagnostic steps (lab, x-ray, etc.) undertaken?*
8. *Was medical care adequate & appropriate?*

	Nov	Dec	Jan	Mean
N*	40	34	36	
n	19	17	18	
%S	48	50	50	
%C				
1	100	100	100	100
2	100	100	100	100
3	100	100	100	100
4	86	100	90	92
5	NA	NA	NA	NA
6	NA	NA	NA	NA
7	100	100	100	100
8	100	100	100	100
Mean	98	100	98	99

4. **Medical Emergency Response:** The Director of the Medical Service reviewed all episodes of medical emergency response (MER) that occurred during September 2006 to January 2007. The following are the monitoring indicators and a summary of the data:

1. *EMS activated (dialed #6)*
2. *Time physician arrived within 15 minutes*
3. *Time HSS arrived within 15 minutes*
4. *Time paramedics arrived within 15 minutes*
5. *Vital signs recorded?*
6. *CPR initiated?*
7. *AED applied?*
8. *Oxygen initiated 2L/minute or more?*
9. *Transfer to off-site hospital?*

	Sep	Oct	Nov	Dec	Jan	Feb	Mean
N*	4	5	4	3	3	1	
n	4	5	4	3	3	1	
%S	100	100	100	100	100	100	
%C							
1	100	100	100	100	100	100	100
2	34	80	100	100	100	100	100
3	66	100	100	100	67	100	100
4	100	100	100	100	100	100	100
5	NA	NA	NA	NA	NA	NA	NA
6	NA	NA	NA	NA	NA	NA	NA
7	100	100	100	100	100	100	100
8	86	86	100	100	96	100	100
Mean	93	93	100	100	98	100	100

5. **Quality of Care (Diabetes) Monitor:** The medical service reviewed a sample of the total target population of individuals diagnosed with diabetes mellitus to assess care provided to these individuals. Monitoring was conducted for November 2006, and January and February 2007. The following are the monitoring indicators and a summary of the data:

1. *Is blood pressure $\leq 130/80$?*
2. *Is Blood glucose (FBS, Glucoscan) currently monitored?*
3. *Is Quarterly HgbA1C $< \text{ or } = 7\%$?*
4. *Is FBS $< 126\text{g/dl}$?*
5. *Is Dyslipidemia present?*
6. *If yes to #5, has it been treated?*
7. *Is HDL level M > 45 , F > 55 ?*
8. *LDL level < 100 ?*

9. *Triglyceride <=150?*
10. *Does individual have a BMI >=27?*
11. *Has special diet been ordered?*
12. *Has weight control program been initiated?*
13. *Has dietary consultation been ordered within 30 days?*
14. *Has diabetes education been given?*
15. *Is diabetes diagnosis discussed and included in Wellness & Recovery Planning Conference? (WRPC)*
16. *Is Diabetes included on Focus 6 in the WRP?*
17. *Is Diabetes included on Axis III in the WRP?*
18. *Does the WRPC reflect objectives and interventions for Diabetes?*
19. *Unless contraindicated, (and if individual is age 40 or older), has aspirin been ordered for the individual.*
20. *Has ophthalmologist/optometrist completed an eye exam at least annually with the individual?*
21. *Has foot care been given at least annually by podiatrist?*
22. *Have monofilament and foot circulation tests been completed?*
23. *If hypertension is present, has it been treated?*

	Nov	Jan	Feb	Mean
N*	75	73	75	
n	43	22	27	
%S	57	30	36	
%C				
1	41	70	74	62
2	93	77	96	89
3	72	81	84	79
4	63	59	82	68
5	54	55	65	58

	Nov	Jan	Feb	Mean
6	82	90	82	85
7	29	48	23	33
8	83	86	81	83
9	66	68	89	74
10	68	55	67	63
11	95	91	85	90
12	84	71	82	79
13	50	94	83	76
14	81	96	96	91
15	81	96	100	92
16	86	96	100	94
17	88	96	93	92
18	79	96	96	90
19	75	78	75	76
20	87	90	96	91
21	79	91	92	87
22	67	74	81	74
23	91	91	92	91
Mean	74	80	83	79

6. **Quality of Care (Hypertension) Monitor:** The facility used a similar mechanism to assess the care provided to individuals diagnosed with hypertension. Monitoring was conducted for October and December 2006 and January and February 2007. The following is an outline of the data:

1. *Is blood pressure < 130/80?*
2. *Is Dyslipidemia present?*

3. *If yes to #2, has it been treated?*
4. *Is HDL level M>45, F>55?*
5. *LDL level <100?*
6. *Triglyceride < 150?*
7. *Does the individual have a BMI >27?*
8. *Has a special diet been ordered?*
9. *Has a weight control program been initiated?*
10. *Has dietary consultation been ordered within 30 days?*
11. *Does the individual have a history of smoking?*
12. *If the individual is currently a smoker, is smoking cessation discussed and included in the WRPC?*
13. *Has ophthalmologist/optometrist completed an eye exam at least annually with the individual?*
14. *Unless contraindicated, (and if the individual is age 40 or older) has aspirin been ordered for the individual?*
15. *Is Hypertension included on focus 6?*
16. *Does the WaRMSS reflect objectives and interventions for Hypertension?*

	Oct	Dec	Jan	Feb	Mean
N*	73	77	74	75	
n	33	14	20	24	
%S	45	18	27	32	
%C					
1	56	46	60	63	56
38	71	31	60	44	52
3	91	100	67	80	85
4	30	57	38	43	42
5	53	17	50	70	48
6	64	67	53	73	64

	Oct	Dec	Jan	Feb	Mean
7	65	58	75	79	69
8	91	92	90	71	86
9	90	67	94	75	82
10	55	80	100	47	71
11	78	100	84	75	84
12	15	27	41	58	35
13	90	100	95	82	92
14	76	85	89	65	79
15	85	100	100	91	94
16	82	100	100	95	94
Mean	68	70	75	69	71

7. **Quality of Care (Asthma/COPD) Monitor:** The facility has monitoring data for individuals diagnosed with Asthma/COPD (September and December 2006 to February 2007). The following is a list of the indicators and a data summary:

1. *If Shortness of Breath (SOB) present, has peak expiratory flow rate (PEER) been checked?*
2. *Has Asthma/COPD been included in WRP Axis III diagnosis?*
3. *Has Asthma/COPD been included in focus 6 of the WRP?*
4. *If individual smokes, is a smoking cessation intervention discussed and included in individual's WRP conference?*
5. *If the individual has been here for one year, documentation evident of a yearly flu vaccination?*

	Sep	Dec	Jan	Feb	Mean
N*	50	50	50	50	
n	4	6	13	27	
%S	8	12	26	54	
%C					
1	40	17	50	50	39
2	57	84	58	56	64
3	86	50	88	85	77
4	28	0	9	41	20
5	63	100	33	54	63
Mean	55	50	48	57	53

Recommendation 3, September 2006:

Ensure easy access by physicians to the laboratory information system, radiology data/reports, chart notes and consultation reports.

Findings:

MSH has contracted to purchase an Automated Laboratory Information System (LIS). The system utilizes a barcode system intended to eliminate errors related to individuals' information and test results. The system should make test results available as soon as they are performed by using an electronic interface between the LIS and laboratory equipment (analyzers). Anticipated advantages include easy access by physicians/nurses to archived results and improved alerts to physicians of significant changes in results.

The facility has monitoring data to assess systems for reporting of x-ray, EKG and STAT/critical laboratory results. The following is a summary of compliance:

	Oct 2006	Nov 2006	Dec 2006	Jan 2007	Feb 2007
1. STAT x-ray orders should be done within one hour	100%	72%	100%	100%	100%
2. Accuracy of x-ray interpretation by PMC	100%	100%	98%	100%	98%
3. STAT EKGs notified within 30 minutes	100% (2/2)	None	100% (2/2)	100% (2/2)	100% (3/3)
4. Timely reporting of EKG within 48 hours	100% (64/64)	100% (51/51)	100% (59/59)	100% (62/62)	100% (52/52)
5. Critical and STAT lab result monitoring	100% (22/22)	100% (31/31)	100% (12/12)	100% (32/32)	100% (30/30)

Recommendation 4, September 2006:

Same as in C.1.c.i.

Findings:

Same as in C.1.c.i

Other findings:

The monitor reviewed the charts of six individuals who were transferred to outside medical facilities during the past year and interviewed the physicians and surgeons who were involved in their care. The following table outlines the individuals' initials, the reason for the transfer, the date/ and time of the medical evaluation upon the transfer and the date and time of actual transfer:

Individual's initials	Reason for transfer	Date/time of evaluation	Date/time of transfer
JS	Syncopy with hypotension	01/31/2007 10:00	01/31/07 10:00
EB	Hypotension	02/22/07 11:55	Not specified.
PW	Seizure activity	02/06/07 07:45	02/06/07 08:05
DR	Lithium toxicity	12/21/06 13:00	Not specified
TR	Cellulitis, Right Buttock	11/18/2006 19:00	Not specified
RS	Seizure activity	10/27/06 11:15	10/27/06 11:20

The review showed that, in general, the facility provided adequate and timely care to these individuals. However, there are a number of deficiencies that must be corrected in order to achieve substantial compliance with requirements of the EP. The following are case examples:

1. DR: There is evidence of delay in the recognition of a serious medical condition. The individual fell during a WRPT meeting attended by the physician and was transferred in a timely manner to an outside facility due to severe lithium toxicity. However, there is no documentation by nursing of a change in the individual's balance/motor function prior to the team meeting.
2. TR: the individual had a fever due to possible cellulitis (on November 17, 2006), without evidence of appropriate intervention

		<p>by the on-call physician.</p> <ol style="list-style-type: none"> 3. PW: The nurse's documentation of the change in the medical condition fails to include the time of physician notification. In this case, the physician witnessed recurrent seizure activity but did not document important events during that episode. 4. EB: The physician was unable to find documentation in the chart of when the change of the medical status was recognized and of the timeliness of the nurse's notification of the physician about this change. <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that the medical policy and procedure adequately address all of the requirements outlined in the findings under recommendation 1, September 2006. 2. Implement the revised medical policy and procedure. 3. Continue to monitor this requirement and ensure at least 20% sample size. 4. Consolidate the monitoring instruments utilizing indicators that are aligned with the policy and procedure, that address preventive, routine, specialized and emergency care and that are integrated with the peer review system.
b	Each State hospital shall develop and implement protocols and procedures, consistent with generally accepted professional standards of care, that:	
b.i	require the timely provision of initial and ongoing assessments relating to medical care, including but not	Current findings on previous recommendation:

	<p>limited to, vision care, dental care, and laboratory and consultation services;</p>	<p>Recommendation, September 2006: Same as above.</p> <p>Findings: Same as above.</p> <p>Compliance: Partial.</p> <p>Current recommendations: Same as above.</p>
b.ii	<p>require the timely provision of medical care, including but not limited to, vision care, dental care, and laboratory and consultation services; timely and appropriate communication between nursing staff and physicians regarding changes in an individual's physical status; and the integration of each individual's mental health and medical care;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Same as above.</p> <p>Findings: Same as above.</p> <p>Compliance: Partial.</p> <p>Current recommendations: Same as above.</p>
b.iii	<p>define the duties and responsibilities of primary care (non-psychiatric) physicians;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Ensure that the duty statement outlines the performance standards</p>

		<p>and expectations as above.</p> <p>Findings: Same as above.</p> <p>Compliance: Partial.</p> <p>Current recommendations: Same as above.</p>
b.iv	<p>ensure a system of after-hours coverage by primary care physicians with formal psychiatric training (i.e., privileging and proctorship) and psychiatric backup support after hours; and</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Develop and implement competency-based training curriculum in psychiatric emergencies for on-site primary care physicians.</p> <p>Recommendation 2, September 2006: The above training must comport with current generally accepted standards and be sufficient to ensure the safety of individuals during after-hours.</p> <p>Findings: Since the baseline assessment, a senior psychiatrist at MSH has provided competency-based training on psychiatric emergencies. The curriculum addresses recognition, diagnosis and management of psychiatric emergencies. The scope of the training is appropriate to the needs of non-psychiatric physicians. All non-psychiatric physicians at the facility have successfully completed this training. In addition, the facility has implemented a system to ensure availability</p>

		<p>by psychiatrists for back-up coverage during off-hours.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue current practice. 2. DMH should ensure that individuals residing in all facilities receive the same level of psychiatric back-up support after hours.
b.v	endeavor to obtain, on a consistent and timely basis, an individual's medical records after the individual is treated in another medical facility.	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Develop and implement adequate tracking system.</p> <p>Findings: Since the baseline evaluation, MSH has developed and implemented a system to track the availability of medical records upon return transfer of individuals from outside hospitalization. The facility has data that demonstrate appropriate follow up when individuals return without required medical records (since November 2006). In addition, the facility has monitoring data based on the Outside Appointments and Hospitalization Monitoring Form (October 2006 to February 2007). In this mechanism, the facility reviewed all outside transfers due to medical emergencies. The following is an outline of the monitoring indicators and a summary of the data:</p> <ol style="list-style-type: none"> 1. <i>Did the patient return with forms MSH # 1147A & 1147B ?</i> 2. <i>Did the patient return with the hospital physician notes?</i> 3. <i>Did the patient return with a discharge summary?</i>

4. Was there a follow-up appointment scheduled by the hospital?
 5. Did the patient receive timely care?

	Oct	Nov	Dec	Jan	Feb	Mean
N*	34	22	24	29	29	
n	34	22	24	29	29	
%S	100	100	100	100	100	
%C						
1	97	100	100	93	100	98
2	97	100	96	96	100	98
3	80	100	100		100	95
4	74	64	96	55	52	68
5	100	100	100	100	100	100
Mean	90	93	98	86	90	91

Compliance:
 Substantial.

Current recommendations:
 Continue current practice.

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:

Recommendation 1, September 2006:
 Develop and implement monitoring and tracking instruments to ensure that the foci of hospitalization address current assessed medical needs and that foci, objectives and interventions are modified in a timely basis to address the changes in the physical status of the individuals.

Recommendation 2, September 2006:
 Develop and implement formalized mechanisms to improve integration

of medical staff into the interdisciplinary functions of the WRP.

Findings:

The revised Medical Services Policy and Procedure includes the requirement that medical conditions requiring ongoing care are entered on focus 6 and that physicians participate in the WRPC as requested by the team.

Since the baseline evaluation, MSH has developed the Medical Conditions Focus 6 Monitoring Form to assess compliance. Implementation began in February 2006. Data are summarized as follows:

1. *Each of the open medical conditions listed on the Medical Conditions List are identified in the WRP under Focus #6.*
2. *Each Medical Condition listed in Axis III is identified in the Medical Conditions list and in the WRP under Focus #6.*
3. *All changes in medical status of the Individual are incorporated in the WRP.*
4. *Each Focus #6 has a corresponding objective and active and/or therapeutic milieu intervention.*
5. *The Medical Consultant was present during the WRP.*

	Feb
N*	750
n	38
%S	5
%C	
1	50
2	61

		<table border="1" data-bbox="1094 277 1325 469"> <tr> <td></td> <td>Feb</td> </tr> <tr> <td>3</td> <td>71</td> </tr> <tr> <td>4</td> <td>74</td> </tr> <tr> <td>5</td> <td>x3x</td> </tr> <tr> <td>Mean</td> <td>59</td> </tr> </table> <p>Other findings: As mentioned in sections C.2 and F.1, the monitor found deficiencies in the implementation of this requirement for individuals suffering from a variety of conditions including, but not limited to, seizure disorders, cognitive disorders, involuntary movement disorders (TD) and substance abuse. These deficiencies must be corrected to achieve substantial compliance.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to monitor this requirement and ensure a sample size of at least 20%. 2. Improve compliance with this requirement. 		Feb	3	71	4	74	5	x3x	Mean	59
	Feb											
3	71											
4	74											
5	x3x											
Mean	59											
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.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Develop and implement a formalized physician peer review system that utilizes indicators aligned with the standards and expectations outlined in F.7.a. .</p>										

		<p>Findings: Since the baseline evaluation, MSH has recruited a part-time board-certified physician who provides peer reviews utilizing three monitoring instruments: <i>Ongoing Medical Care</i>, <i>Quality of Care (Diabetes)</i> and <i>Quality of care (Hypertension)</i>. The facility recently developed a <i>Medical Staff Audit Form</i> for peer review purposes. The audit form assesses appropriate documentation of medical care, diagnostic and medical work up, specific management strategies in specific medical conditions (based on standards recommended by medical societies/associations) and completeness of admission and annual medical assessments. The facility implemented this audit in January 2007 and has yet to aggregate the data. In September 2006, the medical service conducted a cross-sectional review all individuals at the facility who were diagnosed with <i>Metabolic Syndrome</i>. The purpose was to assess distribution by sex, age, length of stay, race, psychiatric diagnosis, BMI and type of new-generation antipsychotic medication. The facility did not utilize the data to develop outcome indicators for performance improvement purposes.</p> <p>Recommendation 2, September 2006: Continue to provide data on the medical triggers identified in the Key Indicators. The facility may establish additional indicators of outcome to the individuals and the medical systems of care.</p> <p>Findings: Since the baseline evaluation, the facility has provided data on the medical triggers. The facility did not implement additional indicators of medical outcomes.</p>
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		<p>Recommendation 3, September 2006: Identify trends and patterns based on clinical and process outcomes.</p> <p>Findings: The facility has yet to implement this recommendation.</p> <p>Recommendation 4, September 2006: Expedite efforts to automate data systems to facilitate data collection and analysis.</p> <p>Findings: The facility is in the process of implementing this recommendation. Automated systems for data aggregation and analysis should be in place by September 1, 2007.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Same as in F.7.a. 2. Continue to provide data on the medical triggers identified in the Key Indicators. The facility may establish additional indicators of outcome to the individuals and the medical systems of care. 3. Identify trends and patterns based on clinical and process outcomes. 4. Provide corrective actions to address problematic trends and patterns. 5. Expedite efforts to automate data systems to facilitate data collection and analysis.
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8	Infection Control	
	<p>Each State hospital shall develop and implement infection control policies and procedures to prevent the spread of infections or communicable diseases, consistent with generally accepted professional standards of care.</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Charlene Hooper, PHN 2. Loraine Clinton, PHN <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Auditing instruments developed by Patton State Hospital; Immunization Auditing Form, PPD Auditing Form, Hepatitis C Auditing Form 2. Health Care Monitoring form: Employees 3. Health Care Monitoring form: Individuals 4. Infection Control Surveillance Monitoring Tool 5. Infection Control Monitoring form 6. Significant Infections forms 7. TB screening for Employees and Individuals tools 8. SIV/AIDS, Hepatitis C and B, and Significant infections forms 9. Inservice sheet for Infection Control monitoring data collection and auditing tools dated March 15, 2007 10. In-service sheets for Quality Improvement Activity #4 dated March 1 and 12, 2007 11. Inservice sheet for TB Skin Testing, Converters and Reactors dated November 20, 2006 12. Inservice sheet for TB control dated February 2, 2007 13. Inservice sheet for QI activity dated February 20, 2007 14. Inservice sheet for Monitoring Tools for Infection Control dated February 15, 2007 15. In-service sheets for Employees' Screening Auditing Tool dated February 20, 26 and 27, 2007

		<ul style="list-style-type: none"> 16. In-service sheet for One to One Alcohol Use Audit dated March 1, 2007 17. Infection Control Process: Algorithm 18. MSH Infection Control Plan including process, risk assessment, addendum to Annual Plan, surveillance strategies, and infection control committee 19. MSH AD 3403, Infection Control Program 20. MSH Public Health Protocols for Antibiotic Resistant Organisms (ARMs), Communicable Diseases that may be used in Bioterrorism, Consensual Sexual Behaviors and Sexually Transmitted Diseases, Gastroenteritis, Hepatitis B, Measles: Live Vaccine, Mumps: Live Vaccine, Rubella: Live Vaccine, Varicella-Zoster Virus: Live Vaccine, Care and Treatment of Patients with HIV Disease, Steps to Follow after a Significant Exposure, Screening for Tuberculosis, and Quadrivalent Human Papillomavirus Vaccine (HPV) 21. Tuberculin Skin Test and Evaluation form 22. Audit of Infection Control Standards form 23. Summary of Acute Gastroenteritis Outbreak report 24. MSH Interdepartmental Performance Improvement Committee Meeting minutes dated November 27, 2006 25. Public Health Completion Tracking Form, Medical Surveillance Lower priority risks dated July 1, 2006-June 30, 2006 26. Infection Control policies for the following departments: Central Program Services, General Housekeeping, Central Supply, Dietetic Services, Housekeeping Department, Laboratory, Laundry Department, Pharmacy, and Plant Operations 27. Reviewed sample data provided 28. Surveillance of Employees' Illness data
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		<p>29. Hand Hygiene audit tools</p> <p>30. Summary feedback report dated March 6, 2007</p> <p>31. MSH AD #2100, Fingerprinting and Background Investigation</p> <p>32. MSH AD #3055 Supervision for High-risk Individuals</p>
a	Each State hospital shall establish an effective infection control program that:	Compliance: Partial.
a.i	actively collects data regarding infections and communicable diseases;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Develop and implement a monitoring system for the key elements of these requirements.</p> <p>Findings: MSH has developed an Infection Control surveillance tool, a health care monitoring tool for both employees and individuals, and an infection control process monitoring tool. However, these instruments do not adequately and accurately reflect the required elements of the EP. Although a statewide committee has been implemented to develop instruments addressing the requirement of the EP, there continues to be much confusion regarding the development of this system.</p> <p>Recommendation 2, September 2006: Develop and implement statewide monitoring instruments to monitor the key elements for Infection Control.</p> <p>Findings: This recommendation has not yet been adequately addressed.</p>

		<p>Recommendation 3, September 2006: Provide training on the above recommendations to Infection Control staff.</p> <p>Findings: Since the above recommendations have not yet been adequately addressed, this recommendation has not been appropriately implemented.</p> <p>Recommendation 4, September 2006: Revise policies and procedures to reflect key elements in the requirements for Infection Control.</p> <p>Findings: The facility has begun to revise its policies and procedures to reflect the elements of this requirement. This will be an ongoing process as the monitoring system is developed and implemented.</p> <p>Recommendation 5, September 2006: Review and update disciplines Infection Control policies.</p> <p>Findings: Thus far the facility has reviewed and updated as needed the Infection Control policies for the following disciplines: Central Program Services, Central Supply, Dietary, Housekeeping, Laboratory, Laundry, Pharmacy, Plant Operations, Rehab Therapy.</p> <p>Other findings: MSH provided this reviewer a significant amount of information regarding the types of information the department collects and tracks.</p>
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		<p>In addition, the facility provided a comprehensive summary report of a recent outbreak of Acute Gastroenteritis in program 3 and 5, which included a detailed account of data collection through corrective actions. The report also included specific implications for MSH's Quality Assurance.</p> <p>Clearly, the Infection Control Department collects a significant amount of surveillance data and provides interventions for the facility. The confusion regarding the development and implementation of a system to monitor the department in alignment with the EP has been an outstanding barrier which affects the department's ability to present the data in a systematic format. This has hindered the process of establishing a baseline for compliance with the EP. After a lengthy interview, discussing the development of a system that represents the requirements of the EP, the department continues to struggle with conceptualizing an overall departmental monitoring system.</p> <p>Current recommendations: Assist the Infection Control Departments in all four facilities in developing and implementing a uniform monitoring system in alignment with the requirements of the EP.</p>
a.ii	assesses these data for trends;	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Same as above.</p> <p>Findings: Same as above.</p>

		<p>Current recommendations: Same as a.i.</p>
a.iii	initiates inquiries regarding problematic trends;	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Same as above.</p> <p>Findings: Same as above.</p> <p>Current recommendations: Same as a.i.</p>
a.iv	identifies necessary corrective action;	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Same as above.</p> <p>Findings: Same as above.</p> <p>Current recommendations: Same as a.i.</p>
a.v	monitors to ensure that appropriate remedies are achieved; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Same as above.</p>

		<p>Findings: Same as above.</p> <p>Current recommendations: Same as a.i.</p>
a.vi	integrates this information into each State hospital's quality assurance review.	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Same as above.</p> <p>Findings: Same as above.</p> <p>Current recommendations: Same as a.i.</p>
9	Dental Services	
	Each State hospital shall provide individuals with adequate, appropriate and timely routine and emergency dental care and treatment, consistent with generally accepted professional standards of care.	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Dr. Nguyen, DDS 2. Dr. Tan, DDS <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. WRP Dental Plan for the following individuals: SF, SG, MW, IN, QV, GL, DI, PS, JW, RL, KD, AC, VC, AW, SR, JS, JD, JP, PS, PB, JE, KL, OA, and TP 2. MSH's Dental Clinic Incomplete/Missed Appointments instrument and raw data

		<ol style="list-style-type: none"> 3. MSH's Daily Dental Treatment instrument and raw data 4. MSH's Medication Log instrument and raw data 5. MSH's Extraction Data instrument and raw data 6. MSH's Dental Clinic Monthly Reports 7. MSH's Appointment Schedule Quality Assurance Monitor data 8. MSH's Dental Clinic Treatment Scheduling Policy and Procedure 9. MSH's Timely Response to Dental Referrals raw data 10. MSH's Consultation Referral and Report form 11. Annual and 90-day exam raw data 12. MSH's Timely Response to Dental Referrals instrument and raw data 13. MSH's Daily Dental Treatment instrument and raw data 14. Memorandum of Action form 15. MSH Patient Dental Refusal Form 16. WRP Dental Treatment Plan Form 17. Refusal Memo tracking instrument
a	<p>Each State hospital shall retain or contract with an adequate number of qualified dentists to provide timely and appropriate dental care and treatment to all individuals it serves;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Evaluate the need for additional dentists, dental auxiliary staff, a Chief dentist position, and clerical staff for the dental department.</p> <p>Findings: The facility reported that from October 1, 2006 through December 31, 2006 MSH had only one dentist since the retirement of Dr. Herdeg. In January 2007, Dr. Herdeg returned as an annuitant, working two days per week. In addition, another full-time dentist was also hired in January. MSH currently as 2.5 dentists but only two dental assistants. The department is in need of another assistant/clerical position.</p>

		<p>Recommendation 2, September 2006: Separate data for 90-day and annual examinations.</p> <p>Findings: MSH reported that the data regarding 90-day and annual dental examinations have been separated. The data submitted by MSH supports this issue.</p> <p>Recommendation 3, September 2006: Develop and implement a policy to address the management of after-hours dental emergencies.</p> <p>Findings: MSH reported that it will maintain the current policy regarding after-hours dental emergencies, which indicates that the unit physician will manage the dental pain or infection after hours and the individual will be referred to the dental clinic during the clinic hours. From my interview with Dr. Nguyen and Dr. Tan, it was reported that in serious cases, the individual would be sent out of the facility for certain treatments.</p> <p>Recommendation 4, September 2006: Obtain a dental management software package to reduce time spent on record keeping and to ensure accurate data.</p> <p>Findings: MSH reported that the dentists from the other facilities have been in contact regarding the review of different dental software programs. Once a program is agreed upon, a request for the program will be</p>
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forwarded on to Sacramento for approval.

Other findings:

MSH has monitoring data based on reviews conducted from September 2006 to February 2007. The following table lists the mean compliance rates (%) for each indicator during this six-month period. The facility's data did not adequately specify the target populations and sample sizes used each month. It was suggested by this reviewer to include the percentage and numbers of noncompliant timely exams as well as the number of individuals who refused along with the percentages to clarify the data.

Indicator	Mean %C
1. Emergencies seen within 24 hours of referral	85%
2. Timely 90-day exams	64%
3. Noncompliant 90-day exams (due to refusals)	49%
4. Timely annual exams	49%
5. Noncompliant annual exams (due to refusals)	73%

The above data showed lower compliance rates for October, November and December 2006. MSH reported that that the lower rates were due to the lack of dentists during that time.

Compliance:

Partial.

Current recommendations:

1. Secure the services of an additional assistant/clerical position.

		<ol style="list-style-type: none"> 2. Continue the process of obtaining a dental software program. 3. Include percentages and numbers of individuals regarding data indicating noncompliance with timely annual and 90-day exams and include number of individuals that account for refusals in these categories. 4. Continue to monitor this requirement and specify target population, actual population reviewed and sample size.
b	Each State hospital shall develop and implement policies and procedures that require:	<p>Compliance: Partial.</p>
b.i	comprehensive and timely provision of dental services;	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Review and revise policies and procedures as need to address this requirement.</p> <p>Findings: MSH did not present data regarding this recommendation. From my interview with Dr. Nguyen and Dr. Tan, it was reported that the systematic changes and monitoring that have been implemented have not been incorporated into the dental policies and procedures as of yet.</p> <p>Other findings: MSH has developed a monitoring tool to track the provision of comprehensive dental services. It has recently been implemented (in February 2007). In addition, the Dental Department has been utilizing a monitoring instrument to track the timeliness of response to a referral written by the unit's physician for dental care (seen within two</p>

		<p>weeks of the referral). MSH's compliance data is summarized in the table below. The data do not specify the total target population (vs. population reviewed) and sample size.</p> <p><i>Timely response to dental referrals:</i></p> <table border="1" data-bbox="1014 462 1797 578"> <thead> <tr> <th></th> <th>Sep</th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>n</td> <td>4</td> <td>11</td> <td>5</td> <td>6</td> <td>15</td> <td>2</td> <td></td> </tr> <tr> <td>%</td> <td>100</td> <td>100</td> <td>40</td> <td>100</td> <td>100</td> <td>50</td> <td>82</td> </tr> </tbody> </table> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Review and revise policies and procedures as need to address this requirement. 2. Continue to monitor this requirement and specify total target population, population reviewed and sample size. 		Sep	Oct	Nov	Dec	Jan	Feb	Mean	n	4	11	5	6	15	2		%	100	100	40	100	100	50	82
	Sep	Oct	Nov	Dec	Jan	Feb	Mean																			
n	4	11	5	6	15	2																				
%	100	100	40	100	100	50	82																			
b.ii	documentation of dental services, including but not limited to, findings, descriptions of any treatment provided, and the plans of care:	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Ensure that dental information contained in resident's records is accurate and up to date.</p> <p>Findings: The facility reported that a new form has been developed that includes a description of services for each dental visit and is placed under the "Consultation" tab in the chart. An identical form is also kept in the dental clinic. Dental x-rays will continue to be kept in the dental office.</p> <p>Recommendation 2, September 2006: Ensure that staff brings resident's records to all dental appointments.</p>																								

		<p>Findings: The facility has implemented a reminder system to "bring all charts" on the daily schedule for the clinic escorts.</p> <p>Other findings: The facility has recently implemented a monitoring instrument, the Daily Dental Treatment, to address the elements of this requirement.</p> <p>Current recommendations: Continue to monitor this requirement and specify total target population, population reviewed.</p>
b.iii	use of preventive and restorative care whenever possible; and	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Increase the number of dental staff to provide appropriate and timely services.</p> <p>Findings: As noted in F.9.a under Recommendation 1, 2006.</p> <p>Recommendation 2, September 2006: Continue to monitor this requirement.</p> <p>Findings: MSH reported that from September 2006 through January 2007, only 6.6% of all dental procedures conducted were restorative procedures. In addition, only 11% of all dental procedures done were preventative. The facility cites the lack of dentists from October through December</p>

2006 as a factor in the low percentages. The following tables outline the compliance rates for each procedure during this six month period. The data do not specify the total target population (vs. population reviewed) and sample size.

Preventative:

	Sep	Oct	Nov	Dec	Jan	Feb	Mean
n	191	50	114	64	193	20	
%C	2	12	7	22	14	11	11.3

Restorative:

	Sep	Oct	Nov	Dec	Jan	Feb	Mean
n	191	50	114	64	193	15	
%C	3	4	9	4	13	8.5	6.9

Current recommendations:

1. Secure the services of an additional assistant/clerical position.
2. Continue to monitor this requirement and specify total target population (vs. population reviewed) and sample size for each month.

Current findings on previous recommendation:

Recommendation, September 2006:

Develop and implement a system to ensure that dental information contained in resident's records is accurate and up to date.

b.iv tooth extractions be used as a treatment of last resort, which, when performed, shall be justified in a manner subject to clinical review.

		<p>Findings: See b.ii, Findings section under Recommendation 1, 2006.</p> <p>Other findings: MSH has developed and implemented a monitoring instrument, Extraction Data, to meet the requirements of this cell. MSH's data regarding tooth extractions as a last resort are summarized below.</p> <table border="1" data-bbox="1014 537 1797 651"> <thead> <tr> <th></th> <th>Sep</th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>n</td> <td>3</td> <td>4</td> <td>7</td> <td>N/A</td> <td>4</td> <td>9</td> <td></td> </tr> <tr> <td>%C</td> <td>100</td> <td>100</td> <td>100</td> <td>N/A</td> <td>100</td> <td>100</td> <td>100</td> </tr> </tbody> </table> <p>Current recommendations: Continue to monitor this requirement.</p>		Sep	Oct	Nov	Dec	Jan	Feb	Mean	n	3	4	7	N/A	4	9		%C	100	100	100	N/A	100	100	100
	Sep	Oct	Nov	Dec	Jan	Feb	Mean																			
n	3	4	7	N/A	4	9																				
%C	100	100	100	N/A	100	100	100																			
c	<p>Each State hospital shall ensure that dentists demonstrate, in a documented fashion, an accurate understanding of individuals' physical health, medications, allergies, and current dental status and complaints.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Develop and implement a monitoring instrument that adequately addresses this requirement.</p> <p>Findings: MSH has developed and recently implemented a Daily Dental Treatment monitoring instrument. It was noted during the review that "allergies" were not included on the instrument as required by the EP. The instrument was immediately modified by the dental department.</p> <p>Recommendation 2, September 2006: Develop and implement a system to monitor this requirement.</p>																								

		<p>Findings: The following is an outline of the facility's monitoring data:</p> <p><i>Checked medical history:</i></p> <table border="1" data-bbox="1012 423 1350 540"> <thead> <tr> <th></th> <th>Feb</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>n</td> <td>84</td> <td></td> </tr> <tr> <td>%C</td> <td>100</td> <td>100</td> </tr> </tbody> </table> <p><i>Understands physical health, meds, and allergies:</i></p> <table border="1" data-bbox="1012 651 1795 768"> <thead> <tr> <th></th> <th>Sep</th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>n</td> <td>10</td> <td>5</td> <td>7</td> <td>2</td> <td>2</td> <td>4</td> <td></td> </tr> <tr> <td>%C</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> </tr> </tbody> </table> <p>Compliance: Partial.</p> <p>Current recommendations: Continue to monitor this requirement</p>		Feb	Mean	n	84		%C	100	100		Sep	Oct	Nov	Dec	Jan	Feb	Mean	n	10	5	7	2	2	4		%C	100	100	100	100	100	100	100
	Feb	Mean																																	
n	84																																		
%C	100	100																																	
	Sep	Oct	Nov	Dec	Jan	Feb	Mean																												
n	10	5	7	2	2	4																													
%C	100	100	100	100	100	100	100																												
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.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Ensure that adequate staffing and transportation is available for residents to attend their dental appointments.</p> <p>Recommendation 2, September 2006: Improve the communication between the unit staff, clinical scheduling coordinator, and dental assistants to ensure residents are available for</p>																																	

their dental appointments.

Findings:

The facility monitored this requirement using the following indicators that preclude individuals from attending appointments. The table below summarizes the monitoring data. The data are based on a review of missed appointments (n) and outline the relative contribution of each of these factors.

1. *Staffing issues from dental clinic.*
2. *Transportation*
3. *Unit acuity (lock down)*
4. *Lack of staff for 1:1 individuals*
5. *Individual not available (court, sick, activity)*
6. *Individual refused dental tx*
7. *Individual's behavior prevents dental appointment*

	Sep	Oct	Nov	Dec	Jan	Feb	Mean
n	56	18	39	27	46	30	
%C							
1	4%	0%	2%	37%	19%	0	10%
2	0%	0%	0%	0%	0%	0%	0%
3	0%	0%	0%	0%	0%	13%	2%
4	4%	38%	0%	0%	0%	0%	7%
5	10%	11%	2%	0%	4%	13%	7%
6	82%	50%	92%	59%	76%	73%	72%
7	2%	0%	2%	4%	0%	0%	1%

		<p>The data demonstrates that during the past 6 months; only 10% of missed appointments were due to clinic staff being sick and 7% due to the lack of 1:1 staff. There were no reported appointments missed due to lack of transportation. The data indicated that 72% of missed appointments were attributed to individuals' refusals.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to monitor this requirement. 2. Develop and implement corrective actions based on results of this monitoring.
e	<p>Each State hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to overcome individual's refusals to participate in dental appointments.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Develop and implement a system to monitor and track interventions and outcomes for dental refusals.</p> <p>Findings: MSH reported that after two dental appointment refusals the unit psychiatrist is asked to intervene with the individual's refusal issues and advise the dental clinic as to the strategies and follow-up plan. The Dental Department has developed and implemented a Memorandum of Action form regarding dental refusals that is sent to the Program Director and is to be signed by the individual's psychiatrist and the Unit Supervisor and returned to the dental department. MSH reported that in the past six months, over 50 Memorandum of Action forms have been</p>

		<p>sent to the units. Only three have been returned to the dental department. This system has not been formalized as a policy/procedure and there has been staff training conducted regarding this process.</p> <p>Although the Memorandum of Action brings dental refusals to the attention of the psychiatrist and Unit Supervisor, it does not ensure that interdisciplinary teams review, assess, and develop strategies to overcome individual's refusals to participate in dental appointments as outlined in the EP.</p> <p>Recommendation 2, September 2006: Develop and implement a facility-wide system to facilitate communication with dental and the Wellness and Recovery teams regarding individualized strategies to address refusals of dental appointments and treatments.</p> <p>Findings: The Dental Department has developed a new form, the Dental Treatment Plan, to be included in the WRP to inform the team of the recommended dental treatments for each individual. This system has not yet been implemented.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none">1. Develop and implement? policy/procedure addressing the process of dental refusals and conduct staff in-services.2. Continue to develop and implement a facility-wide system to
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		<p>facilitate communication with dental and the Wellness and Recovery teams regarding individualized strategies to address refusals of dental appointments and treatments.</p> <p>3. Continue to monitor this requirement.</p>
10	Special Education	
	<p>Each State hospital shall provide the school-age and other residents, as required by law, who qualify for special education ("students"), individualized educational programs that are reasonably calculated to enable these students to receive educational benefits, as defined by applicable law.</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Marilu Tiberi-Vibrai, Assistant Chief, Central Program Services, and Pam Lopez, Assistant Chief, CPS, Education (March 20) 2. Mishelle Ross, Project Manager, and Jennifer Miller, Principal, along with Ms. Tiberi-Vibrai and Ms. Lopez (March 20) 3. Mr. Williams, teacher 4. Ms. Bowers, teacher 5. Mr. Barnhart, teacher <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. MSH Enhancement Plan Progress Report (Special Education, Section F.10; March, 2007) - including Psycho-Educational Assessment Audits; Individual Education Plan Audit Interviews; Individual Education Plan Meeting Audits; Individual Education Plan Review Tools; Curriculum-based measurement (CBM) data; teacher interviews; etc. 2. Individualized Education Plans (SF, CG, and JL) 3. Behavior support plans (SF, CG, and JL) <p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. Classrooms of Mr. Williams and Ms. Bowers 2. Staff meeting of teachers and TAs

a	<p>Each State hospital shall develop and implement uniform systems for assessing students' individual educational needs and monitoring their individual progress.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Use modified and newly created assessment tools (Psycho Educational Assessment Audit, Individual Education Plan Audit Interview, Individual Education Plan Meeting Audit, and Individual Education Plan Review Tool) to monitor compliance.</p> <p>Findings: Assessment tools used to monitor compliance were revised and the revisions comply with the requirements of the EP. Many of the timeline issues that were prevalent in the previous report were not noted in the three IEPs that were reviewed.</p> <p>Recommendation 2, September 2006: Use students' IEP annual goals and short-term objectives to inform instruction in the classroom.</p> <p>Findings: IEPs reviewed were much better written than previous documents reviewed in September, 2006. Generally annual goals and short-term objectives were measurable. Some redundancy was noted in several of the short-term objectives, without including conditions under which learning would take place. IEP Audit Interview form indicates teachers, to some degree, use information on the IEP to inform their instruction in the classroom.</p> <p>Recommendation 3, September 2006: Use curriculum-based measurements (CBM) to collect data weekly on</p>
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		<p>student progress in math, reading, and writing.</p> <p>Findings: All teachers began collecting data weekly on student progress beginning in the fall of 2006. The quality and validity of the data collected varied across teachers and students as there doesn't appear to be a system in place for administering learning probes and documenting student progress. For example, instances of monitoring of accuracy data in mathematics (rather than fluency), data collection methods not matching objectives, unclear grade-levels of reading probes, and data outcomes that don't match data collection methods suggest areas for training and technical assistance.</p> <p>Recommendation 4, September 2006: Develop uniform behavior management system that both aligns with students' management system in their living units as well as allows for data collection and graphing.</p> <p>Findings: A uniform behavior management system that aligns with that in students' living units has not been developed. Behavior support plans are included in the most recent IEPs, however, and they can be used to help fulfill this recommendation. While the behavior support plans contain a large amount of pertinent information, positive behavior supports included in the plans aren't often referenced in the IEPs. Moreover, teachers most often identify problem behavior (in the IEP Audit Interview) as the "target behavior" rather than a replacement behavior, and identify punishers as consequences for the "target behavior."</p>
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		<p>Recommendation 5, September 2006: Use behavioral data to modify instruction to better meet students' needs.</p> <p>Findings: Curriculum-based measurement (CBM) data has been collected on individual students' reading, writing and mathematics progress, although the data collected is of varying quality and validity. There aren't clear indications of the use of data to modify instruction to better meet students' needs. There were instances of data collection occurring over time where a student was not making progress but changes in instruction were not documented. However, on February 23 Dr. Diane Haager conducted a workshop on using CBM data to improve instruction and will return to conduct further trainings, and the administration and staff appear committed to making improvements in this area.</p> <p>Recommendation 6, September 2006: Provide training to teachers and staff in the use of Excel to organize and graph academic and behavioral data.</p> <p>Findings: Staff was trained on November 2, 2006 on using Excel to organize and graph data. All teachers and many, if not all, TAs attended.</p> <p>Other findings: Not all teachers have access to a computer. Easy access to a computer is necessary for data collection; in addition, moving to having students self-graph their data is impossible without computer access. Following Dr. Haager's training, the administration has begun investigating the use of DIBELS (Dynamic Indicators of Basic Early Literacy Skills),</p>
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which would serve as a standardized, systematic means for assessing literacy. This becomes even more important as some students may transition between Andrew Young School and School B during their stays, and standardized assessment would allow for continued monitoring of students' progress even when their classroom placement changes.

Compliance:

Partial

Current recommendations:

1. Use modified and newly created assessment tools (Psycho-Educational Assessment Audit, Individual Education Plan Audit Interview, Individual Education Plan Meeting Audit, and Individual Education Plan Review Tool) to continue to monitor compliance.
2. Use students' IEP annual goals and short-term objectives to inform instruction in the classroom.
3. Use curriculum-based measurements (CBM) to collect data weekly on student progress in math, reading, and writing, ensuring that data collected is valid and based upon standardized measurement procedures.
4. Use behavior support plans to provide some consistency for students across settings; teachers should become familiar with target (i.e., replacement) behaviors and antecedent and consequent events that can promote and reinforce the use of desired replacement behavior.
5. Use behavioral data to modify instruction to better meet students' needs. Use decision rules to indicate when a change in instructional method/delivery is made; document what changes are made.

b	<p>Each State hospital shall ensure that all Individual Education Plans ("IEPs") are developed and implemented consistent with the Individuals with Disabilities Education Act, 20 U.S.C. § 1400 <u>et seq.</u> (2002) ("IDEA").</p>	<p>Current findings on previous recommendations:</p> <p><i>Note that Recommendation 1 was inadvertently divided into three numbered lines in the Baseline Report. The numbering from the Baseline Report has been retained to avoid confusion.</i></p> <p>Recommendation 1, September 2006: Provide training to teachers and staff to ensure that IEP goals and objectives are measurable and related to assessment data.</p> <p>Findings: Training schedule indicates professional development for staff beginning on November 2, 2006 and continuing until May 7, 2007. Training, February 23, by Dr. Dianne Haager entitled "Data-driven Instructional Practices" was attended by teachers, support staff, and administrators.</p> <p>Recommendation 4, September 2006: Utilize the Individual Education Plan Meeting Audit form to both help structure meetings as well as documenting critical components.</p> <p>Findings: IEP meeting audit form developed. Staff will begin using a facilitated IEP Agenda Form to ensure that critical components occur and are documented.</p> <p>Recommendation 5, September 2006: Collaborate with families in establishing meeting times rather than informing them when meetings will occur.</p>
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		<p>Findings: Student files reviewed (SF, CG, and JL) indicated attempts to collaborate with families/guardians in establishing IEP meeting times. An IEP contacts checklist for scheduling IEP meetings has been developed to help structure family contacts as well as documenting attempts to contact and involve families.</p> <p>Recommendation 6, September 2006: Have signed parental consent documentation prior to performing assessment procedures.</p> <p>Findings: Item #3 on Psycho-Educational Assessment Monitoring Form indicates that all assessments completed since September, 2006 have not been conducted until an assessment plan is signed by a parent.</p> <p>Recommendation 7, September 2006: Ensure that present levels of performance, in both academic and behavioral domains, are included in IEPs and Psycho-Educational Assessments.</p> <p>Findings: Student files reviewed (SF, CG, and JL) included present levels of performance in both academic and behavioral domains. Present level of performance items added to Psycho-Educational Assessment Monitoring Form (items #16-19). Section on Present Level of Performance included in the Facilitated IEP Agenda form.</p> <p>Compliance: Partial.</p>
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		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue providing high-quality professional development to teachers and staff. 2. Ensure that IEP annual goals and objectives are measurable and tied to classroom assessment data.
c	<p>Each State hospital shall ensure that teachers providing instruction to students at each State hospital have completed competency-based training regarding teaching and academic instruction, behavioral interventions, monitoring of academic and behavioral progress and incident management and reporting.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Provide necessary supports to ensure that third teacher is fully credentialed.</p> <p>Findings: California Commission on Teacher Credentialing indicates that teacher (TB) is fully credentialed.</p> <p>Recommendation 2, September 2006: Provide ongoing professional development to teachers and support staff on effective academic instruction (e.g., the use of CBM, peer tutoring, cooperative learning, learning strategies, note-taking skills, etc.), behavioral interventions (e.g., use of functional behavior assessment data to inform behavior intervention plans, antecedent control, reinforcement principles, etc).</p> <p>Findings: Training schedule indicates professional development for staff beginning on November 2, 2006 and continuing until May 7, 2007. Training on February 23, 2007 by Dr. Dianne Haager entitled "Data driven instructional practices" was attended by teachers, support</p>

		<p>staff, and administrators. Topics for trainings include <i>CBM</i> progress monitoring, self-graphing, <i>CBM-Math</i>, Data driven instructional practices, IDEA and NCLB, research-based comprehension strategies, and strategies for effective instruction.</p> <p>Recommendation 3, September 2006: Provide support to teachers and support staff to pursue professional development opportunities (e.g., graduate coursework, reputable workshops, etc.).</p> <p>Findings: Training schedule indicates professional development for staff beginning on November 2, 2006 and continuing until May 7, 2007. No other evidence reviewed that suggests opportunities for professional development beyond that are provided at MSH.</p> <p>Recommendation 4, September 2006: Provide training to volunteers on specific skills that might support student learning (e.g., reading strategies, comprehension strategies, etc.).</p> <p>Findings: Training schedule indicates professional development for staff beginning on November 2, 2006 and continuing until May 7, 2007. Sign-in sheets indicates participation of volunteers.</p> <p>Compliance: Partial.</p>
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		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Provide opportunities for teachers and staff to seek professional development (e.g., graduate coursework, workshops) beyond that provided by MSH. 2. Provide targeted training to volunteers based upon their interest, skills, and relationships with students. For example, providing reading tutoring skills in fluency training might be appropriate for one volunteer, while training in comprehension strategies might be appropriate for another.
d	<p>Each State hospital shall ensure that students receive instruction and behavioral supports appropriate to their learning abilities and needs, consistent with generally accepted professional standards of care.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Use CBM data to modify instruction to better meet students' needs.</p> <p>Findings: All three teachers conducted some form of progress monitoring on all students since the last monitoring visit. There was a wide range of variability in the validity of the data collected, as well as the methods used, across both teachers and individual students.</p> <p>Recommendation 2, September 2006: Create and conduct CBMs that relate directly to students' annual goals, particularly in the areas of reading, math, and writing.</p> <p>Findings: All three teachers conducted some form of progress monitoring on all students since the last monitoring visit. As mentioned earlier, the quality of these CBMs varied across teachers and students. One IEP reviewed (JL) included an annual goal tied to CBM data.</p>

		<p>Recommendation 3, September 2006: Develop uniform behavior management system that both aligns with students' management system in their living units as well as allows for data collection and graphing.</p> <p>Findings: Student records review indicates the inclusion of behavior support plans developed by the psychologist. Plans were well written and included both antecedent and consequent strategies to increase desirable behavior; in at least two cases the student was included in the development of the plan. Teacher interviews indicated a lack of understanding of target behaviors of each student as well as limited understanding of the antecedent and consequent strategies included in the support plans.</p> <p>Recommendation 4, September 2006: Use behavioral data to modify instruction to better meet students' needs.</p> <p>Findings: Because of the lack of collaboration between psychologist and teachers in the development of behavior support plans data collection is lacking in this area.</p> <p>Recommendation 5, September 2006: Include a measurable annual goal and short-term objectives for every student in the domain of self-determination.</p>
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		<p>Findings: Review of IEPs (SF, CG, and JL) and communication with Marilu Tiberi-Vibrai (March 27, 2007) indicate no goals and short-term objectives for students in self-determination skills.</p> <p>Recommendation 6, September 2006: Include a measurable annual goal and short-term objectives for every student in the domain of vocational skills.</p> <p>Findings: Review of IEPs (SF, CG, and JL) and communication with Marilu Tiberi-Vibrai (March 27, 2007) indicate goals and short-term objectives for students in vocational skills</p> <p>Recommendation 7, September 2006: Provide training to volunteer staff, particularly in the area of tutoring skills.</p> <p>Findings: Training schedule indicates professional development for staff beginning on November 2, 2006 and continuing until May 7, 2007. Sign-in sheets indicates participation of volunteers. No specific training in tutoring skills provided.</p> <p>Compliance: Partial.</p> <p>Current recommendations: 1. Include teachers as well as students in the development of behavior support plans.</p>
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		<p>2. Include annual goals and short-term objectives for self-determination skills in IEPs.</p> <p>3. Provide targeted training to volunteers based upon their interest, skills, and relationships with students, particularly in tutoring.</p>
e	<p>Each State hospital shall provide appropriate literacy instruction, consistent with generally accepted professional standards of care, for students who show deficits in one or more common areas of reading (e.g., decoding or comprehending).</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Provide word recognition instruction using direct instruction.</p> <p>Findings: No indication of direct instruction being used. Training schedule indicates upcoming training on effective academic instruction but no specific training and/or materials on direct instruction noted.</p> <p>Recommendation 2, September 2006: Provide fluency instruction using methods with a research base such as reciprocal peer tutoring, and repeated readings.</p> <p>Findings: No indication of fluency training being used. Training schedule indicates upcoming training on effective academic instruction but no specific training and/or materials on fluency training noted.</p> <p>Recommendation 3, September 2006: Provide comprehension instruction using methods with a research base such as reciprocal peer tutoring, reciprocal teaching, activating prior knowledge, making predictions, K-W-L (What I know-What I want to know-What I learned), and questioning strategies.</p>

		<p>Findings: No indication of comprehension instruction being used. Training schedule indicates upcoming training on effective academic instruction but no specific training and/or materials on comprehension instruction noted.</p> <p>Recommendation 4, September 2006: Provide writing instruction using methods with a research base such as brainstorming, prewriting, editing, and conferencing.</p> <p>Findings: No indication of writing instruction using methods with a research base being used. Training schedule indicates upcoming training on effective academic instruction but no specific training and/or materials on writing instruction noted.</p> <p>Recommendation 5, September 2006: Create and conduct CBMs that relate directly to students' annual goals, particularly in the areas of reading and writing.</p> <p>Findings: Review of IEPs indicated one instance of CBM tied to a student's annual goal. All teachers implementing some form of CBM in their classrooms in reading and writing.</p> <p>Recommendation 6, September 2006: Demonstrate use of CBM data to modify instruction to better meet students' needs.</p>
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		<p>Findings: Due to the lack of validity of some of the <i>CBM</i> data collected, using this data to modify instruction would not be warranted. Additionally, the interpretation of some of the data by teachers was not correct.</p> <p>Recommendation 7, September 2006: Include a measurable annual goal and short-term objectives for every student in the domain of literacy.</p> <p>Findings: IEPs reviewed (<i>SF</i>, <i>CG</i>, and <i>JL</i>) indicate annual goals and short-term objectives in literacy.</p> <p>Recommendation 8, September 2006: Provide training to volunteer staff, particularly in the area of tutoring skills in reading.</p> <p>Findings: Training schedule indicates professional development for staff beginning on November 2, 2006 and continuing until May 7, 2007. Sign-in sheets indicates participation of volunteers. No specific training in tutoring skills in reading provided.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Training and materials should be provided to allow teachers to use direct instruction to teach reading to those students who are struggling.
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		<ol style="list-style-type: none"> 2. Training and materials should be provided to allow teachers to use fluency training to help struggling readers. 3. Training and materials should be provided to allow teachers to use comprehension strategies to help struggling readers. 4. Training and materials should be provided to allow teachers to use writing instruction methods with a research base to help struggling writers. 5. Continue to use CBM to improve instruction. Teachers should attend trainings to ensure that they implement CBM procedures correctly, increasing the validity of the data collected. 6. As the validity of the data collected improves, teachers should begin to use this data to inform their instruction. 7. Teachers should begin having students graph their own CBM data on Excel spreadsheets. 8. One teacher does not have access to a computer; computer should be provided to this teacher so he can allow his students to self-graph. 9. Goals and objectives in literacy should continue to be refined. Using CBM data can make these measurable and more closely match individual students' needs (e.g., some students may need a goal in fluency, while others may read fluently but need a goal in passage comprehension). 10. Provide targeted training to volunteers based upon their interest, skills, and relationships with students, particularly in reading tutoring.
f	Each State hospital shall on admission and as statutorily required thereafter, assess each student's capacity to participate, with appropriate supports and services, in an integrated, non-institutional, education environment, and	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Ensure that upon admission and yearly thereafter the IEP team will</p>

	<p>provide access to an integrated education environment for those students who can participate in one with appropriate supports and services.</p>	<p>assess each student's capacity to participate, with appropriate supports and services, in an integrated, non-institutional educational environment.</p> <p>Findings: Review of IEPs indicates that a rationale for the Least Restrictive Environment provision was included in each IEP. Participation of Local Educational Agency was documented in IEP review. Interviews with staff indicate that the IEP/IDT will utilize risk assessment information provided by the treatment unit to assess student's capacity to participate in non-institutional educational environment.</p> <p>Recommendation 2, September 2006: Ensure that all IEP meetings discuss non-institutional educational environments as options for all students.</p> <p>Findings: Data from IEP Meeting Audit Form and IEP Document Review indicates compliance with this recommendation.</p> <p>Recommendation 3, September 2006: Ensure that IEP documents an explanation of the extent to which the student will participate with non-disabled peers.</p> <p>Findings: Data from IEP Meeting Audit Form and IEP Document Review indicates compliance with this recommendation.</p> <p>Recommendation 4, September 2006: Develop a plan with the local school district for providing educational</p>
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		<p>services in non-institutional settings, with appropriate supports and services.</p> <p>Findings: Local agreements with Little Lake School District and Whittier Union High School District completed and signed by appropriate parties.</p> <p>Compliance: Full.</p> <p>Current recommendations: Document participation of Local Education Agency through use of IEP Document Review Audit Tool (item #11).</p>
g	<p>Each State hospital shall ensure that all students receive their education in the least restrictive setting pursuant to the requirements of the IDEA, consistent with their legal and clinical status.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Ensure that all IEP meetings discuss the least restrictive environment for all students.</p> <p>Findings: Data from IEP Meeting Audit Form and IEP Document Review indicates compliance with this recommendation.</p> <p>Recommendation 2, September 2006: Ensure that the IEP documents an explanation of the extent to which the student will participate with non-disabled peers.</p> <p>Findings: Data from IEP Meeting Audit Form and IEP Document Review indicates</p>

		<p>compliance with this recommendation.</p> <p>Recommendation 3, September 2006: Develop a plan with the local school district for providing educational services in non-institutional setting, with appropriate supports and services.</p> <p>Findings: Local agreements with Little Lake School District and Whittier Union High School District completed and signed by appropriate parties.</p> <p>Compliance: Full.</p> <p>Current recommendations: Continue current practice.</p>
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G	Documentation	
		<p>Summary of Progress:</p> <ol style="list-style-type: none"> 1. MSH has implemented a number of policies and procedures to improve the quality of the documentation. 2. The DMH WRP manual includes criteria for the proper documentation of the new WRP model. 3. MSH has adequate monitoring instruments regarding the timeliness and completeness of the initial and integrated psychiatric assessments, reassessments and inter-unit transfer assessments. 4. Several of the monitoring instruments implemented at MSH have identified areas that have adequate documentation and areas that need improvement. 5. A number of disciplines have demonstrated timeliness in the completion of assessments, and the quality of documentation has improved in a few areas.
	<p>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</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Revise, update, and implement policies and procedures related to documentation to include specific criteria required by the EP.</p> <p>Recommendation 2, September 2006: Develop and implement a system to monitor and track the quality of documentation addressing the required elements in the Plan.</p> <p>Recommendation 3, September 2006: Provide ongoing training regarding documentation requirements.</p>

	<p>clinically relevant information remains readily accessible.</p>	<p>Findings: The previously mentioned findings of deficiencies in the documentation of admission and integrated assessments (D.1. through D.7) and the main components of integrated therapeutic and rehabilitation services (C.2.b through C.2.i) and specific therapeutic and rehabilitation services (F.1 through F.7) must be corrected to achieve substantial compliance with this requirement.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Monitor and track the quality of documentation regarding all the required elements in the plan. 2. Address and correct factors related to inconsistent compliance. 3. Provide ongoing training regarding documentation requirements
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H	Restraints, Seclusion, and PRN and STAT Medication	
		<p>Summary of Progress:</p> <ol style="list-style-type: none"> 1. MSH's policies and procedures regarding restraints, seclusion, and PRN and STAT medications have been revised in alignment with the EP. 2. MSH has implemented many of the required monitoring systems addressing restraints, seclusion, and PRN and STAT Medication. 3. MSH has openly identified and reported areas where they felt the compliance data were "artificially or questionably" high and have developed strategies in efforts to ensure data reliability. 4. MSH continues to demonstrate its commitment to decreasing the use of restraints, seclusion, and PRN and STAT medications. 5. Significant efforts have been devoted to organizing and interpreting the restraint, seclusion, and PRN and STAT medication data.
	<p>Each State hospital shall ensure that restraints, seclusion, psychiatric PRN medications, and STAT medications are used consistent with generally accepted professional standards of care.</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Michael Nunley, RN, Standards Compliance Director. 2. Carmen Fayloga, RN/HSS. 3. Lisa Dieckmann, Ph.D., Standards Compliance Psychologist. 4. Cynthia Lusch, RN, Hospital Administrator. 5. Aurora Hendricks, CNS <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Charts of 18 individuals (SW,WH, JV, CR, PL, PZ, NM, DY, JD, NMA, LN, MG, JP, EG, DC, LB, HN and SF).

		<ol style="list-style-type: none"> 2. MSH AD #3306 Behavioral Seclusion or Restraints. 3. Nursing Policy/Procedure (NP) #250 Behavioral Seclusion or Restraints. 4. Psychology Monitoring Form, instructions and data. 5. Seclusion/Restraint Review monitoring instrument, instructions, and data. 6. PRN & STAT Medication Data: Timeliness of Data Entry per unit. 7. Nursing Policy/Procedures #528 PRN Orders and #530 STAT Orders. 8. MSH AD #3133.1 Trigger Response. 9. WRP Response to PRN & STAT Medication Use Triggers data for January 4 to March 5, 2007. 10. DMH Nursing Services: PRN/STAT Medication Monitoring Form and data. 11. Use of Side Rails and Other Device/Equipment Monitoring and tracking tools. 12. List of individuals that use side rails. 13. MSH Fall Reduction Program. 14. Staff member's attendance documentation for the JCAHO & CMS (HCFA) Restraint Standards & Falls Prevention course. 15. Request for Restraint Standards and Fall Prevention training. 16. MSH lesson plans for Medication Administration. 17. Course information, outline, and examination for Preventative Management of Assaultive Behavior (PMAB). 18. Addendum to the Statewide PMAB Manual, Special Precautions when using prone containment dated October 8, 2002. 19. Data for Timeliness of Data Entry for PRN and STAT medications and for seclusion and restraints.
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1	<p>Each State hospital shall revise, as appropriate, and implement policies and procedures regarding the use of seclusion, restraints, psychiatric PRN medications, and STAT Medications consistent with generally accepted professional standards of care. In particular, the policies and procedures shall expressly prohibit the use of prone restraints, prone containment and prone transportation and shall list the types of restraints that are acceptable for use.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Revise the statewide training program to prohibit the use of prone restraints, prone containment, and prone transportation.</p> <p>Findings: The facility reported that prone restraints, containment and prone transport are prohibited by Special Order #119.6 (May 2006) and AD #3306 (revised February 2007). MSH reported that staff training for these changes has not yet been conducted</p> <p>Recommendation 2, September 2006: Review and revise policies and procedures that currently allow the use of prone restraints.</p> <p>Findings: AD #3306 was revised February 2007 to include the following under Prohibited Practices: "Prone restraints including those used for transportation."</p> <p>Recommendation 3, September 2006: Prohibit the use of prone restraints, prone containment, and prone transportation immediately.</p> <p>Findings: AD #3306 was revised February 2007 to address this requirement. The revised AD complies with the EP.</p>
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		<p>Other findings: From my review of restraint/seclusion incidents for 12 individuals (SW,WH, JV, CR, PL, PZ, NM, DY, JD, NMA, LN and SF), I found no indication that prone containment was used.</p> <p>Compliance: Partial.</p> <p>Current recommendations: 1. Provide staff training regarding revisions to policies and procedures for restraint/seclusion. 2. Continue to monitor this requirement.</p>
2	Each State hospital shall ensure that restraints and seclusion:	<p>Compliance: Partial.</p>
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;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Develop and implement a system to adequately document the use of least restrictive measures prior to the implementation of restraints.</p> <p>Findings: The revised AD #3306 (February 2007) comports with requirements of the EP. In addition, NP #250 requires that the Registered Nurse must complete an initial assessment and an assessment every hour (hourly IDN summary). The procedure indicates that the hourly note should provide a summary of the previous hour. It includes requirements for the assessment to address the physical and psychological status of the individual and to include least restrictive</p>

interventions attempted prior to the placement of S&R and the individual's response to those interventions.

MSH added an indicator to the Seclusion Restraint Review Form (CNS 30) to address this requirement, and provided instructions (in November 2006) regarding this indicator. The facility has monitoring data based on the Seclusion Restraint Form (N=number of all episodes of seclusion/restraints per month, n=number reviewed). The following is a summary:

Least restrictive alternatives are documented (IDN).

	Sep	Oct	Nov	Dec	Jan	Feb	Mean
N	187	124	150	113	156	102	
n	187	124	150	113	156	102	
%C	98	98	93	92	94	95	95

MSH noted that the compliance rates decreased in November when written instructions were given to auditors, but noted that the results are still artificially high. The facility plans to address this issue through training, cross-checking and assessment of inter-rater reliability.

From my review of 12 incidents of restraint/seclusion (SW, WH, JV, CR, PL, PZ, NM, DY, JD, NMA, LN, And SF), I found only two (WH and SW) that had adequate documentation of least restrictive alternative documented.

Recommendation 2, September 2006:

Ensure that policies and procedures include implementing seclusion and restraints only after a hierarchy of less restrictive measures have

		<p>been considered in a clinically justifiable manner or exhausted with supporting documentation to be logged in the medical record.</p> <p>Findings: The revision to AD #3306 in February 2007 complies with this recommendation.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that staff training regarding changes in policies and procedures for this requirement is provided. 2. Continue to monitor this requirement.
b	<p>are not used in the absence of, or as an alternative to, active treatment, as punishment, or for the convenience of staff;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Develop and implement a system to monitor the key elements of this requirement.</p> <p>Findings: The facility reported that an indicator was added to Seclusion Restraint Review in November 2006 to address this requirement. Instructions were developed (Nov 2006) and revised in January 2007 to reflect this revision.</p> <p>The following is a summary of the facility's data:</p> <p>Seclusion Restraint Review: <i>Restraints and seclusion are not used in the absence of, or as an alternative to, active treatment, as punishment, or for the convenience of staff.</i></p>

		<table border="1" data-bbox="1014 277 1793 415"> <thead> <tr> <th></th> <th>Sep</th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>187</td> <td>124</td> <td>150</td> <td>113</td> <td>156</td> <td>102</td> <td></td> </tr> <tr> <td>n</td> <td>187</td> <td>124</td> <td>150</td> <td>113</td> <td>156</td> <td>102</td> <td></td> </tr> <tr> <td>%C</td> <td></td> <td></td> <td></td> <td>42</td> <td>55</td> <td>77</td> <td>58</td> </tr> </tbody> </table> <p data-bbox="1014 459 1904 711">Compliance data relating to the use as punishment and for convenience of staff need to be broken out. In addition, collecting and reporting hours per week at mall and data relating to absence or as an alternative to active treatment would provide meaningful clinical information. Also, reviewing staff issues, such as unit overtime hours or number of new staff, and data relating to restraint and seclusion use related to staff convenience may provide additional useful information.</p> <p data-bbox="1014 756 1346 781">Current recommendations:</p> <ol data-bbox="1014 792 1766 894" style="list-style-type: none"> 1. Separate and report data regarding the elements of this requirement. 2. Continue to monitor this requirement. 		Sep	Oct	Nov	Dec	Jan	Feb	Mean	N	187	124	150	113	156	102		n	187	124	150	113	156	102		%C				42	55	77	58
	Sep	Oct	Nov	Dec	Jan	Feb	Mean																											
N	187	124	150	113	156	102																												
n	187	124	150	113	156	102																												
%C				42	55	77	58																											
c	are not used as part of a behavioral intervention; and	<p data-bbox="1014 943 1598 967">Current findings on previous recommendation:</p> <p data-bbox="1014 1013 1472 1037">Recommendation, September 2006:</p> <p data-bbox="1014 1049 1759 1073">Develop and implement a system to monitor his requirement.</p> <p data-bbox="1014 1125 1125 1149">Findings:</p> <p data-bbox="1014 1161 1845 1227">MSH began using DMH Psychology Monitoring Form to monitor this requirement.</p> <p data-bbox="1014 1273 1845 1339">The following is an outline of the facility's data (N=total number of behavioral plans, n=number of plans reviewed):</p>																																

		<p>DMH Psychology Monitoring Form: <i>Behavioral interventions, which include positive behavior support plans, are based on a positive behavior supports model and do not include the use of aversive or punishment contingencies.</i></p> <table border="1" data-bbox="1014 423 1703 565"> <thead> <tr> <th></th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>1</td> <td>10</td> <td>16</td> <td>27</td> <td>24</td> <td></td> </tr> <tr> <td>n</td> <td>1</td> <td>10</td> <td>16</td> <td>27</td> <td>24</td> <td></td> </tr> <tr> <td>%C</td> <td>100</td> <td>100</td> <td>63</td> <td>25</td> <td>30</td> <td>64</td> </tr> </tbody> </table> <p>The restraint/seclusion data for this requirement was not broken out in the table above. When the data was separated during the review, 100% compliance was noted for October 2006-February 2007. From my review, I found no indication that restraint/seclusion are used as part of behavioral interventions.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Separate and report data for elements of this requirement. 2. Continue to monitor this requirement. 		Oct	Nov	Dec	Jan	Feb	Mean	N	1	10	16	27	24		n	1	10	16	27	24		%C	100	100	63	25	30	64
	Oct	Nov	Dec	Jan	Feb	Mean																								
N	1	10	16	27	24																									
n	1	10	16	27	24																									
%C	100	100	63	25	30	64																								
d	are terminated as soon as the individual is no longer an imminent danger to self or others.	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Ensure accurate interpretation of compliance data.</p> <p>Findings: MSH's progress report indicated that instructions were developed (Nov 06) for the monitoring indicator on Seclusion Restraint Review (CNS 30) that addresses this requirement.</p> <p>The following summarizes the facility's data:</p>																												

		<p>Seclusion Restraint Review [CNS 30]: <i>Individual Released When Criteria Met (1029 & IDN Documentation).</i></p> <table border="1" data-bbox="1012 386 1814 496"> <thead> <tr> <th></th> <th>Sep</th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>187</td> <td>124</td> <td>150</td> <td>113</td> <td>156</td> <td>102</td> <td></td> </tr> <tr> <td>%C</td> <td>98</td> <td>98</td> <td>99</td> <td>90</td> <td>97</td> <td>94</td> <td>96</td> </tr> </tbody> </table> <p>The facility reported that although instructions were developed, compliance results remained questionably high. To address this, in April 2007, the following actions will be implemented for the Seclusion Restraint Review (CNS 30):</p> <ol style="list-style-type: none"> 1. Auditor training, 2. Establishment of inter-rater reliability, and 3. 20% cross-checking of the data. <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Implement interventions to ensure accuracy of the compliance data. 2. Continue to monitor this requirement. 		Sep	Oct	Nov	Dec	Jan	Feb	Mean	N	187	124	150	113	156	102		%C	98	98	99	90	97	94	96
	Sep	Oct	Nov	Dec	Jan	Feb	Mean																			
N	187	124	150	113	156	102																				
%C	98	98	99	90	97	94	96																			
3	<p>Each State hospital shall comply with 42 C.F.R. § 483.360(f), requiring assessments by a physician or licensed clinical professional of any individual placed in seclusion or restraints within one hour. Each State hospital shall also ensure that any individual placed in seclusion or restraints is continuously monitored by a staff person who has successfully completed competency-based training on the administration of seclusion and restraints.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Develop and implement a system to monitor and ensure compliance with all elements of this requirement.</p> <p>Findings: There are no data to address the requirement of competency-based</p>																								

		<p>training for staff providing the continuous monitoring.</p> <p>Recommendation 2, September 2006: Ensure accurate interpretation of data.</p> <p>Findings: The facility added an indicator to the Seclusion Restraint Review (CNS 30) to address this requirement and provided instructions (in November 2006). The following is a summary of the data:</p> <p><i>Physician conducted a face to face evaluation within one hour.</i></p> <table border="1" data-bbox="1014 683 1797 824"> <thead> <tr> <th></th> <th>Sep</th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>187</td> <td>124</td> <td>150</td> <td>113</td> <td>156</td> <td>102</td> <td>139</td> </tr> <tr> <td>n</td> <td>167</td> <td>124</td> <td>150</td> <td>113</td> <td>156</td> <td>102</td> <td>139</td> </tr> <tr> <td>%C</td> <td>96</td> <td>98</td> <td>95</td> <td>97</td> <td>96</td> <td>97</td> <td>96</td> </tr> </tbody> </table> <p>In reviewing the monitoring instrument, I noted that data are collected regarding a physician face-face evaluation, but do not include or credit other licensed clinical professionals. This may be related to additional requirements of oversight agencies.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Continue developing and implementing a system to monitor and ensure compliance with all elements of this requirement.</p>		Sep	Oct	Nov	Dec	Jan	Feb	Mean	N	187	124	150	113	156	102	139	n	167	124	150	113	156	102	139	%C	96	98	95	97	96	97	96
	Sep	Oct	Nov	Dec	Jan	Feb	Mean																											
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%C	96	98	95	97	96	97	96																											
4	Each State hospital shall ensure the accuracy of data regarding the use of restraints, seclusion, psychiatric PRN	Current findings on previous recommendations:																																

medications, or STAT medications.

Recommendation 1, September 2006:

Improve timeliness of data entry for PRN, STAT medication and Seclusion/Restraint data entry.

Findings:

MSH reported that the Audit Trail reports track time difference between seclusion, restraint, PRN or STAT medication use event and data entry. Average time difference per unit is reported to Programs on a monthly basis by the Standards Compliance Department.

The facility has monitoring data based on the Audit Trail Reports that are summarized as follows (N= total PRN and STAT medication administrations per month for both psychiatric and non-psychiatric indications, n=number reviewed):

PRN & STAT Time Difference by Unit (Goal = 1.5 days).

	Sep	Oct	Nov	Dec	Jan	Feb	Mean
N	2674	2719	2215	905	2278	1879	
n	2674	2719	2215	905	2278	1879	
Avg. days	1.4	1.8	1.8	1.5	1.7	1.2	1.6

Seclusion or Restraint Time Difference by Unit (Goal = 1.5 days).

	Sep	Oct	Nov	Dec	Jan	Feb	Mean
N	168	122	155	116	144	100	
Avg. days	5.3	8.0	6.2	6.0	4.0	4.5	5.7

MSH also reported that from September 2006 through February 2007, these reports were sent to program management for follow-up.

		<p>Data need to be separated for PRN, STAT, restraint, and seclusion.</p> <p>Recommendation 2, September 2006: Identify problems with timeliness of data entry and develop and implement a plan of correction.</p> <p>Findings: MSH has implemented this recommendation. The revised AD #3306 outlines the following processes:</p> <ol style="list-style-type: none"> 1. Program Directors are responsible for ensuring that seclusion and restraint use data are accurately entered into the hospital seclusion and restraint computer database by 12:00 p.m. (noon) on the next business day. 2. Nursing Coordinators are responsible for ensuring that PRN and STAT medication use data are accurately entered in to the hospital PRN and STAT medication use computer database by 7:00 a.m. on the next calendar day. 3. Monthly timeliness reports by unit are sent to the Program Directors and Nursing Coordinators for follow-up. <p>In March 2007, the facility formulated an action plan to improve timeliness of Seclusion or Restraint data entry. The following are the main action items:</p> <ol style="list-style-type: none"> 1. Program Directors (PDs) will identify backup person for data entry. 2. Eliminate delays in submitting data collection forms to data entry person (e.g., delay at Nursing Coordinator's desk for signature)
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		<p>3. PDs to cross-check CNS/HSS Daily Summary for completeness and accuracy of data.</p> <p>4. HSSs assigned to triggers to notify PDs via Standards Compliance Director when a discrepancy is discovered.</p> <p>Recommendation 3, September 2006: Data should be entered in real time</p> <p>Findings: The facility has set the goal and is currently trying to consistently achieve data entry within 1.5 days.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Separate and report data regarding PRN, stat, restraint, and seclusion data entry. 2. Continue to monitor this requirement.
5	<p>Each State hospital shall revise, as appropriate, and implement policies and procedures to require the review within three business days of individuals' therapeutic and rehabilitation service plans for any individuals placed in seclusion or restraints more than three times in any four-week period, and modification of therapeutic and rehabilitation service plans, as appropriate.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Revise appropriate policies and procedures to ensure compliance with this requirement.</p> <p>Findings: MSH reported that AD#3306 was revised in February 2007 to address this requirement.</p>

		<p>Recommendation 2, September 2006: Develop and implement a monitoring system to ensure that there is documentation of a review within three business days of WRPs for any individuals placed in seclusion or restraints more than three times in any four-week period and modification of therapeutic and rehabilitation service plans, as appropriate.</p> <p>Findings: The faculty added a monitoring indicator to Seclusion Restraint Review (CNS 30) Form to address this requirement. In November 2006, instructions were provided regarding the monitoring process. The following summarizes the facility's data:</p> <p>Seclusion Restraint Review [CNS 30]: <i>If an individual has been placed in S/R more than 3 times in a 4 week period, the WRP is reviewed within 3 business days and revised as appropriate. (WRP).</i></p> <table border="1" data-bbox="1014 906 1797 1049"> <thead> <tr> <th></th> <th>Sep</th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>187</td> <td>124</td> <td>150</td> <td>113</td> <td>156</td> <td>102</td> <td></td> </tr> <tr> <td>n</td> <td>187</td> <td>124</td> <td>150</td> <td>113</td> <td>156</td> <td>102</td> <td></td> </tr> <tr> <td>%C</td> <td></td> <td></td> <td></td> <td>32</td> <td>46</td> <td>59</td> <td>46</td> </tr> </tbody> </table> <p>Compliance: Partial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>		Sep	Oct	Nov	Dec	Jan	Feb	Mean	N	187	124	150	113	156	102		n	187	124	150	113	156	102		%C				32	46	59	46
	Sep	Oct	Nov	Dec	Jan	Feb	Mean																											
N	187	124	150	113	156	102																												
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%C				32	46	59	46																											
6	Each State hospital shall develop and implement policies and procedures consistent with generally accepted	<p>Compliance: Partial.</p>																																

	<p>professional standards of care governing the use of psychiatric PRN medication and STAT medication, requiring that:</p>	
a	<p>such medications are used in a manner that is clinically justified and are not used as a substitute for adequate treatment of the underlying cause of the individual's distress.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Same as in D.1.b.</p> <p>Findings: Same as in D.1.b.</p> <p>Recommendation 2, September 2006: Same as in F.1.b.</p> <p>Findings: Same as in F.1.b.</p> <p>Recommendation 3, September 2006: Same as in F.3.a.i through F.3.a.iii.</p> <p>Findings: Same as in F.3.a.i through F.3.a.iii.</p> <p>Recommendation 4, September 2006: Develop and implement policy/procedure to outline facility's standards regarding PRN/STAT medication use consistent with the requirements of the EP.</p> <p>Findings: The facility reported that NP #528 (PRN Orders) and NP #530</p>

		<p>(STAT Orders) were revised in December 2006 to comply with the EP.</p> <p>Recommendation 5, September 2006: Develop and implement triggers for review and follow through by medical and nursing leadership.</p> <p>Findings: MSH reported that AD #3133.1 Trigger Response was revised in February 2007. From January 4, 2007 through February 28, 2007, 36 WRPT action responses to PRN triggers and eight WRPT action responses to STAT medication use triggers were received by Standards Compliance.</p> <p>Current recommendations: Continue to monitor this requirement.</p>
b	PRN medications, other than for analgesia, are prescribed for specified and individualized behaviors.	Same as above.
c	PRN medications are appropriately time limited.	Same as above.
d	nursing staff assess the individual within one hour of the administration of the psychiatric PRN medication and STAT medication and documents the individual's response.	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Develop and implement a monitoring instrument to accurately monitor this requirement.</p> <p>Findings: MSH reported that the PRN/STAT Medications Monitoring Forms were implemented in September 2006. The following is an outline of the facility's monitoring data (N=total PRN or STAT medication</p>

administrations per month for psychiatric indications only):

PRN Medications Monitoring Form:

Nursing staff assesses the individual within one hour of the administration of the psychiatric PRN medication.

	Sep	Oct	Nov	Dec	Jan	Feb	Mean
N	1354	1133	839	682	738	552	
n	235	183	183	166	160	289	
%C	65	63	68	72	81	69	70

PRN Medications Monitoring Form:

Nursing staff documents the Individual's response to PRN medication.

	Sep	Oct	Nov	Dec	Jan	Feb	Mean
N	1354	1133	839	682	738	552	
n	235	183	183	166	160	289	
%C	63	57	75	86	82	61	71

STAT Medications Monitoring Form:

Nursing staff assess the Individual within one hour of the administration of the psychiatric PRN medication.

	Sep	Oct	Nov	Dec	Jan	Feb	Mean
N	328	229	271	209	215	257	
n	79	88	82	81	87	220	
%C	72	72	72	81	68	72	73

STAT Medications Monitoring Form:

Nursing staff documents the Individual's response to PRN medication.

		<table border="1"> <thead> <tr> <th></th> <th>Sep</th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>328</td> <td>229</td> <td>271</td> <td>209</td> <td>215</td> <td>257</td> <td></td> </tr> <tr> <td>n</td> <td>79</td> <td>88</td> <td>82</td> <td>81</td> <td>87</td> <td>220</td> <td></td> </tr> <tr> <td>%C</td> <td>66</td> <td>79</td> <td>83</td> <td>85</td> <td>69</td> <td>59</td> <td>74</td> </tr> </tbody> </table> <p>From my review of ten individuals who received PRN and/or STAT medications, I found similar findings to those submitted by MSH.</p> <p>Current recommendations: Continue to monitor this requirement.</p>		Sep	Oct	Nov	Dec	Jan	Feb	Mean	N	328	229	271	209	215	257		n	79	88	82	81	87	220		%C	66	79	83	85	69	59	74
	Sep	Oct	Nov	Dec	Jan	Feb	Mean																											
N	328	229	271	209	215	257																												
n	79	88	82	81	87	220																												
%C	66	79	83	85	69	59	74																											
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.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Develop and implement a monitoring instrument to address this requirement.</p> <p>Findings: Same as in F.1.b.</p> <p>Recommendation 2, September 2006: Same as in recommendations 1 though 3 in H.6.a.</p> <p>Findings: Same as in H.6.a.</p> <p>Current recommendations: Same as H.6.a.xxx</p>																																
7	Each State hospital shall ensure that all staff whose responsibilities include the implementation or assessment	<p>Current findings on previous recommendations:</p>																																

	<p>of seclusion, restraints, psychiatric PRN medications, or STAT medications successfully complete competency-based training regarding implementation of all such policies and the use of less restrictive interventions.</p>	<p>Recommendation 1, September 2006: Develop and implement competency-based training on this requirement.</p> <p>Findings: The revised AD #3306 complies with this requirement. In addition, Nursing Education provides competency-based training during Nursing Orientation and Nursing Annual Updates on Medication Administration which includes PRN and STAT medications. The Nursing Education competency-based Curriculum on Medication Administration was revised in January 2007 and the Nursing Annual Update on Medication Administration was revised in August 2006. Also, the Office of Professional Education and Training provides competency-based training on PMAB which includes Seclusion/Restraints, during Employee Orientation and Hospital Annual Updates. It utilizes the statewide Manual on Management of Assaultive Behavior which is integrated in a competency-based curriculum.</p> <p>Recommendation 2, September 2006: Develop and implement a monitoring instrument to accurately monitor this requirement.</p> <p>Findings: The facility reported that currently, the Training Database cannot produce summary reports of percentage compliance for a specific Topic (e.g., PMAB) or Employee Class (e.g., PTAs). There is a global out-of-compliance report for <i>everyone</i> who is currently out of compliance with <i>any</i> training requirement for any Topic.</p> <p>Although records of all required training are entered into the database, there are problems with employees being associated with the</p>
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		<p>wrong training requirements (e.g., the Standards Compliance Psychologist was entered as Direct Care Nursing) and with the same Topic being entered under several variations of the Topic Name (e.g., MAB, PMAB, P.M.A.B.).</p> <p>A Training Database Steering Committee has met and developed an action plan to develop standardized compliance reports by Topic and Employee Class.</p> <p>Recommendation 3, September 2006: Develop and implement a system to ensure that staff completes the required mandatory training for PMAB.</p> <p>Findings: In conjunction with the above database issues, MSH reported that the facility's managers and supervisors have read-only access to the Training Database and can create a training report for a specific employee for a specified period of time.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue the development and implementation of a monitoring instrument to accurately monitor this requirement. 2. Continue to monitor this requirement.
8	Each State hospital shall:	<p>Compliance: Partial.</p>

a	develop and implement a plan to reduce the use of side rails as restraints in a systematic and gradual way to ensure individuals' safety; and	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Develop and implement a plan to reduce the use of side rails as restraints in a systematic and gradual way to ensure individuals' safety.</p> <p>Findings: The revised AD #3306 complies with this recommendation. In addition, the following steps were reportedly initiated to address this recommendation:</p> <ol style="list-style-type: none"> 1. On January 10, 2007 six staff attended a Workshop entitled "JCAHO & CMS (HCFA) Restraint Standards and Falls Prevention." 2. A Fall Committee Charter was drafted in March 2007. The Fall Committee should develop, implement, and oversee the MSH hospital-wide Fall Reduction Program. The Program is to include, but not be limited to, the following: <ol style="list-style-type: none"> a. Review findings from the Failure Mode Effects Analysis (FMEA) and Process Action Team (PAT); b. Select and implement the use of a valid and reliable instrument for Falls assessment and re-assessment; c. Develop and implement ongoing Falls Prevention training to all staff; d. Develop an AD on Falls Prevention based on hospital data; e. Review of best practices; and f. Develop a process to integrate individualized, interdisciplinary falls treatment plans into the WRP process. 3. The Falls PAT recommended that staff be required to exhaust a specified hierarchy of less restrictive measures prior to using side
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		<p>rails.</p> <p>4. In March 2007, baseline data were collected on individuals who were currently using side rails and other safety devices.</p> <p>From my review of six individuals for whom side rails are being utilized (MG, JP, EG, DC, LB, and HN), I found no plan to reduce the use of side rails in their WRPs or medical records.</p> <p>MSH has only recently been reviewing its use of side rails. Although system and some clinical issues are being reviewed and addressed, the facility needs to continue progress in addressing this requirement.</p> <p>Recommendation 2, September 2006: Develop and implement a monitoring instrument to accurately monitor the key element of this requirement.</p> <p>Findings: MSH indicated that a Tracking Instrument, Use of Side Rails and Other Device/Equipment was drafted in February 2007 to be used on the units. The plan is to integrate data from this instrument into a computer database at Standards Compliance Dept. with a target date of implementation in April 2007.</p> <p>Other findings: There does not appear to be a system in place to monitor the use of "soft tie" and medical restraints to ensure that proper procedures are followed and that strategies and plans for their reduction are developed and implemented, if appropriate.</p>
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		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to develop and implement a plan to reduce the use of side rails as restraints in a systematic and gradual way to ensure individuals' safety 2. Develop and implement a system to monitor, track, and reduce, if appropriate, the use of soft tie and other medical restraints. 3. Continue to monitor this requirement.
b	<p>ensure that, as to individuals who need side rails, their therapeutic and rehabilitation service plans expressly address the use of side rails, including identification of the medical symptoms that warrant the use of side rails, methods to address the underlying causes of such medical symptoms, and strategies to reduce the use of side rails, if appropriate.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Develop and implement a system to ensure that, as to individuals who need side rails, their therapeutic and rehabilitation service plans expressly address the use of side rails, including identification of the medical symptoms that warrant the use of side rails, methods to address the underlying causes of such medical symptoms, and strategies to reduce the use of side rails, if appropriate.</p> <p>Findings: See H.8.a, under Findings for recommendation #2.</p> <p>Recommendation 2, September 2006: Develop and implement an instrument to accurately monitor this requirement.</p> <p>Findings: MSH has developed a monitoring instrument, Use of Side Rails and Other Device/Equipment Monitoring Form, to be implemented in April 2007.</p>

		<p>Current recommendations:</p> <ol style="list-style-type: none">1. Implement the monitoring instrument addressing this requirement.2. Continue to monitor this requirement.
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I	Protection From Harm	
	<p>Each State hospital shall provide the individuals it serves with a safe and humane environment and ensure that these individuals are protected from harm.</p>	<p>Summary of Progress:</p> <ol style="list-style-type: none"> 1. MSH has the capacity to produce trend and pattern data on incidents. It has not yet produced this analysis. 2. The hospital has produced lists of incidents by type and level of injury and some data related to location and time of day of selected incidents. This data is not produced on a monthly basis. 3. MSH has the capacity to identify repeat aggressors and repeat victims. This report is not produced on a regular basis. 4. Investigations are severely hampered by the lack of timeliness. 5. Rationales for disposition/outcome of investigations are not sufficiently developed and do not reference the relevant portion of the definition of abuse and neglect under consideration. 6. The incident review process is identifying some programmatic corrective actions, including additional staff training. The review process is not, however, identifying problems in the conduct of the investigation. 7. Deficiencies in the conduct of investigations are contributing to the zero substantiation rate for allegations of abuse investigated between September 1, 2006 and February 28, 2007. 8. The hospital has adopted AD 3133.1 (March 2007) to direct the process of collecting, alerting WRP teams to, and responding to triggers. MSH has not yet developed a system for monitoring implementation. 9. The hospital has taken measures to reduce suicide risks and has plans for additional measures. Environmental reviews are conducted regularly, some daily, monthly and semi-annually.

		<p>The environmental reviews need to include consideration of the appearance of individuals in care (cleanliness, grooming and condition of clothing) as these problems were evident during this tour. Improvements in documentation of environmental reviews are necessary.</p> <p>10. Attention to ADLs needs to be part of the WRP for those individuals who need assistance in grooming and maintaining a clean environment.</p> <p>11. The Individuals' Council is active, maintains minutes, is engaged in work to identify ways of reducing violence, and surveys its members semi-annually. Influential hospital administrators and staff have attended these meetings to listen and respond to questions.</p> <p>5.</p>
1	Incident Management	
	<p>Each State hospital shall develop and implement across all settings, including school settings, an integrated incident management system that is consistent with generally accepted professional standards of care.</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. C. Lusch, Hospital Administrator 2. D. Bates, Human Resource Director 3. H. Mears, Chief of Hospital Police 4. C. Rivera, Graduate Student Assistant 5. M. Nunley, Standards Compliance Director <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Mortality Review Committee minutes for 2006 and January 2007. 2. 15 investigations completed by the Office of the Special Investigator or hospital police 3. 30 SIRs (Special Incident Reports)

		<ul style="list-style-type: none"> 4. Investigation Compliance Monitoring Data 5. Investigation Recommendation Follow-up Monitoring Data (compiled by Human Resources Dept.) 6. Five investigations of deaths 7. Personnel records of eight staff members 8. Aggregate incident data 9. Records of 12 individuals to find signed acknowledgement of rights forms.
a	Each State hospital shall review, revise, as appropriate, and implement incident management policies, procedures and practices that are consistent with generally accepted professional standards of care. Such policies, procedures and practices shall require:	<p>Compliance: Partial.</p>
a.i	that each State hospital not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of individuals;	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Ensure that sufficient time is given in the revised training to a discussion of the obligation to report abuse/neglect through formal channels on an incident reporting form.</p> <p>Findings: A new curriculum on abuse/neglect training has been developed and will be used statewide. The first class for persons entering employment at MSH was held in March 2007. This is a three-hour training.</p> <p>Other findings: Several investigations reviewed raised the question whether staff members are identifying allegations of abuse and neglect. For example,</p>

		<p>the abuse investigation related to KS (date of incident: 9/10/06) revealed that while the individual was being treated for her injuries, she told the physician she wanted to press charges. The physician did not question the individual and took no action to report what one reasonably would construe to be an allegation of abuse by staff or aggression by a peer. This failure was not addressed with the physician.</p> <p>In the investigation of the allegation of abuse of PD (date of incident: June 19, 2007) there appears to be sufficient evidence to question whether the containment and subsequent use of restraint and seclusion were necessary or whether unnecessary force was used. The misuse of restraint violates Special Order #227. 07.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue new employee orientation training using the new curriculum. 2. Ensure that the training on abuse and neglect and the training on the use of behavior management techniques stresses that the misuse of restraint and seclusion is abuse and will be treated as such. 3. Conduct unannounced reviews of unit documents (logs, calls to physicians and police, etc.) looking for under-reporting of incidents. Document the conduct of these reviews.
a.ii	<p>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</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Revise the incident reporting form to specifically address sexual abuse (staff to individual sexual contact regardless of whether coercion is</p>

	<p>to, death, abuse, neglect, and serious injury, using standardized reporting across all settings, including school settings;</p>	<p>present).</p> <p>Findings: This work is being completed by a statewide work group which is revising the SIR form and the sexual abuse definitions.</p> <p>Recommendation 2, September 2006: Revise the other definitions related to sexual contact.</p> <p>Findings: See above.</p> <p>Recommendation 3, September 2006: Clarify roles as designated on the reporting form.</p> <p>Findings: This issue is also being addressed by the statewide work group. Particular attention is needed in clarifying roles in incidents involving self-harm.</p> <p>Recommendation 4, September 2006: Provide a space to document notification of child abuse allegations.</p> <p>Findings: The revised SIR form will include a space to document notification of child abuse allegations.</p> <p>Other findings: Review of 30 SIR reporting forms revealed that the coding of incident type, date, level of injury, and the role of staff and individuals was</p>
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		<p>accurate in all but three instances. Exceptions included: incident # 2-9497 lacked an injury code, incident # 6-8944 listed an individual as involved but who was not mentioned in the narrative as having a role in the incident, and the date of the incident is incorrect in # 1-8738. This represents improvement over the last review.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue the work of the statewide group revising incident management for the four hospitals. 2. Continue the careful review and correction, as necessary, of the SIRs.
a.iii	<p>mechanisms to ensure that, when serious incidents such as allegations of abuse, neglect, and/or serious injury occur, staff take immediate and appropriate action to protect the individuals involved, including removing alleged perpetrators from direct contact with the involved individuals pending the outcome of the facility's investigation;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Include in abuse and neglect training the responsibility to report injuries and the responsibility to observe for injuries that may not show up for several hours.</p> <p>Findings: This recommendation has been addressed. Section VI: Response for Investigation in the DMH Investigation Manual requires that the investigator should document and photograph injuries initially and then later.</p> <p>Recommendation 2, September 2006: Continue current practice of removing alleged perpetrators from contact with individuals until the investigation is closed.</p>

		<p>Findings: The hospital has continued the practice of removing alleged perpetrators to positions that do not require contact with individuals when an abuse/neglect investigation is ongoing.</p> <p>Other findings: The practice of removing alleged perpetrators of abuse or neglect is causing disruption on some units and resulting in hardship on other staff when they are required to work overtime to fill in for the staff member(s) who has/have been reassigned. In conversation with the Hospital Administrator we identified a possible way to alleviate this situation somewhat, as described in the recommendation below.</p> <p>The new Incident Management training clearly established that the first responsibility in the event of an incident is to see to the physical care and protection of the victim.</p> <p>In all of the investigations reviewed where abuse was alleged, the investigation contained a statement that the staff member has been reassigned to a position requiring no contact with individuals.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue the practice of moving staff to non-individual contact positions during investigations of allegations of physical, psychological, and sexual abuse and neglect. 2. Weigh the risks and benefits of removing staff members from units when the allegation is verbal abuse. For example, in those instances of alleged verbal abuse where the staff member has an excellent work history, there are no witnesses to the verbal abuse (individuals as well as staff) or other evidence
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		<p>immediately available to support the allegation, the decision might be made to allow the employee to work on his/her unit, but always under supervision, until the investigation is completed.</p> <p>3. Provide the necessary clinical interventions through the WRP to those individuals who have a history of making false allegations and monitor the effectiveness of the interventions.</p>
a.iv	<p>adequate competency-based training for all staff on recognizing and reporting potential signs and symptoms of abuse or neglect, including the precursors that may lead to abuse;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Continue with plans to increase orientation and annual refresher abuse and neglect training for nursing staff.</p> <p>Findings: Abuse and neglect training is presently occurring during orientation and in the Patients Rights course. Beginning in March 2007, new staff began receiving a three-hour course on Incident Management which covers more specifically than in previous training the definitions of abuse and neglect, the hospital's investigative response, and presents scenarios of common abusive, neglectful incidents for discussion.</p> <p>Recommendation 2, September 2006: Increase orientation and annual refresher training for non-nursing personnel.</p> <p>Findings: See above.</p>

		<p>Current recommendations: Continue to implement the expanded training. See also the recommendation in a.i. regarding the misuse of restraint and seclusion.</p>															
a.v	<p>notification of all staff when commencing employment and adequate training thereafter of their obligation to report abuse or neglect to each State hospital and State officials. All staff persons who are mandatory reporters of abuse or neglect shall sign a statement that shall be kept with their personnel records evidencing their recognition of their reporting obligations. Each State hospital shall not tolerate any mandatory reporter's failure to report abuse or neglect;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Continue to secure the missing forms.</p> <p>Findings: The hospital has continued to secure the missing forms and reports that nearly 97% of staff is in compliance.</p> <p>Review of the personnel records of eight staff members revealed that the hospital is taking measures to get signed forms from all staff. See February 2007 signature date for LM, as an example. One of the eight files reviewed did not have signed mandatory reporter (MR) forms for both child and dependent abuse as indicated below.</p> <table border="1" data-bbox="1012 980 1625 1352"> <thead> <tr> <th>Staff initials</th> <th>Date of hire</th> <th>Date MR form signed</th> </tr> </thead> <tbody> <tr> <td>JV</td> <td>9/2/86</td> <td>Child-9/2/86 Adult-9/6/86</td> </tr> <tr> <td>SC</td> <td>6/4/04</td> <td>Child & Adult 6/4/04</td> </tr> <tr> <td>GD</td> <td>7/2/04</td> <td>Child & Adult 7/2/04</td> </tr> <tr> <td>FM</td> <td>10/26/87</td> <td>Child & Adult 10/26/87</td> </tr> </tbody> </table>	Staff initials	Date of hire	Date MR form signed	JV	9/2/86	Child-9/2/86 Adult-9/6/86	SC	6/4/04	Child & Adult 6/4/04	GD	7/2/04	Child & Adult 7/2/04	FM	10/26/87	Child & Adult 10/26/87
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FM	10/26/87	Child & Adult 10/26/87															

Staff initials	Date of hire	Date MR form signed
RH	3/6/89	Child & Adult 3/6/89
LM	5/8/87	Child & Adult 2/2/07
SS	3/26/90	Child-no form Adult-3/26/96
JR	2/27/04	Child & Adult 2/27/04

The hospital is keeping a list of staff members who have not yet signed the Mandatory Reporter forms. SS was not included on that list, but has been added.

Recommendation 2, September 2006:

Continue the monthly log—either paper or computer.

Findings:

The facility has continued to keep a paper log of all newly hired staff members. The log identifies the staff member by name, the date of hire, and the date the Mandatory Reporter form was completed.

Recommendation 3, September 2006:

During investigations, ask individuals to whom they made the first report of the allegation.

Findings:

This criterion has been added to the Investigation Compliance

		<p>Monitoring Form revised March 8, 2007. Because of its recent inclusion, the hospital has no data yet on compliance.</p> <p>Other findings: The investigation of the physical abuse allegation (9/10/06) made by KS indicates that several staff interviewed did not remember signing the Mandated Reporter form, and some were unclear about their reporting responsibilities and the need to complete an SOC 341 as well as an SIR. SOC 341 forms were not available on the unit where this incident occurred.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue work on identifying staff members who have not acknowledged their mandatory reporting responsibilities in writing. 2. In the annual abuse/neglect training, include reminders to staff that they have signed this form acknowledging their responsibility to report dependent adult and child abuse. 3. Emphasize the need to complete both an SIR and SOC341 form when there is an allegation of abuse. 4. Ensure that both of these forms are available on all units.
a.vi	mechanisms to inform individuals and their conservators how to identify and report suspected abuse or neglect;	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: At the WRP meeting nearest to the anniversary of the individual's admission date, ask the individual to again review and sign the rights statement.</p>

		<p>Findings: This recommendation had not been implemented at the time of the visit.</p> <p>Other findings: A new Administrative Directive, effective March 2007, entitled Notification of Patients' Rights, requires that an individual will receive a Notification of Rights for signature annually at the WRP conference or when there is a change in legal status.</p> <p>A review of 12 records on six units revealed that only those individuals who had been admitted in within the past year had a current form. Two individuals had no signed form in their records—DM and FR on unit 412.</p> <p>Current recommendations: Spot-check compliance with the new Administrative Directive for annual signing of the rights statement.</p>
a.vii	posting in each living unit and day program site a brief and easily understood statement of individuals' rights, including information about how to pursue such rights and how to report violations of such rights;	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Add the name of the Patient Rights Advocate when one is hired.</p> <p>Findings: This recommendation has been implemented. On all six units toured, the Patient Rights poster was displayed and included the name and phone number of the Patient Rights Advocate hired in January 2007.</p>

		<p>Other findings: Forms for making a complaint to the Patient Rights Advocate were present on all units toured. All of the individuals I asked were able to discuss how they would make a complaint. Most said they would talk to the Unit Supervisor; some mentioned the complaint form.</p> <p>Current recommendations: Continue current practice.</p>
a.viii	procedures for referring, as appropriate, allegations of abuse or neglect to law enforcement; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Ensure that hospital police receive notification of allegations of abuse and neglect ASAP so that an investigation can begin in a timely manner.</p> <p>Findings: An investigations log is maintained by the Hospital Police and Special Investigators that contains this information.</p> <p>Other findings: The investigations log (covering September 06-March 07) indicates that of the 66 incidents recorded with the necessary information, 65% were not reported to the hospital police or Special Investigator (as appropriate) within five days of the incident. There are legitimate reasons why some investigations would be delayed, most commonly because the allegation was made some time after the actual incident. Notwithstanding reasonable explanations, the 65% figure is very high. The log does show improvement in late 2006 and 2007.</p>

		<p>Current recommendations: Work to ensure that incidents that require investigation are forwarded to the hospital police and Special Investigator promptly.</p>
a.ix	<p>mechanisms to ensure that any staff person, individual, family member or visitor who in good faith reports an allegation of abuse or neglect is not subject to retaliatory action, including but not limited to reprimands, discipline, harassment, threats or censure, except for appropriate counseling, reprimands or discipline because of an employee's failure to report an incident in an appropriate or timely manner.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Continue current practice,</p> <p>Findings: AD #2010 is still in effect and prohibits retaliation for the reporting of abuse and neglect.</p> <p>Other findings: The investigation of physical abuse of PD (date of incident: 6/19/06) states that when PD was initially interviewed by the Program Assistant she said that a staff member threatened to harm her if she spoke to anyone about her knee injury (the injury allegedly occurred during a physical intervention). There is no evidence this was pursued.</p> <p>Current recommendations: Complete an SIR and an investigation whenever an individual or staff person reports threats of or actual retaliatory action for reporting an allegation.</p>
b	<p>Each State hospital shall review, revise, as appropriate, and implement policies and procedures to ensure the timely and thorough performance of investigations, consistent with generally accepted professional standards of care. Such policies and procedures shall:</p>	<p>Compliance: Partial.</p>

<p>b.i</p>	<p>require investigations of all deaths, as well as allegations of abuse, neglect, serious injury, and theft. The investigations shall be conducted by qualified investigator(s) who have no reporting obligations to the program or elements of the facility associated with the allegation and have expertise in conducting investigations and working with persons with mental disorders;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Ensure that the hospital police receive timely notification of allegations.</p> <p>Findings: MSH has not yet implemented this recommendation.</p> <p>Recommendation 2, September 2006: Determine a method for ensuring that trained investigators investigate serious injuries.</p> <p>Findings: Presently, serious injuries that are not related to an A/N allegation are investigated at the unit level by staff members who are not yet trained in the conduct of investigations.</p> <p>Recommendation 3, September 2006: Encourage and train the investigators of serious injuries to consult physicians and other clinicians as necessary to ensure a comprehensive and accurate investigation.</p> <p>Findings: The DMH Investigation Manual states, "Special Investigators and Hospital Police Officers will consult medical professionals when conducting investigations into alleged physical abuse when there is evidence of an injury."</p> <p>Individual in care, CG, alleged on July 11, 2006 that a staff member</p>
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		<p>was using PRN medications to punish individuals. The investigation determined that the allegation was unsubstantiated. However, the investigation was concluded without reviewing the use of PRN medications on the unit in question and without talking to any other individuals on the unit.</p> <p>Other findings:</p> <p>The new curriculum that covers incidents from identification through investigation and follow-up, developed by Lee Dean and described in the Napa State Hospital report, will be tested in April 2007 at Napa when train-the-trainer training is held. It has been agreed that all staff from the Executive Director through the Program Managers in each hospital will be trained. At MSH, Unit Supervisors will also be included in that training. MSH plans to have two training teams, each consisting of a supervising clinician and a supervising hospital police officer.</p> <p>In addition to training for program and administrative staff, the state is working on standardized training for hospital police, with the objective of improving the level of competence and integrating the hospital police more fully and more effectively into the life of the hospital. This training will provide the police officers at all of the hospitals with Level 2 California Peace Officer Standards and Training (POST) Reserve Training (equal to approximately 350 hours of training) that they must pass before completing their probationary period.</p> <p>The Mortality Review Committee minutes contain vague language (which could be construed as a purposeful attempt to avoid an unfavorable conclusion) and a failure to pursue specific information requested. Specifically, the minutes of the January 23, 2007 meeting in</p>
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		<p>addressing recommendations made by a community hospital physician state, "[the physician] made recommendations that may not have been followed." Also, "it was understood by the Nursing Dept. that when medical results were received that the Medical Consultant would be notified." The questions remain—were the recommendations followed, and if not, why not, and did the nurse notify the Medical Consultant when the lab test results were received?</p> <p>The May 2006 minutes state that two physicians would be asked to attend a subsequent meeting. The minutes of later meetings do not indicate they attended or provide a reason for their failure to appear.</p> <p>The three-page death summaries coming from the Medical Director's office disproportionately address the medical care of the individual and the circumstances of the death as compared with criminal and other historical information.</p> <p>The Mortality Review Committee minutes indicate the participants' recognition of the need to be able to provide hospice services to individuals who need them.</p> <p>The log maintained by the hospital police and Office of the Special Investigator indicates that 65% of the incidents that require an investigation are not received by the hospital police or Special Investigator's Office within five days of the incident.</p> <p>See a.viii for further details.</p> <p>Current recommendations:</p> <ol style="list-style-type: none">1. Continue work on the training initiatives for hospital police and
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		<p>the investigation training for administrators and program and unit supervisors.</p> <ol style="list-style-type: none"> 2. Avoid ambiguous language, including the use of passive voice, in the Mortality Review Committee minutes. 3. Pursue information and personnel necessary to complete a death review and track this through completion in the minutes. 4. Review the death summaries from the Medical Director's office to see if reformatting would increase the pertinent information presented. 5. Continue to pursue avenues for making hospice services available to individuals in care. 6. Work on ensuring timely notification to the hospital police and Office of the Special Investigator of incidents that require investigation.
b.ii	<p>ensure that only the State Hospital staff who have successfully completed competency-based training on the conduct of investigations be allowed to conduct investigations of allegations of petty theft and all other unusual incidents;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Continue current practice.</p> <p>Findings: The hospital police continue to investigate incidents that might constitute a crime. See cell b.i. for plans for increased training for police officers. Some other unusual incidents are investigated by program staff. Under the new Incident Management Training Plan these staff will receive training in the conduct of investigations. This training will take a minimum of eight hours.</p> <p>Other findings: There has been substantial improvement in the content of the incident</p>

		<p>reviews/investigations conducted on the unit level. Nearly none of the program reviews in the sample of SIR reports I reviewed were repeat recitations of the circumstances of the incident, but instead indicated the actions taken in response to the incident. Specifically, in 29 of the 30 SIR reports reviewed, the program review appropriately addressed the initial and continuing program response to the incident.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Move forward with the initiative to provide hospital police increased training. 2. Continue to encourage programs to complete SIRs appropriately and do not accept SIRs that are not completed accurately.
b.iii	<p>investigations required by paragraph I.1.b.i, (above) provide for the safeguarding of evidence;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Continue current practice.</p> <p>Findings: The hospital has continued to identify in the investigation reports those objects and photos that are secured as evidence. The hospital reports 80% compliance over the six-month period from September 06 through February 07. In all but one month, December 2006, the compliance score was 100%.</p> <p>Other findings: Several of the investigation files I reviewed contained photos and a copy of the evidence log that described the objects put into evidence. In all instances, the narrative portion of the investigation report also</p>

		<p>identified the objects put into evidence and the photos taken.</p> <p>Current recommendations: Continue current practice.</p>
b.iv	<p>investigations required by paragraph I.1.b.i, (above) require the development and implementation of standardized procedures and protocols for the conduct of investigations that are consistent with generally accepted professional standards. Such procedures and protocols shall require that:</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Convene investigation reviewers to discuss and identify those elements of an investigation that they will review for, using the information above as a starting point.</p> <p>Findings: The facility has hired a staff member to review all of the investigations to score them using a 32-item checklist, the Investigation Compliance Monitoring Form. Every investigation is reviewed twice. The first review is done by the supervising hospital police officer and the second by the impartial staff member.</p> <p>The facility is currently undertaking a test of inter-rater reliability using this instrument.</p> <p>Other findings: There are several items on the checklist that ask if the investigation sets forth explicitly and separately the persons interviewed and the documents reviewed. These items are receiving high compliance scores because in the body of the report, the persons interviewed are identified. This information needs to be added to the face sheet of the investigation, which presently includes some identifying information. The dates the investigation was opened and closed, the</p>

		<p>type of allegation, the name of the investigator, and the final disposition also need to be added to the face sheet.</p> <p>The Investigation Compliance Monitoring Form does not ask whether the rationale for the disposition specifically references the definition of the allegation under investigation. For example, the rationale for not substantiating an allegation of physical abuse should reference the relevant portions of the definition of physical abuse.</p> <p>Some of the investigations reviewed did not meet current practice standards. Problems included the following:</p> <ul style="list-style-type: none"> • Failure to begin and conclude investigations in a timely fashion; • Failure to interview individuals who may have been witnesses; • Failure to ask for clinical/medical help when necessary; • Failure to reconcile conflicting information; • Failure to write a concise rationale for the determination/outcome; and • Failure to apply the definition of abuse as written in Special Order 227.07. <p>Examples of these failures to meet practice standards are provided in several cells in this section of the report.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Create a face sheet for investigation reports that includes the date closed, the names/titles of persons interviewed and the disposition in addition to the information already provided on
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		<p>the face sheet.</p> <ol style="list-style-type: none"> 2. Add to the Investigation Compliance Monitoring Form an item that asks if the rationale for the disposition addresses the relevant sections of the definition of the allegation under review as presented in Special Order 227.07. 3. Indicate on the Investigation Compliance Monitoring Form when the "N" for an item differs from that indicated for the month. 4. See also the recommendations in other cells that would improve the quality of investigations.
b.iv.1	<p>investigations commence within 24 hours or sooner, if necessary, of the incident being reported</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Continue to triage cases. Ensure the individual is safe and has received medical attention, if necessary, and interview the alleged victim as quickly as possible.</p> <p>Findings: In all of the investigations reviewed, MSH has ensured that the individual was safe and medical attention was provided if needed. The hospital has not been able to conduct timely interviews in all instances.</p> <p>Other findings: MSH's self-assessment indicates that from September 2006 through February 2007, approximately 14 percent of the investigations commenced within 24 hours. This figure does not reflect that portion of the investigation initiated at the program level.</p> <p>Several investigations reviewed were seriously flawed and the disposition/outcome called into question because of the time lapse</p>

		<p>between the incident and the interviews of the relevant parties. For example, in the investigation of the allegation of abuse made on behalf of PD on 6/22/06, interviews of staff present, the alleged perpetrator, and the alleged victim did not occur until four and five months after the incident. The alleged perpetrator acknowledged not remembering critical information. The other staff did not acknowledge an inability to remember, and so the investigation has numerous instances of conflicting testimony on critical elements.</p> <p>Similarly, in the investigation of the alleged abuse of KS (September 10, 2006), interviews of relevant persons began on October 12, 2007 and continued for nearly three months until January 4, 2007 when the alleged perpetrator was interviewed. In this investigation, it is impossible to determine where the physical intervention occurred that was the source of the abuse allegation and whether PRN medication was administered and found ineffective, as stated by the alleged perpetrator, before the individual was placed in restraint and seclusion or whether the restraint and seclusion happened simultaneously with the administration of the PRN.</p> <p>This practice of stretching interviews over several months is continuing: abuse allegations by PZ and MC both made in November 2006 were still under investigation in March 2007 at the time of our tour.</p> <p>Current recommendations:</p> <ol style="list-style-type: none">1. Hire the two additional Special Investigators as quickly as possible.2. Interview all relevant parties while their recollections of the incident are fresh.
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b.iv.2	<p>investigations be completed within 30 business days of the incident being reported, except that investigations where material evidence is unavailable to the investigator, despite best efforts, may be completed within five business days of its availability;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Ensure that hospital police receive timely notification of an allegation, as this will maximize the chance of completion within 30 days.</p> <p>Findings: See "Other findings" below.</p> <p>Recommendation 2, September 2006: Tackle the autopsy problem at the administration level in hopes of coming to an understanding with the Medical Examiner's Office for requesting and receiving autopsies.</p> <p>Findings: Receiving autopsies in a timely manner is still a problem in some but not all cases, as indicated in the chart below.</p> <table border="1" data-bbox="1014 943 1761 1174"> <thead> <tr> <th>Individual</th> <th>Date of death</th> <th>Date autopsy received</th> </tr> </thead> <tbody> <tr> <td>LM</td> <td>9/23/05</td> <td>11/10/05</td> </tr> <tr> <td>JW</td> <td>5/6/06</td> <td>5/23/06</td> </tr> <tr> <td>MC</td> <td>3/24/06</td> <td>1/23/07</td> </tr> <tr> <td>EG</td> <td>4/14/06</td> <td>1/26/07</td> </tr> <tr> <td>JP</td> <td>6/24/06</td> <td>1/26/07</td> </tr> </tbody> </table> <p>Other findings: MSH data indicates that in the period from September 2006 through February 2007, approximately 39% of the investigations were completed within 30 business days. Statistics related to the timely</p>	Individual	Date of death	Date autopsy received	LM	9/23/05	11/10/05	JW	5/6/06	5/23/06	MC	3/24/06	1/23/07	EG	4/14/06	1/26/07	JP	6/24/06	1/26/07
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JP	6/24/06	1/26/07																		

		<p>initiation and closure of investigations may improve with the hiring of two additional Special Investigators within the next few weeks.</p> <p>The log maintained by the hospital police and Office of the Special Investigator indicates that 65% of the incidents that required an investigation were not received by the hospital police or Special Investigator's Office within five days of the incident in the period September 2006 to March 2007. Additional delays occurred as interviews continued over several months. For example, in the investigation of the alleged abuse of AG (date of incident: June 6, 2006) the first interview was conducted in June and the concluding interviews were conducted in early October 06.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Develop a tickler system to alert investigators to renew the request for the autopsy periodically or to ask for assistance when his/her efforts have not been successful. 2. Avoid spreading interviews over several months if at all possible. When this cannot be avoided, provide the reason for the delays in conducting interviews.
b.iv.3	<p>each investigation result in a written report, including a summary of the investigation, findings and, as appropriate, recommendations for corrective action. The report's contents shall be sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly and separately:</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Adopt a standard face sheet for an investigation that includes the identifying information, persons interviewed, documents reviewed and the outcome. Include relevant dates, such as date case received, assigned, closed.</p>

		<p>Findings: The face sheet, as described above, is not in use. The present face sheet contains some, but not all, of the elements above.</p> <p>Other findings: In the review of investigations of allegations of abuse and investigations of death, a summary report was written in all instances, except in the review of the death of RP.</p> <p>The investigation reports of abuse allegations include a summary of the investigation and some contain recommendations for corrective actions. Most corrective actions are identified on the SIR or during the review process.</p> <p>The investigation reports do not contain a statement that summarizes the evidence that supports the investigator's conclusion regarding substantiation. Rather, the reports contain a summary of some of the findings and a statement such as "I could not substantiate the allegation of abuse." The summary statement needs to address the elements of the definition of abuse and the evidentiary standard used.</p> <p>Current recommendations: Conclude all investigations with a statement of facts that supports the disposition determination and specifically addresses the elements of the abuse definition and whether the evidence standard has been reached.</p>
b.iv.3(i)	each allegation of wrongdoing investigated;	Current findings on previous recommendations:

		<p>Recommendation 1, September 2006: Continue current practice.</p> <p>Findings: MSH investigation reports continue to identify each allegation of wrongdoing under investigation.</p> <p>Recommendation 2, September 2006: Same as b.iv.3.</p> <p>Findings: Same as b.iv.3.</p> <p>Other findings: See a.ix. An allegation of threatened retaliation was made during an investigation, but was not pursued.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Include in any investigation training the requirement to file an SIR on any allegation of retaliation for reporting abuse and neglect. 2. In the review of investigations and other documents, look for statements from individuals that suggest or reference threats of retaliation and ensure they have been investigated.
b.iv.3(ii)	the name(s) of all witnesses;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Document attempts to find individuals who may be witnesses to an</p>

		<p>incident.</p> <p>Findings: This recommendation has not been implemented. For example, in the investigation of the physical abuse of PB, the initial conflict was said to have occurred in the dining room during meal time and was reported by a witness who was an individual in care, yet no other individuals were interviewed to determine if they witnessed the incident. [I recognize that the interview pattern described in b.iv.1 would have compromised the usefulness of these interviews.]</p> <p>Recommendation 2, September 2006: Interview all staff on duty at the time.</p> <p>Findings: The investigations reviewed revealed a conscientious attempt to interview all staff on duty.</p> <p>Other findings: At the conclusion of the investigation of an allegation of physical abuse by KS (incident date: September 10, 2006), the investigator noted that the investigation would have been more complete had the staff members from another unit who participated in the physical intervention been identified. The investigator suggested that staff from other units be identified if they placed hands on the individual.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Develop a method for identifying off-unit staff members who participate in physical interventions so that this information can be available to investigators if it is needed
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		<p>later.</p> <p>2. Document attempts to find individuals who may be witnesses to incidents.</p>
b.iv.3(iii)	the name(s) of all alleged victims and perpetrators;	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Continue current practice.</p> <p>Findings: MSH investigations continue to include the name of the alleged victims and perpetrators.</p> <p>Current recommendations: Continue current practice.</p>
b.iv.3(iv)	the names of all persons interviewed during the investigation;	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Continue current practice.</p> <p>Findings: All persons interviewed were identified in the investigation reports reviewed.</p> <p>Current recommendations: Include the name and title/position of all persons interviewed on the face sheet of the investigation.</p>
b.iv.3(v)	a summary of each interview;	Current findings on previous recommendations:

		<p>Recommendation 1, September 2006: Identify interview questions and answers.</p> <p>Findings: The investigations reviewed show improvement in documenting interviews in such a way that one can discern questions and answers.</p> <p>Recommendation 2, September 2006: Question and document where staff members were when the incident occurred and why they could not see or hear what was occurring.</p> <p>Findings: This recommendation has been implemented.</p> <p>Other findings: Investigators should avoid phrases like "allegedly" and "reportedly" without attribution of the statements to the source. For example, in the investigation of physical abuse of PD (date of incident: 6/19/06), the investigator wrote that the individual who made the complaint on behalf of PD, but who was not interviewed because he had been discharged, "allegedly wanted to get staff in trouble."</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Attribute all statements to the source. 2. Identify hearsay evidence.
b.iv.3(vi)	a list of all documents reviewed during the investigation;	Current findings on previous recommendations:

		<p>Recommendation 1, September 2006: Review relevant documents and copy relevant portions that are critical to the findings and outcome.</p> <p>Findings: This recommendation has been implemented. The investigations reviewed commonly contained copies of relevant documents including treatment notes, WRP, Administrative Directives, staff training records, etc.</p> <p>Recommendation 2, September 2006: Identify documents reviewed on the cover page of the investigation.</p> <p>Findings: Documents reviewed are listed on the final page of the investigation. This listing meets the intent of this recommendation.</p> <p>Current recommendations: Continue current practice</p>
b.iv.3(vii)	all sources of evidence considered, including previous investigations and their results, involving the alleged victim(s) and perpetrator(s);	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Continue to review WRPs for relevant treatment objectives.</p> <p>Findings: The investigations reviewed frequently referenced an individual's treatment objectives.</p>

		<p>Recommendation 2, September 2006: Avoid general statements with no objective data that claim an individual is not credible.</p> <p>Findings: The investigations reviewed revealed improvement in this area. Rather than general, unsubstantiated statements about an individual's credibility, some investigations referenced the number and type of incidents the individual had been involved in recently.</p> <p>Recommendation 3, September 2006: Review a staff member's incident history not only for the number of incident he/she was involved in, but also for the type of incident to look for similarities in language used, etc.</p> <p>Findings: This recommendation has been implemented inconsistently. There is documentation in some investigations reviewed that investigators are reviewing a staff member's previous incident history. However, in the abuse investigation related to PD (date of incident: 6/19/06), while the investigator cites the previous allegations, important information is lacking about one of them made against this same staff member, i.e., the determination and rationale and similarities or lack thereof to the current allegation.</p> <p>In other instances, investigators are inconsistently referencing whether the staff member has been the focus of any other investigation. In the abuse investigation involving KS (incident date: 9/10/06), the investigator referenced whether the alleged perpetrator and two staff members who were found to have failed to</p>
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		<p>report the allegation had been the subjects of previous allegations. The investigator did not provide this information about the third staff member who failed to report.</p> <p>Other findings: The hospital is now able to identify staff members who have been the subjects of abuse/neglect allegations and has the capacity to run such a report on staff members.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to work on providing investigators access to the incident history of individuals and staff members. This information should include at a minimum the date, location, type of allegation, and the disposition. 2. When necessary, review a staff member's incident history not only for the number of incidents he/she was involved in, but also for the type of incident to look for similarities in circumstances, language used, etc.
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	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Identify the location and activities of all staff when investigating an incident.</p> <p>Findings: This practice was evident in most of the investigations reviewed.</p> <p>Recommendation 2, September 2006: Write a clear and concise statement of findings that supports the</p>

		<p>conclusion.</p> <p>Findings: The facility has yet to implement this recommendation.</p> <p>Other findings: See b.iv.3.</p> <p>Current recommendations: Write a complete and concise summary of findings that supports the determination and addresses the elements of the abuse allegation and how the findings meet the standard of evidence.</p>
a.iv.3(ix)	<p>the investigator's reasons for his/her conclusions, including a summary indicating how potentially conflicting evidence was reconciled; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Deal with the problem of conflicting evidence by doing second interviews.</p> <p>Findings: In several of the investigations reviewed, investigators conducted second interviews to clarify information.</p> <p>Other findings: When the second interview occurs months after the first, one can question the validity of the information received. For example, in the investigation involving KS, the first interview of a staff member was conducted on 11/14/06 and the second was conducted on 1/3/07. During the second interview, the staff member remembered an exact quote made by another staff member on 9/13/06. While this may be</p>

		<p>an accurate recollection, a reasonable person could question its accuracy.</p> <p>When investigations are delayed and interviews occur remote from the time of the incident, conflicting information increases and reconciliation becomes more difficult, and sometimes impossible. For example, in the abuse allegation involving PD there is conflicting information in at least these fundamentally important areas:</p> <ul style="list-style-type: none"> • Was PD held prone on the floor in the dining room? • Did PD use the food tray in a threatening manner ("like a weapon") or did she hold it at waist level and surrender it when asked? • Which staff, if any, attempted to calm PD before moving onto more restrictive techniques? • How could the two staff member have been "forced" to put PD in restraints when she was on the floor unable to walk because of a knee injury? Was she on the floor unable to walk? <p>Current recommendations: Do not spread interviews over several months unless there are extenuating circumstances, which should be described in the investigation report.</p>
b.iv.4	<p>staff supervising investigations review the written report, together with any other relevant documentation, to ensure that the investigation is thorough and complete and that the report is accurate, complete, and coherent. Any deficiencies or areas of</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Same as in b.iv.</p>

	<p>further inquiry in the investigation and/or report shall be addressed promptly. As necessary, staff responsible for investigations shall be provided with additional training and/or technical assistance to ensure the completion of investigations and investigation reports consistent with generally accepted professional standards of care.</p>	<p>Findings: All SIR investigations are put through a layered review process that begins at the program level and moves through nursing, Clinical Administrator, physician, Executive Director and ends with Personnel.</p> <p>Other findings: It is time-consuming to have these high-ranking staff members read each investigation, comment on it, and make recommendations. In most instances, recommendations for corrective actions are made early in the process and are accepted by subsequent reviewers. The identification of corrective measures is commendable. The problem lies in the failure of any of the reviewers to comment on the deficiencies in the conduct of the investigations, such as the lack of timeliness and its probable impact on the integrity of the investigation and the inadequate rationales for determinations. This suggests that reviewers are not focused on that aspect of the review process.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. <u>Consider</u> a different review process that uses an Incident Review Committee composed of a variety of staff with various expertise and job titles. 2. If the decision is to keep the present process, the reviews would be enhanced by the identification of four to five critical elements that the reviewers must address in their review.
c	<p>Each State Hospital shall ensure that whenever disciplinary or programmatic action is necessary to correct a situation or prevent reoccurrence, each State hospital shall implement such action promptly and thoroughly, and track and document such actions and the corresponding</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Develop the capacity to identify the outcome of each investigation and provide this in a monthly report, along with incident type and location</p>

<p>outcomes.</p>		<p>as a start for tracking patterns and trends.</p> <p>Findings: This recommendation has been partially implemented.</p> <p>Recommendation 2, September 2006: As Adverse Action cases are closed, either keep them on the log with the closing date noted or keep a separate log.</p> <p>Findings: The Human Resource office is keeping a paper record of recommendations resulting from investigations that indicates by program the number of investigation reports, the number of recommendations and the number of responses received back from the program and the date of the responses.</p> <p>Other findings: In the review of three investigations where corrective actions related to employee discipline or the need for additional training, the recommended actions had been completed in all cases. Specifically, required training was provided for staff members SC, GD and JR, a copy of a warning letter was in the personnel file of staff member, GD, and evidence of demotion was in JR's personnel file.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue current practice of routing all investigations with their review forms to Human Resources.
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		<p>2. Refine the Human Resource form to include, in addition to the information currently provided, the incident number, the type of recommendation using a simple coding system, (e.g. T=training, CS=change of shift, AD=review Administrative Directive), the date the notice was sent to the program.</p>
d	Each State hospital shall have a system to allow the tracking and trending of investigation results. Trends shall be tracked by at least the following categories:	<p>Compliance: Partial.</p>
d.i	type of incident;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Identify those elements that the database can report on and begin producing a monthly report that identifies basic incident information, such as type of incident, date, location, conclusion (substantiation or not), individual involved.</p> <p>Findings: This recommendation has not been implemented.</p> <p>Recommendation 2, September 2006: Later display this information in a meaningful form that will facilitate the identification of patterns and trends.</p> <p>Findings: This recommendation has not been implemented.</p> <p>Other findings: MSH has the capacity to aggregate incident data by type, name of victim, name of aggressor, location, time of day. Standards Compliance</p>

produced a report of victims and a report of aggressors during our visit. It had not been produced previously.

A review of the incident data for 2006 indicates a sharp rise in several types of allegations as illustrated below. This may be due to better reporting practices and/or other factors. The January 2007 minutes of the Performance Improvement Committee attribute the rise to the fact that in July the hospital "began requiring SIRs on all aggressive acts, not just those associated with injuries." This would have a significant impact on the numbers. Verbal aggressive acts toward staff also increased. The assumption that the number of aggressive acts that involve injury has not increased should be validated.

Incident type	Number of incidents, Jan-Jun 2006	Number of incidents, Jul-Dec 2006
Physical aggression to another individual	352	558
Aggressive act to self	272	588
Physical aggression to staff	148	562
Verbal aggression to staff	28	175

Current recommendations:

1. Determine what reports will be useful to the hospital on a monthly and quarterly basis, to whom they should be sent, and how they will be reviewed.
2. Use the capacity of the incident database to produce these

		<p>reports and accompany them with narrative analyses.</p> <p>3. Review the reports, including the report for 2006 referenced above, to identify areas that need further study or recommendations for preventative measures.</p>
d.ii	staff involved and staff present;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Account for all staff present in investigation reports.</p> <p>Findings: This recommendation has been implemented in most of the investigations reviewed. In these instances, staff members assigned to the unit are interviewed and their location at the time of the incident is included in the report narrative. See also b.iv.3(ii).</p> <p>Recommendation 2, September 2006: Clarify roles on the incident reporting form.</p> <p>Findings: See "Other findings" below.</p> <p>Recommendation 3, September 2006: Update the data regularly (weekly) to maintain its integrity and usefulness.</p> <p>Findings: A limited review of 30 SIRs revealed three errors--two very minor--indicating that the data reviewed was clean.</p>

		<p>Other findings: One of the SIRs reviewed contained an error related to the role of a relevant party. In that instance, someone was identified and coded on the SIR but not mentioned in the narrative or in the reviews.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Start producing reports related to staff accused in allegations of abuse and neglect and circulate as appropriate. 2. Allow investigators access to "staff as subject" information in the incident database.
d.iii	individuals directly and indirectly involved;	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Same as in d.ii.</p> <p>Findings: The facility has the capacity to produce reports of individuals who have been named as aggressors in incident reports and those named as victims in incident reports.</p> <p>Other findings: MSH is presently not using the information in the database to identify on a regular basis and over time those individuals who are repeat victims and repeat aggressors.</p> <p>During our visit, the hospital produced a report of individuals who had been the victim of two or more incidents of peer aggression from January 1 through March 23, 2007. This report included the identity of the aggressor, the date of the incident, day of the week, location</p>

		<p>and severity of injury. The report indicates that half of the 12 individuals identified were victimized by the same peer more than once.</p> <p>A review of aggregate incident data run by type revealed some confusion in coding the involvement of individuals in some incidents of self-harm.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Develop a report that is produced and reviewed regularly that identifies repeat aggressors and repeat victims and other relevant information, such as described above. 2. Ensure distribution of the report and a response from the WRP teams. 3. Review the coding of the role of individuals in self-harm incidents and clarify whether the individual should be coded the aggressor or the victim.
d.iv	location of incident;	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Ensure that the database can identify where the incident took place.</p> <p>Findings: The incident database has the capacity to produce a report on the location of incidents. The Hospital Administrator reported that a report identifying the location of incidents raised concerns about the number of incidents occurring in bathrooms. Methods of increased surveillance, without infringing on privacy, are being discussed and implemented on some units.</p>

		<p>Other findings: MSH is not currently producing a report on incident location on a regular basis.</p> <p>Current recommendations: Start producing a report on the location of incidents on a regular basis, accompanied by analysis of the data, documentation of the results of the review of this information, and any recommendations stemming from the review.</p>
d.v	date and time of incident;	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Same as in d.i.</p> <p>Findings: MSH has the capacity to produce a report of time and date of incidents.</p> <p>Other findings: The hospital produced raw data identifying the number and percent of incidents of aggressive acts to staff and aggressive acts to self by time of day for 2006. The January minutes of the Performance Improvement Committee contain analyses of this data, which indicates that 38% of aggressive acts to staff occurred between 3:00 PM and 8:00PM and slightly over half the aggressive acts to self occurred between 1:00PM and 8:00PM.</p> <p>My review of data on the number and percent of incidents of aggression between individuals by time of day revealed similar results.</p>

		<p>37.5% of aggressive acts between individuals occurred between 4:00PM and 9:00 PM and 14% occurred in the two-hour period between 8:00 and 10:00AM.</p> <p>Current recommendations: Produce, analyze and review reports on day and time of incidents on a regular basis.</p>
d.vi	cause(s) of incident; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Consider during the review of the incident reporting form if the broad incident types could be reworded to provide cause.</p> <p>Findings: See below for an alternate way to address the issue.</p> <p>Other findings: DMH is working on a form for follow-up on Headquarters Reportable Incidents (Special Incident Brief). These incidents include all allegations of abuse and neglect. The form is comprehensive and should result in a far clearer picture of what took place, the response, analysis, referrals, outcome and follow-up. A portion of the form that would require a listing of contributing factors is under consideration. This may provide more information than trying to pinpoint a cause. [The first attempts at trying to identify cause at another hospital sometimes resulted in suppositions about the motivations of staff and individuals. I would like to avoid this.]</p>

		<p>Current recommendations: Continue work on this form and implement it across hospitals once it is approved.</p>
d.vii	outcome of investigation.	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: See b.iv.3(viii).</p> <p>Findings: All investigations concluded with an outcome--a determination of whether the allegation was substantiated or not.</p> <p>Other findings: The rationales for the outcome of the investigations do not address the relevant section of the definition of abuse or the standard of evidence.</p> <p>Current recommendations: Write a complete and concise summary of findings supporting the determination that addresses the elements of the abuse allegation and whether the findings meet the preponderance standard of evidence.</p>
e	Each State hospital shall ensure that before permitting a staff person to work directly with any individual, each State hospital shall investigate the criminal history and other relevant background factors of that staff person, whether full-time or part-time, temporary or permanent, or a person who volunteers on a regular basis. Facility staff shall directly supervise volunteers for whom an	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Continue current practice.</p> <p>Findings: I have no evidence to suggest that the hospital is not fulfilling its</p>

	<p>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.</p>	<p>obligation to investigate the criminal histories of employees. This information was present in the personnel files reviewed.</p> <p>Other findings: In the investigations reviewed, either the SIR or the investigation report stated that the staff member alleged to have abused an individual was placed on non-individual contact duty.</p> <p>Compliance: Partial (very nearly full).</p> <p>Current recommendations: Add a check box on the face sheet of the investigation to indicate that the staff member was reassigned to non-individual contact duty and include this question on the monitoring tool. This will facilitate the hospital's own self-assessment of this portion of the Enhancement Plan.</p>
2	Performance Improvement	
	<p>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</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. M. Nunley, Standards Compliance 2. C. Lusch, Hospital Administrator <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Trigger data 2. Trigger definitions and business rules 3. AD #3133.1 Trigger Response

	consistent with generally accepted professional standards of care and shall include:	
a	Mechanisms for the proper and timely identification of high-risk situations of an immediate nature as well as long-term systemic problems. These mechanisms shall include, but not be limited to:	Compliance: Partial.
a.i	data collection tools and centralized databases to capture and provide information on various categories of high-risk situations;	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Continue to refine the collection of data and check on accuracy.</p> <p>Findings: Work has continued on this recommendation through a statewide work group and at MSH.</p> <p>Other findings: The hospitals agreed on the definitions of the triggers and the business rules governing how the triggers will be counted in September 2006, so that all hospitals are collecting the same information and counting it in the same way.</p> <p>Validation of the compatibility of the trigger data and the SIR data on abuse/neglect/exploitation is not possible (without reading the SIRs and/or the investigations) until the definitions of sexual activity are rewritten to distinguish between coercive or exploitive sexual activity, sexual activity between staff and individual and consensual adult sexual activity.</p> <p>See other sections of this report for assessments of the validity and usefulness of data presented during the tour.</p>

		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to refine the data collection systems to ensure the data is useful, accurate and not duplicative. 2. Redefine sexual incidents to, at a minimum, distinguish between coercive or exploitive sexual activity, sexual activity between a staff member and an individual in care and consensual adult sexual activity. Redefine rape. 3. Ensure the data makes sense, perhaps by having someone outside of the discipline/program review the data. 4. Begin testing for inter-rater reliability.
a.ii	<p>establishment of triggers and thresholds that address different levels of risk, as set forth in Appendix A; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Same as a.i.</p> <p>Findings: MSH and DMH Central Office continue to work on a centralized system for collecting trigger data.</p> <p>Other findings: MSH data indicates that programs have identified various interventions to address an individual's behavior that reached a trigger. A checklist of possible interventions is proving helpful.</p> <p>Current recommendations: Continue to implement AD 3133.1</p>
a.iii	<p>identification of systemic trends and patterns of high-</p>	<p>Current findings on previous recommendation:</p>

	<p>risk situations.</p>	<p>Recommendation, September 2006: Continue to refine data collection methods to improve accuracy so that trending and pattern data, when produced, will be useful.</p> <p>Findings: The hospital is not producing trend data or identifying high-risk situations. It is identifying individuals who reach a trigger and is reviewing these individuals weekly in a group clinical meeting. This process is governed by AD 3133.1 (See b.iii.)</p> <p>Other findings: Assuming that the data from October 2006 has been collected according to the agreed upon rules, the MSH data related to aggression and abuse and neglect shows relatively stable rates of occurrence per 1000 patient days.</p> <p>There is no trigger to identify individuals who are repeat victims.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. In addition to identifying individuals who are high risk because of their aggressive behavior, identify those who are at high risk because they are repeat victims. 2. Begin tracking these individuals to determine whether interventions are effective and report this information in the appropriate forum.
b	<p>Mechanisms for timely interventions and other corrective actions by teams and disciplines to prevent or minimize risk of harm to individuals. These mechanisms shall include, but</p>	<p>Compliance: Partial.</p>

	not be limited to:	
b.i	a hierarchy of interventions by clinical teams that correspond to triggers and thresholds;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Continue work on procedures for the return of the response forms.</p> <p>Findings: The newly adopted AD 3133.1 (March 2007) lays out procedures for responding to triggers. See b.iii.</p> <p>Recommendation 2, September 2006: Adopt guidelines for monitoring the implementation of a sample of the response forms.</p> <p>Findings: This recommendation has not been implemented.</p> <p>Current recommendations: Implement AD #3133.1 and track the responses from the WRPTs for compliance.</p>
b.ii	timely corrective actions by teams and/or disciplines to address systemic trends and patterns;	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Same as a.iii and b.i.</p> <p>Findings: When AD #3133.1 is implemented it will guide the timely notification of and response to an individual reaching a trigger.</p>

		<p>Current recommendations: Implement AD #3133.1 and track the responses from the WRP teams for compliance.</p>
b.iii	<p>formalized systems for the notification of teams and needed disciplines to support appropriate interventions and other corrective actions;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Continue the current practice of alerting units when an individual has reached a trigger.</p> <p>Findings: Units are notified within 48 hours when an individual has reached a trigger.</p> <p>Recommendation 2, September 2006: Continue to provide the individual's trigger history on the alert and at the Trigger Meetings.</p> <p>Findings: Trigger Meetings are held weekly and address those individuals who have reached triggers during the last seven days and other individuals defined in the AD who have continued to reach triggers.</p> <p>Other findings: The hospital has adopted AD #3133.1 effective March 8, 2007 entitled Trigger Response that describes an effective system for identifying, and tracking responses to triggers. In addition to identifying the composition and work of the weekly trigger meetings, the AD identifies a tracking form that requires the tem to document reviews and actions taken. This form is to be returned within 48 hours</p>

		<p>with a copy to Standards Compliance for tracking.</p> <p>Current recommendations: Implement AD #3133.1.</p>
b.iv	<p>formalized systems for feedback from teams and disciplines to the standards compliance department regarding completed actions; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Continue with plan to increase compliance with the return of the response forms.</p> <p>Findings: See b.iii.</p> <p>Current recommendations: Implement AD #3133.1</p>
b.v	<p>monitoring and oversight systems to support timely implementation of interventions and corrective actions and appropriate follow up.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Continue with plans for the full development of the trigger identification, response and oversight system.</p> <p>Findings: Work on the trigger system continues both at the hospital and at the DMH Central Office level.</p> <p>Other findings: The hospital has no system in place to ensure the timely implementation of interventions and corrective actions.</p>

		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Select a sample of the responses from WRP teams and ensure that the actions described have been implemented by the date indicated. 2. Produce a report on these findings.
c	<p>Utilize, on an ongoing basis, appropriate performance improvement mechanisms to assess and address the facility's compliance with its identified service goals.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Provide more discipline-/area-specific training to staff on methods for collecting their data and ensuring its accuracy.</p> <p>Findings: The facility reports that the Standards Compliance Psychologist has made formal presentations and provided ongoing consultation and feedback on auditing processes. Copies of the power-point slides were made available.</p> <p>Recommendation 2, September 2006: Test to be sure staff members understand what they have been taught, so that they can help improve the process.</p> <p>Findings: There was no competency test after the training, but competency will be assessed through review of the data produced.</p> <p>Compliance: Partial</p>

		<p>Current recommendations: In response to the findings in this report related to monitoring tools, identify those that are helpful and eliminate those that are unnecessary and/or ineffective.</p>
3	Environmental Conditions	
	<p>Each State hospital shall develop and implement a system to review regularly all units and areas of the hospital to which individuals being served have access to identify any potential environmental safety hazards and to develop and implement a plan to remedy any identified issues, consistent with generally accepted professional standards of care. Such a system shall require that:</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. C. Lusch, Hospital Administrator 2. E. Park, Health and Safety Analyst 3. L. Maldonato, Assistant Hospital Administrator 4. M. Marshall, Chief of Plant Operations 5. K. Moran, Health and Safety Analyst 6. A. Hendricks, Nursing Services Coordinator <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Selected portions of the semi-annual environmental reviews of three units. 2. Inspection Tracking Grid 3. A sample of Housekeeping Daily Inspection Checksheets <p><u>Toured:</u> Units 407, 401, 409, 403, 412 and 414.</p>
a	<p>Potential suicide hazards are identified and prioritized for systematic corrective action, and such action is implemented on a priority basis as promptly as feasible;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2006: Continue to remove the atmospheric vacuum breakers.</p>

		<p>Findings: According to the Chief of Plant Operations, all vacuum breakers have been removed. I did not see any vacuum breakers in the bathrooms on the units I toured.</p> <p>Recommendation 2, September 2006: Review conduits in all units and address any gaps from the wall.</p> <p>Findings: I did not see any gaps between conduits and the wall during this tour.</p> <p>Recommendation 3, September 2006: Remind staff of the importance of accurate counts when individuals are leaving the unit, lest someone get locked into a bedroom or bathroom.</p> <p>Findings: I have no information directly related to this finding. Staff do hourly documented head counts.</p> <p>Recommendation 4, September 2006: Complete the development of tools for the daily walk-through and the monthly self-inspections.</p> <p>Findings: This recommendation has been partially implemented. Monthly nursing inspections are supposed to be conducted and documented. Daily walk-through inspections are supposed to be documented in the nursing log. This latter is not proving to be an effective method of documentation.</p>
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		<p>Other findings:</p> <p>In conversation about how to facilitate documentation of daily rounds that would be easy to monitor, without creating a paper burden, the suggestion that follows was tentatively accepted: Create a peel-and-stick label that can be affixed to the log each day that contains 5-6 essential inspection elements, e.g. supplies (including personal hygiene supplies and linens on beds), environment, mail distribution, water and ambient temperature.</p> <p>A budget proposal for the expenditure of approximately \$400,000 has been submitted and will be reviewed at the end of May to change the bathroom stall partitions and eliminate other suicide hazards in the bathrooms.</p> <p>The hospital is in the process of replacing shower valves with push buttons to eliminate this suicide hazard. Similarly, the hospital is installing sloped strobe light covers to eliminate a hanging point hazard. This project should be completed by June 2007.</p> <p>MSH is working with a vender to develop a substitute for the tall bedroom lockers. The hospital is testing a low-profile three-drawer dresser that is lockable, has no metal glides, and contains stops that prevent the drawers from being removed. Once an approved model is developed, these dressers will replace the lockers. These dressers were in use in some bedrooms reviewed.</p> <p>The Environment of Care Committee (EOC), which meets monthly, reviews the results of the semi-annual inspections and prioritizes for action those findings related to suicide risk and those issues that represent high and intermediate health and safety risks.</p>
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		<p>An Inspection Tracking Grid was developed in March 2007 and tracks the date of the semi-annual inspection, unit/area inspected, date the report was sent to the EOC and to the Program and the response received. The form was too recently developed to provide information on the timeliness of the responses of the programs reviewed.</p> <p>During the tour of six units, several environmental problems were evident. Of the 61 beds inspected, 44% had no sheets and 21% had no pillow or no pillowcase. This was due, in part, to the new mattresses that are covered in plastic. The sheets do not stay on the mattress, and the individual ends up sleeping on the plastic, which is uncomfortable. There was nearly unanimous disapproval of the mattresses, with some individuals complaining about not being able to sleep since the changeover and others complaining of backaches.</p> <p>Smoking odor was strong in the bathroom of one of the units, and urine odor was strong on a second unit.</p> <p>Some individuals observed were dirty, disheveled, and dressed in soiled clothing. Some were walking the units barefoot. In questioning staff about one individual who was particularly poorly groomed and whose clothes were filthy, the staff member explained, "He chooses to dress that way."</p> <p>A 10:00 AM review of one unit revealed that 30% (11 of 38) of the individuals had not gone to mall programming (or to another appointment), and most of these individuals were in bed.</p> <p>The semi-annual inspection report of Unit 412 indicated that the</p>
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		<p>monthly inspections were not being conducted and documented. This information was not supplied for Units 416 and 414.</p> <p>The semi-annual inspection reports for Units 412, 414 and 416 identified some environmental problems, but the section of the form requiring the inspector to answer whether a work order had been completed was not filled in for any of the deficiencies cited.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Discuss the documentation system described above for daily inspections of the units with nursing personnel and implement it, if nursing finds it helpful. 2. Continue current practices in addressing suicide and self-harm risks and in care of the environment in general. 3. Include in the list of work to be completed on suicide hazards the enclosure of bathroom sink plumbing. 4. Include on all inspection instruments (daily through semi-annually) a review of the appearance of the individuals in care (cleanliness, grooming, clothing). 5. Ensure that ADL issues are addressed in the WRPs of those individuals who need support in grooming, etc. 6. Review the semi-annual inspection reports for completeness. 7. Continue the use of the Inspection Tracking Grid to ensure timely reports to and response from the programs/areas inspected.
b	All areas of the hospital that are occupied by individuals	Current findings on previous recommendations:

	<p>being served have adequate temperature control and deviations shall be promptly corrected;</p>	<p>Recommendation 1, September 2006: Check the water temperature and make required adjustments, including to the alert system.</p> <p>Findings: The facility has implemented this recommendation.</p> <p>Recommendation 2, September 2006: Include a review of water temperature on the monthly in-house environmental reviews.</p> <p>Findings: The facility checks water temperature more frequently than monthly. Additionally, a review of water temperature has been included on the inspection checklist that is used to inspect each unit semi-annually.</p> <p>Other findings: According to the Chief of Plant Operations, water temperature is checked weekly on each unit at the tempering valve by his staff. If problems are found, an adjustment is made at the tempering valve. During our tour, one unit did not have hot water. This was likely due to plumbing work being done.</p> <p>MSH has supplied each unit with a digital thermometer for checking water temperature. During our tour, we learned that some of the thermometers record only air temperature, not water temperature.</p> <p>Compliance: Partial.</p>
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		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue current practice. 2. Ensure that each unit has a thermometer that measures water temperature, as well as one that measures air temperature.
c	<p>Each State hospital reviews, revises, as appropriate, and implements procedures and practices so that individuals who are incontinent are assisted to change in a timely manner;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Create individual incontinence plans for those persons living outside the SNF who require them. Include bathroom schedules and other measures as appropriate that help preserve the individual's dignity.</p> <p>Findings: The facility has yet to implement this recommendation.</p> <p>Other findings: A nursing policy/procedure has been written (March 2007) and when adopted and implemented will address the needs of individuals with incontinence in all units of the hospital. The policy needs language changes to ensure that goals and interventions for dealing with incontinence are incorporated into each individual's WRP.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Revise the text of the Nursing Policy and Procedure entitled "Bowel and Bladder Incontinence Management" to eliminate the language that limits the inclusion of goals and interventions into

		<p>the WRP to only those individuals whose incontinence is <u>irreversible</u>.</p> <p>2. Adopt and implement the revised policy/procedure.</p>
d	<p>Each State hospital thoroughly reviews and revises, as appropriate, its policy and practice regarding sexual contact among individuals served at the hospital. Each State hospital shall establish clear guidelines regarding staff response to reports of sexual contact and monitor staff response to incidents. Each State hospital documents comprehensively therapeutic interventions in the individual's charts in response to instances of sexual contact; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Join with the staff of other hospitals in dealing with this very challenging topic and devising a set of guidelines for how staff is supposed to respond to consensual sexual activity between individuals.</p> <p>Findings: MSH has not produced clear guidelines regarding sexual contact between individuals.</p> <p>Other findings: AD #3412 "Sexuality and the Safety of Individuals" was revised in February 2007 and contains guidelines for assessments regarding sexual behaviors and measures for consideration that would prevent exploitation.</p> <p>The copy I reviewed requires editing because words are missing in several sections, the definition of staff intervention is unnecessarily confusing, and Item 6.2.1 must have been incorrectly typed because it does not make sense.</p> <p>More importantly, the AD is unclear as to whether consensual sexual activity between adults is permitted. The AD states that self-stimulation in private and the touching of non-intimate body parts of another to express warm regard, caring, etc. are permissible, and staff</p>

		<p>should not intervene. The AD further states that staff should intervene if an individual is engaging in unprotected sexual activity that could result in STD transmission or pregnancy and in any sexual activity where there is an element of coercion, such as to gain property, repay debts. A reader could conclude that consensual, protected sex between adult individuals in care conducted in reasonable privacy is permissible, and staff should not intervene. If this is the intended conclusion, the AD should state so. The AD requires all unprotected sexual activity between individuals to be reported on a Special Incident report.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Write a set of sexuality guidelines that are easy to understand. This can be a separate document or a revision of the AD 3412. The document produced should straightforwardly address consensual sexual activity between adults. 2. Consider simplifying the definition of "staff intervention" in the present policy to read, "Action by staff that interrupts the natural sequence of events <i>that would have otherwise occurred.</i>" 3. Consider asking the Individual Council or a subcommittee of the Council for assistance in drafting the guidelines.
e	Each State hospital develops and implements clear guidelines stating the circumstances under which it is appropriate to utilize staff that is not trained to provide mental health services in addressing incidents involving	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Develop a training curriculum for the situations described, as the need</p>

	<p>individuals. Each State hospital ensures that persons who are likely to intervene in incidents are properly trained to work with individuals with mental health concerns.</p>	<p>arises.</p> <p>Findings: MSH has implemented this policy.</p> <p>Other findings: MSH has developed a course for non-clinicians who will be conducting mall groups. The course was offered in October 2006 and 20 staff members attended, including physicians, hospital police officers, Plant Operations and Information Technology personnel, and administrators. In addition to this course, Basic Group Leadership, all staff teaching mall groups must have completed CPR and PMAB training.</p> <p>Compliance: Partial.</p> <p>Current recommendations: Develop a method whereby the hospital is assured that everyone who is not a clinician but is working in the mall has completed the Basic Group Leadership course and the other prerequisites.</p>
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J	First Amendment and Due Process	
		<p>Summary of Progress:</p> <ol style="list-style-type: none"> 1. The hospital has a functioning Individuals' Council that meets monthly and keeps minutes. Attendance at the meetings by influential staff and administrators illustrates the hospital's commitment to listening and responding to individuals. 2. Semi-annual surveys are conducted covering topics important to the current quality of life of individuals and preparation for life after discharge. 3. A committee of staff and individuals is studying ways to reduce violence that have been tried in other institutions.
	<p>Each State hospital unconditionally permits individuals to exercise their constitutional rights of free speech, including the right to petition the government for redress of grievances without State monitoring, and provides them due process.</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Ten individuals 2. K. Layman, Treatment Enhancement Coordinator <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Minutes of meetings of the Individuals' Council 2. Minutes of the project to enhance safety and reduce violence 3. First Amendment and Due Process Surveys dated August 2006 and March 21, 2007. <p><u>Observed:</u></p> <p>Senate meeting.</p>

		<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2006: Continue to engage in an authentic dialogue with the Individual Council over the issues raised by these surveys.</p> <p>Findings: The hospital is implementing this recommendation. The Executive Director of the hospital, the Standards Compliance Director, dietary staff and "BY CHOICE" representatives, and the Treatment Enhancement Coordinator are among the staff and administrators who have been present at these meetings to listen and answer questions.</p> <p>Other findings: The minutes of the Council meetings are available in Spanish, as well as English. The September 2006 minutes state that copies of the Enhancement Plan were distributed. Items still under consideration include: law library improvements, informal meetings with the Patients Rights Advocate, and including individuals in A/N training.</p> <p>A committee of individuals and staff to study ways to reduce violence has been formed and is reviewing programs in other Ca. hospitals and in other states.</p> <p>A comparison of the results of the August 2006 and March 2007 First Amendment and Due Process Survey on selected topics indicate the following:</p>
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You are:	% yes 8/06	% yes 3/07
Treated with respect	81	89
Assisted in meeting WRP goals	79	81
Able to communicate with family, attorneys, etc.	80	76
Taught what constitutes A/N	70	63
Taught about your rights	64	66
Does the grievance process work here?	64	74

In interviews, individuals spoke about the population mix, citing the difficulty of avoiding run-ins with some individuals who are intrusive and aggressive. The individuals talked about sleeping sometimes five to a room and not being able to get away from troublesome individuals and the consequence of "doing more time here" because they have been involved in an incident with one of these difficult individuals.

Compliance:
Partial.

- Current recommendations:**
1. Continue current practice.
 2. Pursue those initiatives that are still pending.
 3. Use the incident data and conversations to identify individuals who are repeatedly involved in incidents.
 4. Consider environmental factors that may be contributing to incidents.

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