

REPORT 1
METROPOLITAN STATE HOSPITAL BASELINE EVALUATION

September 18-22, 2006

THE HUMAN POTENTIAL CONSULTING GROUP
ALEXANDRIA, VIRGINIA

Introduction

A. Background Information

The evaluation team, consisting of court monitor (Mohamed El-Sabaawi, M.D.) and three expert consultants (Vicki Lund, Ph.D., M.S.N, A.R.N.P.; Ramasamy Manikam, Ph.D.; and Elizabeth Chura, M.S.R.N.) visited Metropolitan State Hospital (MSH) from September 18 to 22, 2006 to evaluate the facility's compliance with the Enhancement Plan (EP). The evaluators' objective was to develop a detailed baseline assessment of the status of compliance with all action steps of the EP.

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

1. The methodology of evaluation -summarized in one cell at the beginning of each section or major subsection (C1, C2, D1 through D.7, E, F1 through F 10, G, H., I and J);
2. Current findings focused on the requirements in each action step of the EP-this includes, as appropriate, the facility's internal monitoring data and the evaluators' monitoring data;
3. Compliance status in terms of the EP; and
4. Recommendations.

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

B. Methodology

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

C. Findings

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

1. Key Indicator Data

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

- a) The key indicator data provide a global assessment of the clinical and process outcomes at the facility and should not be seen as just another requirement of the EP.
- b) At present, the key indicators lack completeness, consistency and reliability. As a result, the data cannot provide the basis for an accurate global assessment. Consequently, it cannot be used to improve the functional status of the individuals and/or drive changes in processes at the system level. The following are examples:
 - i. The reliability of the data is an issue that must be addressed by the facility (e.g. seclusion and restraints data).
 - ii. The facility presented data regarding individuals' non-adherence to their WRPs. However, the current systems that identify the individual's attendance in various treatment and rehabilitation activities are inconsistent and unreliable, which raises concerns about meaningfulness of these data.
 - iii. The data collection systems and the definition of many key indicators appear to vary from facility to facility. These must be uniform statewide.
 - iv. There is a need to accelerate efforts to automate data collection systems to improve consistency and timeliness in the gathering, aggregation and presentation of data across all facilities.

2. Monitoring and mentoring

The facility has developed and implemented a variety of processes that utilized a number of monitoring tools to assess its compliance with the EP. However, it was very clear to the monitoring team that there were serious flaws inherent in the process used for self-monitoring. The following observations are relevant to this effort.

- a) Some of the facility's tools are well aligned with the requirements of the EP. Examples include the tools related to case formulation (yet to be implemented) and inter-unit transfers.
- b) A significant number of the tools do not address the key requirements of the EP (e.g. some WRP processes and general medical services).

- c) Not all the tools are accompanied by instructions and operational definitions that can standardize the use within and across the facilities.
- c) The monitoring tools were not used accurately and the monitoring data were substantially unreliable.
- d) The ratings were very liberal, did not match with the original sources, and gave the impressions that clinical service delivery at Metropolitan is much better than it actually is.
- e) In many cases, the sample size monitored was far too small to be meaningful and the method of selection unstated. The sample size must be representative of the total population or subpopulations that are being assessed..
- f) In some cases, the data were not timely (e.g. psychiatry data were presented only up to June instead of August 2006, as requested).
- g) Staff presenting the data to the Court Monitor's Team was not only unfamiliar with the methods used to collect the data, but also not well-informed about the data they presented.
- h) In some cases, critical data could not be located or had not been collected.
- i) The data analyses were substandard.
- j) The clinical interpretation of the data was inadequate.
- k) There was minimal indication that the data were used to enhance clinical practice.
- l) There is no reliability data on internal monitoring. Approximately 20% of the data collected should be assessed for reliability.
- m) Monitoring is not always undertaken by staff that is trained to competency in the process of monitoring. The frequent change in the core of monitors is a system's deficit that must be corrected.
- n) All monitoring tools must be standardized for use statewide.
- o) Given the amount of monitoring that is required, the tools and data collection must be automated.

The longitudinal data showed that the current mentoring system at MSH is weak and ineffective. The essence of collecting monitoring data is that it will be closely followed by feed back and mentoring. This was severely lacking in most areas. The monitors must be well versed in their respective areas with regards to the requirements of the EP and should also serve as the mentors to the staff and clinicians. The monitoring and mentoring functions cannot be divorced from each other. The chiefs of all clinical disciplines should have the administrative responsibility for monitoring and mentoring in their respective areas. Discipline seniors should be trained to not only monitor, but also mentor clinicians in their areas. In addition, there should be monthly reviews of the monitoring data at the facility level by all discipline chiefs and the senior executives so that the data can be used to enhance service delivery at the system level within the hospital. Further, the monitoring data across hospitals should be reviewed quarterly by the State with their chief consultant so that the aggregate data can be used to enhance the mental health services provided throughout the DMH system. The EP was developed to change the DMH mental health system and not to change one hospital at a time.

3. Self-Evaluation

Using the above mentioned monitoring system, the facility has conducted a self-evaluation of its processes and status of compliance relevant to the EP. Although there are issues with the overall reliability of the data, the self-assessment process had the potential of being useful in evaluating the current status of compliance. This process is an essential tool to ensure proper attention by facility staff and leadership to the expectations of the EP as well preparing the facilities for eventual self-monitoring independent of external oversight. The following observations are important at this stage:

- a) The above mentioned monitoring deficiencies must be corrected to ensure that that the process is meaningful and has integrity.
- b) In the process of verifying the validity and reliability of the data, the court monitor and expert consultants require that the facilities readily demonstrate methods of data collection, where the data is documented and information about timeliness, completeness and quality of the documentation.
- c) To ensure the proper utilization of the current monitoring tools in the process of self-evaluation, the tools must address quality of services and not be limited to timeliness and presence or absence of various components. It is expected that quality indicators change slowly overtime, but the process must be oriented to these indicators from the beginning.
- d) Other issues were noted in specific areas. For example, in some critical areas of nursing education, what is being taught is out-of-date and not recovery-focused. Thus, monitoring data presented in these areas were essentially meaningless. Further, some of the nursing data were incomprehensible because the data collection tools used violated the basic principles of data gathering.
- e) Even though the Court Monitor provided details of the planned evaluation for each section of the EP for assessing the quality of clinical services, except for psychology and nutrition, no other discipline used these details as the basis for their self-evaluation.

4. Implementation of the EP

- a) Structure of current and planned implementation:
 - i. The state and its consultants have instituted a person-centered wellness and recovery oriented model of service delivery. This model embodies all the key requirements of the EP. It provides the basis for services that can meet the full needs of individuals, including not only reduction of symptoms of the illness but also provision of skills and supports to assist individuals in overcoming the impairments that accompany the illness and interventions to improve the quality of life of the individuals.

- ii. The Wellness and Recovery Planning (WRP) model is a state-of-the-art system that utilizes the potential of the recovery model for all individuals served in the state inpatient system, including all individuals with forensic issues.
 - iii. The Positive Behavior Support (PBS) and By CHOICE programs are by design state-of-the-art.
 - iv. The Psychosocial Rehabilitation Mall (PSR) mall is state-of-the-art in terms of its potential for delivering recovery-focused services.
- b) Function of current and planned implementation:
- i. Although there is an excellent manual of WRP, the implementation of the principles and practice requirements outlined in this manual is, in general, inadequate. The content of the WRPs is deficient in almost all the key components, including case formulation, foci of hospitalization, objectives and interventions.
 - ii. Many staff members are not familiar with the actual requirements of the EP and therefore have little knowledge of the key changes that they need to make.
 - iii. Although many professionals and direct care professionals have embraced the new model, some key disciplines have not yet learned the model or accepted its potential to achieve the desired outcomes.
 - iv. Staff is not fully conversant with the recovery model, concepts of psychiatric rehabilitation, and the PBS and By CHOICE systems. Most of the interdisciplinary providers are not yet trained to competency regarding the principles and practice of the new model.
 - v. Functional outcomes of the current structural changes are yet to be identified and implemented to guide further implementation.
 - vi. In general, staff appears to utilize the format of the new system to transfer the same content of the old system.
 - vii. MSH has yet to implement a system to ensure linkage between interventions provided at the PSR mall and objectives outlined in the WRP. At present, there is a disconnection between the mall activities and the WRP and between mall manual and actual group interventions.
 - viii. The facility did not adequately implement the requirement regarding continuing education of its Psychiatry Staff. The reasons for this are unclear, especially because this requirement is one of the key provisions of the EP and compliance does not demand the level of system change that most other plan provisions do.
 - ix. The facility does not currently have a psychopharmacology consultant, as required for implementation of plan provisions regarding medication management.
 - x. In the past four years, MSH has made a number of significant structural changes, including the introduction of the psychosocial rehabilitation (PSR) mall, the positive behavioral support (PBS) team and the BY CHOICE program. Additionally, MSH has restructured the WRP teams with appropriate staffing. However, the quality of services still requires substantial improvement to approach compliance with the EP.

5. Staffing

The MSH staffing table below shows the staffing pattern at the hospital as of July 1, 2006. For the most part, MSH meets current staffing standards. There were 164.8 vacancies. The majority of the vacancies were in nursing (RN.= 57; LVN = 9; PT.= 44.5), social work (n=12.1), staff psychiatrists (n=11), and psychology (n=6). Further, there are 10.4 "CRIPA" senior psychology positions (retained by the facility to assist in monitoring and implementation of the EP), 3.4 positions in rehabilitation therapy services, and 3.5 registered nurses positions that need to be filled before the next evaluation. All these vacancies should be filled as quickly as possible because they impact clinical services. For example, these staff should be able to provide additional groups on the Malls, thus increasing choices for the individuals. In addition, the senior psychology positions will enable the psychology department to conduct the additional assessments required by the EP, undertake all monitoring and mentoring on a timely basis, and provide much neglected services such as family therapy and neurocognitive remediation programs. The rehabilitation therapy services can be filled with an OT, a PT and a SPL-staff that will fulfill current gaps in services at MSH as identified in the body of this report.

Identified Clinical Positions	Positions (05/06 FY)	Filled	Vacancies	CRIPA Positions
Assistant Coordinator, Nursing Services	5.00	5.00	0.00	0.00
Assistant Director, 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 and Surgeon	0.00	0.00	0.00	0.00
Chief, Central Program Services	1.00	1.00	0.00	0.00
Clinical Dietician/Pre-Reg. Clin. Dietician	7.00	6.50	0.50	0.00
Clinical Laboratory Technologist	5.00	4.00	1.00	0.00
Coordinator, Nursing Services	1.00	0.00	1.00	0.00
Coordinator, 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
E.E.G. Technician	1.00	1.00	0.00	0.00
Hospital Worker	6.00	6.00	0.00	0.00
Health Services Specialist	32.00	30.00	2.00	0.00

Institution Artist Facilitator	0.80	0.80	0.00	0.00
Licensed Vocational Nurse	62.00	53.00	9.00	0.00
Medical technical Assistant	0.00	0.00	0.00	0.00
Nurse Instructor	4.00	4.00	0.00	0.00
Nurse Practitioner	1.00	1.00	0.00	0.00
Nursing Coordinator	6.00	6.00	0.00	0.00
Pathologist	0.00	0.00	0.00	0.00
Pharmacist I	18.60	18.60	0.00	0.00
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	0.00
Physician & Surgeon	18.70	17.50	1.20	0.00
Pre-Licensed Pharmacist	0.00	0.00	0.00	0.00
Pre-licensed Psychiatric Technician	17.00	17.00	0.00	0.00
Program Assistant	6.00	4.00	2.00	0.00
Program consultant (RT, PSW, Psych)	2.00	2.00	0.00	0.00
Program Director	7.00	4.00	3.00	0.00
Psychiatric Social Worker	55.20	43.10	12.10	0.00
Psychiatric Technician	318.30	273.80	44.50	0.00
Psychiatric Technical Trainee	0.00	0.00	0.00	0.00
Psychologist-HF, (Safety)	43.00	37.00	6.00	0.00
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	187.80	130.80	57.00	3.50
Reg Nurse Pre-Registered	0.00	0.00	0.00	0.00
Rehabilitation Therapist	55.60	54.10	0.00	0.00
Speech Pathologist I	0.00	0.00	0.00	0.00
Sr. Psychiatrist	8.00	7.00	1.00	1.40
Sr. Psychologist	3.00	2.00	1.00	10.40
Sr Psych Tech (Safety)	54.00	51.00	3.00	0.00
Sr Radiologic Technologist (Specialist)	1.00	1.00	0.00	0.00
Staff Psychiatrist	51.90	40.90	11.00	0.00

Supervising Registered Nurse	9.00	7.00	2.00	0.00
Teacher-Adult Educ. /Vocational Instructor	7.00	7.00	0.00	0.00
Teaching Assistant	10.00	8.00	2.00	0.00
Unit Supervisor	21.00	20.00	1.00	0.00
Vocational Services Instructor	2.00	2.00	0.00	0.00

Following the evaluation, the monitor received information from the state to indicate that staffing pattern of the hospital was adjusted in August 2006 (based on the quarterly census), which is not reflected in the above table. This adjustment resulted in a loss of allocated positions. There were actually 34 vacancies after the adjustment. The majority of the vacancies were in nursing and other clinical areas (RN=.9.3; LVN=.2; PT=.16.2;CSW.= 3.6; Staff Psychiatrist=.5.7; Psychology=.2.1; and Rehabilitation Therapist=.5. Further, there are "CRIPA" BCP positions that are being phased in with the following positions (allocated as of September 1, 2006): Psychiatric technician = 4 (all filled); Sr. psychologist = 4 (all filled using Staff Psychologists); and RN = 5 (3 are filled). Additional "CRIPA" positions will be allocated on November 1, 2006, with completion of the phase in positions by June 1, 2007.

D. Monitor's Evaluation of Compliance

The status of compliance is assessed considering the following factors:

1. An objective review of the facility's data and records;
2. Observations of individuals, staff and service delivery processes.
3. Interviews with individuals, staff, facility and State administrative and clinical leaders.
4. An assessment of the stability of the facility's current structure and functions in terms of potential for self-sustenance in order adequately meet the needs of individuals currently and in the future.
5. Assessment of trends and patterns of change rather than single and/or temporary occurrences of compliance or noncompliance that is inconsistent with these patterns and trends.
6. When no instance requiring implementation of a specific requirement was found in the baseline assessment, the compliance was rated as Not Applicable for This Evaluation.

E. Next Steps

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

	Oct	Nov	Dec
ASH		13-17	
PSH			4-8

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

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

	<p>address each individual's needs and to assist individuals in meeting their specific recovery and wellness goals, consistent with generally accepted professional standards of care. Each State hospital shall ensure clinical and administrative oversight, education, and support of its staff in planning and providing care and treatment consistent with these standards.</p>	
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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. MSH is transitioning from a traditional medical psychiatric and forensic model of care to a person-centered Wellness and Recovery system. 2. MSH has a Wellness and Recovery Plan (WRP) manual that codifies state-of-the-art elements in recovery-oriented services for individuals with serious mental illnesses. 3. MSH provides services within an interdisciplinary team model. 4. MSH has initiated improvements in its substance abuse programs guided by the adoption of a manual that contains current generally accepted professional standards of care. 5. Many of the providers at MSH are dedicated and caring professionals who are making a sincere effort to provide services within the new wellness and recovery system. 6. MSH has implemented the new template for the Wellness Recovery Plan (WRP). 7. MSH has initiated the implementation of a new model of providing services to individuals through the psychosocial rehabilitation mall. This model represents current professionally accepted standards in psychosocial rehabilitation of individuals with serious mental illnesses in hospital settings. 8. MSH has developed and implemented a variety of monitoring instruments, including both process observations and chart audits, to assess its compliance with the EP. 9. MSH has completed a self-assessment process based on current monitoring instruments. The process has heightened staff's awareness of the EP and its expectations.
1	Interdisciplinary Teams	
	<p>The interdisciplinary team's membership shall be dictated by the particular needs and strengths of the individual in the</p>	<p>Methodology: Interviewed Kenneth Layman, Treatment Enhancement Coordinator.</p>

	<p>team's care. At a minimum, each State Hospital shall ensure that the team shall:</p>	<p>Attended WRP team meetings for quarterly WRP review of one individual (GS).</p> <p>Attended WRP team meetings for monthly WRP reviews of four individuals (IS, AL, SS and JC).</p> <p>Reviewed the DMH WRP Manual (Draft July 7, 2006).</p> <p>Reviewed AD # 3133 regarding Wellness and Recovery Plan (WRP).</p> <p>Reviewed WRP Process Observation Form.</p> <p>Reviewed Process Observation Summary Data of 7-day, 14-day, quarterly, monthly and annual WRP meetings (February-July, 2006).</p> <p>Reviewed WRP Chart Audit Forms.</p> <p>Reviewed WRP Chart Audit Summary Data (April-July 2006).</p> <p>Reviewed the Staff Psychiatrist Manual.</p> <p>Reviewed WRP training post-test.</p> <p>Reviewed facility's database regarding WRP team staffing levels and attendance of core members.</p> <p>Reviewed the Treatment Planning Post-Test Data Base.</p>
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>Findings:</p> <p>MSH has developed a draft DMH WRP manual. The manual (section 3. Assessments, 3.2 Integrated Assessments, 3.4 Strengths, 3.5 stages and Readiness of Change) contains state-of-the-art principles and practice requirements in recovery-oriented services that meet the key elements in this section.</p> <p>MSH has developed (February 16, 2005) an AD (#3133) regarding the new WRP model, which is derived from the DMH WRP manual. The AD includes an overview of the requirements regarding development of case formulation, goals and objectives and interventions as well as plan revisions</p> <p>MSH has instituted a training program for its WRP members regarding the principles and practice of WRP. The program has three phases: introductory, practical applications and in-vivo training on</p>

		<p>units. The State consultants provided initial training. At present, training is provided by the chief of psychiatry, Dr. Gulesakeram and the chief of psychology, Dr. Roy. MSH has developed a post-training test to assess competency of trainees. However, at present, there is no documentation that WRP core team members have been trained to competency.</p> <p>The facility has observation process monitoring data that show overall compliance rates of 78.7% (seven-day master WRP), 63.4 % (14-day review of the WRP), 77.6% (quarterly review of the WRP), 80.6% (monthly review of the WRP), and 81.4% (annual review of the WRP). These data are based on observations of a sample of 7.5 % of WRP team meetings during the period of February to July 2006. The observations are conducted by fourteen auditors from the departments of Central Program Services, Psychosocial Rehabilitation, Standards Compliance and Central Nursing. The observers have been trained to competency by the state consultants but the core members of this group are not stable. All items specified on the process observation form were equally considered in the determination of compliance. However, some of these items do not address the requirements in this section.</p> <p>MSH also has chart audit data based on a review of a sample of charts ranging from 80 to 151 during the period of April to July 2006. The review is conducted by members of the Health Information Management (HIM) department, who have been trained to competency by the state consultants. Based on this process, the facility reports overall compliance rate is 32%.</p> <p>This monitor's observations of WRP team meetings (see C.1.b. through C.1.f) and review of charts (see C.2) indicate that, in general, the process and content of Wellness Recovery Planning at MSH are deficient and that the principles and practice elements outlined in the</p>
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		<p>DMH WRP manual are yet to be properly implemented.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Finalize, approve and implement the DMH WRP manual. 2. Provide documentation that WRP trainers and WRP team members have been trained to competency. 3. Continue and strengthen current training program. In particular, the facility needs to 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. 4. Streamline and refine current WRP monitoring instruments to reflect the specific 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. 5. Standardize the WRP monitoring instruments and sampling methods across State facilities. 6. 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. 7. Ensure that the AD regarding WRP is aligned with all the provisions in the DMH WRP Manual. 8. Ensure a stable core of process observers and chart auditors who have been trained to competency by the state consultants.
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b	Be led by a clinical professional who is involved in the care of the individual.	<p>Findings:</p> <p>At MSH, the psychiatrists are designated as the team leaders and coverage is provided by Psychologists during the absence of the designated leaders. The facility has developed and implemented a monitoring system to assess participation by all disciplines based on observation of meetings and a review of data base gathered by nursing staff. Observation data indicate that during a six month period (February to July 2006), the psychiatrists attendance rate was 87.2% (sample of 7.4%). The database gathered by nursing indicate attendance rate of 92% during the same time period (sample of 37.2%).</p> <p>This monitor reviewed the attendance sheets of programs I and V and found only rare occurrences of non-attendance by psychiatry</p> <p>The team meetings that this monitor attended included participation by psychiatrists as team leaders in all cases. However, the team meetings demonstrate that, with possibly one exception, the team leaders do not perform their primary function of ensuring a structure that allows members to: a) provide, combine and coordinate their efforts; b) address all relevant planning issues during the meeting time; and c) obtain meaningful input from the individuals.</p> <p>In reviewing the DMH WRP manual, this monitor observed that the sequence of tasks identified in the manual regarding the team member responsibilities does not include the responsibility of the leader to ensure that members: a) communicate results of the assessments prior to the planning process; b) understand the parameters for meaningful participation by the individual in the WRP meeting; and b) update the present status section of the case formulation. The DMH WRP manual includes team responsibilities at 7-day, 14-day, monthly, quarterly and annual conferences. The responsibilities at the 14-day and monthly reviews do not include</p>
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		<p>discussion of Positive Behavior Supports (PBS), data regarding monitoring instruments (MOSES) and the individual's current medical status.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Monitor both presence and proper participation by the team leaders in all WRP meetings. 2. Develop and implement a peer mentoring system to ensure competency in team leadership skills. 3. 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. 4. 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. 5. 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. 6. 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. 7. 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.
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c	Function in an interdisciplinary fashion.	<p>Findings: The DMH WRP manual (section 5.2, WRP Team Responsibilities at 7-day, 14-day, quarterly, monthly and annual reviews) outlines the responsibilities of each team member. This outline contains the key requirements that enable an effective interdisciplinary process.</p> <p>The facility has process observation data based on a review of 7.5% sample of WRP meetings (February to July 2006). The data are the same as that reported in section C.1.a above. These data do not address the specific requirement in this section.</p> <p>This monitor's findings under C.1.a are also applicable to this section.</p> <p>Compliance: Partial.</p> <p>Recommendations: Same as in C.1.a. and C.1.b.</p>
d	Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary, and appropriate psychiatric and medical care.	<p>Findings: AD #3133 regarding WRP states that the psychiatrist as team leader has the final responsibility for the plan. The staff psychiatrist manual does not address the specific requirements regarding the role of psychiatrists as team leaders.</p> <p>MSH has conducted a survey to assess the views of all WRP team members in all four programs. Two questions were used: a) is it evident that the psychiatrist assumes primary responsibility for the individual's therapeutic and rehabilitation services, and ensures the provision of competent, necessary and appropriate psychiatric and medical care?; and b) which member of the treatment assumes primary responsibility for the individuals' therapeutic and rehabilitations services and ensures the provision for competent,</p>

		<p>necessary and appropriate psychiatric care? Only 38.7% of staff responded to the questionnaire. The answers were affirmative in 77% regarding question a. With respect to question b, 78.5% of responders stated that the psychiatrist provided that function.</p> <p>The team meetings attended by this monitor indicate a pattern of deficiency regarding the team leaders assuming the primary responsibility for the individual's therapeutic and rehabilitation services. Findings regarding the performance of team leaders in the provision of competent psychiatric and medical care are detailed in Sections D and F below.</p> <p>Compliance: Partial.</p> <p>Recommendations: Same as in C.1.a, b and c.</p> <ol style="list-style-type: none"> 1. Continue current practice of surveying the views of team members regarding the functions of their designated leaders. 2. 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.
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>Findings: MSH utilized the WRP process observations to assess compliance with this item. MSH has identified a variety of deficiency patterns. The observations addressed the 7-day, quarterly, and monthly team conferences. The following is a summary of the facility's findings that are relevant to this step, with the compliance rates identified. The sample sizes for each item varied and the range was 5.9% to 13.7%:</p>

		<ol style="list-style-type: none"> 1. "The team leader received the integrated assessment prior to the meeting (seven-day WRP) (77%);" 2. "The team leader evaluated the need for additional assessments and member took responsibility for scheduling and coordinating the assessment (seven-day WRP) (88%);" 3. "A team member gives a summary report of the individual's progress on each treatment (monthly WRP) (66.3%);" 4. "Treatment team discussed with the individual changes in the case formulation and diagnosis (quarterly WRP) (61%);" 5. "The nurse reviewed with the individual MOSES findings as indicated (quarterly WRP) (39%);" and 6. "The team discussed with the individual the behavioral expectations to meet discharge criteria (quarterly WRP) (68%)." <p>In addition, chart audit data (20% sample) indicate a compliance rate of 13%. The monitoring item states "when the individual has not met the objective at the target date, either the objective or the intervention is changed or a justification for continuing without change is included in the WRP".</p> <p>The team meetings attended by this monitor reveal a general pattern of deficiencies in the implementation of all the key process elements in this section. In addition, this monitor found deficiencies in the implementation of all the key content elements of the WRP system as outlined in section C (case formulation, foci of hospitalization, objectives and interventions) and section D (psychiatric assessments and reassessments) are such that the content of WRP is overall inadequate. The deficiencies in both process and content render the current implementation of the WRP system ineffective in meeting the treatment, rehabilitation and enrichment needs of the individuals. As mentioned earlier, the DMH WRP manual contains almost all required elements.</p>
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		<p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Same as in C.1.a. through C.1.d. 2. Same as in D.1.a. through D.1.e. 3. Improve clinical oversight to ensure competency in the processes of assessments, reassessments, interdisciplinary team functions and proper development and timely and proper updates of case formulations, foci of hospitalization, objectives and interventions. 4. Ensure that the monitoring tools adequately address the quality of assessments.
f	<p>Ensure that assessment results and, as clinically relevant, consultation results, are communicated to the team members, along with the implications of those results for diagnosis, therapy and rehabilitation by no later than the next review.</p>	<p>Findings:</p> <p>MSH has process observation data (February to July 2006) that reveal a number of deficiencies based on several monitoring items. The process involved a review of a sample sizes that ranged from 11.4% to 13.7%. Only one monitoring item addressed the key element in this step. The item states that "assessments were presented by each discipline and were brief and non-redundant". The compliance rates were 68% (7-day) and 70% (quarterly).</p> <p>In addition, chart audits of a 20% sample (April to July 2006) reveal 31% compliance with the requirement that "the present status of the case formulation include assessments, results and implications for treatment."</p> <p>Observations of the team meetings attended by this monitor indicate general deficiency in the key requirements of presenting results of the assessments and analyzing those results to assess implications for diagnosis, treatment and/or rehabilitation of individuals.</p>

		<p>Compliance: Partial.</p> <p>Recommendations: Same as in C.1.a through C.1.e.</p>
g	<p>Be responsible for the scheduling and coordination of assessments and team meetings, the drafting of integrated treatment plans, and the scheduling and coordination of necessary progress reviews.</p>	<p>Findings:</p> <p>The DMH WRP manual (3. Assessment, 3.1 Admission Assessment, 3.2 Integrated Assessment, 3.3 Clinically Indicated Assessment, 3.6 Assessment Schedule, 4. WRP Schedule and 4.3 WRP Conferences) includes practice requirements regarding the key elements in this step.</p> <p>At this time, MSH requires that the admission and integrated assessments and WRP reviews are performed on all units according to the schedules established in the DMH WRP manual.</p> <p>MSH monitors the responsibility for drafting of WRPs and for review and revision of the plans as per schedule. Data based on the WRP process observation method show compliance rates of 98% (7-day) and 99% (quarterly). The monitoring item states that "the team identified a treatment plan recorder who is responsible for drafting the integrated WRP." The sample sizes were 14.4% and 13.7% respectively.</p> <p>Chart audit (20% sample) data show a much lower rate (48%) regarding compliance with the monitoring item stating that "the WRP was reviewed and revised as per schedule."</p> <p>Compliance: Partial.</p>

		<p>Recommendations: Address deficiency in the implementation of this requirement and ensure compliance.</p>
h	<p>Consist of a stable core of members, including at least the individual served; the treating psychiatrist, treating psychologist, treating rehabilitation therapist, the treating social worker; registered nurse and psychiatric technician who know the individual best; and one of the individual's teachers (for school-age individuals), and, as appropriate, the individual's family, guardian, advocates, attorneys, and the pharmacist and other staff.</p>	<p>Findings: The DMH WRP manual (2. Brief Definitions, 2.3 The WRP Team, 5. WRP Team Member Responsibilities) contains needed information regarding this requirement.</p> <p>The facility has database that includes information regarding the core membership of all teams in the facility.</p> <p>MSH monitors the attendance by core members in its WRP team conferences. The process observation data show that during the period of February to July 2006 (296 meetings observed for a sample of 7.4%), an average attendance rate of 67.4% was listed for the disciplines of psychiatry, psychology, nursing, rehabilitation therapists, social work and psychiatric technicians. The attendance rates were lowest among psychiatric technicians (6.4%). The database gathered by nursing show an overall attendance rate of 70%, with an attendance rate of 33.2% for psychiatric technicians (sample of 37%).</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. MSH needs to address and correct the deficiencies regarding attendance by core members in light of the facility's very low vacancy rate. 2. MSH needs to assess and correct discrepancies in the data regarding attendance by psychiatric technicians in the WRP meetings.

		3. MSH should continue to monitor the attendance by core members in the WRP team conferences.
i	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>Findings: MSH has database regarding the case loads for the core WRP team members in all WRP teams. The data show averages of 15.7 in August 2006 and 18 in September 2006 for admission teams. The increase in the case loads in September was influenced by the inclusion of the case loads for psychiatric technicians. The data for long-term teams show case loads under 25 for all core team members in August and September 2006. Human resources data show vacancy rates of 2.7% (psychiatrists), 9.3% (psychologists), 2.2% (social workers) and 1.9% (rehabilitation and recreational therapists). At present, the facility has 34 WRP teams, only four teams have less than full complement of core members (88% have full complement).</p> <p>Compliance: Partial</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure consistent compliance with this requirement. 2. Same as in recommendation #3 under C.1.h.
j	Not include staff that is not verifiably competent in the development and implementation of interdisciplinary wellness and recovery plans.	<p>Findings: The training database at MSH tracks post-test competencies regarding phase I of WRP training. The facility is yet to develop mechanisms to ensure competencies in phases II and III of this training.</p> <p>This monitor's observations of team meetings reveals that most team leaders and members are not yet fully trained to meet this requirement.</p>

		<p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Same as in C. 1.a through C.1.f. 2. Ensure the development and implementation of mechanisms to ensure that all WRP team members are competent in all phases of WRP training.
<p>2</p>	<p>Integrated Therapeutic and Rehabilitation Service Planning (WRP)</p> <p>Each State hospital shall develop and implement policies and protocols regarding the development of therapeutic and rehabilitation service plans, referred to as "Wellness and Recovery Plans" [WRP]) consistent with generally accepted professional standards of care, to ensure that:</p>	<p>Methodology:</p> <p>Attended WRP team meetings for WRP reviews of eight individuals (GS, IS, AL, SS and JC, DR, AL and AC).</p> <p>Observed mall activities, both at the "virtual mall" and at group activities on the units.</p> <p>Reviewed charts of 80 individuals (SP, JES, JD, MSJ, RG, WP, JS, JJ, SF-1, AC, CK, VRF, MR, BRB, SB, SP, RL, FR, DK, RS, CC, RB, GC, AB, TC, JL, CG, SF-2, MW, FEA, ML, KR, FPR, KMO, KS, MP, KVD, KSW, CY, SM, JC, AE, AG, IS, AL, SS, LC, RZ, FJ, JR, DT, CL, SE, JE, RS, KS, DW, VR, OT, RP, CR, TS, AL, FK, TJ, LP, PT, HR, KR, NR, RM, NM, DH, JL, SM, SR, KS, CM, JG and TG).</p> <p>Interviewed SD and EA (411).</p> <p>Interviewed EG, EF and JP (419).</p> <p>Interviewed Kenneth Layman, Treatment Enhancement Coordinator.</p> <p>Interviewed Lisa Adams, Mall Program Director.</p> <p>Interviewed Richard Ettelson, Ph.D., Chairman of the Substance Abuse Committee.</p> <p>Interviewed Ms. Susan Beckkhein, Psyc. Tech, Mall Coordinator</p> <p>Interviewed Mr. Donal Pratt, Psyc. Tech., Point Coordinator</p> <p>Interviewed Jocalyn Agtarap, RN, SNF, Supervisor</p> <p>Interviewed Divina Monalo, RN, SNF.</p> <p>Reviewed DMH WRP Manual (Draft July 7, 2006).</p> <p>Reviewed AD # 3133 regarding Wellness and Recovery Plan (WRP).</p>

		<p>Reviewed WRP Process Observation Form. Reviewed Process Observations Data Summary (February-July 2006). Reviewed Chart Audit Forms. Reviewed WRP Chart Audit Data Summary (April-July 2006). Reviewed WRP/Mall Alignment Protocol. Reviewed WRP/Mall Alignment Protocol Data Summary. Reviewed WRP Case Formulation Monitoring Form. Reviewed draft policy and procedure regarding Substance Abuse Screening. Reviewed MSH data regarding audits of mall lesson plans. Reviewed Substance Abuse Check List and Data. Reviewed Mall Facilitator Monitoring Form. Reviewed preliminary results of the survey by the Individuals' Counsel. Reviewed data regarding individuals scheduled for medication education groups at the mall. Reviewed PSR Mall Schedule. Reviewed PSR Mall curricula and manuals. Reviewed list of all individuals by program x unit x scheduled hours of mall groups or individual therapy x actual hours attended. Reviewed list of all individuals by program x unit x actual hours of attendance during enrichment activities (outside of mall hours). Reviewed MSH trigger Data.</p>
a	<p>Individuals have substantive input into the therapeutic and rehabilitation service planning process, including but not limited to input as to mall groups and therapies appropriate to their WRP.</p>	<p>Findings: MSH has monitoring data based on process observations of the WRP team conferences (seven-day, monthly, quarterly and annual) during the period of February to July 2006. The following is an outline of relevant findings, including the monitoring items and corresponding compliance rates:</p> <ol style="list-style-type: none"> 1. Seven-day master WRP (sample of 11.4%): <ol style="list-style-type: none"> a) "The team reviewed with the individual BY CHOICE points, preferences and allocations (89%);" b) "The team updated the person's life goals and valued

		<p>role functions based on discussion prior to the conference (100%);"</p> <p>c) "The team asked the individual what are the most important treatment outcomes he/she hopes to achieve during this admission (66%);"</p> <p>d) "The team discussed with the individual his/her cultural preferences and concerns that may impact treatment (56%);" and</p> <p>e) "The team asked the individual about the involvement of family and others in relation to treatment (88%)."</p> <p>2. Monthly WRP (sample of 5.9%):</p> <p>a) "The individual was asked about his/her experience of treatment and its effectiveness (90.2%);"</p> <p>b) "The treatment team asked the individual for input in the evaluation of progress in meeting each treatment objective. Each objective was reviewed in light of target dates, data from interventions, or need for new interventions (63%);"</p> <p>c) "The team reviewed with the individual BY CHOICE points, preferences and allocations (67.8%);" and</p> <p>d) "The team discussed with the individual his/her satisfaction with the treatment and services (90.2%)."</p> <p>3. Quarterly and annual reviews (sample of 13.7%):</p> <p>a) "The cultural preferences and concerns of the individual were identified and/or revised (53% and 55%);" and</p> <p>b) "The treatment team asked the individual for input in the evaluation of progress in meeting each treatment objective. Each objective was reviewed in light of target dates, data from interventions or need for new interventions (60% and 81%)."</p> <p>As mentioned in section C.1, this monitor's observations of the WRP</p>
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		<p>team meetings indicate that, in general, the teams do not obtain meaningful input from the individuals in the process of review and revisions of the plans. The main deficiency is that the individual's input is obtained in the context of performing/completing disciplinary assessments rather than interdisciplinary planning of the services necessary to meet the individual's assessed needs. This monitor observed that several team members rely on the WRP meetings to conduct their assessments. The assessments must be completed prior to the WRP meetings. Delaying these assessments till meeting time impedes planning of services and also results in unacceptable delays in determining the current status of the individual regarding a variety of risk factors and in the institution of timely interventions to reduce the risk. The meeting to review the WRP of AL exemplifies unacceptable delay regarding psychiatric assessment of the risk for suicide.</p> <p>In some meetings, the individuals were given choices among PSR groups. However, the PSR groups were selected from standard group offerings and were not matched to the individual's needs. The match between what the individuals needed and the choices offered were tenuous.</p> <p>Too many individuals were not given an opportunity to discuss changes in the allocation of BY CHOICE points. In some cases, the WRP team determined the point allocation without any input from the individuals. In some cases, objectives and discharge criteria were developed when the individuals were sent out of the conference room.</p> <p>The WRP teams were not following the instructions in the DMH WRP Manual.</p> <p>Compliance: Partial.</p>
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		<p>Recommendations:</p> <ol style="list-style-type: none"> 1. Same as in C.1.a through C.1.f. 2. Ensure that monitoring items are not redundant and/or over-inclusive, and are focused on the specific requirement to be monitored. 3. Continue and strengthen WRP training that focuses on the process of engaging the individual in providing substantive input.
b	Therapeutic and rehabilitation service planning provides timely attention to the needs of each individual, in particular:	<p>Compliance: Partial.</p>
b.i	initial therapeutic and rehabilitation service plans (Admission-Wellness and Recovery Plan ("A-WRP")) are completed within 24 hours of admission;	<p>Findings: The facility conducted two different audits by staff from the HIM department. The data show compliance rates of 70.8% and 100% utilizing different sampling methods.</p> <p>Chart reviews by this monitor (SP, JES, JD, MSJ, JD, RG, WP, JS, JJ, SF, AC and CK) showed non-compliance in only one case (CK).</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Continue current practice. 2. Standardize chart sampling methods in the chart audit mechanisms and correct the discrepancies in findings regarding the timelines of the A-WRP.
b.ii	master therapeutic and rehabilitation service plans ("Wellness and Recovery Plan" (WRP)) are completed within 7 days of admission; and	<p>Findings: The facility used the above two audits to assess compliance with this item and yielded compliance rates of 58% and 53.7%.</p> <p>This monitor reviewed eight charts and found evidence of inconsistent practice that corroborates the facility's findings. There was compliance in five (RG, JJ, SF, JS and AC) and non-compliance in</p>

		<p>three (SP, JD and VRF).</p> <p>Recommendations: Address and correct factors related to inconsistent compliance with this requirement.</p>
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>Findings: The above chart audits showed compliance rates of 47 % and 55.3%.</p> <p>This monitor reviewed ten charts and found compliance in seven (RG, JJ, SF, JS, JD, AC and WP) and non-compliance in three (SP, DC, VRF).</p> <p>Recommendations: Same as above.</p>
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>Findings: The DMH WRP manual (7.3. Case Formulation, 7.5 Discharge Criteria, 7.6 Focus of Hospitalization, 7.7 Objectives and 7.8 Interventions) adequately addresses this requirement.</p> <p>MSH has process observation data of the quarterly (13.7% sample) and annual (10.8% sample) WRP reviews. The compliance rates for relevant items are identified as follows:</p> <ol style="list-style-type: none"> 1. "The team updated and continued to develop a case formulation (67% and 67%);" 2. "Treatment team updated present status of the case formulation and diagnosis based on current assessments, progress reviews and the individual's thoughts and concerns about treatment (98% and 100%)." <p>MSH has other process observation and chart audit tools that address other aspects of WRP including case formulation and</p>

		<p>objectives of treatment. However, these tools are not aligned with this requirement.</p> <p>Chart reviews by this monitor indicate that the WRPs of individuals suffering from seizure disorders and are receiving older generation anticonvulsant medications (MR, BRB, SB, SP and RG) are not assessed regarding the possible negative impact of treatment on the cognitive, behavioral and life quality of the individual. As a result, the WRPs do not include objectives/interventions to minimize this risk.</p> <p>This monitor reviewed charts of individuals suffering from cognitive disorders (RL, FR, DK, RS, CC and PS). This review revealed a pattern of deficiencies, including:</p> <ol style="list-style-type: none"> 1. The WRPs fail to include the diagnosis as a focus or to include objectives and interventions for treatment and/or rehabilitation. Examples are found in the charts of RL (dementia due to multiple etiologies) and FR and DK (mild mental retardation). 2. There is no evidence that interventions are provided when the foci of hospitalization include cognitive impairment (RS). 3. When interventions (e.g. cognitive skills groups) are included, there is no documentation of the individual's progress in treatment and its implication for further treatment and rehabilitation (CC) 4. There is no evidence that planned interventions (e.g. cognitive remediation groups) have been carried out as documented in the WRP (PS). <p>The above examples indicate that the WRPs currently performed at MSH generally fail to comply with the key element in this section.</p> <p>Compliance: Partial.</p>
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		<p>Recommendations:</p> <ol style="list-style-type: none"> 1. 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. 2. Continue and strengthen training of WRP teams 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 addresses all identified needs of the individual in the above domains. 3. 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. 4. 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. 5. Develop and implement audit items to ensure that seizure disorders, if present, are documented as a focus and that individualized and appropriate objectives and interventions are provided. The documentation needs to address the interface between seizure disorders (and its treatment), psychiatric status (and its treatment) and psychosocial functioning of the individual.
d	Therapeutic and rehabilitation service planning is based on a comprehensive case formulation for each individual that	<p>Compliance: Partial.</p>

	emanates from interdisciplinary assessments of the individual consistent with generally accepted professional standards of care. Specifically, the case formulation shall:	
d.i	be derived from analyses of the information gathered from interdisciplinary assessments, including diagnosis and differential diagnosis;	<p>Findings: MSH has developed but not yet implemented a WRP Case Formulation Monitoring Form. The monitoring tool adequately addresses the requirements in C.2. d.i through C.2. d.iv.</p> <p>MSH has monitoring data based on the current system of process observations. The following is an outline:</p> <ol style="list-style-type: none"> 1. Seven-day master WRP (sample of 11.4%): "The team developed a case formulation (90%)." 2. Quarterly and annual reviews (sample of 13.7 and 10.8%): <ol style="list-style-type: none"> a) "The team updated and continued to develop a case formulation (67% and 67%);" b) "Treatment team updated present status section of the case formulation and diagnosis based on current assessments, progress reviews, and the individual's thoughts and concerns about treatment (98% and 100%);" and c) "The team discussed with the individual his/her life goals as needed (78% and 100%)." <p>The above data fail to address the quality of the case formulations. The facility does not have a chart audit tool to assess documentation of the case formulation..</p> <p>Chart reviews by this monitor indicate that, in general, the case formulations are not based on careful analysis of the information in the assessments. Almost all the charts reviewed demonstrate a pattern of significant deficiencies in the quality/content and completeness of case formulations. The key deficiencies include:</p>

		<ol style="list-style-type: none"> 1. The case formulations are not consistently completed in the 6-p format (pertinent history; predisposing, precipitating and perpetuating factors; previous treatment history, and present status). 2. The linkages within different components of the formulations are often missing. 3. The formulations contain inadequate analysis of assessments and derivation of hypothesis regarding the individual's treatment, rehabilitation and enrichment needs. 4. There is inadequate linkage between the material in the case formulations and other key components of the WRP (e.g. foci of hospitalization, life goals, objectives and interventions). 5. The information in the case formulations does not provide the basis for proper delineation of diagnosis and development and finalization of a differential diagnosis. <p>These deficiencies are such that the current case formulations performed at MSH generally fail to address the key requirements in this step. This finding is also applicable to C.2.d.ii through C.2.d.i.v.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Continue and strengthen training of the WRP teams to ensure that the case formulation adequately addresses the requirements in C.2.d. 2. Implement the newly developed case formulation monitoring instrument. This instrument should consolidate most of the items in the current variety of tools as well as provide a more meaningful process. It should serve as the main tool to assess the quality of case formulations.
d.ii	include a review of: pertinent history; predisposing, precipitating and perpetuating factors; previous treatment history, and present status;	<p>Findings:</p> <p>The Facility reports the same process observation data as above. In addition, the facility reports a compliance rate of 37% to assess</p>

		<p>whether the teams developed the case formulation in the six-p format and if the formulation considered biochemical, psychosocial and psycho-educational factors, as clinically appropriate for each category. The facility's compliance rate applies to both C.2.d.ii and C.2.d.iii.</p> <p>Recommendations: Same as above.</p>
d.iii	consider biomedical, psychosocial, and psychoeducational factors, as clinically appropriate, for each category in § [III.B.4.b] above	Same as above.
d.iv	consider such factors as age, gender, culture, treatment adherence, and medication issues that may affect the outcomes of treatment and rehabilitation interventions;	<p>Findings: MSH used chart audits (20% sample) to assess compliance with this item. The facility reports a compliance rate of 17% (the same as that reported by NSH for this item).</p> <p>Recommendations: Same as above.</p>
d.v	support the diagnosis by diagnostic formulation, differential diagnosis and Diagnostics and Statistical Manual DSM-IV-TR (or the most current edition) checklists; and	<p>Findings: The facility utilizes the psychiatric Evaluation Monitoring Form to assess whether the integrated psychiatric assessment "included pertinent positive and negative findings (related to differential diagnosis); and addressed findings which may support other diagnoses." While the psychiatric assessment should provide the basis for adequate case formulation in the area of diagnosis, the facility does not monitor the case formulation in order to satisfy this requirement.</p> <p>Recommendations: Same as above.</p>

d.vi	enable the interdisciplinary team to reach sound determinations about each individual's treatment, rehabilitation, enrichment and wellness needs, the type of setting to which the individual should be discharged, and the changes that will be necessary to achieve discharge.	<p>Findings: The facility has data from chart audit (20% sample) that assesses the discharge criteria in the WRP, but these data do not address the requirement in this section.</p> <p>Recommendations: Same as above.</p>
e	The therapeutic and rehabilitation service plan specifies the individual's focus of hospitalization (goals), assessed needs (objectives), and how the staff will assist the individual to achieve his or her goals/objectives (interventions);	<p>Findings: MSH has chart audit data (20% sample) that indicate the following patterns of deficiency. The compliance rates are identified for each item:</p> <ol style="list-style-type: none"> 1. "There is at least one objective and intervention for each focus of hospitalization (55%);" 2. "The WRP includes observable measurable and behaviorally worded objectives written in terms of what the individual will do (30%);" 3. "The WRP includes interventions that are clearly linked to the objective and are written in terms of what the staff will do (40%);" and 4. "The WRP includes names of specific staff responsible for implementing each intervention, type of intervention, and frequency and duration of the interventions (10%)." <p>Chart reviews by this monitor indicate that, in almost all cases, the foci of hospitalization are incomplete, usually limited to one or two areas, are identified in generic terms and do not offer meaningful targets for treatment, rehabilitation and enrichment of the individuals. Deficiencies are noted in the following areas:</p> <ol style="list-style-type: none"> 1. Identification of foci of hospitalization that address individuals' special needs (see monitor's findings in C.2.c and C.2.o). 2. Proper formulation and execution of objectives and

		<p>interventions (see the monitor's findings in C.2.f.i through C.2.f.vii).</p> <p>3. Appropriate revision of foci and objectives (see the monitor's finding in C.2.g).</p> <p>Compliance: Partial.</p> <p>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>Compliance: Partial.</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 not addressed, provide a rationale for not addressing the need;</p>	<p>Findings: MSH has data derived from process observations of the Seven-day (11.4% sample), Quarterly (13.7% sample) and Annual (10.8% sample) WRP reviews. The data show compliance rates of 66%, 35% and 39% with the requirement that "individuals' strengths were utilized in the interventions for each objective." MSH has data based on other process observation items that do not adequately address this requirement.</p> <p>The facility has chart audit data (20% sample) that indicate 14% compliance rate with the requirement that "the Individual's strengths are used in the interventions to assist the individual to achieve an objective." MSH has other chart audit items that do not adequately address this requirement.</p>

		<p>This monitor reviewed five charts (CC, WP, BRB, JD and RL) to assess compliance with this requirement. This review demonstrated inconsistent compliance, with failure to meet the requirement in two cases (CC and BRB) and partial compliance in three cases (JD, RL and BRB).</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Continue and strengthen training of WRP teams to ensure that objectives and interventions are implemented in accordance with the requirements in the DMH WRP manual. 2. Address and resolve the discrepancies between process and audit data regarding this requirement. 3. Develop and implement a monitoring system to assess if goals/objectives are reasonable and attainable, if they address the identified need and if there is a rationale for not addressing the need.
f.ii	<p>ensure that the objectives/ interventions address treatment (e.g., for a disease or disorder), rehabilitation (e.g., skills/supports, motivation and readiness), and enrichment (e.g., quality of life activities);</p>	<p>Findings: MSH has a variety of chart audit tools to assess this requirement. However, none of these tools is aligned with the main requirement.</p> <p>Chart reviews by this monitor demonstrate non-compliance with this requirement in all five cases (CC, WP, BRB, JD and RL).</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Same as in recommendation #1 in C.2.f.i. 2. Develop and implement monitoring tools that clearly address the key required elements. 3. Same as in C.2.e.
f.iii	<p>write the objectives in behavioral, observable, and/or measurable terms;</p>	<p>Findings: MSH has monitoring data based on process observation of the seven-day WRP review (11.4% sample). The data indicate 70% compliance</p>

		<p>with the requirement that "the team developed objectives for each focus that are behaviorally defined and measurable." The facility has data from other process observation items that are not aligned with the requirement in this section.</p> <p>MSH has chart audit data (20% sample) that demonstrate 30% compliance with the requirement that "the WRP includes observable, measurable and behaviorally worded objectives written in terms of what the individual will do."</p> <p>Chart reviews by this monitor show non-compliance in three cases (CC, WP and JD) and partial compliance in two (BRB and RL).</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Same as in recommendation #1 in C.2.f.i 2. Address and correct the discrepancy between process observation and chart audit data regarding this requirement.
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>Findings:</p> <p>MSH has chart audit data (20% sample) that demonstrate the following compliance rates:</p> <ol style="list-style-type: none"> 1. "The WRP includes all objectives from the individual's current stage of change or readiness for rehabilitation to the maintenance stage for each focus of hospitalization, as clinically appropriate (26%);" and 2. "The objectives are linked to the individual's stages of change, if appropriate (42.8%)." <p>Case reviews by this monitor (CC, WP, BRB and JD) show non-compliance due to failure to identify any stages of change or to include an adequate outline of the stages. Partial compliance is noted in the chart of RL.</p>

		<p>Recommendations:</p> <ol style="list-style-type: none"> 1. Same as in recommendation #1 in C.2.f.i. 2. Same as in C.2.e.
f.v	<p>ensure that there are interventions that relate to each objective, specifying who will do what, within what time frame, to assist the individual to meet his/her needs as specified in the objective;</p>	<p>Findings: MSH has chart audit data (20% sample) that indicate the following compliance rates:</p> <ol style="list-style-type: none"> 1. "The WRP includes interventions that are clearly linked to the objectives and are written in terms of what the staff will do (40%);" and 2. "The WRP plan includes names of specific staff responsible for implementing each intervention, type of intervention and frequency and duration of the intervention." (10%). <p>Case reviews by this monitor show overall inadequate implementation of this requirement, with non-compliance in two cases (CC and JD), partial compliance in two (WP and BRB) and compliance in one (RL).</p> <p>Recommendations: Same as in recommendation #1 C.2.f.i</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>Findings: MSH has chart audit data (20% sample) that demonstrate 5% compliance with the requirement that "interventions include at least 20 hours of planned mall groups or individual therapy that is linked to objectives". The tool assesses only the number of hours scheduled by the team. The facility does not monitor nor have aggregated data regarding the number of hours actually attended by the individual.</p> <p>Chart reviews by this monitor demonstrate overall inadequate implementation of this requirement. Examples include CC (scheduled for 92 hours during the month of August 2006, but attended only 13.3 hours), WP (scheduled for 25 hours in August 2006 and attended</p>

		<p>only 11) and JD (scheduled for 156 hours in August 2006 and attended 38.6). Examples of more adequate implementation include BRB and JD (both attended 67 hours of active treatment in August 2006).</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Assess and address the factors related to inadequate scheduling by the WRP teams and/or participation by individuals to ensure compliance with the requirement. 2. Monitor hours of active treatment scheduled and attended.
f.vii	<p>maximize, consistent with the individual's treatment needs and legal status, opportunities for treatment, programming, schooling, and other activities in the most appropriate integrated, non-institutional settings, as clinically appropriate; and</p>	<p>Findings:</p> <p>MSH has chart audit data (20% sample) indicating only 4% compliance with the requirement. The monitoring item states "when legal status permits (Civil Commitments), the individual is scheduled for off-grounds activities for community reintegration, e.g., unemployment office, education, employment, recreation, skills development."</p> <p>This monitor's review of the charts of adult civilly committed individuals (RB, AC, GC, AB and TC) does not show evidence of activities that meet the requirement in this item. My review of the charts of child and adolescent civilly committed individuals (JL, CG, SF and MW) demonstrates that only one individual (MW) received activities in accordance with this requirement.</p> <p>Recommendations:</p> <p>Assess and correct factors related to lack of programs.</p>
f.viii	<p>ensure that each therapeutic and rehabilitation service plan integrates and coordinates all services, supports, and treatments provided by or through each State hospital for the individual in a manner specifically responsive to the plan's therapeutic and rehabilitation goals. This requirement includes but is not limited to</p>	<p>Findings:</p> <p>MSH does not have monitoring data that measure compliance with the first element in this section. The facility developed and implemented a monitoring tool-"Mall Alignment Protocol" to measure compliance with the second element of this section. This tool includes a variety of important process items. However, this protocol does not address</p>

	<p>ensuring that individuals are assigned to mall groups that link directly to the objectives in the individual's WRP and needs.</p>	<p>the key element of aligning objectives of mall groups with the objectives in the WRP.</p> <p>All chart reviews conducted by this monitor demonstrate lack of documentation that supports linkage between mall activities and objectives outlined in the WRP. Personal interviews with a sample of staff psychiatrists confirm a disconnection between the WRP and interventions provided at the mall.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a mechanism to ensure proper linkage between type and objectives of mall activities and objectives outlined in the WRP as well as documentation of this linkage. 2. Revise the WRP/mall alignment check protocol to properly address this requirement. 3. Implement electronic progress note documentation by all mall and individual therapy providers.
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>Compliance: Partial.</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>Findings: The DMH WRP manual does not include specific parameters for review and revision of the foci, objectives and interventions.</p> <p>MSH has process observation data (monthly WRP) that indicate 80.2% compliance with this requirement. The monitoring item states "the team revised or added new treatment objectives and/or interventions, as appropriate." The facility has four other process</p>

		<p>observation monitoring items that do not address this requirement.</p> <p>This monitor's findings show a much lower compliance rate. In four out of the five charts reviewed by this monitor (CC, WP, BRB, JD and RL), there was evidence of failure to revise the foci and/or objectives/interventions to reflect the individuals changing needs.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that the DMH WRP manual contains specific requirements for review and revision of foci, objectives and interventions to address changes in the individual's status. 2. Continue and strengthen training to WRP teams to ensure that foci and objectives are reviewed and revised and that new interventions are developed and implemented as clinically needed. 3. Ensure that monitoring items are based on operational criteria that are focused on the specific requirements in the plan.
g.ii	<p>review the focus of hospitalization, needs, objectives, and interventions more frequently if there are changes in the individual's functional status or risk factors (i.e., behavioral, medical, and/or psychiatric risk factors);</p>	<p>Findings:</p> <p>MSH has data based on process observations of the seven-day, 14-day, quarterly and annual WRP reviews as well as chart audits. However, the monitoring items used fail to address the specific requirement of more frequent reviews.</p> <p>This monitor reviewed the charts of five individuals that experienced restrictive interventions in the past year (FEA, ML, KR, FPR and KMO). This review indicated full compliance with the requirement in three cases (ML, KMO and KR), partial compliance in one (FEA) and non-compliance in one (FPR).</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Same as above. 2. Revise current monitoring tool to include individuals whose

		functional status have improved.
g.iii	ensure that the review process includes an assessment of progress related to discharge to the most integrated setting appropriate to meet the individuals assessed needs, consistent with his/her legal status; and	<p>Findings: MSH has data based on process observation of the monthly WRP reviews (13.7% sample). The data demonstrate 66.3% compliance with the monitoring item requiring that "a team member gives a summary report of the individual's progress on each treatment objective and progress in meeting discharge criteria."</p> <p>MSH has other data derived from process observations and chart audit tools that do not adequately assess compliance with this requirement.</p> <p>Chart reviews by this monitor (CC, WP, BRB, JD and RL) indicate a general trend of adequate inclusion of discharge criteria in the WRP but failures in the documentation of the following: a) team discussion of the individual's progress toward discharge; b) update of the present status section of the case formulation regarding the individual's progress; and c) revision of the interventions if no sufficient progress has been made toward discharge.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Continue and strengthen training to WRP teams to ensure consistent implementation of this requirement. 2. 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).
g.iv	base progress reviews and revision recommendations on data collected as specified in the therapeutic and	<p>Findings: MSH uses the above- mentioned process observation item to measure</p>

	rehabilitation service plan.	<p>compliance with this item. Based on this item, the facility has monitoring data for the monthly (5.9% sample), quarterly (13.7% sample) and annual (10.8% sample) WRP reviews. The compliance rates are reported at 66.3%, 68% and 80% respectively. This monitoring item addresses this requirement only partially. The facility has other process observation and chart audit items that are not aligned with this requirement.</p> <p>Chart reviews by this monitor demonstrate failure to conduct data-based reviews in the WRP in four (CC, WP, BRB and JD) out of five charts.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Same as in C.2.g.i. 2. Same as recommendation #3 in C.2.f.viii.
h	Individuals in need of positive behavior supports in school or other settings receive such supports consistent with generally accepted professional standards of care.	<p>Findings:</p> <p>MSH has two full-time PBS teams. One of these teams is involved mostly with the child and adolescent program and the other is dedicated to the adult service. While the child and adolescent program has a census of only 27, the needs of this population still require the attention of one full-time PBS team. This means that the facility needs a second team for the adult service to achieve compliance with the EP. It is not possible to provide appropriate support to the line staff and the individuals they serve without an additional team.</p> <p>PBS team leaders were very motivated to work within the Recovery Model and fulfill all criteria of the EP, and they participated in an in-depth analysis of the PBS program with the Monitor.</p> <p>It is apparent that there are a number of serious concerns as to how the PBS teams function within the hospital's matrix system and the</p>

		<p>barriers to full implementation of PBS program, including:</p> <ol style="list-style-type: none"> 1. Difficulty in training line staff due to lack of cooperation and support from all programs. 2. There is a general lack of commitment by the unit staff to treatment implementation, integrity of implementation, and valid and reliable data collection. 3. A number of PBS team leaders are assigned to other duties limiting their participation in PBS plans. 4. PBS psychologists do not have the authority to write orders for the implementation of PBS plans. <p>The number of individuals on PBS plans (i.e., 17 as of September 18, 2006) is too small given the large number of individuals in the facility who are in need of behavioral interventions for learned maladaptive behaviors, as evidenced by the high usage of crisis management and seclusion and restraint procedures.</p> <p>The Monitor's interviews with program and unit staff strongly suggested that many of the problems faced by the PBS teams arise from the matrix system of administration at MSH. There is a lack of strong commitment from the Clinical Administrator, and some of the program directors and unit supervisors to the functions of the PBS teams as required by the EP. The PBS teams are seen as external agents rather than a specialist team that is integral to the well being of all individuals in all programs.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that PBS psychologists have the authority to write orders for the implementation of PBS plans.
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		<ol style="list-style-type: none"> 2. Ensure that all staff implement PBS plans and collect reliable and valid outcome data. 3. Hire an additional PBS team. 4. 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. 5. Provide competency-based training to all staff in PBS procedures, and provide on going training and support for PBS team members, as needed. 6. Ensure that there is full administrative support for the PBS teams.
i	Adequate active psychosocial rehabilitation is provided, consistent with generally accepted professional standards of care, that:	<p>Compliance: Partial.</p>
i.i	is based on the individual's assessed needs and is directed toward increasing the individual's ability to engage in more independent life functions;	<p>Findings: The monitoring items used in the self-evaluation for this item are not correct.</p> <p>MSH's psychosocial rehabilitation services are severely deficient.</p> <p>When asked by the Monitor, and when observed during WRP conferences, most staff were able to identify the need to direct individuals to engage in more independent life functions, but their planning and execution towards the goal is sorely lacking.</p> <p>Often, group and individual therapy providers are not identified on the WRP plans. In a number of cases, the identified provider was no longer in the facility (for as long as 3 months or more; if the identified provider is listed in the individual's WRP, in practice that person may not be the one facilitating the Mall activity or group/individual therapy (case examples include: RZ, FJ, JR, and CL.).</p> <p>A number of individuals do not attend therapy groups, but they are</p>

		<p>not tracked to make sure that they are given other choices or their non-adherence with their WRP is addressed. The so-called "Recovery" groups are a misnomer and do not meet the needs of the individuals who refuse to attend groups. For example, there are no groups for these individuals that use Motivational Interviewing or Narrative Therapy and other cognitive behavioral approaches to minimize their WRP refusal. During interviews with staff, no group providers were trained in or even familiar with these approaches. Staff generally felt that these issues were not addressed by the Mall Director or the Clinical Administrator.</p> <p>The individual's needs for psychosocial rehabilitation are not carefully assessed to enable the WRP team to assign the individual to specific groups and individual therapy that will enhance more independent functional status. Most of the recommendations/conclusions of discipline-specific assessments I reviewed do not clearly address the individuals' rehabilitation needs. In some cases, the same group activity is recommended for a number of different objectives in a manner that violates PSR principles in terms of individualization of treatment needs. In other cases, group objectives are taught instead of individual objectives within a group. This speaks to a lack of monitoring and supervision of the groups.</p> <p>Recommendations:</p> <ol style="list-style-type: none">1. All discipline-specific assessments should include a section that states the implications of the assessment for rehabilitation activities.2. The WRP team should integrate these assessments and prioritize the individual's assessed needs3. 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.4. Ensure that group leaders are consistent and enduring for
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		<p>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> <p>6. Provide better leadership in the PSR Mall.</p>
i.ii	Has documented objectives, measurable outcomes, and standardized methodology	<p>Findings:</p> <p>In a majority of the charts reviewed, the objectives were vague, not stated or written in behavioral, observable and/or measurable terms (see findings in C.2.f.i); and the objectives were not clearly linked to a relevant focus. The outcomes expected of the individual were not clear.</p> <p>Often the objectives and interventions were confused—sometimes the objectives were written in terms of what the staff would do rather than what the individual will learn and how the learning outcome will be measured.</p> <p>The WRP chart audit showed only 49% of the individuals Life Goals were linked to treatment rehabilitation and enrichment. However, this monitor's review showed a much lower level of such linkage. Further, only 7% of the eligible individuals were scheduled for off-ground activities.</p> <p>In more than one WRP conference it was communicated to the individual that he/she is not eligible for off ground/community/discharge privileges not for what he/she did but rather for what the WRP team thinks he/she might do.</p> <p>Recommendations:</p> <p>1. Ensure that the objectives are written in behavioral, observable and/or measurable terms, as specified in the DMH WRP Manual.</p> <p>2. Ensure that the learning outcomes are stated in measurable</p>

		<p>terms.</p> <p>3. Ensure that each objective is directly linked to a relevant focus of hospitalization.</p>
i.iii	<p>Is aligned with the individual's objectives that are identified in the individual's Wellness and Recovery Plan</p>	<p>Findings:</p> <p>MSH has established a psychosocial rehabilitation (PSR) mall concept for providing group and some individual therapy options for its individuals. This is a recovery-oriented system that should enable the facility to meet the treatment, rehabilitation and enrichment needs of the individuals. The PSR Mall is supposed to be run according to the PSR Mall manual. This is not the case. The Mall is fragmented and, for the most part, groups and other therapies are not aligned with the needs of the individuals. During Mall observations, I noted the following deficiencies in the way Mall groups were conducted:</p> <ol style="list-style-type: none"> 1. There is little organization. 2. Goals are rarely made clear. 3. There is a lack of rules and enforcement across groups and providers. 4. Functioning capacity of participants ranged widely within groups. 5. Co-providers did very little during the groups. 6. There are more individuals in the hallways than in groups during mall hours. <p>The objectives specified in the individuals' WRPs and the groups they are assigned to, as well as the contents of the groups, are not aligned with the individual's needs. There are two main problems: a) the objectives stated in the individuals' WRPs are not fully aligned with their assessed needs; and b) the content of groups the individuals attend frequently do not meet the assessed needs of the individuals.</p> <p>Some group facilitators do not address content areas that their group is designated to address. The focus of the group is on the activity</p>

		<p>itself rather than the skills/education/training/ that the individual is to derive by attending the Mall group.</p> <p>There is evident lack of knowledge and administrative ability demonstrated by the Mall director as well as a lack of accountability on the part of the Clinical Administrator who has overall authority over the PSR Malls.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that WRP teams write objectives in behavioral, observable, and/or measurable terms. 2. Ensure that all therapies and rehabilitation services provided in the malls are aligned with the assessed needs of the individuals. 3. 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.
i.iv	utilizes the individual's strengths, preferences, and interests;	<p>Findings:</p> <p>Chart reviews showed that only 14% of the WRPs identified the individual's strengths, preferences, and interests in the interventions.</p> <p>Observations, staff interviews, and chart reviews showed that the group offerings in the PSR Mall typically did not show any evidence of incorporating individual strengths, interests, and preferences into activity planning or implementation. Some staff could not identify any strength that they could use with an individual; rather they blamed the individual for lacking motivation.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that the individual's strengths, preferences, and interests are clearly specified in the interventions in the individual's WRP in accordance with the DMH WRP manual. 2. Ensure that the group facilitators and individual therapists know and use the individual's strengths, preferences and

		interests when delivering rehabilitation services.
i.v	focuses on the individual's vulnerabilities to mental illness, substance abuse, and readmission due to relapse, where appropriate;	<p>Findings: MSH has chart audit data that do not adequately address this requirement.</p> <p>This monitor's review of WRPs and interviews with staff showed that the case formulation is inadequate in presenting or discussing an individual's vulnerabilities to mental illness and substance abuse (predisposing, precipitating and perpetuating factors).</p> <p>Chart reviews and staff interviews revealed that case formulation using the 6-p format is uneven in quality, has almost no analysis, and does not follow the content guidelines established in the DMH WRP Manual. Most of the case formulations are a cut-and-paste from old notes, which defeats the intent of the formulation in serving as the functional bridge between the assessments and the WRP.</p> <p>MSH has developed an interdisciplinary substance abuse committee to serve as an advisory and training body. The committee conducted needs assessment regarding numbers of groups provided, and types and numbers of groups needed to assist WRP teams in the identification of stages of change. The main reference used by the committee is the Group Treatment for Substance Abuse: A Stages-of-Change Therapy Manual by Mary Velasquez, Gaylyn Gaddy Maurer, Cathy Crouch, and Carlo C. DiClemente. This is an excellent, evidence-based manual on the trans-theoretical model of substance abuse groups. The committee developed a 12-week lesson plan based on the Velasquez model, identified the providers with certification in substance abuse as well as the types of skills and knowledge needed to ensure staff competency. The committee has provided overview training to clinical staff but has yet to develop and implement a formalized training curriculum and program.</p>

		<p>Chart reviews show that, in general, there is not a clear focus of treatment on those factors that precipitated readmission due to relapse. The groups assigned are varied and often global. There is almost no reference in the case formulation to an individual's vulnerability to relapse. There is no subsequent focus on developing objectives and interventions that are related to these vulnerabilities.</p> <p>The monitor's findings under C.2.d are also applicable to this section.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Undertake clinical case formulation as a team rather than by assigning the task to a team member or to non-team members. 2. Include the individual's vulnerabilities in the case formulation under predisposing, precipitating, and perpetuating factors. 3. 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 o preempt relapse. 7. Same as in C.1.d.i
i.vi	is provided in a manner consistent with each individual's cognitive strengths and limitations;	<p>Findings:</p> <p>Mall groups, as well as other group activities, are almost never assigned by cognitive levels. Providers tend to judge an individual's cognitive level based on their physical and mental attributes without formal assessment. The current Mall groups and Group activities, with a very few exceptions, observed by the Monitor presented with individuals with wide ranging cognitive levels and physical disabilities.</p>

		<p>MSH Chart Audit data for this item was 0%.</p> <p>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	<p>Provides progress reports for review by the Wellness and Recovery Team as part of the Wellness and Recovery Plan review process</p>	<p>Findings:</p> <p>Chart reviews and staff interviews showed that often progress reports are not written or not available by the next WRP conference for review by the WRP team. In one case the monitor found a blank signed note without any contents in the note. In addition, as witnessed by the monitor when attending WRP team conferences, a number of WRP teams failed to use the progress notes to develop objectives, adjust BY CHOICE points, or reinforce individuals where applicable.</p> <p>MSH Chart Audit data showed that this occurred only 75.5% of the time. In light of the information derived from staff interviews and direct observation during the WRP process the reliability of the data is very questionable.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that all group and individual therapy providers provide the WRP teams with progress reports on all individuals prior to each individual's scheduled WRP review. 2. Automate this system to make it feasible for the group facilitators and individual therapists to provide progress notes in a timely manner. 3. Use the data from monthly Mall Progress Notes in the WRP

		review process.
i.viii	is provided five days a week, for a minimum of four hours a day (i.e., two hours in the morning and two hours in the afternoon each weekday), for each individual or two hours a day when the individual is in school, except days falling on state holidays;	<p>Findings: The PSR Mall provides a wide variety of groups, but not enough for the individuals to choose from in order to fulfill the required elements.</p> <p>Mall services are provided five days a week, but structured Mall services are not provided two hours in the morning and 2 hours in the afternoon. Mall services provided in the afternoons or in the residential units are not structured and do not comport with current professional standards. Program I provides two hours in the morning and 2 hours in the afternoon, while Program III and Program V offer three hours in the morning, and one hour in the afternoon, and in Program VI provides two hours in the morning and two hours of unit based service in the afternoon. All programs should provide mall services for a minimum of two hours in the morning and 2 hours in the afternoon.</p> <p>Shortage of staff is given as reason for the shortage of groups conducted. However, the data show that all disciplines regardless of staffing levels do not provide enough hours of service in the PSR Malls.</p> <p>On the average, the various disciplines on long-term units should provide at least the following hours of PSR groups: psychology (six-eight hours/week), social work (ten-12 hours/week), rehabilitation therapists (12-15 hours/week), nursing and psychiatric technicians (ten-15 hours/week), and psychiatry (five-eight hours/week). These are minimum hours and do not include individual therapy hours—which should be undertaken in addition to these hours. However, staff on the admissions' units should be allowed to do fewer hours due the nature of other work assignments.</p>

		<p>Overall the PSR Mall is not run according to the requirements of the EP.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Provide PSR Mall groups as required by the EP, five days a week, for a minimum of four hours a day (i.e. two hours in the morning and two hours in the afternoon each weekday), for each individual or two hours a day when the individual is in school, except days falling on state holidays. 2. Mandate that all staff at 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. All Mall sessions must be 50 minutes in length. Sessions less than 20 minutes do not contribute to an individual's active treatment hours. 4. Provide groups as needed by the individuals and written in the individuals' WRPs. 5. Add new groups as the needs are identified in new/ revised WRPs.
i.ix	is provided to individuals in bed-bound status in a manner and for a period that is commensurate with their medical status;	<p>Findings:</p> <p>A few bed-bound individuals receive some form of 'Mall activity", most often in their own bed. The activities range from 15 to 30 minutes in length, and the range of activities are very limited; in fact, music and television seem to be most common activities these individuals get, except when visited by PTs and OTs. These Mall activities also are not provided during prescribed times but rather at the convenience of the staff.</p> <p>WRP audit data showed that 2 bed bound individuals (JP, EG), who are not the only bed bound individuals in SNF, received only 32.6 % and 40.9% of their eligible hours of services, respectively.</p>

		<p>Recommendations:</p> <ol style="list-style-type: none"> 1. Include individuals' skill-building activities with bed-bound individuals commensurate with their cognitive status, medical, health, and physical limitations. 2. Therapy can be provided in any physical location within the hospital as long as the services are structured and consistent with scheduled Mall activities. 3. Ensure that all activities are documented. 4. Widen the repertoire of activities individuals in bed-bound status receive.
<p>i.x</p>	<p>routinely takes place as scheduled;</p>	<p>Findings:</p> <p>The PSR Mall does mandate that therapies must be provided as scheduled. Review of the hospital data, staff interviews, interviews with the individuals and observations showed that group facilitators determine how and when they provide the services, or when they will cancel groups without informing the Mall administrators. Further, Mall administrators noted that a large number of cancellations are due to the unavailability of staff.</p> <p>Staff interviews and observations suggested that the MSH is not fully adhering to a PSR Mall model of service delivery. To enable the malls to be run properly, all residential units should be closed (except for a centralized unit for emergency medical care for individuals who are ill) and all staff should be providing groups in the Mall. All clinical staff should also be in the malls. Psychiatrists were rarely observed to provide groups during mall hours. Other disciplines did not provide enough hours of mall service. Nurses and PTs were under represented as mall group facilitators.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Implement a more focused Mall program that is regularly scheduled, implemented, and provided within the individual's

		<p>cognitive, medical, physical and functional status.</p> <ol style="list-style-type: none"> 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.
i.xi	<p>includes, in the evenings and weekends, additional activities that enhance the individual's quality of life; and</p>	<p>Findings: The hospital's self-assessment findings reveal that the average hours of enrichment activities are minimal. Cancellations occur due mainly to staff unavailability. Very few structured enrichment activities are provided during the weekends. Many individuals do not have any programmed enrichment activity, and in some cases individuals do not take the opportunity to participate in scheduled enrichment activities.</p> <p>Program is said to have started a tracking system to account for weekend enrichment activities.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop a list of all enrichment activities available along with staff names competent in facilitating the activities in accordance with generally accepted professional standards of care. 2. Plan and organize these activities such that there is minimal interruption, individuals are reinforced to participate regularly in these activities, and as much as possible eliminate competing activities that act as a barrier for individuals to participate in such activities. 3. Increase the number of hours of enrichment activities per individual provided in the evenings and weekends.

i.xii	is consistently reinforced by staff on the therapeutic milieu, including living units.	<p>Findings: The DMH WRP Manual contains information that captures this requirement. Chart reviews showed that 20% of the WRPs included therapeutic milieu in the intervention section. Observation and staff interviews by the monitor showed that this is a rare occurrence, supporting MHS audit data showing 20% occurrence. Further, there is no evidence that there is any mention of the objectives and interventions during change of shift communication.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that all 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>Findings: Enrichment and MAPP schedules show that group exercises and recreational activities are provided, but not in sufficient quantity to meet the needs of all individuals. MSH data show that between 5 to 6 hours of individual exercise and recreational activities per week are available to individuals who are interested and / or recommended to such activities.</p> <p>MSH has a significant number of individuals with a BMI of 25 or greater and would benefit immensely with increased and varied exercise options and vigorous recreational options.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Establish group exercises and recreational activities for all

		<p>individuals.</p> <ol style="list-style-type: none"> 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>Findings: MSH has put in place a family therapy monitoring system. However, efforts to assess the need for family therapy services are minimal as is evidenced by the lack of discussion of such during WRP conferences and in social work progress notes, and there is no evidence that family therapy is part of the MAPP documentation of services.</p> <p>Available MSH data revealed that 55% of the time referral problems and goals of therapy are identified. And, at least 78% of the time therapists speak in the individual/family preferred language. The Monitor's chart review, interview with staff, and observations suggest that these data are unreliable and high.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Conduct a needs assessment with individuals and/or their families. 2. Use individual discharge plan goals as a way to identify families that may need family therapy to help them assist and support their family members upon discharge. 3. Review pre-admission reports and services/treatments provided to identify the need for family therapy services. 4. Ensure that family therapy needs are fulfilled.

l	<p>Each individual's therapeutic and rehabilitation service plan identifies general medical diagnoses, the treatments to be employed, the related symptoms to be monitored by nursing staff (i.e., registered nurses ["RNs"], licensed vocational nurses ["LVNs"] and psychiatric technicians) and the means and frequency by which such staff shall monitor such symptoms, consistent with generally accepted professional standards of care.</p>	<p>Findings: The facility used the Medical Condition Monitor Audit form to measure compliance with the key elements of this requirement for 42 charts. The results indicated:</p> <ol style="list-style-type: none"> 1. "Open medical conditions are identified in the WRP under Focus # 6 (17%);" 2. "(Plan identifies) general medical diagnoses (62%);" 3. "(Plan identifies) treatments to be employed (40%);" 4. "(Plan identifies) related symptoms to be monitored by nursing staff (36%);" 5. "(Plan identifies) by what means staff will monitor these symptoms (29%);" and 6. "(Plan identifies) by what frequency staff will monitor these symptoms: 29%. <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that staff implements the key elements of this requirement. 2. Continue to monitor the key elements of this requirement using the Medical Conditions Monitor audit.
m	<p>The children and adolescents it serves receive, consistent with generally accepted professional standards of care:</p>	<p>Compliance: Partial.</p>
m.i	<p>Therapy relating to traumatic family and other traumatic experiences, as clinically indicated; and</p>	<p>Findings: MSH's Family Therapy Monitor Audit captured a very small number of cases (N=7). The available data showed that abuse history is adequately captured 97% of the time, and follow-up steps were</p>

		<p>identified 95% of the time.</p> <p>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>Findings: MSH data presented for this cell is similar to that of m.i above. A review of social work notes showed that most of the seven individuals captured in the audit are having their issues addressed at this time.</p> <p>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>Findings: MSH has a draft policy and procedure regarding Substance Abuse Screening, which is yet to be finalized. The policy outlines guidelines and responsibilities for the appropriate screening of all individuals for substance abuse as clinically indicated. The procedures do not address one of the two main purposes of the policy, that is to ensure that screening and assessment of substance abuse is available and used to provide therapeutic and rehabilitation services that are consistent with generally accepted professional standards of care.</p> <p>Compliance: Partial.</p>

		<p>Recommendations:</p> <ol style="list-style-type: none"> 1. Revise the screening policy to address the above deficiency. 2. Finalize and implement the policy and procedure.
o	<p>Individuals who require treatment for substance abuse are provided appropriate therapeutic and rehabilitation services consistent with generally accepted professional standards of care.</p>	<p>Findings:</p> <p>MSH has monitoring audit data derived from a substance abuse check list. The Data are based on a review of 74 charts of individuals diagnosed with substance abuse disorders. The review was conducted by clinical members of the substance abuse committee. Compliance rates were identified as follows:</p> <ol style="list-style-type: none"> 1. "Substance abuse diagnosis is identified in Axis I (67%);" 2. "Substance abuse is identified in the 6 p's (87%);" 3. There is an objective and corresponding intervention under Focus #5 -Substance Abuse (69%);" 4. Individual's current stage of change is identified in the WRP (50%);" and 5. Identified stages of change are consistent with corresponding objectives and interventions under focus # 5 (44%)." <p>In addition, the facility has chart audit data (20% sample reviewed by HIM department). The data show compliance rate of 53% with the documentation of substance abuse diagnosis on Axis I and the presence of at least one corresponding objective and intervention.</p> <p>Chart reviews by this monitor (KS, MP, KVD, TR, KSW, CY, SM, JC, AE and AG) indicate the following pattern of key deficiencies:</p> <ol style="list-style-type: none"> 1. There are no objectives or interventions listed when the diagnosis of substance abuse is identified as a focus for hospitalization (KSW and CY). 2. There is no evidence of recovery-based interventions due to either failure to identify stages of change for the individual (e.g. KS, MP) or inappropriate identification of those stages

		<p>(KVD, TR, JC, AE and AG). This finding is inconsistent with the hospital's data regarding the identification of stages of change for individuals with substance abuse.</p> <ol style="list-style-type: none"> 3. There is no evidence of recovery-based interventions when the stages of change are properly identified (SM). 4. In all charts reviewed, the case formulations do not address the factors that precipitate or predispose, or perpetuate relapse and readmission and the WRPs do not address the interventions needed to overcome these factors. <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Standardize the substance abuse auditing mechanisms across all state facilities. 2. Develop a formalized substance recovery program with designated administrative and clinical leadership. 3. Develop and implement training curriculum and process derived from the trans-theoretical model for substance abuse. 4. The substance recovery program should develop and utilize clinical outcomes for individuals and process outcomes for the program. 5. Same as in recommendation #4 under C.2.c.
<p>p</p>	<p>Group facilitators and therapists providing therapeutic and rehabilitation services (in groups or individual therapy) are verifiably competent regarding selection and implementation of appropriate approaches and interventions to address therapeutic and rehabilitation services objectives, are verifiably competent in monitoring individuals' responses to therapy and rehabilitation, and receive regular, competent supervision.</p>	<p>Findings: Except for substance abuse, there are no competency data on facilitators of PSR Mall groups or other forms of group activities. No self-assessment data were provided by MSH.</p> <p>In speaking with and observing PSR Mall facilitators it appears that some facilitators have the knowledge base to teach at the level of the individuals participating in their groups. However, low motivation, poor</p>

		<p>organizational and poor management skills are severe deficiencies amongst these facilitators. In one group, nearly 30 individuals were watching television for over 25 minutes and the facilitator was engaged in many other activities besides speaking with or talking to participants who needed guidance in understanding the theme or focus of the show. The facilitator did not divide the group into two, so one group could watch while the facilitator briefed the other group and rotated them though in 15-minute time slots. Further, an assessment was being conducted with one of the participants in the same area. It is advisable that space be set aside by each program for all disciplines to conduct their assessments.</p> <p>Compliance: Partial.</p> <p>Recommendations: Monitor the competency of group facilitators and therapists in providing rehabilitation services.</p>
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>Findings: No self-evaluation data were provided by MSH regarding this requirement.</p> <p>Review of substance abuse provider certification list and survey results showed that some of the substance abuse providers are certified, have specialized training, or have the experience and are undergoing training at this time. Peer teaching, with non-certified peers, and training without a proper curriculum should not count towards providing this specialized service. The NSH training curriculum should serve as the basis for substance abuse facilitator certification.</p>

		<p>Compliance: Partial.</p> <p>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>Findings: According to the hospital's self-evaluation data, 26% of scheduled appointments were cancelled between January and August, 2006. A high percentage of those cancellations were because the individuals refused to go or refused treatment. Another reason was that the individual was not available. The self-assessment noted that transportation continues to be a continuing problem.</p> <p>There is no automated system for tracking individuals who miss their appointments.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Review reasons for cancellations and assess and correct factors contributing to such events. 2. Complete and implement the Medical Scheduler. 3. Assess why individuals refuse medical appointments and find ways to resolve their concerns.

s	<p>Adequate oversight to treatment, rehabilitation and enrichment groups is provided to ensure that individuals are assigned to groups that are appropriate to their assessed needs, that groups are provided consistently and with appropriate frequency, and that issues particularly relevant for this population, including the use of psychotropic medications and substance abuse, are appropriately addressed, consistent with generally accepted professional standards of care.</p>	<p>Findings: As discussed in earlier sections, the number of Mall hours and the number of enrichment hours, both on weekdays and weekends are insufficient. Further, group assignments do not take into account cognitive levels, and observation of Mall activities indicated that there is much change by way of organization and management of activities before there can be a sense that individuals actually benefit from these activities. MSH Chart Audit data showed that the content of the intervention is 100% consistent with the course outline. However, appropriate content is necessary, but not sufficient. The content has to be translated into meaningful practice for the individuals to benefit from the activities. This aspect of translational factor needs great improvement.</p> <p>Compliance: Partial.</p> <p>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>Findings: MSH has developed an audit tool to assess the PSR Mall services against operational criteria. The Mall Director conducted 46 audits of the mall lesson plans. The tool evaluates a number of items to assess the appropriateness of the lesson plan, including whether lesson plan goals and content are relevant to the topic, can be</p>

		<p>achieved within the specified lessons and are geared to the participants' comprehension level. The facility reports an overall compliance rate of 51% based on this tool. In addition, the discipline chiefs monitor the clinicians in their disciplines when they perform as group facilitators. This mechanism utilizes a number of observational items related to the course facilitator's instruction skills, course structure, use of positive instructional techniques and the learning process. The facility is in the process of aggregating the data derived from this tool.</p> <p>Compliance: Partial.</p> <p>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.
u	<p>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>	<p>Findings: The Mall Director at MSH has identified 110 groups that address the general topic of Wellness and Recovery. However, only 40 of these groups were provided in August 2006. The facility does not have data regarding the number of mall groups that are educationally-based. Reportedly, MSH provides one group activity on each admission unit that includes an educational component regarding the purpose of treatment, rehabilitation and enrichment activities.</p> <p>This month, the facility conducted a survey (11.3 % sample) completed</p>

		<p>by the Individual Council at MSH. The survey assessed whether individuals received education regarding the purpose of their treatment, rehabilitation and enrichment services. Preliminary results show that 67% of the individuals responded in the affirmative.</p> <p>Compliance: Partial.</p> <p>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 WRP 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>Findings: During August, MSH offered 150 medication groups and 73 of these groups were actually provided. The facility has data to indicate that 42% of all individuals residing at MSH were scheduled for at least one medication group during August 2006. The facility reports that the above mentioned survey assessed whether individuals were taught about their medications and side effects of treatment and that 81% of responders answered in the affirmative.</p> <p>At this time, MSH does not have data to indicate the attendance and participation by individuals in medication groups and to assess whether these groups are sufficient to meet the clinical needs of individuals. Furthermore, the facility does not have a mechanism to ensure that the individuals' needs are assessed in this regard and to</p>

		<p>assist individuals to make choices based on both needs and available services.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Increase the number of mall groups that offer education regarding medication management. 2. The DMH WRP manual needs to include guidelines to WRP teams regarding the assessment of individuals' needs regarding this requirement, and to assist individuals in making choices based on both need and available services.
w	<p>Interdisciplinary teams review, assess, and develop positive clinical strategies to overcome individual's barriers to participation in therapeutic and rehabilitation services.</p>	<p>Findings: MSH is currently developing mechanisms to track lack of participation by the individuals in their WRPs. The facility does not have monitoring tools in this area and is yet to report key indicators regarding individuals' non-adherence to the plans.</p> <p>At present, the WRP teams do not have a methodology to assess individuals' barriers to participation. In addition, the WRP teams do not provide individuals with clinical strategies to help them achieve readiness to engage in group activities.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Provide Key Indicator data regarding individuals' non-adherence to interventions in the WRP. 2. Assess barriers to individuals' participation in their WRPs and provide strategies to facilitate participation.

		<ol style="list-style-type: none">3. Ensure that the DMH WRP manual includes guidelines to WRP teams regarding assessment methodology and strategies, including cognitive interventions, to facilitate individuals' participation.4. Develop and implement monitoring tools to assess compliance with this item.
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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. MSH is transitioning to a new system of integrated assessment. When fully implemented, the system provides comprehensive assessments of the individual's needs and serves as the basis for meaningful recovery model of service planning. 2. In general, the admission medical and psychiatric assessments, psychiatric reassessments and the transfer assessments are completed in a timely manner. 3. MSH has established a Forensic Review Panel. 4. MSH has developed and, in some cases, implemented a variety of monitoring instruments that are aligned with the key requirements in the EP (e.g. inter-unit transfer assessments).
1	Psychiatric Assessments and Diagnoses	
	<p>Each State hospital shall provide all of the individuals it serves with routine and emergency psychiatric assessments and reassessments consistent with generally accepted professional standards of care; and,</p>	<p>Methodology:</p> <p>Interviewed Sarath Gunatilake, M.D., Medical Director. Interviewed Nady Hanna, M.D., Senior Psychiatrist (covering for Chief of Psychiatry, Bala Gulasekram, M.D). Interviewed Michael Marsom, M.D., President of Medical Staff. Interviewed six staff psychiatrists. Reviewed charts of 22 individuals (RG, VV, AC, JJ, SOF, JS, AB, MAC, DAC, FMK, JAO, DLL, BNT, VRF, ALC, ANE, MP, FRG, CAT, DC, TOC and DT). Reviewed a roster of all psychiatrists at MSH and their board certification status.</p>

		<p>Reviewed form regarding "MSH Application for Appointment to the Medical Staff."</p> <p>Reviewed MSH "Professional reference Questionnaire for Appointment/Reappointment."</p> <p>Reviewed questionnaire used by the Medical Staff Psychiatry Interview Panel.</p> <p>Reviewed MSH Psychiatry Clinical privileges Delineation Form.</p> <p>Reviewed MSH draft "Physician Performance profile."</p> <p>Reviewed MSH "Staff Psychiatrist manual."</p> <p>Reviewed "Initial Admission Assessment Monitoring Form."</p> <p>Reviewed Initial Admission Assessment Monitoring summary data.</p> <p>Reviewed "Psychiatric Evaluation Monitoring Form."</p> <p>Reviewed Psychiatric Evaluation Monitoring summary data.</p> <p>Reviewed "Psychiatric Progress Note Monthly Monitoring Form."</p> <p>Reviewed Psychiatric Progress Note Monitoring summary data.</p> <p>Reviewed "Physician Transfer Summary Monitoring Form."</p> <p>Reviewed Physician Transfer Summary Monitoring Summary data.</p> <p>Reviewed a list of all individuals at MSH, including name, diagnoses, current medications, name of attending physician and unit of residence.</p>
a	<p>Each State hospital shall use the diagnostic criteria in the most current Diagnostics and Statistical Manual of Mental Disorders ("DSM") for reaching the most accurate psychiatric diagnoses.</p>	<p>Findings:</p> <p>Using the Psychiatric Evaluation Monitoring Form, MSH has monitoring data based on monthly audits conducted by five senior psychiatrists. A total of 65 audits were completed from January to June 2006. The most relevant indicator used was focused on whether the treating psychiatrist has "included the diagnostic criteria for the given diagnoses" in the integrated assessment. The data indicate a compliance rate of 89%.</p> <p>Chart reviews by this monitor indicate that, by-and-large, psychiatric diagnoses are stated in terminology that is consistent with the current version of DSM. However, admission and integrated psychiatric assessments (see D.1.c.i through D.1.c.iii) are inconsistently completed</p>

		<p>and the information needed for adequate diagnostic formulations is either missing or does not provide the basis the reaching the most reliable diagnosis.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a monitoring instrument to assess accuracy of psychiatric diagnoses. 2. Address all recommendations in section D.1. 3. 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.
b	Each State hospital shall ensure that all psychiatrists responsible for performing or reviewing psychiatric assessments:	<p>Compliance: Partial.</p>
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>Findings: The facility reported that it currently employs 46 staff psychiatrists, four part-time psychiatric consultants and two part-time forensic psychiatry fellows for a total of 44 full-time equivalences. However, review of the facility's staff vacancy data indicates that the current number of staff psychiatrists at the facility is 41. The facility has data to show that 21 psychiatrists (approximately 50% of current staff) are board-certified and that all staff completed at least three years of psychiatry residency training in an accredited program. MSH requires that all applicants for psychiatry positions present documentation of satisfactory completion of psychiatry residency program approved by the ACGME Residency Review Committee (or</p>

		<p>osteopathic equivalent).</p> <p>Recommendations: Continue current practice and encourage all psychiatrists to obtain board certification.</p>
b.ii	<p>Are verifiably competent (as defined by privileging at initial appointment and thereafter by reprivileging for continued appointment) in performing psychiatric assessments consistent with each State Hospital's standard diagnostic protocols.</p>	<p>Findings: The facility has an interview panel to assess the competency of applicants for psychiatry position. The panel consists of the Medical Director, Chief of psychiatry and President of the Medical Staff. The panel uses a list of standard questions including vignettes of clinical situations that test assessment and diagnostic skills, including risks of medications and clinical reasoning in their selection. The current criteria for reprivileging of the psychiatrists include results of the senior psychiatrists' assessment of physicians' performance. At present, the facility does not have formalized mechanisms regarding the indicators used in the performance evaluations. However, the psychiatry department is currently developing a format of quality indicators to be considered in the reprivileging process.</p> <p>The facility has a manual for the psychiatry staff that includes the monitoring forms for admission and integrated assessments and psychiatry progress notes as well as instructions regarding their use. These forms and the associated instructions are the current mechanism used by the facility to outline its performance expectations.</p> <p>Compliance: Partial.</p>

		<p>Recommendations:</p> <ol style="list-style-type: none"> 1. Finalize the quality indicators to be used in the new format of performance evaluations and ensure that the indicators address the requirements of the EP in the areas of diagnosis, assessment and reassessment. 2. Ensure that the staff psychiatrist manual includes clear performance expectations regarding the format and the content of all assessments and reassessments.
c	Each State hospital shall ensure that:	<p>Compliance: Partial.</p>
c.i	Within 24 hours of an individual's admission to each State hospital, the individual receives an Admission Medical Assessment that includes:	<p>Findings:</p> <p>MSH monitors this process using the Initial Admission Assessment Monitoring Form. MSH has data based on a review of 81 charts on the acute units during the period of March to July 2006. The reviews were completed by five senior psychiatrists and data show compliance rate of 100% for all the components of this section (i.e. timeliness of the medical assessment, review of systems, medical history, physical examination, diagnostic impressions and management of acute medical conditions). In addition, a review by the staff of the Health Information Management (HIM) of 100% sample during the period of April to July 2006 reportedly shows 100% compliance regarding the timeliness of the initial medical assessment.</p> <p>This monitor's review of 15 charts corroborates the facility's data regarding the timeliness of the medical assessment (e.g. RG, VV, AC, JJ, SOF, JS, AB, MAC, DAC, FMK, JAO, DLL, BNT and VRF). However, this review reveals much lower compliance rates for the content components. The following are examples:</p> <ol style="list-style-type: none"> 1. The review of systems was missing in the charts of AC, VV, AB

		<p>and VRF)</p> <ol style="list-style-type: none"> 2. There was no description of a skin rash in the physical examination component in the chart of RG. 3. The examination of the rectum was deferred (VV, AC, JJ and DC) or not done due to refusal of the individual (MC) without follow-up. 4. The examination of genitals was deferred, without follow up (VV and SOF). 5. The physical examination did not include the eyes (e.g. MAC) <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure completeness of the admission medical examination within the specified time frame. 2. Ensure that there is a rationale for deferral of items on the examination and that deferred items are subsequently addressed to ensure compliance with the intent of this item. 3. Ensure that monitoring of the admission physical examination addresses completeness of the examination and that the overall compliance rate accounts for the content and quality of each item.
c.i.1	a review of systems;	As above.
c.i.2	medical history;	As above.
c.i.3	physical examination;	As above.
c.i.4	diagnostic impressions; and	As above.
c.i.5	management of acute medical conditions	As above.
c.ii	within 24 hours of an individual's admission to each State hospital, the individual receives an Admission	<p>Findings: MSH utilizes the above-mentioned form and process to monitor this</p>

	<p>Psychiatric Assessment that includes:</p>	<p>item. In a personal interview, the medical staff (Senior Psychiatrist and President of the Medical Staff) reported an overall compliance rate of 93%. The facility's compliance rates for specific items in this section are listed below for each respective item. These rates were presented in the facility's written report of compliance status. In addition, the facility reported a rate of 100% for consultations ordered. In addition, review by HIM staff of 100% sample (April to July 2006) showed 96% compliance with the timeliness of the assessment.</p> <p>Reviews by this monitor of the above mentioned 15 charts demonstrate much lower compliance rates for the content and quality of the components of the assessment. The following are examples:</p> <ol style="list-style-type: none"> 1. There is evidence of incomplete mental status examination in most charts. The missing components include such essential items as suicidality (e.g. AC, SOF and AB), aggression/self-abuse (e.g. RG, AC, AB, DAC and MAC), thought content and process (AC), cognition (AC) and nature of delusions and/or auditory or visual hallucination (e.g. RG, JJ, SOF, JS, DAC, FMK, JAO, DLL and VRF). 2. The mental status examinations included inadequate assessment of aggression/self-abuse (RG and VV) and judgment (AB). 3. There is no chart documentation of a plan of care when the suicide assessment tool indicated high risk (AB). <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. 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
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		<p>titled "elaborate on positive mental status examination."</p> <p>2. Update the staff psychiatrist manual to include the requirements regarding D.1. c.ii.1 through D.1.c.ii.6.</p> <p>3. 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>
c.ii.1	psychiatric history, including a review of presenting symptoms;	98%.
c.ii.2	complete mental status examination;	100%."
c.ii.3	admission diagnoses;	100%.
c.ii.4	completed AIMS;	100%.
c.ii.5	laboratory tests ordered; and	100%.
c.ii.6	consultations ordered.	No written aggregated data were available; the medical staff verbally reported a rate of 100%.
c.iii	within 7 days (60/72 hrs) of an individual's admission to each State hospital, the individual receives an Integrated Psychiatric Assessment that includes:	<p>Findings:</p> <p>MSH monitors the integrated assessments using the Psychiatric Evaluation Monitoring Form. Data are based on a review by five senior psychiatrists of 91 charts on the acute units during the period of March to July 2006. In a personal interview, the medical staff (Senior Psychiatrist and President of the Medical Staff) reported an overall compliance rate of 91%. The facility's compliance rates for each component, as presented in the facility's written report, are listed below for each respective item.</p> <p>In addition, MSH has data regarding compliance with the timeliness of the assessment. The data are based on a review by HIM staff of a</p>

		<p>100% sample. The compliance rate is reported at 48%.</p> <p>This monitor reviewed the above mentioned 15 charts to assess compliance with this section. The review identified significant deficiencies summarized as follows:</p> <ol style="list-style-type: none"> 1. The integrated assessment is absent (FMK and MAC) or delayed (DAC); 2. Important components are missing, including: <ol style="list-style-type: none"> a) Chief complaint (AB); b) Past medical history (VV); c) Psychosocial history (AB); d) Family history (AB); e) Substance abuse history (AB); f) Religious/cultural influences (AB and DLL); g) Risk assessment for suicide/aggression/fire-setting/elopement (AB); h) Strengths (AB); i) Diagnostic formulation (RG); and j) Management of identified risks, including suicide (RG and SOF). 3. Important components are assessed in a vague and generic or clinically inappropriate manner, including: <ol style="list-style-type: none"> a) History of present illness (BNT); b) Psychiatric history (BNT, DLL and JAO); c) Social history (BNT); d) Current suicide risk (VV); e) Strengths (VRF, RG, AC, SOF, JAO, BNT and DLL); and f) Management of identified suicide risk (JJ). 4. Many charts contain mental status examinations with important parts that are missing and/or inadequately assessed, including: <ol style="list-style-type: none"> a) Most components due to the individual's muteness, without appropriate follow up (AC, JS,);
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		<p>b) Attitude/cooperation (BNT); c) Speech (DAC); d) Perceptual alterations (AB); e) Cognition (VRF); f) Insight and judgment (RG, VV, JJ, AC and DAC).</p> <p>5. There is no evidence of appropriate differential diagnosis (or diagnostic formulation). This deficiency is noted even in individuals who are in most need for this assessment. Examples are individuals who are receiving diagnoses listed as not otherwise specified (NOS), including mood disorder, NOS (RG) and cognitive disorder, NOS (VRF).</p> <p>6. Although the risk assessments are present in most of the charts that this monitor reviewed, these assessments, by and large, do not include important information regarding how recent the risk is, the relevance of risk to current dangerousness, the assessment of mitigating factors and planned interventions to reduce the risks.</p> <p>7. Many of the assessments are completed on the day of admission. This is a deficiency because the practice does not permit the integration of data that becomes available during the first week of admission, thus defeating a key purpose of the integrated assessment.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure completeness of the integrated assessment within the specified timeframe. The assessment must integrate information that cannot be obtained at the time of admission but becomes available during the first 7 days of admission. 2. Update the staff psychiatrist manual to include the requirements regarding D.1. c.iii.1 through D.1.c.iii.10.
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		<p>3. 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>4. Ensure that monitoring of the integrated assessment addresses the practice of conducting the assessments so early that the purpose is defeated.</p>
c.iii.1	psychiatric history, including a review of present and past history;	83.7% (present history) and 85.1% (past history).
c.iii.2	psychosocial history;	100%.
c.iii.3	mental status examination;	87%.
c.iii.4	strengths;	93.5%.
c.iii.5	psychiatric risk factors;	80.8.
c.iii.6	diagnostic formulation;	92%.
c.iii.7	differential diagnosis;	81.3%.
c.iii.8	current psychiatric diagnoses;	100%.
c.iii.9	psychopharmacology treatment plan; and	No written aggregated data were available, but the medical staff reported a rate of 63%.
c.iii.10	management of identified risks.	No written aggregated data were available; the medical staff reported a rate of 87%.
d	Each State hospital shall ensure that:	Compliance: Partial.

d.i	<p>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>	<p>Findings: The medical staff reported an overall compliance rate of 87% based on the use of the above monitoring mechanism (Psychiatric Evaluation Monitoring Form) to assess whether the integrated assessments include a diagnostic formulation that justifies the established diagnosis. In addition, the facility monitors the psychiatric reassessments as documented in progress notes. Using the Psychiatry Progress Note Monitoring Form, five senior psychiatrists reviewed 155 charts during the period of March to June 2006. The relevant monitoring indicator states that "current diagnosis (changes if any, with evidence to support) includes resolution of NOS, deferred and R/O diagnosis, as applicable." A compliance rate of 92% was reported for this item. The facility's written report of compliance status does not indicate the sampling method nor clearly outline relevant findings.</p> <p>Chart reviews by this monitor show a pattern of inadequate justification and updates of a variety of diagnostic categories. Examples include diagnoses of "dementia, NOS- possible due to psychosis" (ALC), "R/O dementia "(ANE), "cognitive disorder, NOS" (MP), "cognitive disorder secondary to head trauma" (VRF), "amnesic disorder due to history of diabetic coma" (FRJ), "impulse control disorder, NOS" (CAT), "mood disorder, NOS" (MAC) ,"psychotic disorder, NOS" (DAC, DC) and "psychosis NOS" (FMK),</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Provide continuing medical education to psychiatry staff to improve competency in the area of assessment of cognitive and other neuropsychiatric disorders. 2. Revise current monitoring tool to address justification of diagnosis, differential diagnosis and updates of diagnosis, as appropriate.
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d.ii	The documented justification of the diagnoses is in accord with the criteria contained in the most current DSM (as per DSM-IV-TR Checklist);	<p>Findings: MSH has monitoring data based on the use of the Psychiatric Evaluation Monitoring Form. The medical staff reported a rate of 83% for compliance with the monitoring indicator regarding inclusion of "the diagnostic criteria for the given diagnosis. The facility's written report of compliance does not specifically address this item.</p> <p>This monitor's findings under D.1.a. are also applicable to this item.</p> <p>Recommendations: Same as D.1.a.</p>
d.iii	Differential diagnoses, "deferred," or "rule-out" diagnoses, and diagnoses listed as "NOS" ("Not Otherwise Specified") are timely addressed (i.e., within 60 days), through clinically appropriate assessments, and resolved in a clinically justifiable manner; and	<p>Findings: The facility reports a compliance rate of 94% with this item. The process is the same as that described in D.1.d.i.above.</p> <p>This monitor found a much lower compliance rate as indicated by chart reviews listed under D.1.d.i. These findings were based on the review of the charts of nine individuals (ALC, ANE, MP, FRJ, CAT, MAC, DAC, DC and FMK) that had diagnoses listed as NOS or R/O.</p> <p>Recommendations: Same as D.1.d.i.</p>
d.iv	"no diagnosis" is clinically justified and documented.	<p>Findings: The facility reports that it has no individuals with a diagnosis of "no diagnosis." This monitor's review of a list of all individuals at the facility with their current diagnoses corroborates the facility's findings.</p> <p>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>Findings: Using the Psychiatry Progress Note Monitoring Form, five senior psychiatrists reviewed 155 charts during the period of March to June 2006. MSH has data based on the psychiatry progress note monitoring process that is described under D.1.d.i. The facility's data indicate a compliance rate of 60% with this item. This monitor's review corroborates the facility's low compliance rate.</p> <p>Compliance: Partial.</p> <p>Recommendations: Assess and correct factors related to low compliance with the requirement.</p>
f	<p>Each State hospital shall ensure that psychiatric reassessments are documented in progress notes that address the following:</p>	<p>Findings: Using the psychiatry progress note monitoring process, MSH assessed its compliance with items f.i. through f.v.ii. There were some discrepancies between the specific compliance rates verbally reported by the medical staff and those indicated in the facility's written report. Under each of the EP items, the facility's monitoring indicators and corresponding compliance rates are listed below (based on the facility's written report).</p> <p>The facility's compliance rates ranged from 48% to 92% for various items. However, this monitor found much lower compliance in this area. In almost all the charts reviewed by this monitor, there is a pattern of reassessments that do not meet the required elements. In general, the reassessments show the following deficiencies:</p> <ol style="list-style-type: none"> 1. The assessment of interval events is lacking and does not adequately cover significant clinical developments. Most of the reassessments are cross-sectional and more oriented towards current crisis events.

		<ol style="list-style-type: none">2. The diagnoses are not updated in a timely manner. As mentioned earlier, there is little justification for diagnoses listed as not otherwise specified and the diagnostic formulations and differential diagnoses are not adequate when needed. There is little or no documentation to indicate that the psychiatrist has used information regarding the individual's response to specific treatments as data to refine diagnosis.3. The risks and benefits of current treatments are not reviewed in a systematic manner.4. The assessment of risk factors is limited to some documentation of crises that lead to use of restrictive interventions. There is no evidence of proactive evaluation of risk factors or timely and appropriate modification of interventions in order to minimize the risk on an ongoing basis.5. There is limited or no documentation of actual and/or potential side effects of benzodiazepines, anticholinergic medications and/or new generation antipsychotics. This pattern is noted even when these medications are used in individuals who are particularly vulnerable to the risks.6. There is no review of the specific indications for the use of PRN or stat medication, the circumstances for the administration of these medications or the individual's response to this use. Ultimately, the regular treatment is not modified based on the use of PRN or stat medications.7. When behavioral interventions are provided, there is no documentation to indicate an integration of pharmacological and behavioral modalities. In addition, there is little or no discussion of the contextual basis and functional significance of the current symptoms.8. There is no documentation of the 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.
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f.i	significant developments in the individual's clinical status and of appropriate psychiatric follow up;	<ol style="list-style-type: none"> 1. "Progress toward objectives in the WRP: 87%;" 2. "Pharmacologic (rationale for continuation of medications or proposed plans: 80%;" and 3. "Non-pharmacologic (interventions are appropriate and sufficient): 50%."
f.ii	Timely and justifiable updates of diagnosis and treatment, as clinically appropriate;	"Current diagnosis (changes if any, with evidence to support) includes resolution of NOS, deferred and R/O diagnosis, as applicable: 92%."

f.iii	Analyses of risks and benefits of chosen treatment interventions;	"Benefits and risks of current psychopharmacologic treatment; includes benzodiazepines, anticholinergics and polypharmacy, if applicable: 57%."
f.iv	Assessment of, and attention to, high-risk behaviors (e.g., assaults, self-harm, falls) including appropriate and timely monitoring of individuals and interventions to reduce risks;	<ol style="list-style-type: none"> 1. "Risk status (is identified): 65%"-based on verbal report; no written aggregated data were available; and 2. "Non-pharmacologic (interventions are appropriate and sufficient)": 50%.
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;	<ol style="list-style-type: none"> 1. "Benefits and risks of current psychopharmacologic treatment; includes benzodiazepines, anticholinergics and polypharmacy, if applicable: 57%; 2. "Response to pharmacologic treatments: 93%;" 3. "Monitoring of side effects, including sedation: 91%;" 4. "AIMS-quarterly, if applicable (positive AIMS): 87%;" and 5. "Pharmacologic rationale for continuation of medications or proposed plans: 83%." <p>Data for items 2, 3 and 4 were based on verbal reports by the medical staff; no written aggregated data were available.</p>
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	"Rationale for PRN medications and review of rationale for ongoing PRN/Stat medications used: 48%." This was based on verbal report; written aggregated data were unavailable.
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	<ol style="list-style-type: none"> 1. "Progress toward objectives in the WRP: 87%;" 2. "Non-pharmacologic (interventions are appropriate and sufficient): 56%;" and 3. "Consultations, if applicable: 89%"-based on verbal report.

	psychopharmacological treatments, and document evidence of integration of treatments.	
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>Findings: MSH has a monitoring form to review the completeness/content of transfer assessments. The form is adequate for the intended purpose. The monitoring is conducted by the Utilization Review Nurse and reviewed by members of the Department of Psychiatry. Based on verbal reports by the medical staff, 16 charts were reviewed during the period of June and July 2006 and the following rates were estimated for each criterion:</p> <ol style="list-style-type: none"> 1. "Reason for transfer: 43%;" 2. "Five axis diagnosis: 43%;" 3. "Psychiatric course 29%;" 4. "Medical history and current condition: 43%;" 5. "Current target symptoms: 29%;" 6. "Psychiatric risk factors: 29%;" 7. "Review of medication: 57%;" 8. "Current barriers to discharge: 14%;" and 9. "Anticipated benefits of transfer 14%." <p>The facility's written report indicates a different sampling method than that mentioned above. According to this report, 20 charts were reviewed during the period of April through June 2006; no specific compliance rates were available in that report.</p> <p>This monitor reviewed charts of some individuals who required inter-unit transfers for psychiatric indications (TOC, CAT and DT). An inter-unit transfer assessment was not done in the case of TOC. In the other two cases, there is evidence of a transfer assessment on the day of the transfer, but the assessments provide little if any information on the experience of the individuals on the unit of origin. Specifically, the assessments fail to include the reasons for the</p>

		<p>transfer, current target symptoms, psychiatric risk factors, a review of medication trials, the barriers to discharge and the anticipated benefits of the transfer. These assessments do not provide the receiving psychiatrist and WRP with necessary information to ensure continuity of care and to minimize the risk for individuals.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Update the staff psychiatrist manual to include requirements regarding content and quality of inter-unit transfer assessments. 2. 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. 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.
2	Psychological Assessments	
		<p>Methodology:</p> <p>Interviewed Dr. Swati Roy, Chief Psychologist. Interviewed Ms. Denise Bates, Human Resources Director. Interviewed Ms. Barbara Ortega, HR-Labor Relations Analyst. Interviewed Ms. Marie Liza Valdenor (HR T-1, HIMD). Interviewed Ms. Elizabeth Basalo (HR T-1, HIMD). Interviewed Dr. Edwin Poon, Psychologist. Interviewed Dr. Kirk Hartley, Psychologist. Interviewed Dr. Tulin Ozkaragoz, Psychologist. Interviewed Dr. Amy Choi, Psychologist.</p>

		<p>Interviewed Dr. Matthew Jorgensen, Psychologist. Interviewed Dr. Gordon Rose. Interviewed Dr. Larry Ledesma, Psychologist. Interviewed Dr. Patricia Gehr, Psychologist. Interviewed Dr. Walt Sullivan, Psychologist. Interviewed Dr. Cheryl Kempinski, Psychologist. Reviewed 48 charts of individuals (CR, RP, OT, SS, VR, CG, JT, DT, EM, MG, MB, MM, ML, MN, RR, DR, SR, FR, RT, HR, RS, PT, CT, KG, KR, KS, RH, NR, TP, DH, KR, SM, RM, SUM, JL, CG, LS, DT, FJ, SE, RR, CL, JE, JM, NV, ES, MJ and BR). Reviewed DMH WRP Manual (draft July 7, 2006). Reviewed DMH psychology monitoring form. Reviewed Psychology Staff Manual. Reviewed DSM-IV-TR Checklists. Reviewed database on psychologists verifying education, training, privileges, certification and licensure. Reviewed psychological and neurological assessments. Reviewed MSH behavior guidelines. Reviewed MSH self-assessment data. Reviewed hospital organizational chart. Reviewed PBS Technical Manual. Reviewed Clinical Services Review (CSR) Compliance Checklist for Qualitative Standards for Psychological Assessment. Reviewed MSH Hospital Inventory of Assessments.</p>
a	<p>Each State hospital shall develop and implement standard psychological assessment protocols, consistent with generally accepted professional standards of care. These protocols shall address, at a minimum, diagnostic neuropsychological assessments, cognitive assessments, and I.Q./achievement assessments, to guide psychoeducational (e.g., instruction regarding the illness or disorder, and the purpose or objectives of treatments for the same, including</p>	<p>Findings: MSH psychology department has compiled a psychology staff manual. The Chief Psychologist has revised the DMH Psychology Staff Manual (Revised Draft, August 2006). The manual now includes all the elements of the EP. This manual addresses policies and guidelines, privileging procedures, quality assessments, services and standard of practice and service delivery, and ethics. Psychologists reading this manual should understand how to achieve compliance with the EP.</p>

	<p>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>However, not all required elements are being fully implemented at this time, but the Chief of Psychology has plans to achieve compliance with the EP.</p> <p>Interviews with psychologists, chart reviews, and observations showed great inconsistency among psychologists in their understanding of the required elements, such as integrated assessments, clinically indicated assessments, diagnostic assessments, development and implementation of interventions in the PSR Malls, and monitoring of outcomes.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. 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. 2. Develop and implement practice based protocols for inclusion in the DMH draft manual (August 2006). 3. Conduct orientation to the new manual for current psychologists and all future hires.
b	<p>Each State hospital shall require the completion of cognitive and academic assessments within 30 days of admission of all school-age and other individuals, as required by law, unless comparable testing has been performed within one year of admission and is available to the interdisciplinary team.</p>	<p>Findings: MSH is very deficient in this criterion. Available data (MSH self-assessment, August 30th, 2006) shows that a small number of individuals admitted to the facility had their academic and cognitive assessments conducted within a year of their admission to MSH. Of the remaining, only two individuals had their cognitive assessments conducted within 30 days. All other individuals did not get their academic and cognitive assessments done within 30 days. The average</p>

		<p>time taken to conduct the assessments was 66 days. Further, the list of eligible individuals below the age of 22 is not complete. It appears that the list provided by the Information Systems is not accurate.</p> <p>Compliance: Non-compliance.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. 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. 2. Get an accurate count of the individuals eligible to have their academic and cognitive assessments conducted within 30 days 3. Develop and implement monitoring and tracking instruments to assess the key elements of this requirement.
c	<p>Each State hospital shall ensure that all clinicians responsible for performing or reviewing psychological assessments and evaluations are verifiably competent in the methodology required to conduct the assessment.</p>	<p>Findings: Credentialing files of all psychologists in MSH were reviewed. Ten of the psychologists, selected from the various groups and programs represented by the hospital were interviewed. A review of the credentialing list showed that all the psychologists in the department have the appropriate education and credentialing as defined by their job responsibilities. Although not all psychologists showed competency in the content of actual assessments, they showed competency in the methodology required for conducting the assessment.</p> <p>The chief of psychology has the authority to hire psychologists, however, the chief of psychology has no authority to determine the staff placement in the units that match their skills with the needs of the department. For example, if there is a need for psychologist with bilingual skills on the unit, the chief of psychology does not have any</p>

		<p>input into the hiring and WRT team assignment of such a professional that would best serve the department. In addition, the chief of psychologist is not included on annual reviews or on exit debriefings of psychologists.</p> <p>This is a gross deficiency of clinical supervision process that is a direct consequence of the matrix model used in DMH hospitals. Unless the chief of psychology has the authority to hire, fire, and assign psychologists to specific settings, and the authority to supervise, monitor and hold each psychologist accountable for their hours of work, and the content and quality of their work, it will be very difficult for the discipline to meet the requirements of the EP.</p> <p>Finally, the Chief of Psychology should be directly responsible for closely supervising the work of the senior psychologists who undertake the discipline-specific monitoring of assessments and interventions by unit psychologists. The senior psychologists must also provide mentoring based on the outcome of their monitoring. This mentoring by the senior psychologists should be supervised by the Chief of Psychology. [The same principle applies to all other disciplines].</p> <p>Compliance: Substantial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that the Chief of Psychology has the administrative authority for conducting annual reviews and exit debriefing of psychologists who resign their positions. 2. Ensure that Chief of Psychology is the primary person authorized to determine staffing needs and appropriate hiring for those needs. 3. Ensure that the Chief of Psychology has the administrative and
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		clinical authority for directly supervising the senior psychologists who monitor and mentor line psychologists in the implementation of the EP.
d	Each State hospital shall ensure that all psychological assessments, consistent with generally accepted professional standards of care, shall:	Compliance: Partial.
d.i	expressly state the clinical question(s) for the assessment;	<p>Findings: This monitor reviewed 34 psychological assessments (RH, TB ,KR ,KZ FL, KM, EW, PW, CG, DP, DY, PC, RB, LW, TS, MB, OS, EB, FL, BR, PW, JR, RP, RA, JS, CL, RA, SD, RD, BM, PC, CL, AA, CM.) Most of the reviewed psychological assessments were generally adequate, and contained statements regarding the reason for the referral. BM, for example, had pointed sentences clearly defining the statement, "...referred her for testing in order to obtain information about her cognitive and intellectual functioning as well as to assist with treatment planning" On the other hand, in 6 of the assessments reasons for referral/reason for assessment/referral question sections did not clearly specify the clinical question. For example, the assessment of RD, the reasons given included justification for PBS plans, and the contents sound more in line with what would be found in a background information section. Other psychological assessments, reviewed in the context of assessing WRPs, showed great variability in content and quality. Further, no assessments could be located in several charts.</p> <p>Most assessments failed to link summary and conclusions to specific interventions plans, or recommend individuals to available therapy groups within MSH.</p> <p>Other psychological assessments, reviewed in the context of assessing WRPs, showed a great variability in content and quality. A number of the assessments reviewed by the monitor were asked to be reviewed</p>

		<p>by MSH psychologists, and their conclusions on the quality of the reports were in agreement with the monitor's findings. Neuropsychological assessments were more consistent in their organization and presentation.</p> <p>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 conclusions to appropriate recommendations and therapies available within MSH. 3. Ensure that all psychological assessments meet at least generally acceptable professional standards.
d.ii	include findings specifically addressing the clinical question(s), but not limited to diagnoses and treatment recommendations;	<p>Findings: All psychological assessments reviewed, except for 3 (RH, RP and RD), met this requirement.</p> <p>Recommendation: Continue and improve on current practice.</p>
d.iii	Specify whether the individual would benefit from individual therapy or group therapy in addition to attendance at mall groups;	<p>Findings: The hospital's self-evaluation showed only 55% compliance on 64 focused assessments. My own findings corroborate the hospital's monitoring data. Interview with the Neuropsychologists revealed that some of them were unaware of the integration of assessments to services.</p> <p>Recommendation: Ensure that all psychological assessments specify whether the individual would benefit from individual therapy or group therapy.</p>

d.iv	be based on current, accurate, and complete data;	<p>Findings: The psychological assessments reviewed met this requirement.</p> <p>Recommendation: Continue and improve on current practice.</p>
d.v	determine whether behavioral supports or interventions (e.g., behavior guidelines or mini behavior plans) are warranted or whether a full positive behavior support plan is required;	<p>Findings: The hospital's self-assessment showed 52 % compliance on 23 focused assessments. The monitor's findings mirror the hospital's findings.</p> <p>Recommendation: Ensure that all psychological assessments of individuals with maladaptive behavior meet this requirement.</p>
d.vi	include the implications of the findings for interventions;	<p>Findings: The hospital's self-assessment (for the months of July and August showed 100% compliance on 24 focused assessments.</p> <p>The monitor's findings vary significantly from the hospital's findings. My review showed that 40% of assessments did not consistently specify the implications of the psychological findings and, often, the stated implications were not related to the type of groups that would be most appropriate for the psychological status of the individual. For example, RP's assessment does not contain results or interpretations sections, and recommendations do not address the referral question.</p> <p>Recommendation: Ensure that all focused psychological assessments include the implications of the findings for interventions, especially psychosocial rehabilitation.</p>

d.vii	<p>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>Findings: The hospital's self-assessment showed 94% compliance on 23 focused assessments.</p> <p>I found that 44% of the assessments reviewed did not sufficiently address issues that needed clarification or further testing.</p> <p>Recommendation: Ensure that all focused psychological assessments meet this requirement.</p>
d.viii	<p>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>	<p>Findings: All assessments reviewed, except for 1 (RA lacked any evidence-based tools for functional behavioral assessment (FBA), only used chart reviews and unstated format for interview, or tools used for observations), used appropriate assessment tools relevant to the individual's cognitive level and reading ability. It could not be determined from the charts and assessments if the testing was in accordance with the American Psychological Association Ethical Standards and Guidelines for testing.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Continue and improve upon current practice. 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>Findings: This monitor's review showed less than 50% compliance. For example, additional testing was recommended for KR but not conducted and follow up testing was recommended for KZ but not conducted. Assessments were conducted too early (TG, conducted on the day of admission; and CC, within 2 days of admission) or not conducted at all (SP, admitted on 7/25/06, therefore assessment would be due by</p>

		<p>8/2/06; however, it was not conducted as of 9/18/06).</p> <p>Recommendation: Ensure that psychological tests are completed in a timely manner, as specified in the EP.</p>
f	<p>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>	<p>Compliance: Partial.</p>
f.i	<p>before an individual's therapeutic and rehabilitation service plan is developed, a psychological assessment of the individual shall be performed that will:</p>	<p>Findings: The MSH self-assessment showed 80% compliance on this item in the last two months (March and April, 2006) that the charts were reviewed. My own chart reviews produced a similar result.</p> <p>Recommendation: Ensure that integrated psychological assessments are conducted in a timely manner as required.</p>
f.i.1	<p>address the nature of the individual's impairments to inform the psychiatric diagnosis; and</p>	<p>Findings: The MSH self-evaluation did not report any data on this criterion. Fewer than 3% of the charts I reviewed contained the Integrated Assessment that addressed the nature of the individual's impairments to inform the psychiatric diagnosis.</p> <p>Recommendation: Ensure that integrated psychological assessments address the nature</p>

		of the individual's impairments to inform the psychiatric diagnosis.
f.i.2	provide an accurate evaluation of the individual's psychological functioning to inform the therapeutic and rehabilitation service planning process;	<p>Findings: Review of the DMH Psychology Monitoring Form showed the evaluations were not performed on Integrated Assessments. My review of integrated assessments showed that less than 20% provided sufficient data on the individual's psychological functioning that would inform the WRP process. For example, TG's integrated assessment suggested follow up evaluation for IQ and cognitive screening, but there was no evidence that these were followed through.</p> <p>Recommendation: Ensure accurate evaluation of psychological functioning that informs that WRP team of the individual's rehabilitation service needs.</p>
f.ii	if behavioral interventions are indicated, a structural and functional assessment shall be performed, consistent with generally accepted professional standards of care, by a professional having demonstrated competency in positive behavior supports; and	<p>Findings: My review confirmed the hospital's self-evaluation data. Very few structural and functional assessments were evident in the charts reviewed when an individual had a learned maladaptive behavior. For example, assessments were indicated for KM, FL, HL, SS, TS, and CW but there was no evidence that these had been conducted.</p> <p>Recommendation: Ensure appropriate structured and functional assessments are undertaken by a qualified psychologist when an individual has learned maladaptive behavior.</p>
f.iii	additional psychological assessments shall be performed, as appropriate, where clinical information is otherwise insufficient, and to address unresolved clinical or diagnostic questions, including differential diagnosis, "rule-out," "deferred," "no-diagnosis" and "NOS" diagnoses.	<p>Findings: My review showed that unresolved clinical or diagnostic questions are rarely addressed by the psychological assessments. Most often there was no evidence of testing even when changes to diagnosis were made. For example, IS went from "deferred," to "rule out," to "no diagnosis"; CG had a "no diagnosis" on Axis II without any justification or follow up</p>

		<p>assessments, and 3 months of WRP planning was missing; KZ had a "rule out MR," yet the MR diagnosis has been in existence at least since 6/23/06.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that additional psychological assessments are performed, as appropriate, where clinical information is otherwise insufficient, and address unresolved clinical or diagnostic questions, including differential diagnosis, "rule-out," "deferred," "no-diagnosis," and "NOS" diagnoses. 2. Ensure that the facility's monitoring instrument that address "no diagnosis" are aligned with the key requirement, i.e. that "no diagnosis" is backed up by clinical data, especially in individuals with forensic issues.
g	<p>For individuals whose primary language is not English, each State hospital shall endeavor to assess them in their own language; if this is not possible, each State hospital will develop and implement a plan to meet the individuals' assessment needs, including, but not limited to the use of interpreters in the individual's primary language and dialect, if feasible.</p>	<p>Findings:</p> <p>The hospital produced a list containing names of 56 individuals whose primary/preferred language is other than English. However, it was learned that the list is incomplete. The list is pulled from the Clinical Information System and the system is said to be almost always incomplete. There is no system for identifying individuals whose primary or preferred language is not English and no plans are in place to improve the situation. Many members of the psychology staff are bilingual and can provide services in as many as 15 different languages. From the results of the staff survey on language usage for testing, at least 9 individuals' assessment has not been conducted due to non-availability of language services.</p> <p>Compliance:</p> <p>Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that examiners consider cultural aspects when choosing

		<p>assessment instruments with individuals whose preferred language is not English.</p> <p>2. Ensure that psychological assessments are provided in the individual's preferred language using interpreters.</p>
3	Nursing Assessments	
		<p>Methodology: Interviewed Anna Sobolewska, HSS, NPIC. Interviewed Aurora Hendricks, Coordinator of Nursing Services. Interviewed Kanya Sitanggang, RN, Psychiatric Nurse Education Director. Interviewed Mary Granado, RN, Nurse Coordinator. Toured unit 419 Skilled Nursing Facility Unit (SNF). Attended shift report for unit 419. Reviewed charts for RC, GW, BB, CL, GA, JS, CC, DG, AM, LW, EG, JC, HN, FG, AM, FA, SB, PC, RT, VK, AD, JP and HG. Interviewed Linda Gross, RN, Program Coordinator. Reviewed NP 101: Nursing Assessment And Plan Of Care. Reviewed NP 102: Nursing Assessment Guidelines. Reviewed Nursing Admission Assessment form # pending. Reviewed Admission Nursing Assessment Monitoring Form. Reviewed Admission Nursing Assessment Monitoring Instructions. Reviewed Admission Nursing Assessment Monitoring data for March-August, 2006. Reviewed Integrated Nursing Assessment Monitoring data for March-August, 2006. Reviewed Annual Nursing Assessment Monitoring Tool. Reviewed NP 216: Pain Assessment and Management. Reviewed Pain Management Audit tool. Reviewed Pain Scales. Reviewed Pain Screening, Assessment and Management tool. Reviewed Pain Assessment for initial assessment and unresolved episode of pain form.</p>

		<p>Reviewed Nursing Assessment Competency Validation tool.</p> <p>Reviewed Post Nursing Orientation and NAU Knowledge/Competencies data.</p> <p>Reviewed MSH Nursing Orientation Training by Course data for Nursing from 3/06 to 8/31/06.</p> <p>Reviewed 30 nursing/psychiatric technician personnel files.</p> <p>Interviewed Denise Betes, Human Resource Director.</p> <p>Interviewed Salud Follero, RN.</p> <p>Interviewed Jocelyn Agtarap, RN.</p> <p>Interviewed Renee Kelly, Program Director.</p> <p>Interviewed Linda Arenzana, RN.</p> <p>Observed dinner in the dining room for Program VI.</p>
a	Each State hospital shall develop standard nursing assessment protocols, consistent with generally accepted professional standards of care. These protocols shall address, at a minimum:	<p>Compliance: Partial.</p>
a.i	a description of presenting conditions;	<p>Findings: MSH has recently (August 2006) updated their nursing policies (NP 101 and 102) to include the key elements of a.i, a.ii, a.iii, a.iv, a.v, a.vi, a.vii, a.viii, & a.ix. However, my interviews with nursing staff indicated that these protocols were not consistently implemented and had only been recently updated. In addition, there was much confusion regarding the tracking, documentation, and monitoring process regarding the key elements in Nursing Services and Nursing Assessments. Nursing was unfamiliar with their data and the interpretation of the data regarding compliance with the EP. Much of the data that I reviewed for Nursing was incomplete and inaccurate.</p> <p>From my review, the Admission Nursing Assessment does not adequately address the description of presenting conditions, activities of daily living, and currently prescribed medications. In addition, the Admission Nursing Assessment Monitoring form does not specifically</p>

		<p>address these areas.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that nursing staff is competent in the protocols addressing this requirement. 2. Ensure that nursing staff adequately tracks, documents and monitors this requirement. 3. Revise the Admission Nursing Assessment to reflect this requirement. 4. Revise the Admission Nursing Assessment Monitoring form to adequately measure compliance with this requirement.
a.ii	current prescribed medications;	As above.
a.iii	vital signs;	As above.
a.iv	allergies;	As above.
a.v	pain;	As above.
a.vi	use of assistive devices;	As above.
a.vii	activities of daily living;	As above.
a.viii	immediate alerts (e.g., escape risk, physical assault, choking risk, suicidal risk, homicide risk, fall risk, sexual assault, self-injurious behavior, arson, or fire setting); and	As above.
a.ix	conditions needing immediate nursing interventions.	As above.
b	Nursing may use a systems model (e.g., Johnson Behavioral System Model) for the nursing evaluation.	<p>Findings:</p> <p>MSH has been using the Johnson Behavioral System Model (JBSM) for the nursing evaluation but it does not include recovery and</p>

		<p>rehabilitation concepts or language. NP 101 & 102 includes reference to the use of the JBSM. In addition, the Admission Nursing Assessment and the monthly, quarterly, and annual documentation in the interdisciplinary notes (IDN) is based on this model.</p> <p>From the monitor's review of both NSH and MSH, the use of a medical nursing model does not lend to the integration of nursing practice to the Wellness and Recovery Planning system. The current deficits in the nursing assessments, IDNs, and the ongoing use of nursing diagnoses are in conflict with the process of the Wellness and Recovery Model. Further, training of MSH nurses in some critical areas of nursing is conceptually out of date and not aligned with a psychiatric rehabilitation and recovery model of mental health service delivery.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Replace the Johnson Behavioral System Model with a psychiatric rehabilitation and recovery model for consistency. 2. Revise policies and procedures to include WRP language. 3. Revise Nursing Assessments, Integrated Nursing Assessments and documentation in the IDNs to reflect Wellness and Recovery principles. 4. Discontinue the use of nursing diagnoses. 5. Align current training of nurses with the psychiatric rehabilitation and recovery models used in the WRP system.
c	Each State hospital shall ensure that all nurses responsible for performing or reviewing nursing assessments are verifiably competent in performing the assessments for which they are responsible. All nurses who are employed at	<p>Findings: MSH reported 9% compliance in "Competency Validation" in assessments. It was reported that to verify competence, the nursing supervisor observes nurses while they are performing assessments in</p>

	<p>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>conjunction with chart review and monitoring reports. This process is conducted annually or as needed. The above percentage represents the competency results of one (1) RN.</p> <p>From this monitor's review, the Nursing Assessment Competency Validation tool does not adequately address the key element of competency in performing assessments. In addition, assessing competency in the assessment process for nurses annually is inadequate. Clearly, verifying competency has not been occurring on a regular basis since MSH data indicated that only 1 RN's assessment skills had been observed.</p> <p>This monitor's review of 30 nursing/psychiatric technicians personnel files indicated 100% compliance with having passed the NCLEX-RN and having a license to practice in the state of California.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a monitoring system to adequately address this requirement. 2. Initiate and document regular monitoring, at least quarterly, of nursing assessment competency.
d	<p>Each State hospital shall ensure that nursing assessments are undertaken on a timely basis, and in particular, that:</p>	<p>Compliance: Partial.</p>
d.i	<p>Initial nursing assessments are completed within 24 hours of the individual's admission;</p>	<p>Findings: MSH reported a total of 97.4% compliance with this requirement for the time period including March-August, 2006.</p> <p>From review of MSH data, there were inconsistencies regarding the</p>

		<p>number of charts reviewed each month from March - August 2006. The data sheet reporting the item "Identifiers" indicated that a total of 38 charts were reviewed during this timeframe. From my interview with nursing, I was told that the number of charts reviewed from March - August were 88, 89, 85, 81, 105, 153, respectively. The information contained on the self-assessment report stated that "The number and frequency of chart reviews were at least 10% of total charts for each program, each month."</p> <p>Chart reviews by this monitor demonstrated that 8 charts out of 32 were not in compliance with this key element.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Review data to ensure accuracy in reporting. 2. Ensure that Initial nursing assessments are completed within 24 hours of each individual's admission;
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>Findings:</p> <p>Data reported from MSH indicated a total of 80.5% with this requirement for the time period of March-August, 2006,</p> <p>The MSH Integrated Nursing Assessment Monitoring data did not include the number of charts reviewed per month. From this monitor's review of 32 charts, 12 were not in compliance.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Include total number of charts reviewed per month in the monitoring data. 2. Ensure that further nursing assessments are completed and integrated into the individual's WRP within seven days of admission.

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>Findings: MSH reported 82% compliance that nursing assessments were completed annually.</p> <p>The data reported by MSH does not reflect the key elements of this requirement. In addition, the Annual Nursing Monitoring Tool indicator I., only addresses if the "nursing assessment was complete, signed, and dated (with time of assessment)".</p> <p>Recommendations: Develop and implement a monitoring system to address the key elements of this requirement.</p>
<p>4 Rehabilitation Therapy Assessments</p>		
		<p>Methodology: Interviewed Mari Cobb, Chief of Rehabilitation Services. Interviewed Joellen Arce, RN. Interviewed Rommel Dizon, DPT. Interviewed Meseret Seyoum, OT. Interviewed Edward Arguijo, SLP. Reviewed Occupational Therapy Manual. Reviewed Table of Organization for Committee Structure. Reviewed Executive Branch Organization Chart. Reviewed Organizational Chart for Clinical Services. Reviewed Organizational Chart for Administrative/Support Services. Reviewed Organizational Chart for Medical Services Department. Reviewed Speech Pathology Manual. Reviewed MSH Rehabilitation Services Manual. Reviewed Physical Therapy Manual. Reviewed Integrated Rehabilitation Therapy Assessments. Reviewed Comprehensive Evaluation in Recreational Therapy (CERT). Reviewed AD Required Time Frame for Patient Record Documentation.</p>

		<p>Reviewed Rehabilitation Therapy Documentation Audit. Reviewed list of individuals with adaptive equipment. Reviewed list of individuals at risk for choking. Reviewed list of individuals at risk for dysphagia and aspiration. Reviewed list of individuals with hearing aids. Observed individuals in wheelchairs on units 418 and 419. Observed mealtime for Program I. Reviewed OT and PT caseloads. Reviewed OT, PT, and Speech assessments. Reviewed bed bound client charts. Received report on individuals during walking rounds on unit 418 and 419.</p>
a	<p>Each State hospital shall develop standard rehabilitation therapy assessment protocols, consistent with generally accepted professional standards of care, for satisfying the necessary components of a comprehensive rehabilitation therapy assessment.</p>	<p>Findings: From this monitor's review, the Rehabilitation Therapy assessment did not include components to trigger an OT, PT and/or Speech Therapy referral when appropriate. In addition, OT, PT, and Speech Therapy are essentially not included under Rehabilitation Services. These therapy specialties are separated under medical and do not have integration with the Rehabilitation Department.</p> <p>In addition, the Occupational Therapy Manual, Speech Pathology Manual and the Physical Therapy Manual need to be reviewed for consistency with psychiatric rehabilitation and recovery model of service delivery.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Integrate OT, PT, and Speech Therapy into the Rehabilitation Therapy Services. 2. Revise the Comprehensive Rehabilitation Assessment to include

		<p>functional abilities that would indicate a need for OT, PT and/or Speech Therapy.</p> <ol style="list-style-type: none"> 3. Revise, update, and implement policies, procedures, operations manuals and ADs to address this requirement. 4. Develop and implement a monitoring system to address the key elements of this requirement. 5. Review and revise OT, PT, and Speech Pathology Manuals to include Wellness and Recovery language.
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>Findings: MSH data did not reflect the key elements in this requirement and was unable to be interpreted regarding compliance.</p> <p>From my review, the current Rehabilitation Assessment tool does not provide an accurate and comprehensive assessment as to the individual's functional abilities, functional status, or life goals, strengths, and motivation for engaging in wellness activities related to these areas. As mentioned above, the Rehabilitation Assessment does not include indicators related to OT, PT, and Speech Therapy to trigger a referral to these therapies if needed. Referrals to these therapies are obtained only through a physician's order and usually based only on an acute event, such as a fracture. There is no system in place to proactively identify individuals with OT, PT, and/or Speech Therapy needs. Assessments conducted by OT, PT, and Speech Therapy are not integrated into the MSH's Rehabilitation Assessments or the individual WRPs.</p> <p>Also, from this monitor's observations of individuals on units 418 and 419 as well as from review of the rehabilitation assessments, there are several individuals who have significant unmet rehabilitation needs in</p>

		<p>the areas of OT, PT, and Speech Therapy regarding dysphagia, positioning, mobility and wheelchairs. The needs include interventions that are sufficient to promote appropriate body alignment.</p> <p>In addition, there is no system in place to monitor, track, document, and provide on-going services to individuals who have significant vision and hearing problems and the need for augmentative/adaptive communication devices.</p> <p>From this monitor's observations of adaptive equipment and wheelchairs on units 418 and 419, all of the equipment I observed was in need of significant cleaning.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Revise appropriate policies, procedures and manuals to be aligned with this requirement. 2. Train RT staff regarding changes implemented. 3. Develop and implement a system for monitoring and tracking the key elements of this requirement. 4. Include indicators related to OT, PT, and Speech Therapy in the Rehabilitation Assessments to trigger referrals to these therapy specialties. 5. Identify, assess, develop and implement proactive interventions for individuals with OT, PT, and/or Speech Therapy needs. 6. Integrate OT, PT, and Speech Therapy assessments and interventions into the individual WRPs. 7. Assess and develop 24-hour, proactive interventions for individuals at-risk and high-risk for choking and aspiration. 8. Provide on-going training to all team members regarding dysphagia. 9. Assess the mobility needs and fabricating individual wheelchairs that promote appropriate body alignment for individuals who depend on the use of wheelchairs for the
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		<p>majority of their mobility.</p> <ol style="list-style-type: none"> 10. Streamline the process of obtaining adaptive equipment. 11. Provide and document training to individuals and staff regarding the appropriate use of adaptive equipment. 12. 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. 13. Re-evaluate the adaptive equipment at least annually or in response to individuals' status changes to ensure that it is meeting the individuals' needs. 14. Develop and implement a system to identify, assess, monitor, track, document, and provide on-going services to individuals who have significant vision and hearing problems and the need for augmentative/adaptive communication devices. 15. Provide augmentative/adaptive communication devices for individuals with communications issues. 16. Develop and implement a system to 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 supports needed to facilitate transfer to the next level of care; and	As above.
b.iii	Identifies the individual's life goals, strengths, and motivation for engaging in wellness activities.	As above.
c	Each State hospital shall ensure that all clinicians responsible for performing or reviewing rehabilitation therapy assessments are verifiably competent in performing the assessments for which they are responsible	<p>Findings: MSH reported 100% with pre-hiring credentialing, 100% with orientation and training, 70% with monthly monitoring of staff, and 100% with annual performance evaluations.</p> <p>However, OT, PT, and Speech Therapy were not included in the data for this requirement. In addition, there is no system in place to ensure that these specialty therapies are verifiably competent in performing</p>

		<p>the assessments for which they are responsible. Also, there is no system in place to monitor the key elements of this requirement.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a system to 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>Findings: MSH reported 80% compliance with this requirement. The data indicated that there were 180 rehabilitation therapy assessments yet to be completed.</p> <p>As mentioned above, the current Rehabilitation Assessment tool does not provide an accurate and comprehensive assessment.</p> <p>Compliance: Partial.</p> <p>Recommendations: See recommendations in section 4a.</p>

5	Nutrition Assessments	
	<p>Each State hospital shall provide nutrition assessments, reassessments, and interventions consistent with generally accepted professional standards of care. A comprehensive nutrition assessment will include the following:</p>	<p>Methodology: Interviewed Mary Christine Marshall, Director of Dietetics. Reviewed Nutrition Care Monitoring Tool (NCMT). Reviewed Nutrition Care Process (NCP). Reviewed Department of Dietetics Policy and Procedure Manual. Reviewed Nutrition Status Type (NST) acuity and indicators form. Reviewed Nutritional Screening/High Risk Patients policy. Reviewed Indicators For Nutritionally High Risk Patients. Reviewed AD Patient Meal Service and Nutritional Care. Reviewed Nursing Policy (NP) Height/Weight/BMI/Waist Circumference. Reviewed NP Dysphagia/Choking Assessment. Reviewed NP Foreign Body Airway Obstruction/Choking Management. Reviewed list of residents with dysphagia. Reviewed AD Wellness and Recovery. Reviewed Guidelines For The Nutritional Management Of Patients At Risk of Choking And/Or Aspiration/Aspiration Pneumonia. Reviewed Dysphagia/Choking Screening. Reviewed Dysphagia Program. Reviewed MSH Individual Training Reports. Reviewed MSH Professional Education Training/Nursing Education. Reviewed Enteral Nutrition Support policy. Reviewed dietary data provided by MSH.</p>
a	<p>For new admissions with high risk referral (e.g., type I diabetes mellitus, enteral/parenteral feeding, dysphagia/recent choking episode), or upon request by physician, a comprehensive Admission Nutrition Assessment will be completed within 24 hours of notification to the dietitian.</p>	<p>Findings: The MSH data indicated 86% compliance with this requirement. The data were reported to represent the time frame from June -August 2006. This compliance percentage was based on a total of 8 individuals who met this criterion.</p> <p>At the time of this review, there were no additional individuals that met this criterion to review based on information provided by the</p>

		<p>facility.</p> <p>Compliance: Partial.</p> <p>Recommendations: Develop and implement a high-risk referral monitoring and tracking system to identify individuals who meet this criterion to ensure that they receive adequate and timely nutrition assessments.</p>
b	For new admissions directly into the medical-surgical unit, a comprehensive Admission Nutrition Assessment will be completed within 3 days of admission.	<p>Findings: MSH does not have a medical-surgical unit.</p> <p>Compliance: Not Applicable.</p> <p>Recommendations: Not Applicable.</p>
c	For new admissions directly into the skilled nursing facility unit, a comprehensive Admission Nutrition Assessment will be completed within 7 days of admission.	<p>Findings: MSH data indicated 93% compliance from January 2005-April 2006. The total number of individuals who met this criterion was not reported with the data.</p> <p>At the time of this review, there were no additional individuals that met this criterion to review based on information obtained from the facility.</p> <p>Compliance: Partial.</p> <p>Recommendations: Ensure that new admissions directly admitted into the skilled nursing</p>

		facility unit have a comprehensive Admission Nutrition Assessment completed within 7 days of admission.
d	For new admissions with identified nutritional triggers from Nursing Admission Assessment or physician's consult (e.g., for severe food allergies, tube feeding, extensive dental problems or dental surgery, NPO/clear liquid diet for more than three days, uncontrolled diarrhea/vomiting more than 24hrs, and MAOI, as clinically indicated), a comprehensive Admission Nutrition Assessment will be completed within 7 days of admission.	<p>Findings: MSH reported 100% compliance with the key elements of this requirement. The data were reported to represent the time frame from June -August 2006. However, "NA" was marked for all July data indicators. This compliance percentage was based on a total of 5 individuals who met this criterion.</p> <p>From this monitor's review, I found 3 out of 3 charts in compliance with this requirement. However, I noted that there were problems with the quality of the Admission Assessments in the areas of nutrition education, response to Management and Nutrition treatment (MNT), nutrition goals, and appropriate and complete recommendations.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. 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. 2. Ensure staff competency regarding deficiencies and appropriate procedures for Admission Nutrition Assessments.
e	For new admissions with therapeutic diet orders for medical reasons, a comprehensive Admission Nutrition Assessment will be completed within 7 days of admission.	<p>Findings: MSH reported 100% compliance for the months of July and August, 2006 for a total of 5 individuals who met these criteria. The specific</p>

		<p>methodology for the August data was not included in the facility data.</p> <p>From this monitor's review, the quality of the Admission Nutrition Assessments was inadequate in the areas of nutrition diagnosis, nutrition education, and complete and appropriate recommendations.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that new admissions with therapeutic diet orders for medical reasons receive a comprehensive Admission Nutrition Assessment. 2. Ensure staff competency regarding deficiencies and appropriate procedures for Admission Nutrition Assessments.
f	<p>For individuals with therapeutic diet orders for medical reason after admission, a comprehensive Admission Nutrition Assessment will be completed within 7 days of the therapeutic diet order but no later than 30 days of admission.</p>	<p>Findings: MSH reported "The current practice at MSH Department of Dietetics is to complete nutrition assessments on all patients within 5 days of admission. Thus, diet changes after completion of nutrition assessment on the 5th day are addressed via diet confirmation process."</p> <p>Compliance: Non-compliance.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Complete nutritional assessments within the timeframes indicated in the EP to ensure proper integration of data regarding changes that may occur after the fifth day of admission. 2. Develop and implement monitoring system to ensure compliance with this requirement.

g	For all other individuals, a comprehensive Admission Nutrition Assessment will be completed within 30 days of admission.	<p>Findings: MSH reported 100% compliance with this requirement. A total of 33 charts were reviewed. This monitor found 5 out of 5 Admission Nutrition Assessments were in compliance with this requirement.</p> <p>From this monitor's review, the quality of the Admission Nutrition Assessments was inadequate in the areas of nutrition diagnoses, response to MNT, nutrition goals, There were noted to be a number of appropriate and complete recommendations.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Continue to monitor Admission Nutrition Assessments to ensure that they are completed in a timely manner. 2. Ensure staff competency regarding deficiencies and appropriate procedures for Admission Nutrition Assessments.
h	Acuity level of an individual at nutritional risk will be determined by Nutritional Status Type ("NST") which defines minimum services provided by a registered dietitian.	<p>Findings: The information provided by MSH indicated inconsistent data. The Nutrition Assessment Compliance Report for June/July/August 2006 was noted as "NA" for this item. However, MSH's self-assessment reported 100% compliance with this requirement.</p> <p>From this monitor's review of 10 Admission Nutrition Assessments, all 10 had the NST recorded by the dietitian.</p> <p>Compliance: Partial.</p>

		<p>Recommendations:</p> <ol style="list-style-type: none"> Utilize the NCMT, item 12 to determine compliance with the key element of this requirement. Provide consistent data findings.
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>Findings: The current NCMT does not address all the key elements included in this requirement.</p> <p>Compliance: Partial.</p> <p>Recommendations: Develop and implement tracking and monitoring systems related to the key elements of this requirement.</p>
j.i	<p>Individuals will be reassessed when there is a significant change in condition.</p>	<p>Findings: The Current NCMT does not adequately identify items pertinent to this population. MSH reported data only specific to 2 individuals who were non-administrative transfers to skilled nursing facility. However, this does not adequately capture other individuals who have had a significant change in condition.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> Develop and implement a system to ensure that individuals who have a significant change in condition will be reassessed. Develop and implement monitoring system to ensure that these individuals are adequately reassessed in a timely manner. Provide training on components of an adequate assessment for

		changes in conditions.
j.ii	Every individual will be assessed annually.	<p>Findings: MSH reported 95% compliance with the key element of this requirement.</p> <p>From this monitor's review of 10 annually nutrition assessments, 9 out of 10 were found in compliance. However, the quality of the annual Nutrition Assessments was inadequate in the areas of nutrition diagnoses, nutrition education, response to MNT, nutrition goals, and complete and appropriate recommendations.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Continue monitoring and tracking the key element of this requirement. 2. Ensure staff competency regarding deficiencies and appropriate procedures for annual Nutrition Assessments.
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: Interviewed Susie Chen, LCSW, Acting Chief of Social Work Department. Interview one Staff Psychiatrist. Reviewed charts of twelve individuals (LS, DT, FJ, SE, RR, CL, JE, JM, NV, ES, MJ and BR). Reviewed Social Work Integrated 5 day Monitoring Form. Reviewed Integrated Social Work Assessment Monitoring Form. Reviewed Social Work 30-Day Psychosocial Assessment Monitoring Form. Reviewed Social Work Annual Assessment Monitoring Form. Reviewed Social Work Progress Note Monitoring Form.</p>

		Observed WRP team meetings.
a	Is, to the extent reasonably possible, accurate, current and comprehensive;	<p>Findings: Most Social History Assessments have been conducted in a timely manner. There was a range from 85% to 95% on the timeliness of the social histories. Initial assessment was at 95% overall compliance. Annual assessment was at 90% overall compliance, for the period from 2/06 to 7/06; Annual assessment was at 88% compliance for the period from 7/1/06 to 7/31/06. My chart reviews corroborated the facility data. Self assessment data were focused on timeliness and not on the content (i.e., completeness) and quality of the report. The quality indicators are vague and do not adequately address required elements. A number of charts were reviewed with Ms. Susie Chen and she agreed with the Monitor that the quality of the notes and assessments needs much improvement.</p> <p>Compliance: Partial.</p> <p>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>Findings: Factual inconsistencies affect all aspects of the individual's services. As such, they should be carefully reviewed and resolved at the earliest possible time.</p> <p>This item was not addressed by MSH self-evaluation. Factual</p>

		<p>inconsistencies were not evident in the 6 social histories reviewed by the monitor.</p> <p>Compliance: Partial.</p> <p>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	<p>Is included in the 7-day integrated assessment and fully documented by the 30th day of an individual's admission; and</p>	<p>Findings: According to Ms. Susie Chen this item is monitored through the WRP audits, but no data were presented.</p> <p>One of the five charts reviewed with Ms. Susie Chen was deficient in the 30-day evaluation.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure all SW Integrated assessments are completed and available to the WRP team before the 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	<p>Reliably informs the individual's interdisciplinary team about the individual's relevant social factors and educational status.</p>	<p>Findings: The hospital's self-assessment showed a compliance rate of 55% on this criterion. This monitor's review showed about 60% compliance but the quality of the evaluations varied within and between social workers.</p>

			<p>In some cases, social and educational information was not available from the individual's previous placement.</p> <p>In one case, a DCAT team member provided the social information to the team.</p> <p>Compliance: Partial.</p> <p>Recommendation: Ensure that social histories reliably inform the individual's WRP team about the individual's relevant social factors and educational status.</p>
7	Court Assessments		
			<p>Methodology: Interviewed Jasmine Wynn, M.D., Chair, Forensic Review Panel. Interviewed Donna Gillard., Program Director, Program V and member of the FRP. Reviewed charts of five individuals admitted under PC 1026 (BM, RA, MT, DS and EL). Reviewed charts of five individuals admitted under PC 1370 (DLL, JMS, GG, SH and CJC). Reviewed AD (#3462) regarding forensic admissions. Reviewed memorandum from the chair of the FRP to program directors, psychiatrists and social workers regarding court report monitoring. Reviewed court reports monitoring form for PC 1026 Reviewed court reports form for PC 1370. Reviewed minutes of the FRP meetings between January 18, 2005 and August 2, 2006.</p>

a	Each State hospital shall develop and implement policies and procedures to ensure an interdisciplinary approach to the development of court submissions for individuals adjudicated "not guilty by reason of insanity" ("NGI") pursuant to Penal Code Section 1026, based on accurate information, and individualized risk assessments. The forensic reports should include the following, as clinically indicated:	<p>Compliance: Partial.</p>
a.i	clinical progress and achievement of stabilization of signs and symptoms of mental illness that were the cause, or contributing factor in the commission of the crime (i.e., instant offense);	<p>Findings: MSH has an AD (# 3462) regarding the care of individuals adjudicated NGRI and admitted under PC 1026. The AD describes the process of referral to CONREP, but does not address the specific requirements in the EP regarding WRP team assessments and court submissions. The facility has developed a monitoring form that is aligned with the criteria in items D.7.a.i through D.7.a.ix. Although this tool has already been implemented at other facilities (e.g. NSH), MSH has yet to implement the tool or have any other mechanism to monitor compliance with plan provisions in this section. At this time, the facility's forensic review panel (FRP) does provide any systematic review of court submissions by the WRP teams regarding the status of these individuals. The FRP reviews only those submissions that involve referrals to CONREP.</p> <p>To assess compliance with all provisions in section D.7.a., this monitor reviewed the charts of five individuals adjudicated NGRI. The chair of the FRP (Dr. Wynn) participated in these reviews and concurred with all of the monitor's findings. In reviewing item 7.a.i, this monitor found non-compliance in all cases (BM, RA, MT, DS and EL).</p> <p>Recommendation:</p> <ol style="list-style-type: none"> 1. Ensure that the facility's AD codifies all plan requirements regarding the content of 1026 court submissions. 2. Implement an internal monitoring process utilizing the current

		<p>tool.</p> <p>3. Ensure that the FRP reviews all PC 1026 reports and provide feedback to the WRP teams to achieve compliance.</p>
a.ii	acts of both verbal and physical aggression and property destruction during the past year of hospitalization and, if relevant, past acts of aggression and dangerous criminal behavior;	<p>Findings: This monitor's reviews indicate non-compliance in the charts of BM, MT and DS, and substantial compliance in the charts of RA and EL.</p> <p>Recommendation: Same as above.</p>
a.iii	understanding of potential for danger and precursors of dangerous/criminal behavior, including instant offense;	<p>Findings: This monitor found that most reports (BM, RA and DS) do not address this criterion. There is evidence of partial compliance in the charts of MT and EL.</p> <p>Recommendation: Same as above.</p>
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>Findings: Reviews by this monitor demonstrate non-compliance in one chart (BM) and partial compliance in four (RA, MT, DS and EL).</p> <p>Recommendation: Same as above.</p>
a.v	development of relapse prevention plan (i.e., Personal Wellness Recovery Plan or Wellness Recovery Action Plan) for mental illness symptoms, including the individual's recognition of precursors and warning signs and symptoms and precursors for dangerous acts;	<p>Findings: Reviews by this monitor show non-compliance in two charts (DS and EL) and partial compliance two (BM and MT). This item is not applicable to the case of RA.</p> <p>Recommendation: Same as above.</p>

a.vi	willingness to achieve understanding of substance abuse issues and to develop an effective relapse prevention plan (as defined above);	<p>Findings: In the charts of RA and DS, there is evidence of partial compliance and the item is not applicable to the other three cases.</p> <p>Recommendation: Same as above.</p>
a.vii	previous community releases, if the individual has had previous CONREP revocations;	<p>Findings: This item is applicable only to the case of MT, which demonstrates partial compliance.</p> <p>Recommendation: Same as above.</p>
a.viii	social support, financial resources, family conflicts, cultural marginalization, and history of sexual and emotional abuse, if applicable; and	<p>Findings: This monitor found non-compliance in all five charts reviewed.</p> <p>Recommendation: Same as above.</p>
a.ix	relevant medical issues, all self-harm behaviors, risks for self harm and risk of harm to others, to inform the courts and the facility where the individual will be housed after discharge.	<p>Findings: Chart reviews demonstrate non-compliance in four charts (BM, MT, DS and EL) and compliance in the case of RA</p> <p>Recommendation: Same as above.</p>
b	Each State hospital shall develop and implement policies and procedures to ensure an interdisciplinary approach to the development of court submissions for individuals admitted to the hospital pursuant to Penal Code Section 1370, "incompetent to stand trial" ("IST"), based on	<p>Compliance: Partial.</p>

	<p>accurate information and individualized risk assessments. Consistent with the right of an individual accused of a crime to a speedy trial, the focus of the IST hospitalization shall be the stabilization of the symptoms of mental illness so as to enable the individual to understand the legal proceedings and to assist his or her attorney in the preparation of the defense. The forensic reports should include the following:</p>	
b.i	<p>relevant clinical description of initial presentation, if available, which caused the individual to be deemed incompetent to stand trial by the court;</p>	<p>Findings: The facility's AD does not address the specific requirements in the EP regarding WRP team assessments and court submissions for individuals admitted under PC 1370. The facility has developed a monitoring form that is aligned with the criteria in items D.7.b.a.i through D.7. b.iv. This monitoring tool has already been implemented at other facilities (e.g. NSH). However, MSH has yet to implement the tool or have any other mechanism to monitor compliance with plan provisions in this section. At this time, the facility's PRP does not review court submissions by the WRP teams regarding the status of these individuals.</p> <p>To assess compliance with all provisions in section D.7.b, this monitor reviewed the charts of five individuals admitted under PC 1370 (DLL, JMS, GG, SH and CJC). The chair of the FRP (Dr. Wynn) participated in these reviews and concurred with all of the monitor's findings. In reviewing item D.7.b.i this monitor found partial compliance in the charts of GG, SH and CJC, and compliance in the charts of DLL and JMS.</p> <p>Recommendation: 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>Findings: This monitor found non-compliance in four charts (DLL, JMS, SH and</p>

		<p>JCJ) and partial compliance in one (GG).</p> <p>Recommendation: Same as above.</p>
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>Findings: Chart reviews by this monitor indicate that the court submissions in most charts (DLL, GLG, JMS and JCJ) are in compliance with this item. There is partial compliance in one chart (SH).</p> <p>Recommendation: Same as above.</p>
b.iv	<p>all self-harm behaviors and relevant medical issues, to inform the courts and the facility where the individual will be housed after discharge.</p>	<p>Findings: The reviews demonstrate non-compliance in the charts of DLL, JMS and SH. There is evidence of partial compliance in the charts of GG and JCJ.</p> <p>Recommendation: Same as above.</p>
c	<p>Each State hospital shall establish a Forensic Review Panel (FRP) to serve as the internal body that reviews and provides oversight of facility practices and procedures regarding the forensic status of all individuals admitted pursuant to Penal Code 1026 and 1370. The FRP shall review and approve all forensic court submissions by the Wellness and Recovery Teams and ensure that individuals receive timely and adequate assessments by the teams to evaluate changes in their psychiatric condition, behavior and/or risk factors that may warrant modifications in their forensic status and/or level of restriction</p>	<p>Findings: MSH established an FRP in January 2005. The facility has yet to have a procedure that specifies the duties and responsibilities of the panel. The FRP currently reviews all referrals to CONREP if the team decides that the individual is ready for community treatment. The chair of the FRP states that, on average, the panel reviews three referrals monthly. The review involves a discussion between members of the panel and the WRP team. Recommendations are provided to the WRP teams to clarify aspects of clinical care and to ensure the "objectivity" of the team's assessments. At this time, the panel does not provide routine review of all 1026 or any review of 1370. In a personal interview, the chair of the panel cited other job responsibilities as the main reason</p>

		<p>for this deficiency.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a procedure that specifies the duties and responsibilities of the FRP. 2. 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.
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>Findings: The FRP has adequate membership structure. The core members include the clinical disciplines of psychiatry, psychology, rehabilitation therapy, social work and nursing. The chair of the panel is a board-certified forensic psychiatrist.</p> <p>Compliance: Substantial.</p> <p>Recommendation: Continue current practice and ensure that the panel performs its specified duties and responsibilities.</p>

E	Discharge Planning and Community Integration	
		<p>Summary of Progress:</p> <ol style="list-style-type: none"> 1. MHS has correctly recognized that discharge planning focus begins from the individual's first day of admission. 2. Social workers are provided training in the discharge process. 3. MSH has adopted the WRP as an essential tool towards addressing the individual's rehabilitation needs and preparation of the individual for discharge and community integration.
	<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>Observed WRP team meetings to review four individuals (AL, KL, BM and AC).</p> <p>Interviewed Susie Chen, LCSW, Acting Chief of Social Work Department.</p> <p>Interviewed one Staff Psychiatrist.</p> <p>Reviewed charts of 12 individuals (LS, DT, FJ, SE, RR, CL, JE, JM, NV, ES, MJ and BR).</p> <p>Reviewed WRP Chart Audit Form.</p> <p>Reviewed WRP Chart Audit Data Summary.</p> <p>Reviewed Program I policy # 208 regarding discharge/length of stay.</p> <p>Reviewed documentation of individuals who met discharge criteria but are still in the hospital.</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>Findings:</p> <p>Data from the WRP Chart Audits showed severe deficiency on this objective—achieving less than 20% compliance on issues dealing with quality of the reports, expectations of the individual's performance for discharge, and identification of the placement setting. None of the charts reviewed by the monitor met all required elements for any individual. For example, LS had discharge criteria, but had no matching objective and interventions; DT had discharge criteria, but his objectives and interventions did not match, and his Social Work</p>

		<p>progress note was not integrated into his WRP. All charts reviewed were almost exactly the same.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Achieve continuity of the discharge process from admission to discharge through the WRP and WRP team process. 2. Involve the individual in the discharge process through discussion of discharge criteria and how to meet them by attending relevant PSR Mall groups, individual therapy (as needed), and by practicing newly acquired skills in the therapeutic milieu. 3. Social workers must review discharge status with the WRP team and the individual at all scheduled WRP conferences involving the individual.
1a	those factors that likely would foster successful discharge, including the individual's strengths, preferences, and personal life goals;	<p>Findings: The hospital's WRP Chart Audit data on item # 23 dealing with individual's strengths evidenced only 14% compliance with this objective. The charts reviewed by the monitor failed to meet one or more criteria (e.g., addressing the individual's life goals, strengths, and preferences) of this objective. For example, JM's objective and intervention were not aligned with the discharge criteria; in JM's WRP, there was no link between discharge criteria and objectives and interventions; and CO did not have clearly defined discharge criteria. There were no WRPs in the chart of NV.</p> <p>Compliance: Partial.</p>

		<p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that the individual's strengths and preferences are utilized to achieve discharge goals. These should be linked to the interventions that impact the individual's discharge criteria. 2. The individual's life goals should be linked to one or more focus of hospitalization, with associated objectives and interventions.
1b	the individual's level of psychosocial functioning;	<p>Findings: According to Ms. Susie Chen, Acting Chief of Social Work, there is no monitoring tool to assess this item. Only one of the four WRP teams observed discussed and/or adjusted GAF scores during the WRP meeting. None of the individuals participating in their WRP meeting had any involvement in their GAF. MSH summary data on this item had 37% compliance. None of the charts reviewed included appropriate updates of the functional status (i.e. progress on assigned groups and individual therapies) in the Present Status section of the case formulation.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that the level of psychosocial functioning (functional status) is included in the individual's present status section of the case formulation section of the WRP. 2. Use the DMH WRP Manual in developing and updating the case formulation.
1c	any barriers preventing the individual from transitioning to a more integrated environment, especially difficulties raised in previously unsuccessful placements; and	<p>Findings: This item is very deficient. While many of the charts mentioned problems that may exist for discharge, none of the charts I reviewed detailed barriers to transitioning the individual to a more integrated</p>

		<p>environment or the difficulties raised in previously unsuccessful placements. My findings are significantly different from MSH's self-assessment data. Barriers are generally mentioned in Social Work notes (example MM, IR).</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that discharge barriers, especially difficulties in previously unsuccessful placements, are discussed with the individual at scheduled WRP conferences. 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>Findings: Review of MSP's WRP Chart Audit data dealing with an individual's discharge criteria, expectations, and identification of the next setting showed nearly 58% of the WRP 7-day observations and WRP Quarterly observation as providing some indication of the individual's support requirement. However, there is a lack of attention given to the individual's necessary skills. Often, the emphasis and requirement is for the individual to eliminate a behavior rather than acquisition of a skill.</p> <p>The skills and setting issues are not regularly updated during the WRP conferences or into the WRPs.</p> <p>Compliance: Partial.</p>

		<p>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>Findings:</p> <p>The WRP conferences that this monitor attended (e.g., AL, DR, and AC) indicated that the teams at some point addressed this objective with the individual. However, more often than not, the objective was not fully explicated before moving on to the next item/agenda/topic. Many times there were digressions either by the individual and or the team. The process of WRP outlined in the DMH WRP Manual was not followed and the individuals in the observed WRP conferences left without discussing fully their current discharge status and what they should be doing to hasten their discharge to the next level of care. It may be helpful both for the team and the individual if the discharge issues are specifically reviewed at the end of the meeting so that the last thing the individual hears, as a summation, is his/her discharge issues.</p> <p>The hospital's data on this objective using their WRP Process Observation form regarding an individual's participation in his or her discharge planning showed high percentages (ranging from 60%-93%). From the monitor's chart reviews and a small number of WRP meetings, this appears to be a very generous and unreliable finding.</p> <p>Compliance: Partial.</p>

		<p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that the individual is an active participant in the discharge planning process. 2. Implement the DMH WRP Manual on discharge process. 3. Prioritize objectives and interventions related to the discharge processes.
3	Each State hospital shall ensure that, consistent with generally accepted professional standards of care, each individual has a professionally developed discharge plan that is integrated within the individual's therapeutic and rehabilitation service plan, that addresses his or her particular discharge considerations, and that includes:	<p>Findings:</p> <p>The hospital's self-assessment chart audits showed only 25% compliance on this criterion. As mentioned earlier, the hospital is focused on discharge planning from the individual's first day of admission. However, this is not evident in the individuals' charts. MSH's Social Service Department's procedures emphasize the need for proper documentation of discharge planning processes. However, its documentation is a significant deficiency at MSH. Almost all of the charts reviewed with Ms. Susie Chen, Acting Chief of Social Work, were found to be deficient on some of the required elements.</p> <p>Recommendation:</p> <p>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>
3a	measurable interventions regarding these discharge considerations;	<p>Findings:</p> <p>MSH's self-assessment using the WRP chart audit form indicate a 25% compliance in documenting individual discharge plans written in behavioral terms specifying expected behaviors, achievement, and identification of next placement. This monitor's chart reviews confirm this deficiency.</p> <p>Compliance:</p> <p>Partial.</p>

		<p>Recommendation: Write all interventions, including those dealing with discharge criteria, in behavioral and measurable terms as outlined in the DMH WRP Manual.</p>
3b	the staff responsible for implement the interventions; and	<p>Findings: MSH's self-evaluation using the WRP chart audit form showed only 10% compliance with this criterion.</p> <p>A number of charts reviewed by the Monitor failed to identify the staff responsible for the individual's treatment (example, JE and FJ). Further, in a number of cases, staff identified for implementing the intervention have moved out of the unit (example, KS is placed in the Anger Management Group with DG (PWS); however, the Monitor learned that DG had resigned months ago and staff were unable to inform the Monitor where KS was at this time) or the individual was not in the identified group (example, RR should have been in the Substance Abuse group, but the monitor was told RR was in an unstructured group; and JE was supposed to be in the Social Skills through Karaoke group, but the group facilitator, Mr. KG (PT) stated that JE was not in his group).</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that for each intervention in the Mall or for individual therapy, clearly state the name of the staff member responsible. 2. Confirm that the staff to be listed in the WRP is actually involved in facilitating the activity, group, or intervention. 3. Ensure that the individual does not fall through the cracks if a staff member is no longer responsible for the individual's assigned group.

3c	The time frames for completion of the interventions.	<p>Findings:</p> <p>The hospital's self-assessment showed 53% compliance with this criterion. My review showed less than 10% compliance. Many WRPs have interventions with the same completion dates, regardless of the difficulty of the interventions (example: FJ, JR, AC, TJ, and AL). Further, in some cases the target dates are too far off (example RR's Focus 5 dated 9/22/05 has a target date of 12/11/06 for Objective 5.1.1). And in others there are no dates at all (example JE for Focus 1 which was initiated on 1/12/06).</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. 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. 2. Ensure that target dates for completion of intervention take into account the difficulty of the intervention and previous interventions, if any.
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:	<p>Compliance: Partial.</p>
4a	individuals who have met discharge criteria are discharged expeditiously, subject to the availability of suitable placements; and	<p>Findings:</p> <p>According to information provided by Ms. Susie Chen, Acting Chief of Social Work, and MSH's self-evaluation data, placement for many individuals is delayed. For example, of the 30 individuals referred for out of home placement as of 7/31/06, the waiting period for 19</p>

		<p>individuals was less than 90 days, 4 individuals had 90-180 days, and 7 individuals over 180 days.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Reduce the overall number of individuals still hospitalized after referral for discharge has been made. 2. Identify and resolve system factors that act as barriers to timely discharge. 3. Develop and implement a tracking and monitoring system for obtaining data on all individuals delayed from their discharge.
4b	Individuals receive adequate assistance in transitioning to the new setting.	<p>Findings:</p> <p>By policy, the hospital's responsibilities end when an individual is discharged from the facility. There is no clear way of identifying from the current documentation system if an individual was provided with adequate assistance when transitioning to a new setting. However, Ms. Susie Chen, Acting Chief of Social Work, identified a number of steps she and her staff undertake to assist individuals in transitioning to new settings. These steps include:</p> <ol style="list-style-type: none"> 1. Providing placement packets for the receiving facility; 2. Conducting a meeting with all relevant parties prior to transitioning; and 3. Following up with county case workers post discharge. <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a monitoring and tracking system to address the key elements of this requirement. 2. Ensure and document that individuals receive adequate assistance when they transition to the new setting. 3. Continue with and improve upon the current activities to aid in the transition of individuals upon discharge.

5	For all children and adolescents it serves, each State hospital shall:	Compliance: Partial.
5a	develop and implement policies and protocols that identify individuals with lengths of stay exceeding six months; and	<p>Findings: MSH has developed policies and procedures to address this issue.</p> <p>Review of the facility's records shows the following:</p> <ol style="list-style-type: none"> 1. Six of nine individuals from Unit 101 are yet to be on the Alternative Level of Care (ALOC) status; 2. Three of six individuals from Unit 105 are yet to be on ALOC status; 3. Five individuals from Unit 101 and 3 from Unit 105 have exceeded 6 months and have not been discharged for various reasons including failure to meet criteria; and 4. Eight individuals on ALOC are still awaiting discharge. <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Train staff in the new policy. 2. Ensure that timely meeting and reviews are conducted to clarify delays in discharge of all children and adolescents.
5b	establish a regular review forum, which includes senior administration staff, to assess the children and adolescents identified in § V.E.1 above, to review their treatment plans, and to create an individualized action plan for each such child or adolescent that addresses the obstacles to successful discharge to the most integrated, appropriate placement as clinically and legally indicated.	<p>Findings: MSH has put in place a system of guidelines and set up meetings to attend to barriers to discharge for all children and adolescents. Treatment teams and program managers are to meet on a regular basis to review all individuals who have exceeded 6 months of stay. However, no data were presented to show that all required elements are in place.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that a review committee is established, functioning, and monitored. 2. Provide minutes of the meeting as evidence of the process. 3. Develop individualized action plan for each child or adolescent

		that address obstacles to discharge.
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F	Specific Therapeutic and Rehabilitation Services	<p>Summary of Progress:</p> <ol style="list-style-type: none"> 1. MSH has a medication management system that includes reviews by a Pharmacy and Therapeutics (P & T) Committee and some oversight by senior psychiatrists. 2. MSH collects data regarding adverse drug reactions (ADRs). 3. MSH has a medication variance reporting (MVR) system through the nursing department. 4. MSH has initiated Drug utilization Evaluation (DUE) system and conducted DUEs of some high risk medication uses (e.g. polypharmacy and anticholinergics) and a variety of psychotropic medications. 5. MSH has an adequate network of medical specialty care and consultation services that can meet the needs of its individuals.
1	Psychiatric Services	<p>Methodology:</p> <p>Interviewed Sarath Gunatilake, M.D., Medical Director. Interviewed Stephen Mohaupt, M.D. Chairman, Pharmacy and Therapeutics (P & T) Committee. Interviewed Harold Plon, Pharm D., Assistant Director of the Pharmacy Department. Reviewed list of all individuals at the facility including current medications, diagnoses and attending physicians. Reviewed current California Department of Mental Health Psychotropic Medication Guidelines. Reviewed MSH Drug Utilization Evaluation Work Sheets regarding Polypharmacy, Antipsychotic Polypharmacy, Anticholinergic Agents, Benzodiazepines, Atypical Antipsychotics, Antidepressants, Typical Antipsychotics, Mood Stabilizers I, Mood Stabilizers II. Reviewed MSH Psychopharmacology Guidelines regarding Polypharmacy, Benzodiazepines and Antiparkinsonian (Anticholinergic) medications. Reviewed MSH Drug Utilization Evaluation (DUE) data regarding Polypharmacy, Antipsychotic Polypharmacy, Typical Antipsychotics,</p>

		<p>Atypical Antipsychotics, Anticholinergic Agents and Antidepressants use.</p> <p>Reviewed MSH Pharmacy Bulletin.</p> <p>Reviewed MSH's document titled "Adverse Drug reaction (ADR) Report process)."</p> <p>Reviewed ten completed data collection tools regarding ADRs.</p> <p>Reviewed MSH data aggregates of ADRs reported January to August 2006.</p> <p>Reviewed records of the ADR subgroup of the P & T Committee.</p> <p>Reviewed MSH raw data regarding monthly totals of medication variances.</p> <p>Reviewed ten completed medication variance data collection tools.</p> <p>Reviewed MSH records of data analysis regarding medication variances.</p> <p>Reviewed MSH nursing department's report of performance improvement regarding medication variances in the first and second quarters of 2006.</p> <p>Reviewed MSH procedure regarding tardive dyskinesia (TD).</p> <p>Reviewed minutes of six P & T Committee meetings between January and June 2006.</p> <p>Reviewed a list of all individuals at MSH, including name, diagnoses, current medications, name of attending physician and unit of residence.</p>
1a	<p>Each State hospital shall develop and implement policies and procedures to ensure system-wide monitoring of the safety, efficacy, and appropriateness of all psychotropic medication use, consistent with generally accepted professional standards of care. In particular, policies and procedures shall require monitoring of the use of psychotropic medications to ensure that they are:</p>	<p>Findings:</p> <p>The facility has developed a laboratory monitoring guideline that outlines baseline and maintenance testing requirements regarding the use of lithium, divalproex, carbamazepine and antipsychotics. The guideline has adequate requirements for lithium and divalproex. The facility has one guideline for ziprasidone, a new generation antipsychotic medication. This guideline briefly outlines indications, contraindications, precautions, dosing and administration and preparation for administration. At this time, the facility still utilizes the California Department of Mental Health psychotropic Medication Guidelines. These guidelines were updated in December 2004. The guidelines</p>

		<p>provide some general information on the use of psychotropic medications including antipsychotics, antimanics, antidepressants, anxiolytics and hypnotic agents, stimulants, anticonvulsants, and antiparkinsonians. In addition, the guidelines include information regarding polypharmacy and PRN medication use as well as a protocol regarding the use of clozapine.</p> <p>In general, these guidelines fail to comport with current generally accepted standards. Specifically, the following deficiencies are noted:</p> <ol style="list-style-type: none">1. The current laboratory monitoring guideline that was developed at MSH does not meet the requirements for individualized profiles of laboratory testing for new generation antipsychotic medications. Furthermore, the guideline does not outline expectations regarding indications, contraindications, precautions in use, dosage and administration, adverse effects and outcomes.2. The ziprasidone guideline that was developed at MSH is incomplete.3. The California Department of Mental Health Psychotropic Medication Guidelines still fall short of compliance with current generally accepted standards. Specifically, they are not individualized for most of the classes of psychotropic medications nor outline, in any systematic fashion, the indications, and contraindications, precautions in use, adverse effects and outcomes for different medications. Also, the clozapine protocol does not include needed information regarding the operational criteria for refractory schizophrenia as an indication for treatment, the benefits for individuals suffering from polydipsia, the risks of metabolic abnormalities and development of delirium, blood level interpretation, interactions with other drugs, diet and tobacco smoking, and guidelines for use in individuals who fail to respond satisfactorily.
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		<p>The facility developed and implemented a variety of monitoring mechanisms to assess compliance with items 1.a.i through 1.a.viii. These mechanisms and compliance data are reviewed for each item below. This monitoring process did not utilize complete guidelines that include information regarding indications, contraindications, screening and outcome criteria and that are derived from current literature, relevant experience and professionally accepted guidelines. In addition, the deficiencies listed under Psychiatric Assessments (C.1.c), Diagnosis (C.1.d) and Reassessments (C.1.d) are such that monitoring by MSH of this item is not based on meaningful criteria. As a result, the facility is not in compliance with items F.1.a.i through F.1.a.viii.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop individualized medication guidelines that include specific information regarding indications, contraindications, clinical and laboratory monitoring and adverse effects for all psychotropic and anticonvulsant medications in the formulary. The guidelines must be derived from current literature, relevant clinical experience and current generally accepted professional practice guidelines. 2. Implement recommendations listed in F.1.g. 3. Implement recommendations listed in C.1.c, C.1.d and C.1.e. 4. 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.
1a.i	specifically matched to current, clinically justified diagnoses or clinical symptoms;	To assess compliance with this item, MSH used the Monthly Progress Note Monitoring Form. As mentioned earlier, using this form, five

		<p>senior psychiatrists reviewed a total of 155 charts on all units during the period of March to June 2006. The following data outlines the compliance rates and corresponding indicators. Items 1 and 2 are based on verbal reports by the medical staff; no aggregated written data were available:</p> <ol style="list-style-type: none"> 1. "Rationale for current psychopharmacology plan (83%);" 2. "Rationale for PRN medications and review of rationale for ongoing PRN/STAT medications use (48%);" and 3. "Response to pharmacologic treatments (93%)." <p>In addition, the facility also reviewed the information in the integrated assessments using the Psychiatric Evaluation Monitoring Form. As mentioned earlier, five senior psychiatrists reviewed a total of 91 charts on the acute units during the period of March to July 2006. The following outlines the monitoring items used and compliance rates (based on verbal reports):</p> <ol style="list-style-type: none"> 1. "Reasons for continuing medications individuals came with (63%);" and 2. "Rationale for PRN medications and review of rationale for ongoing PRN/STAT medications used (35%)."
1a.ii	prescribed in therapeutic amounts, as dictated by the needs of the individual served;	<p>The facility used DUE work sheets (see F.1.g) to assess compliance with this item. However, the information derived from this process was not aggregated and analyzed to report the compliance status. In addition, using the psychiatric evaluation and the monthly progress note monitoring processes, the facility's medical staff reported the above mentioned rates of 63% and 83% as applicable to this item. The facility's written report on compliance does not clearly address this requirement.</p>
1a.iii	tailored to each individual's symptoms;	<p>The facility utilized its DUE process to assess compliance with this item. However, as mentioned earlier, no compliance data were reported.</p>

1a.iv	monitored for effectiveness against clearly identified target variables and time frames;	Using the Monthly Progress Note Monitoring Form, the medical staff reported the above mentioned compliance rates of 93% and 83% as applicable to this item. The facility's written report on compliance does not clearly address this requirement.
1a.v	monitored appropriately for side effects;	MSH reported a compliance rate of 91% based on the use of the Monthly Psychiatric Progress Form item regarding "monitoring of side effects, including sedation."
1a.vi	modified based on clinical rationales;	The medical staff reported the above mentioned compliance rates of 93% and 83% as applicable to this item. In addition, the facility' reported a rate of 57% for compliance with the indicator regarding documentation of "benefits and risks of current psychopharmacologic treatment, includes benzodiazepines, anticholinergics and polypharmacy, as applicable."
1a.vii	are not inhibiting individuals from meaningfully participating in treatment, rehabilitation, or enrichment and educational services as a result of excessive sedation; and	The facility reported the above mentioned compliance rate regarding "monitoring of side effects, including sedation" (91%) as applicable to this item.
1a.viii	Properly documented.	The medical staff reported the above mentioned compliance rates of 83%, 91% and 63% as applicable to this item. The facility's written report does not clearly address the requirement.
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.	Findings: The staff Psychiatrist Manual includes some guidelines regarding the use of PRN and STAT medications. The facility monitors this item using the Monthly Progress Note Monitoring Form. A compliance rate of 48% is reported regarding the documentation of "rationale for PRN medications and review of rationale for ongoing PRN/Stat medications use." This item is adequate to assess an important component, but it does not address requirements regarding

		<p>review of the administration of PRN/Stat medications, adjustment of diagnosis and scheduled treatment based on the review of PRN/Stat medications, as appropriate and the timeliness of reviewing Stat medications.</p> <p>The facility has established thresholds regarding patterns of PRN medication use. The thresholds are adequate to ensure attention to high-risk situations on a systemic basis. In personal interviews, the Medical Director and Senior Psychiatrist described the current process of Trigger Meetings regarding the review of PRN medication uses and outlined an informal process of feedback by the senior psychiatrists to practitioners when thresholds are met and formal administrative follow up at the trigger meetings.</p> <p>However, as mentioned in D.1.f, chart reviews by this monitor demonstrate a pervasive trend of poor documentation of PRN and/or Stat medication use. The following are the main deficiencies:</p> <ol style="list-style-type: none">1. There is inadequate review of the administration of PRN and Stat medications, including the circumstances that required the administration of drugs, the type and doses of drugs administered or the individual's response to the drugs.2. PRN medications are prescribed for generic indications, typically "agitation" without specific information on the nature of behaviors that require the drug administration.3. At times, more than one drug is ordered on a PRN basis without specification of the circumstances that require the administration of each drug.4. There is no evidence of a face-to-face assessment by the psychiatrist within one hour of the administration of STAT medication.5. There is no evidence of a critical review of the use of PRN and/or STAT medications in order to modify scheduled treatment and/or diagnosis based on this use.6. PRN medications are frequently ordered when the individual's
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		<p>condition, as documented in psychiatric progress notes, no longer requires this intervention.</p> <p>Compliance: Non-compliance.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Update the medical staff manual to include all requirements in the EP regarding high-risk medication uses, including PRN and/or STAT medications. 2. Continue to monitor the use of PRN and STAT medications to ensure correction of the above deficiencies. 3. Consolidate the monitoring processes for PRN and/or STAT medications and for psychiatric reassessments (progress notes).
c	<p>Each State hospital shall monitor the psychiatric use of benzodiazepines, anticholinergics, and polypharmacy to ensure clinical justification and attention to associated risks.</p>	<p>Findings:</p> <p>As mentioned under F.1.g., MSH has a DUE process regarding the use of benzodiazepines, anticholinergics and polypharmacy. Refer to F.1.g. for discussion of the current deficiencies regarding this process.</p> <p>This monitor reviewed charts of individuals receiving benzodiazepines as a scheduled modality. The review revealed evidence of inadequate monitoring of individuals regarding the risks of treatment, including individuals with substance use disorders (e.g. JM, JB, DF, FL and KV) and/or cognitive impairments (JM, EG, MW, KL and KS). These individuals are at increased risk regarding the adverse effects of unjustified and/or poorly monitored treatment.</p> <p>My review of the charts of individuals receiving anticholinergic treatment as a scheduled modality showed a pattern of inadequate monitoring of individuals for the associated risks. This involved individuals with cognitive impairments (GG, CAT, AE, JM, AE, RS and CG) who are at an increased risk. In the case of AE, the individual is</p>

		<p>also elderly, which increases the risk even further.</p> <p>In personal interviews with attending psychiatrists, this monitor reviewed the care of two individuals who are currently receiving antipsychotic polypharmacy (SL and DT). In both cases, the discussion confirmed that the psychopharmacological strategies employed by the treating psychiatrists did not comport with generally accepted professional standards of care. One of these individuals (DT) continues to experience restrictive interventions due to inadequately treated symptoms.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Update the Staff Psychiatrist Manual to include all requirements regarding high-risk medication uses, including benzodiazepines, anticholinergics and polypharmacy. 2. 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. 3. Consolidate the process of monitoring of all individual medications within the Drug Utilization Evaluation (DUE) Process. 4. Identify patterns and trends regarding high-risk medication uses and implement corrective and educational actions.
d	Each State hospital shall ensure the monitoring of the metabolic and endocrine risks associated with the use of new generation antipsychotic medications.	<p>Findings: As mentioned under F.1.g., MSH has a DUE that addresses the use of new generation antipsychotic medications. Refer to F.1.g. for a discussion of the current deficiencies of this process.</p>

		<p>This monitor reviewed the charts of individuals receiving new generation antipsychotic medications, including olanzapine (JM and FR), risperidone (TP), a combination of risperidone and quetiapine (TR) and clozapine (RB). This review revealed inconsistent practice regarding laboratory and clinical monitoring for the risks of treatment. There was evidence of appropriate monitoring for metabolic risks in three cases (JM, FR and TR), lack of laboratory and clinical monitoring for endocrine risks in one case (TR) and inadequate physician documentation of the status of monitoring for metabolic and cardiac risks in one case (RB).</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Same as in recommendation #1 in F.1.a 2. Same as in C.1.g. 3. 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>Findings: MSH has monitoring data based on review by five senior psychiatrists using the Admission Assessment Monitoring Form (one new admission for each team on the acute units) and the Monthly Progress Note Monitoring form and the Annual Psychiatric Evaluation Monitoring Form (two charts for each physician each month on all units). The review was conducted by five senior psychiatrists during the period March to June 2006.</p> <p>The following is an outline of the monitoring items and corresponding compliance rates:</p> <ol style="list-style-type: none"> 1. "AIMS evaluation completed (upon admission)" (100%); 2. AIMS-quarterly, if applicable (positive AIMS): (87%);" and 3. "Annual AIMS (completed)" (67%).

		<p>The MSH has a procedure that requires that all individuals diagnosed with TD are referred for Therapeutic Review Consultation (TRC), currently provided by senior psychiatrists.</p> <p>A review by this monitor of the charts of three individuals (JC, TB, and JAS) diagnosed with TD shows the following deficiencies:</p> <ol style="list-style-type: none"> 1. A complete AIMS has not been documented since December 13, 2005. A TRC consult was performed in August 20, 2003, which recommended a reevaluation that has not been done (JC). 2. The WRP does not include appropriate treatment and rehabilitation interventions for TD. Furthermore, AIMS has not been done since February 3, 2006 (TB). 3. The WRP fails to recognize TD as a focus for treatment and rehabilitation (JAS). <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that the Staff Psychiatrist Manual includes required criteria for monitoring of individuals with TD. 2. Ensure that the diagnoses listed on the WRP are aligned with those listed in psychiatric documentation. 3. Ensure that TD is recognized as one of the foci of hospitalization and that appropriate objectives and interventions are identified for treatment and/or rehabilitation.
f	Each State hospital shall ensure timely identification, reporting, data analyses, and follow up remedial action regarding all adverse drug reactions ("ADR").	<p>Findings: MSH has an ADR data collection tool that provides information on the current medications, suspected drug, brief description of the reaction, substantiating laboratory data, treatment provided for the reaction and</p>

		<p>response to the treatment and a probability scale. Recently, the facility has adopted the generally accepted Naranjo algorithm for probability assessment of suspected ADRs. This is yet to be incorporated into the data collection tool.</p> <p>MSH has an ADR work group that consists of the Assistant Director of Pharmacy and a staff psychiatrist. This group reviews and analyses ADR reports, assesses severity of the reaction and reports its findings to the P & T Committee.</p> <p>The current system is ineffective due to the following deficiencies:</p> <ol style="list-style-type: none"> 1. Review of the summary report of suspected ADRs prepared by the Assistant Director of Pharmacy indicates that 30 ADRs were reported during the period of January to August 2006. This signifies serious underreporting of ADRs, given that the facility provides services to approximately 700 individuals, most of whom suffer from serious illnesses. 2. MSH does not have a policy and procedure that outlines all the components of an adequate system for reporting, aggregating and analyzing ADRs, as well as information regarding use of the system to improve the performance of practitioners and facility wide systems. 3. MSH does not provide adequate instruction to its clinical staff regarding the proper reporting and investigation and analysis of ADRs. Specifically, the facility does not provide information or have written guidelines regarding the requirements for: <ol style="list-style-type: none"> a) Identification and classification of reporting disciplines; b) Proper description of details of the reaction; c) Additional circumstances surrounding the reaction, including how reaction was discovered, relevant history, allergies, etc; d) Information about all medications that are suspected or could be suspected of causing the reaction; e) A probability rating if more than one drug is suspected
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		<p>of causing the ADR;</p> <p>f) Information about type of reaction (e.g. dose-related, withdrawal, idiosyncratic, allergic, etc);</p> <p>g) Information regarding future screening; and</p> <p>h) Determination of need for intensive case analysis and other actions.</p> <p>4. MSH does not have a formalized system of intensive case analysis based on established ADR-related thresholds.</p> <p>5. MSH does integrate data regarding ADRs in the current system of psychiatric peer review.</p> <p>6. MSH does not provide analysis of individual and group practitioner trends and patterns regarding ADRs.</p> <p>7. MSH has not provided educational programs to address trends in the occurrence of ADRs.</p> <p>Compliance: Partial.</p> <p>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 above. 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,
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		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>A verifiably competent psychopharmacology consultant shall approve the guidelines and ensure adherence to the guidelines.</p>	<p>Findings: Based on the above mentioned guidelines, MSH conducted DUEs regarding the use of antipsychotic polypharmacy (April and August 2006), psychotropic polypharmacy (February 2005), anticholinergic agents (March and July 2005 and May 2006), atypical (new generation) antipsychotic medications (May 2005), typical (first generation) antipsychotics (June 2005) and antidepressants use (September 2005).</p> <p>The DUEs regarding the use of first and new generation antipsychotic medications and use of antidepressants were completed by a peer group that meets once monthly under the guidance of the Pharmacy and Therapeutics (P & T) Committee. The guidelines regarding polypharmacy and anticholinergic medication were completed by the facility's senior psychiatrists. Reportedly, the senior psychiatrists review 100% sample of all uses of polypharmacy, benzodiazepines and anticholinergics in the facility over two month cycles. The results of these are communicated to the P & T Committee and reportedly fed back to individual practitioners. Results of all DUEs are discussed at the medical staff meetings.</p> <p>In these DUEs, the main precautions regarding the use of polypharmacy and anticholinergic medications are aligned with the requirements of the EP. However, by-and-large, the DUEs are inadequate and/or incomplete due to the following deficiencies:</p> <ol style="list-style-type: none"> 1. The DUES are not based on complete and individualized medication guidelines that meet current generally accepted professional standards. 2. Although the current indicators regarding the use of polypharmacy, benzodiazepines and anticholinergic medications are, in general, adequate, MSH does not have a policy and procedure or a system regarding all DUEs to ensure systematic review of all medications, and determine the order in which the

		<p>medications are evaluated, the frequency of evaluation, the indicators to be measured and data collection instruments that are aligned with adequate guidelines and the acceptable sample size and thresholds of compliance.</p> <ol style="list-style-type: none"> 3. MSH did not present data regarding benzodiazepine use in the facility. 4. The results of the DUEs are not aggregated and analyzed to determine the facility's compliance with key requirements of the EP. <p>MSH currently has a contract with a part-time consultant affiliated with the University of California at Irvine. At present, the facility does not have a formalized mechanism to ensure that the consultant is utilized to approve the guidelines and to ensure compliance with them.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Same as recommendation #1 in F.1.a. 2. Develop and implement a policy and procedure to codify 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, acceptable sample size, and acceptable thresholds of compliance. 5. Ensure proper aggregation and analysis of DUE data to determine practitioner and group patterns and trends. 6. Ensure that the individualized medication guidelines are continually updated to reflect current literature, relevant
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		<p>clinical experience and current professional practice guidelines.</p> <p>7. Develop and implement a mechanism to ensure that the psychopharmacology consultant is utilized to satisfy the requirements of the EP.</p>
h	<p>Each State hospital shall ensure documentation, reporting, data analyses, and follow up remedial action regarding actual and potential medication variances ("MVR") consistent with generally accepted professional standards of care.</p>	<p>Findings: The facility presented data on some variances related to physician orders (e.g. unapproved abbreviation, illegible order, incomplete order, order unclear, wrong patient, wrong drug, wrong route), variances identified by the pharmacy department (e.g. expired/unusable drug, wrong drug, wrong dose, wrong patient) and variances identified by nursing (e.g. missing dose, extra dose, wrong dose/strength and wrong drug). The facility has data on those variances that were identified before reaching the individual. There is evidence of incomplete aggregation of data. The analysis of data is inadequate to identify system practitioner trends that can be utilized for performance improvement purposes. The facility does not have practitioner and group trends</p> <p>The current system of MVR is ineffective due to the following deficiencies:</p> <ol style="list-style-type: none"> 1. The facility has no data collection tool to assist clinical staff in reporting medication variances. 2. MSH does not have a policy and procedure that outlines all the components of an adequate system for reporting, aggregating and analyzing medication variances as well as information regarding use of the system to improve the performance of practitioners and facility wide systems. 3. The system provides information on limited categories of variances, and ignores other possible categories that include prescription, documentation, ordering, procurement and storage of medications as well as medication security. 4. MSH does not give proper instruction to the clinical staff

		<p>regarding the appropriate methods of reporting medication variances and of providing information that aid in the investigation and analysis of the variances. Specifically, the facility does not provide information or have written guidelines to staff regarding:</p> <ul style="list-style-type: none"> a) Classification of reporting discipline; b) Proper description of details of the variance; c) Additional facts involving the variance, including how the variance was discovered, how the variance was perpetuated, relevant individual history, etc.; d) Description of the full chain of events involving the variance; e) Classification of potential and actual variances; f) All medications involved and their classification; g) The route of medication administration; h) Critical breakdown points; i) All possible outcome categories; and j) Outline and analysis of contributing factors. <p>5. MSH does not have adequate system to aggregate or analyze MVR data.</p> <p>6. MSH does not have a formalized system of intensive case analysis based on established MVR-related thresholds.</p> <p>7. MSH does not integrate data regarding MVR in the current system of psychiatric peer review.</p> <p>8. MSH does not provide analysis of individual and group practitioner trends and patterns regarding MVR.</p> <p>9. MSH has not provided educational programs to address trends in the occurrence of MVR.</p> <p>10. The current system of MVR is not integrated in any meaningful fashion in the activities of the P & T Committee, the MRC, the Department of Psychiatry or the Department of Medicine. In personal interviews, the Medical Director, the Chairman of the P & T Committee and the Assistant Director of Pharmacy were</p>
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		<p>unable to describe the current system of reporting variances by clinical staff in the absence of a data collection tool, stating that this was the domain of the nursing department.</p> <p>Overall, the above deficiencies render the current system seriously inadequate for performance improvement purposes.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a data collection tool to assist staff in reporting potential and actual variances in all possible categories of variances. 2. Provide instruction to all clinicians regarding the significance of and proper methods in MVR. 3. Develop a policy and procedure regarding MVR that includes a data collection tool. The procedure and the tool must correct the deficiencies identified above. 4. Develop and implement adequate tracking log and data analysis systems to provide the basis for identification of patterns and trends related to medication variances. 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. 6. Ensure that MVR is a non-punitive process.
i	Each State hospital shall ensure tracking of individual and group practitioner trends, including data derived from monitoring of the use of PRNs, Stat medications, benzodiazepines, anticholinergics, and polypharmacy, and of ADRs, DUE, and MVR consistent with generally accepted	<p>Findings: MSH did not present data to indicate proper tracking and identification of individual and group practitioner trends regarding the areas identified in this section. The above mentioned deficiencies in F.1.a through F.1.h must be</p>

	<p>professional standards of care.</p>	<p>addressed and corrected prior to the development of meaningful practitioner trend data. Although fragments of adequate monitoring processes exist (e.g. DUEs and monitoring of anticholinergics and polypharmacy and review of PRN medication uses in the Trigger Meetings), the facility's current structure of psychiatric and pharmacy oversight has not been effectively utilized to ensure improved practice by clinical providers and to provide meaningful data on compliance with this section.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Same as in F.1.a. through F.1.h. 2. Improve IT resources to the pharmacy department to facilitate the development of databases regarding medication use.
<p>j</p>	<p>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>	<p>Findings: Same as in F.1.b. and F.1.i.</p> <p>Compliance: Non-compliance.</p> <p>Recommendation: Same as above.</p>
<p>k</p>	<p>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>	<p>Findings: Same as above.</p> <p>Compliance: Non-compliance.</p>

		<p>Recommendation: Same as above.</p>
l	<p>Each State hospital shall ensure that all physicians and clinicians are verifiably competent, consistent with generally accepted professional standards of care, in appropriate medication management, interdisciplinary team functioning, and the integration of behavioral and pharmacological treatments.</p>	<p>Findings: MSH is in the process of developing a Performance Profile of its psychiatry staff. However, at present, the facility does not have a data-driven process to address this requirement. The findings outlined in team leadership (C.1.b), interdisciplinary functioning (C.1.c.), the integration of behavioral and pharmacological treatments (D.1.f.v.iii.) and medication management (F.1.a through F.1.h.) are applicable to this item.</p> <p>The medical staff participates in the WRP planning, but the training is not competency-based at this time.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Finalize the physician's performance profile and ensure that the quality indicators address and integrate all the medication management requirements outlined in section F. 2. Ensure that the Staff Psychiatrist Manual includes clear expectations regarding medication management that are aligned with all the requirements in section F. 3. Same as in C.1.b., C.1.c., D.1.f.viii. and F.1.a. through F.1.h.
m	<p>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>	<p>Compliance:</p>
m.i	<p>all individuals prescribed continuous anticholinergic treatment for more than two months;</p>	<p>Findings: The findings of deficiencies listed in F.1.c indicate that the current</p>

		<p>system of clinical monitoring and systematic oversight is inadequate.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Same as in F.1.c. 2. Ensure that this practice is triggered for 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 anticholinergic treatment regardless of duration of treatment;	Same as above.
m.iii	all individuals prescribed benzodiazepines as a scheduled modality for more than two months;	Same as above.
m.iv	all individuals prescribed benzodiazepines with diagnoses of substance abuse or cognitive impairments, regardless of duration of treatment; and	Same as above.
m.v	all individuals with a diagnosis or evidencing symptoms of tardive dyskinesia.	<p>Findings:</p> <p>The findings listed in F.1.e indicate that MSH does not have an adequate system that ensures systematic monitoring of all individuals suffering from TD and the recognition of TD as one of the foci of hospitalization that require specialized treatment and/or rehabilitation objectives and interventions.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Same as in F.1.e. 2. 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. 3. Ensure that the facility's monitoring data are based on a review of all individuals diagnosed with TD.

m.vi	all individuals diagnosed with dyslipidemia, and/or obesity, and/or diabetes mellitus who are prescribed new generation antipsychotic medications	<p>Findings: At present, MSH does not have data derived from the DUE system to address compliance with this item. Refer to F.1.d. and F.1.g. for this monitor's findings.</p> <p>Recommendations: Same as in F.1.d. and F.1.g.</p>
n	Each State hospital shall ensure that the medication management of individuals with substance abuse disorders is provided consistent with generally accepted professional standards of care.	<p>Findings: At present, MSH does not have an adequate monitoring mechanism regarding this requirement. This monitor's findings in C.2.o and F.1.c. indicate a pattern of deficiencies that must be addressed and corrected to ensure compliance with this section.</p> <p>Compliance: Partial.</p> <p>Recommendations: Same as in C.2.o and F.1.c.</p>
o	Metropolitan State Hospital shall provide a minimum of 16 hours per year of instruction, through conferences, seminars, lectures and /or videotapes concerning psychopharmacology. Such instruction may be provided either onsite or through attendance at conferences elsewhere.	<p>Findings: Review of MSH training data indicates that, in the past year, the staff psychiatrists have received instruction on a variety of topics concerning psychopharmacology as required by the plan. However, the psychiatrists' participation has been inconsistent and insufficient. The hours of instruction ranged from zero to 17.5 hours per psychiatrist, with a mean of 7.9.</p> <p>Compliance: Partial.</p>

		<p>Recommendation: 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>
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: Interviewed Dr. Swati Roy, Chief of Psychology. Interviewed Mr. Johnson Zohndell (Sean), LVN, BY CHOICE Assistant. Interviewed Ms. Gretchen Hunt, BY CHOICE Coordinator. Interviewed Dr. Edwin Poon, Ph.D., Neuropsychologist. Interviewed Dr. Kirk Hartley, psychologist, PBS Team Leader-Adults. Interviewed Dr. Gordon Rose, psychologist, Team Leader - DCAT Interviewed Dr. Matthew Jorgenson, psychologist, PBS Team Leader - Adolescents. Interviewed many individuals served by MSH staff. Reviewed charts of 48 individuals (CR, RP, OT, SS, VR, CG, JT, DT, EM, MG, MB, MM, ML, MN, RR, DR, SR, FR, RT, HR, RS, PT, CT, KG, KR, KS, RH, NR, TP, DH, KR, SM, RM, SUM, JL, CG, LS, DT, FJ, SE, RR, CL, JE, JM, NV, ES, MJ and BR). Reviewed Memberships of PBS Teams. Reviewed PBS Team Assignments. Reviewed AD for Psychology Services. Reviewed MSH Psychology Department Manuals. Reviewed PBS Manual. Reviewed APA Ethics Standards of Practice. Reviewed Mall Curriculum. Reviewed Psychology Protocols and Assessment Tools. Reviewed BCC treatment plans. Reviewed DMH audit forms. Reviewed WRP audit forms. Reviewed By CHOICE Manual Reviewed Hospital Organizational Chart.</p>

		<p>Reviewed MSH Psychology Department Organizational Chart. Reviewed individuals x program x unit needing behavioral interventions. Reviewed list of individuals on PBS plans. Reviewed personnel CVs. Reviewed personnel certification and licensure documents. Reviewed PBS monitoring form. Reviewed PBS-BCC summary sheets and checklist. Reviewed training records of PBS plans Observed virtual Mall sessions. Observed unit Mall sessions. Observed WPR team conferences to review the WRPs of four individuals (AC, DR, AL and LK). Visited BY CHOICE stores.</p>
a	<p>Each State hospital shall ensure that it has positive behavior support teams (with 1 team for each 300 individuals, consisting of 1 clinical psychologist, 1 registered nurse, 2 psychiatric technicians (1 of whom may be a behavior specialist), and 1 data analyst (who may be a behavior specialist) that have a demonstrated competence, consistent with generally accepted professional standards of care, in the following areas:</p>	<p>Findings: The State has established guidelines on the composition, duties, responsibilities and regulations governing the PBS teams. The guidelines are aligned with the requirements of the EP.</p> <p>The PBS manual does not provide clear guidelines for the PBS teams.</p> <p>The hospital currently has two PBS teams. They are short one full PBS team. The current team to individual ratio is not in line with the EP requirement of a ratio of 1:300. The PBS teams lack data analysts.</p> <p>The team composition criterion is met, but the competency criterion is not. The PBS team members were interviewed, and not all of them demonstrated competence in their understanding of current generally accepted standards in Positive Behavior Supports.</p> <p>A review of the CVs revealed that not all the PBS team members have had sufficient competency-based training in Positive Behavior Supports at the university level. Many of them (e.g., Ms. Wilma Fuentes, RN., Dr.</p>

		<p>Matthew Jorgensen, psychologist, Dr. Amy Choi, psychologist, Dr. Kirk Hartley, Psychologist, Dr. Gordon Rose, PhD. Psychologist, and Dr. Swati Roy, Chief of psychology) have undergone on the job training through Dr. Nirbhay N. Singh and Ms. Angela Atkins (MSH Consultants), and have attended related conferences.</p> <p>Based on interviews and discussions with Dr. Swati Roy, Chief of Psychology, and other PBS team members it was evident that the referral process to the PBS teams is not clearly followed by the WRP teams.</p> <p>The Chief of Psychology lacks the authority to hire psychologists and or place them according to departmental needs. Further, the Chief of Psychology does not have the clinical and administrative authority for psychologists serving in various teams at MSH. This violates the requirements of the EP.</p> <p>Interview of PBS team members and others in the department reveals a severe shortage of resources for them to fully accomplish the job mandate placed upon them. Lack of resources includes permanent office space, computers, telephones, and office assistants, among others.</p> <p>Training has been provided across all units and programs at MSH. However, further and continued training is needed as many hospital staff continues to have an incomplete understanding of PBS and Behavior Guidelines, and they continue to resort to traditional consequence-based approach of behavior management and behavior suppression techniques.</p> <p>All the WRP team members interviewed agreed that there is a very poor understanding of what structural and functional assessments are.</p> <p>Staff interviews revealed that there is lack of motivation to</p>
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		<p>collaborate, and to use PBS plans in group therapy. Further, there is no proper monitoring system. Implementation is poor, around 55% fidelity.</p> <p>PBS team members are involved in other areas of work including suicide risk assessment and nursing. The department has no senior psychologists who can provide oversight and training to PBS team members.</p> <p>The PBS-BCC Checklist has not been used as the pathway for referrals to the PBS teams or the BCC.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Revise the statewide PBS manual to include clear guidelines on the referral process (i.e., what triggers a referral, who is responsible for making the referral and what is expected once a referral is made, timelines). 2. Include in the PBS manual clear guidelines on how structural and functional assessments are to be performed. 3. Identify in the manual specific evidence-based tools to use for each type of assessment. 4. Use the terms Behavior Guidelines and PBS plans instead of Type A and Type B plans, which are not meaningful to staff or the individuals. 5. Recruit an additional PBS team. 6. Ensure that all PBS psychologists use the PBS model as currently identified in the literature. 7. Provide Positive Behavior Supports training to all PBS team members. Specifically, train these members on the reliable use of evidence-based tools. 8. Standardize the referral system and the format for developing PBS structural and functional assessments across all facilities. 9. Recruit data analysts for all PBS teams. 10. Ensure senior psychologists primary duties involve monitoring
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		<p>and mentoring psychology staff and specialist team members.</p> <ol style="list-style-type: none"> 11. Ensure that the Chief of Psychology is given the necessary responsibility in hiring psychologists with specific education, training, and experience to suit departmental needs. 12. 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.
a.i	<p>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>	<p>Findings: Many PBS team members failed to demonstrate a clear understanding of and the linkage between the PBS and the Recovery Model.</p> <p>Upon review, the structural/functional assessments failed to meet criteria for generally accepted professional standards.</p> <p>Evidence-based tools were not consistently or reliably used.</p> <p>This monitor evaluated 18 Functional Assessments and 17 PBS plans using the PBS Monitoring Tool. The following patterns were identified:</p> <ol style="list-style-type: none"> 1. The individual's Wellness and Recovery Plan (WRP) Team is involved in the assessment and intervention process—100% 2. Broad goals of intervention were determined—56% in compliance and 44% in partial compliance 3. At least one specific behavior of concern was defined in clear, observable and measurable terms—78% showed full compliance and 22% partial compliance 4. Baseline estimate of the maladaptive behavior was established in terms of objective measure—28% showed full compliance and 72% partial compliance 5. Pertinent records were reviewed—56% in full compliance and 44% in partial compliance 6. Structural assessments (e.g., ecological, sleep, medication effects, mall attendance, etc) were conducted, as needed, to

		<p>determine broader variables affecting the individual's behavior—28% in full compliance and 67% in partial compliance 5% not in compliance.</p> <p>7. Functional assessment interviews were conducted with people (e.g., individual, parents and family members, therapists and care staff, teachers) who often interact with the individual within different settings and activities—100% in partial compliance.</p> <p>8. Direct observations were conducted across relevant circumstances (e.g., multiple settings, over time) and by more than one observer, as appropriate—17% in complete compliance, 83% in partial compliance.</p> <p>9. Other assessment tools (e.g., rating scales, checklists) were used to produce objective information regarding events preceding and following the behavior of concern, as well as ecological and motivational variables that may be affecting the individual's behavior- 22% in complete compliance, 52% in partial compliance and 22% not in compliance.</p> <p>10. Patterns were identified from the data collected that included (1) circumstances in which the behavior was most and least present (e.g. when, where, and with whom) and (2) specific functions the behavior appeared to serve the individual (i.e what the individual gets or avoids by engaging in the behaviors of concern)-6% full compliance, 44% partial compliance and 50% not in compliance.</p> <p>11. Broader variables (e.g., activity patterns, curriculum) that may be affecting the individual's behavior were identified—100% in partial compliance.</p> <p>12. Patterns were summarized into written hypotheses based on structural and/or functional assessments. These statements were clear, concise, and based on data—11% in full compliance, 67% in partial compliance and 22% not in compliance.</p> <p>13. Intervention strategies were clearly linked to the hypotheses derived from the structural and/or functional assessments—</p>
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		<p>76% in partial compliance and 24% not in compliance.</p> <p>14. The individual's PBS Team designed a positive behavior support plan (PBS plan) collaboratively with the individual's WRP Team that includes: Description of the behavior, patterns identified through the structural and functional assessments and goals of intervention—100% in full compliance.</p> <p>15. Modifications to the social, environmental or cultural milieu that may prevent the behavior and/or increase the likelihood of alternative appropriate behavior(s)—100% in partial compliance.</p> <p>16. Specific behaviors (skills) to be taught and/or reinforced that will: (i) achieve the same function as the maladaptive behavior, and (ii) allow the individual to cope more effectively with his/her circumstances—41% full compliance and 59% in partial compliance.</p> <p>17. Strategies for managing consequences so that reinforcement is maximized for positive behavior and (ii) minimized for behavior of concern, without the use of aversive or punishment contingencies—29% in full compliance and 71 in partial compliance.</p> <p>18. The PBS plan is clearly specified in the Objective and Intervention sections of the individual's Wellness and Recovery Plan. The PBS Plan itself need not be included in the individual's WRP—18% in full compliance, 53% in partial compliance and 29% not in compliance.</p> <p>19. If necessary to insure safety and rapid de-escalation of the individual's maladaptive behavior, crisis management procedures and criteria for their use and termination were determined and documented—24% in full compliance, 47% in partial compliance, 12% not in compliance and 17% not applicable.</p> <p>20. Everyone working with the individual on a regular basis is familiar with the PBS plan and implements its strategies with high degree of fidelity (>90%)— 100% in compliance.</p> <p>21. Implementation of the PBS plan is monitored to insure that</p>
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		<p>strategies are used consistently across all intervention settings—0% in compliance.</p> <p>22. Objective information is collected to evaluate the effectiveness of the PBS plan. This information includes decreases in maladaptive behavior—18 % in full compliance 41%, partial compliance and 41% not in compliance.</p> <p>23. Increases in replacement skills and/or alternative behaviors 24% full compliance, 53% in partial compliance, 23% not in compliance.</p> <p>24. Achievement of broader goals—12% full compliance, 76% partial compliance and 12% not in compliance.</p> <p>25. Durability of behavior change—47% partial compliance and 53% not in compliance.</p> <p>26. The individual's WRP team reviews, at scheduled Wellness and Recovery Plan Conferences, the individual's progress and a PBS Team member or the WRP Team psychologist makes necessary adjustments to the PBS plan, as needed—18% in full compliance, 32% partial compliance and 50% not in compliance.</p> <p>The PBS teams' self-analysis using the PBS Monitoring tool was inconsistent with the monitor's review, reporting higher compliance rates.</p> <p>Training of line staff to implement these plans consists mainly of a verbal review of the PBS plan. This is not in accordance with the State's Special Order on PBS.</p> <p>PBS plans are not regularly revised to reflect outcome data.</p> <p>Data analysis did not indicate whether the PBS plan was a variable that affected treatment outcomes.</p> <p>Evidence of a review of the monthly or quarterly outcome data was</p>
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		<p>missing in many charts.</p> <p>Very few BCC meetings have been held in recent months and the PBS-BCC checklist has not consistently been utilized for referral to the BCC.</p> <p>The PBS teams and the hospital do not currently use clear trigger system to determine when it is appropriate to make a referral to PBS.</p> <p>Given the high numbers of episodes and hours of Seclusion and Restraint in the hospital the number of PBS plans is significantly small. The PBS teams reported that this is due to the teams working 1:1 with the WRP teams and staying engaged long after the treatment plan is in effect, further interviews revealed that PBS teams do not feel that they are successful in working with the WRP teams.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that all PBS staff members receive systematic training in all aspects of the PBS plans, including the relationship between PBS and recovery principles. 2. Conduct treatment implementation fidelity checks regularly. 3. Senior Psychologists should be assigned to review treatment plans and Crisis Intervention plans for content and appropriateness. 4. PBS team leaders need to develop a systematic way of evaluating treatment outcomes and reporting those outcomes. 5. 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 inline staff is
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		<p>necessary to improve treatment implementation.</p> <ol style="list-style-type: none"> 6. PBS teams and WRP teams need to follow the PBS-BCC checklist for all referrals to the BCC. 7. The PBS teams, WRP teams and the BCC require further training to fully understand their roles, agenda at the BCC and tracking of referrals made to the BCC. 8. Ensure that all PBS team leaders receive training in the development of structural assessment, functional assessment and functional analysis, and the development and implementation of PBS plans. 9. Ensure that all RNs, PTs and data analysts on the PBS teams receive guidelines for using evidence-based tools for referrals, training on evidence-based tools for data collection and that a team leader performs reliability checks in this area. 10. Develop a training protocol for all PBS plans to ensure that all staff who will be responsible for implementing the plan are consistently and appropriately trained prior to implementation of the plan (i.e., behavioral rehearsals, demonstrations, role plays, modeling). 11. Integrate a response to triggers in the referral process. 12. Ensure that team psychologists and PBS psychologists are trained in the WRP process. The DMH WRP manual outlines the requirements for including PBS programs in the Objectives and Interventions of an individual's WRP.
a.ii	<p>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>	<p>Findings: The hospital has implemented the statewide BY CHOICE incentive program. There is a statewide BY CHOICE manual, and associated training materials for staff and individuals for implementing the program facility-wide. The BY CHOICE program is being implemented facilitywide, however, not all programs have completed the curriculum and objectives for all the groups in practice.</p>

		<p>Ms. Hunt Gretchen, the BY CHOICE program coordinator, is currently involved in training staff and putting together a system that will make the BY CHOICE program meaningful and effective.</p> <p>According to the BY CHOICE coordinators both at Napa and MSH, some of the barriers include: (a) staff not filling out cards in each cycle; (b) often the cards are filled in as individuals enter the Mall or other areas, before their participation and achievement of objectives are clear, and (c) staff are having difficulty in keeping up with individuals who come up to them to fill cards all day long. These appear to be training issues and developmental pains of a new program, as staff frequently complain that "this is another thing to do, and that individuals are not capable of carrying their cards."</p> <p>Individuals in the BY CHOICE programs complain that the price is too high to earn meaningful rewards, and that they do not always remember to carry their cards.</p> <p>Staff understanding of and support for the program is weak. Poor attendance at meetings often due to competing schedules. Attendance to meetings is about 10%.</p> <p>The BY CHOICE manual needs to be updated to reflect the intent and application with the State Wide Hospitals' EP and Recovery model.</p> <p>There is no dedicated staff other than the BY CHOICE coordinator to run the program facilitywide.</p> <p>The incentive stores' operating hours is a problem as in many programs individuals crowd the store and it is difficult to serve them in a timely manner. Further, the incentive stores are supposed to be like community shops (e.g., 7-Eleven) that are open for extended hours so that individuals at increasing levels of recovery can avail themselves of</p>
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		<p>the option of "shopping" when they choose to do so.</p> <p>BY CHOICE matters are rarely discussed with the individual during WRP conferences.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Train all staff in correctly implementing the BY CHOICE program. 2. Implement the program as per the manual. 3. Ensure that the program has additional resources, including computers and software that will assist in running the systems monthly. 4. Hire dedicated staff to the BY CHOICE program to assist with management of the data and program matters. 5. Assure that the individuals have the final choice in allocating points per cycle, ranging from 0 to 100 per cycle. 6. BY CHOICE point allocation should be determined by the individual at the WRP conference, with facilitation by the staff. 7. Report BY CHOICE point allocation in the Present Status section of the individual's case formation and update at every scheduled WRP conference.
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>Findings: Dr. Swati Roy, Chief of Psychology, is currently responsible for the administration of the PBST and the BY CHOICE incentive program. However, members of the PBS teams are often given additional duties by nursing and other staff. This is in violation of the EP.</p> <p>The State's Special Order contains all the required elements of PBS. In addition, MSH has a PBS AD.</p>

		<p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Use the Special Order as the MSH AD. 2. Implement the AD. 3. Follow the requirements of the EP.
c	Each State Hospital shall ensure that:	<p>Compliance: Partial.</p>
c.i	behavioral assessments include structural and functional assessments and, as necessary, functional analysis;	<p>Findings: Of the 11 PBS plans and assessments that this monitor reviewed (TA, RC, JB, TG, EM, ED, FR, ST, KD, FR and TC), less than 10% met compliance on the DMH Psychology Monitoring Tool Item #27 due to the quality of the assessments not meeting generally accepted professional standards. Peer review of these same assessments by psychologists at MSH was in agreement with my findings.</p> <p>MSH recently has developed the Behavioral Interventions Needs Assessment (BINA), a monitoring system to determine if behavioral assessments include structural and functional assessments, and where necessary functional analysis. Evaluations are given to Ms. Angela Atkins (MSH consultant) for review. This tool has not been approved at the State level by the DMH Chief CRIPA Consultant.</p> <p>The PBS-BCC checklist had been used infrequently and not been used appropriately, thus making it difficult to determine when an individual may require a referral to PBS for an assessment.</p>

		<p>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. Use the PBS-BCC checklist for all consultations. 4. Senior Psychologists should be utilized to monitor the appropriateness of Behavior Guidelines, Crisis Intervention Plans and the need for a referral to PBS teams.
c.ii	hypotheses of the maladaptive behavior are based on structural and functional assessments;	<p>Findings: Many of the plans reviewed by this monitor did not have well formulated behavioral hypotheses. PBS team leaders interviewed concurred with the monitors findings.</p> <p>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>Findings: Less than 5% of the charts reviewed by this monitor had expressly stated documentation of previous behavioral interventions and their effects. MSH self-monitoring data for documentation of previous behavioral interventions showed that only 23% of the charts reviewed met this criterion.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Document previous behavioral interventions. 2. Document effectiveness of previous interventions.

c.iv	behavioral interventions, which shall include positive behavior support plans, are based on a positive behavior supports model and do not include the use of aversive or punishment contingencies;	<p>Findings: None of the behavioral interventions this monitor reviewed included any aversive or punishment contingencies. However, most of the interventions also did not conform to the positive behavior supports model.</p> <p>Recommendation: Ensure that all behavioral interventions are based on a positive behavioral supports model without any use of aversive or punishment contingencies.</p>
c.v	behavioral interventions are consistently implemented across all settings, including school settings;	<p>Findings: None of the PBS plans reviewed showed evidence that interventions were being consistently implemented across settings. However, training across settings have been conducted. PBS team leaders reported poor collaboration and support from line staff.</p> <p>Mall staff did not always know individuals who have a plan. I did not witness any evidence of a copy of the plan used in the Mall areas visited.</p> <p>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	triggers for instituting individualized behavioral interventions are specified and utilized, and that these triggers include excessive use of seclusion, restraint, or psychiatric PRN and Stat medication for behavior control;	<p>Findings: Staff is not fully knowledgeable about trigger data on individuals. At present the trigger data are rarely considered in referring individuals with maladaptive behavior to the PBS teams.</p> <p>The Chief of Psychology, PBS Team leaders, and DCAT leaders, along</p>

		<p>with neuropsychologists attend trigger meetings regularly to discuss individuals who activate triggers.</p> <p>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>Findings: This is not a practice at this time. Only one of 12 charts reviewed had clearly documented evidence of other treatments being integrated with the behavioral interventions.</p> <p>MSH has developed an Integration of Behavioral Intervention Form, which is in draft status, to address this criterion. This form will need appropriate approvals.</p> <p>Recommendation: 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>Findings: In six of the 12 charts (50%) reviewed, PBS plans were specified in the objectives and interventions sections of the individual's WRP. Interview with PBS team members and other staff indicated that there was a lack of understanding of this requirement. However, the DMH WRP Manual clearly specifies how this is to be done.</p> <p>Recommendations: Specify PBS plans in the objectives and interventions sections of the individual's WRP Plan as outlined in the DMH WRP Manual.</p>
c.ix	<p>all positive behavior support plans are updated as indicated by outcome data and reported at least</p>	<p>Findings: Two of the 12 (16%) PBS plans reviewed met this criterion.</p>

	<p>quarterly in the Present Status section of the case formulation in the individual's Wellness and Recovery Plan</p>	<p>MSH's internal audit of five WRPs conducted in April 2006, showed 33% compliance with this criterion.</p> <p>Recommendation: 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>
c.x	<p>all staff has received competency-based training on implementing the specific behavioral interventions for which they are responsible, and performance improvement measures are in place for monitoring the implementation of such interventions.</p>	<p>Findings: Staff generally does not receive competency based training on implementing behavioral interventions for which they are responsible for.</p> <p>Performance improvement measure in the way of the DMH PBS integrity checklist is being used as a means to track performance improvement.</p> <p>Recommendation: Provide competency-based training to appropriate staff on implementing specific behavioral interventions for which they are responsible, and have performance improvement measures in place for monitoring the implementation of such interventions.</p>
c.xi	<p>all positive behavior support team members shall have as their primary responsibility the provision of behavioral interventions;</p>	<p>Findings: Some team members are involved in other areas of service to individuals some of which is by their choice, and others as a requirement (example, nurses are involved in unit coverage, and are included in the MOT Master list for coverage).</p> <p>MSH's self-assessment report also indicates PBS/DCAT team members are unable to fulfill their duties due to them being asked to attend to other areas of work. This is in violation of this criterion.</p>

		<p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that all PBS team members provide PBS services fulltime until the needs of all individuals requiring behavioral interventions is met. 2. Ensure that the Chief of Psychology has responsibility to determine PBS team members duties.
c.xii	the By CHOICE point allocation is updated monthly in the individual's Wellness and Recovery Plan.	<p>Findings:</p> <p>Two of the 12 (16%) charts reviewed showed an update of BY CHOICE allocation in the WRP. BY CHOICE program is not fully operational in all units. For example, individuals who are bed-bound and individuals whose primary language is not English are not fully involved in the plan.</p> <p>MSH's audit data was in great variance with the monitors findings.</p> <p>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; 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	<p>Findings:</p> <p>MSH has one DCAT team. The team lacks a data analyst. At present, the DCAT team receives referrals for individuals mainly with diagnosis of MR, dementia, seizure, cognitive disorder, amnestic, and TBI.</p> <p>At present the DCAT team has 2 working PBS plans. The DCAT team members agreed that they need additional training. Furthermore, team members identified the following concerns:</p> <ol style="list-style-type: none"> 1. Unit staff is not clear as to who should be referred to the DCAT and PBS teams. 2. The monitoring system for referrals is unclear.

	<p>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>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Hire all members of the DCAT team. 2. Ensure that DCAT team members' primary responsibility is consistent with EP. 3. Ensure that all DCAT team members receive appropriate training.
<p>e</p>	<p>Each State Hospital shall develop and implement a Behavioral Consultation Committee (BCC), chaired by the Chief of Psychology, and co-chaired by the Chief of Psychiatry, to review the Wellness and Recovery Plan and maladaptive behavior(s) of the individuals who have not made timely progress on positive behavior support plans. The Chief of Psychology is responsible for the functions of this committee, together with members of the positive behavior support team (in functions of the committee that relate to individuals under the care of those team members). The committee membership shall include all clinical discipline heads, including the medical director, as well as the clinical administrator of the facility.</p>	<p>Findings: Dr.Swati Roy, Chief of Psychology, is the chair of the Behavior Consultation Committee (BCC) that is co-chaired by Dr. Gulasekaram (Chief of Psychiatry).</p> <p>BCC meeting attendance record shows poor attendance by standing committee members at these meetings (percent attendance for 2005 ranges from 32.5% to 87.5%., some members have not attended any of the meetings)</p> <p>BCC recommendations and plans are often not implemented or inadequately implemented. The BCC does not have any authority over the implementation of their plans.</p> <p>BCC and PBS team members agree that the number of BCC referrals is currently low because MSH started to implement the PBS/BCC check list. Given the number of individuals with learned maladaptive behaviors at this hospital, especially those who end up in seclusion and restraints and 1:1 observations, one would expect greater number of referrals.</p> <p>There is a PBS-BCC checklist that lists the sequence of steps that is not always used appropriately.</p>

		<p>Compliance: Partial.</p> <p>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. 2. Ensure that all standing members of the BCC attend every meeting. 3. Include PBS team members and WRP team members at BCC team meetings periodically to problem solve as to why plans are not fully implemented 4. Set up a system of accountability to ensure that BCC plans are properly implemented when indicated.
f	<p>Each State Hospital shall ensure that it has sufficient neuropsychological services for the provision of adequate neuropsychological assessment of individuals with persistent mental illness.</p>	<p>Findings: At present, MSH has two FTE neuropsychologists on staff to provide services to all individuals of ages 18 and over in the facility. Clearly, this number of neuropsychologists is inadequate to fully serve such a large number of forensic individuals. In addition, neuropsychologists are also asked to step into other roles.</p> <p>A total of 92 referrals were received since 2004, for neuropsychological evaluation. The waiting time for evaluation is between 1 and 2 months.</p> <p>WRP teams do not fully utilize the neuropsychological services, and if they did the current number of neuropsychologists will not be able to fulfill their requests.</p> <p>Neuropsychological evaluations requiring Spanish speaking or pediatric neuropsychologists are not completed.</p> <p>The neuropsychology sub-section of the psychology department is</p>

		<p>unable to provide cognitive remediation and cognitive retraining groups in the PSR Mall because of their high caseloads.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that WRP teams, especially psychologists, make referrals that are appropriate for neuropsychological assessments. 2. Ensure that neuropsychologists provide cognitive remediation and cognitive retraining groups in the PSR Mall. 3. Increase the number of neuropsychologists to meet the anticipated demand for neuropsychological services.
g	All clinical psychologists with privileges at any State Hospital shall have the authority to write orders for the implementation of positive behavior support plans, consultation for educational or other testing, and positive behavior support plan updates.	<p>Findings: The hospital's psychologists currently do not have the authority to write orders. This was an issue at NSH as well and should have been remedied by now.</p> <p>Compliance: Partial.</p> <p>Recommendations: The hospital and/or state must provide psychologists the authority to write orders as specified in the EP.</p>
3	Nursing Services	
	Each State hospital shall provide adequate and appropriate nursing care and services consistent with generally accepted professional standards of care to individuals who require such services.	<p>Methodology: Interviewed Anna Sobolewska, HSS, NPIC. Interviewed Aurora Hendricks, Coordinator of Nursing Services. Interviewed Kanya Sitanggang, RN, Psychiatric Nurse Education Director. Interviewed Mary Granado, RN, Nurse Coordinator.</p>

		<p>Toured unit 419 Skilled Nursing Facility Unit (SNF). Attended shift report for unit 419. Reviewed charts for Reviewed charts for RC, GW, BB, CL, GA, JS, CC, DG, AM, LW, EG, JC, HN, FG, AM, FA, SB, PC, RT, VK, AD, JP, HG. Interviewed Linda Gross, RN, Program Coordinator. Reviewed Statewide Medication Administration Monitoring Tool. Reviewed Medication Administration Monitoring data. Reviewed proposed PRN/STAT Medication Monitoring Form. Reviewed NP 548 24 Hour Medication Audit. Reviewed NP 530 STAT Orders. Reviewed NP 528 PRN Medications for Psychiatric Symptom Management. Reviewed Nursing Performance Improvement Medication Errors By Unit form. Reviewed Error Types/Description From 24-Hour Medication Audit form. Reviewed MSH MERBU Q 1 & 2 2006. Reviewed Documentation of the Circumstances Requiring PRN and STAT Administration of Medications form. Reviewed Cross Sample Audit data. Reviewed Regular Audit data. Reviewed DMH Nursing Services: Nursing Monitoring: Nursing Interventions. Reviewed DMH Nursing Services: Nursing Monitoring: Nursing Interventions Form Instructions. Reviewed NP #103 regarding Wellness and Recovery Plan (Plan of Care) Role of Nursing Staff. Reviewed Nursing Self-Assessment Nursing Interventions in WRP. Reviewed Nursing Services: Nursing Staff Working With An Individual Shall Be Familiar With The Goals, Objectives, and Interventions For That Individual. Reviewed Nursing Services: Nursing Staff Working With An Individual Shall Be Familiar With The Goals, Objectives, and Interventions For</p>
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		<p>That Individual Monitoring Form.</p> <p>Reviewed Nursing Self-Assessment Nursing Staff WRP Interview Tool.</p> <p>Reviewed NP #110 regarding Documentation Frequency and Guidelines.</p> <p>Reviewed Nursing Progress Notes Monitoring form.</p> <p>Reviewed Nursing Progress Notes Monitoring Revised data.</p> <p>Reviewed (I) Item 56, 3g. Monitoring of Bed Bound Individuals Tool.</p> <p>Reviewed Nursing Self-Assessment Audit for Justification of Bed Bound Status.</p> <p>Reviewed Post Nursing Orientation & NAU Knowledge/Competencies form.</p> <p>Reviewed Training - By Course data.</p> <p>Reviewed MSH Diagnostic and Statistical Manual IV-TR (DSM-IV-TR) and Co-morbid Conditions.</p> <p>Reviewed Nursing Orientation Day 3, Day 5, Day 9 Post Test.</p> <p>Reviewed MSH Nursing Documentation.</p> <p>Reviewed Nursing Orientation Day 9: Medication Administration.</p> <p>Reviewed MSH Milieu Therapy.</p> <p>Reviewed MSH Proactive Techniques for Reducing Seclusion or Restraint and Post Test.</p> <p>Reviewed Therapeutic Milieu Observation Monitor tool.</p> <p>Reviewed Therapeutic Milieu Observation Monitoring data.</p> <p>Reviewed Nursing Training list for PBS.</p> <p>Reviewed MSH NAU: Medication Administration.</p> <p>Reviewed Nursing Annual Update Post Test Medication Re-Certification.</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>Findings: MSH has utilized a Medication Administration Monitoring Tool to assess</p>

		<p>its compliance with this requirement.</p> <p>MSH reported 98% compliance that dosing time of last PRN was checked before administering PRN, 95% assessed the individual before administering PRN medication, and 98% documented effects of PRN medication within 1 hour. It was unclear from the data if STAT medications were included in these data since the Statewide Medication Administration Monitoring Tool combines both PRN and STAT medications.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Continue to develop and implement policies and procedures that ensure the safe administration of PRN medications and STAT medications. 2. Continue to monitor the administration and documentation of medication administration, including PRN and STAT medications. 3. Report PRN medication data and STAT medication data separately. 4. Ensure staff competency regarding deficiencies and appropriate procedures for safe administration of PRN medications and STAT medications. 5. Revise Statewide Medication Administration Monitoring Tool to reflect PRN medication and STAT medication data separately.
a.ii	documentation of the circumstances requiring PRN and Stat administration of medications;	<p>Findings:</p> <p>MSH reported 84% compliance with the documentation of PRN/STAT medications. However, PRN and STAT medication data were not reported separately.</p> <p>From this monitor's review of 12 individuals who received a PRN, only 4 were in compliance with this requirement. From review of 10 individuals who received a STAT medication, 6 were in compliance.</p>

		<p>The monitor's findings under D.1.f and F.1.b are also applicable to this section.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Revise proposed PRN/STAT Medication Monitoring Form to report PRN and STAT data separately. 2. Revise 24-hour Medication Audit Form to include STAT medications. 3. Revise language in NP 528 and 530 to include the "circumstances" requiring PRN and STAT administration of medications. 4. Revise all monitoring forms to reflect PRN and STAT data separately. 5. Provide staff training on policy and procedure revisions. 6. Ensure staff competency regarding deficiencies and appropriate procedures for safe administration of PRN medications and STAT medications. 7. Same as in D.1.f. and F.1.b.
a.iii	documentation of the individual's response to PRN and Stat medication.	<p>Findings:</p> <p>MSH reported 77% compliance with this requirement. However, PRN and STAT medication data were not reported separately.</p> <p>From my review of 12 individuals who received a PRN, all had only the word "effective" documented as to the individual's response. From review of 10 individuals who received a STAT medication, 9 had a description of the individual's response to the STAT medication.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure staff competency regarding the documentation of specific indicators describing an individual's response to PRN and STAT medications. 2. Clarify and specify criteria regarding what should be

		<p>documented regarding an individual's response to PRN and STAT medications to ensure consistent data.</p> <ol style="list-style-type: none"> 3. Revise 24 Hour Medication Audit tool to include response to STAT medications. 4. Ensure staff competency regarding deficiencies and appropriate procedures for safe administration of PRN medications and STAT medications.
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>Findings: MSH's current monitoring tools do not address the MTR and the controlled medication log separately in the data. In addition, the current Medication (Variance) Error Procedure policy does not adequately address this requirement.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Revise monitoring tools to include this requirement. 2. 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. 3. Develop and implement a system to monitor that appropriate follow-up occurs to prevent recurrence of such variances. 4. Provide training to staff regarding the above.
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</p>	<p>Findings: MSH reports 60% compliance with the requirement that nursing interventions are written in a manner that is aligned with the rest of the interventions in the WRP. Compliance with observable was 65%, behavioral was 56%, and measurable was 55% for Objectives. The data reporting separate nursing care plans and nursing diagnoses present was</p>

	<p>measurable terms. No nursing care plans other than the nursing interventions integrated in the therapeutic and rehabilitation service plan are required. No nursing diagnoses other than as specified in the therapeutic and rehabilitation service plan, in terms of the current DSM criteria, are required.</p>	<p>not clear as to percent of compliance.</p> <p>From my review, I noted that there are still separate nursing care plans and nursing diagnoses in some of the charts. In addition, many of the nursing interventions that are included in the WRPs are not proactive and include meaningless language such as "will monitor".</p> <p>In addition, there is generally no clinical objective data that is generated from most of the nursing interventions to determine if individuals are better or worse. Interventions that included "will monitor" did not specify what was to be monitored, how often, where it should be documented, when it would be reviewed and by who.</p> <p>As in accordance with the MSH data, I noted that many of the interventions were not written in observable, behavioral, and/or measurable terms.</p> <p>The monitoring and tracking tools do not reflect specific criteria for appropriate interventions to ensure accurate data.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Revise policies and procedures to reflect this requirement. 3. Ensure that all nursing and psychiatric technicians are competent with regard to the WRP and the Recovery Model. 4. Ensure that interventions are written in observable, behavioral, and/or measurable terms. 5. Develop and implement proactive interventions related to the individuals needs. 6. Revise appropriate monitoring and tracking instruments to
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		ensure accuracy of data collected.
d	All nursing staff working with an individual shall be familiar with the goals, objectives and interventions for that individual.	<p>Findings: MSH reported 36% compliance with staff familiar with the individuals' goals, 37% compliance with staff familiar with the individuals' objectives, and 41% compliance with staff familiar with the individuals' interventions for 146 individuals. There was no indication what time frame these data represented. In addition, the data did not indicate how many staff was interviewed. There also was no indication from the data if all staff interviewed were regular staff or floats from other units or agencies.</p> <p>From this monitor's interviews with staff, most were very familiar with the medical issues of the individuals. However, they were not familiar with the goals, objectives, or interventions contained in the WRPs.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Fully integrate nursing into the WRP process for individuals. 2. Ensure staff competency in developing, reviewing, revising and implementing the WRP. 3. Evaluate staffing patterns to promote continuity of care. 4. Continue to monitor and track this requirement. 5. Develop and implement a statewide monitoring tool for the key elements of this requirement.
e	Each State hospital shall ensure that nursing staff timely monitor, document and report the status of symptoms, target variables, health, and mental health status, of individuals in a manner that enables interdisciplinary teams to assess each individual's status, and response to	<p>Findings: MSH does not have a monitoring system in place for this requirement. The MSH Nursing Progress Notes Monitoring tool that nursing used to address this requirement is inadequate in measuring compliance with this requirement.</p>

	<p>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>In addition, MSH does not have a monitoring system in place to address nursing shift changes reviewing changes in status of individuals on the units.</p> <p>The shift change report that I observed on unit 419 was not representative of a routine shift-to-shift report. The one I attended included the medical physician, psychiatrist, and psychologist and lasted over 2 hours. When asked if this was the regular make-up of disciplines for this shift change report, I was informed it was not and did not take over 2 hours to complete.</p> <p>Compliance: Non-compliance</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a system for monitoring and tracking the key elements of this requirement. 2. Develop and implement policies and procedures addressing criteria for shift change reports.
f	<p>Each State hospital shall develop and implement a system to monitor nursing staff while administering medication to ensure that:</p>	<p>Compliance: Partial.</p>
f.i	<p>nursing staff are knowledgeable regarding each individual's prescribed medications;</p>	<p>Findings: MSH reported: 86% compliance in verbalizing generic and trade names. 99% compliance in identification of target symptoms, usual doses, and routes (these elements need to be broken out to provide accurate data). 99% compliance describing therapeutic effects of medications. 96% compliance differentiating expected side effects from adverse reactions. 98% compliance with explanation on how to administer sliding scale for</p>

		<p>regular insulin and appropriate interventions of hypo/hyperglycemia.</p> <p>From my review, there appears to be a greater emphasis on the knowledge of the medical medications as opposed to the psychotropic medications. Knowledge of both is essential.</p> <p>In addition, it was reported that nursing instructors rather than unit supervisors basically monitor medication administration. Also, there is no system in place to ensure that every nurse that administers medication is observed on a quarterly basis. The current practice is to conduct observations annually.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. 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. 2. Include unit supervisors in the process of observing medication administration. 3. Develop and implement system to ensure that every nurse that administers medication is observed on a quarterly basis.
f.ii	education is provided to individuals during medication administration;	<p>Findings:</p> <p>MSH reported a total of 107 staff were observed passing medications from March through August 2006. Compliance with this requirement was reported 87%.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure staff competency regarding the implementation of this requirement. 2. Continue to monitor and track this requirement.

f.iii	nursing staff are following the appropriate medication administration protocol; and	<p>Findings: MSH reported 95% compliance. However, the monitoring instrument was revised and it is unclear if these data reflect the revisions. In addition, the monitoring instrument does not measure compliance with signing the MTR at the time medications are given. Blanks on the MTRs have been problematic in the past.</p> <p>Recommendation: Revise monitoring instrument to reflect the complete medication administration protocol to ensure appropriate medication administration practices.</p>
f.iv	medication administration is documented in accordance with the appropriate medication administration protocol.	<p>Findings: MSH reported 76% compliance for signed out narcotics correctly, 93% compliance that medication that was given was documented on MTR and 94% compliance that medication that was not given was documented as not given on MTR, 100% compliance with documented reasons for administering PRN/STAT medications, 100% compliance with documented phone orders, and 90% compliance with documented Involuntary/Emergency medication administration for PRN.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Continue to monitor the key element of this requirement. 2. Ensure staff competency regarding documentation of medication administration in accordance with the appropriate medication administration protocol.
g	Each State hospital shall ensure that individuals remain in a "bed-bound" status only for clinically justified reasons.	<p>Findings: MSH reported 2 residents who meet this criterion with data indicating 100% compliance with this requirement.</p> <p>From this monitor's review of the same 2 residents, I found both records not in compliance with this requirement.</p>

		<p>Compliance: Non-compliance.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Revise policies and procedures to address the key element in this requirement. 2. Revise monitoring and tracking system to address the key element of this requirement and the specific criteria for documentation to ensure accurate data.
h	Each State hospital shall ensure that, before they work directly with individuals, all nursing and psychiatric technicians have successfully completed competency-based training regarding:	<p>Compliance: Partial.</p>
h.i	mental health diagnoses, related symptoms, psychotropic medications and their side effects, monitoring of symptoms and target variables, and documenting and reporting of the individual's status;	<p>Findings: The data reported from nursing reported 100% compliance with each of the key elements of this requirement. However, from my interview with the Human Resource Director, it was reported that there is no system in place to verify that all staff have completed nursing orientation. From my review of 14 personnel files, there was no indication that orientation or mandatory training had been completed.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a reliable system to monitor and track staff that has not completed orientation and annual mandatory training. 2. Assign responsibility for follow-up for attendance at orientation and other required training. 3. Ensure completion of classes and skill demonstration prior to competency validation.

h.ii	the provision of a therapeutic milieu on the units and proactive, positive interventions to prevent and de-escalate crises; and	<p>Findings: There is no system in place to monitor and track this requirement. The data provided by the nursing department did not reflect the implementation of this requirement.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that there are training classes to specifically address therapeutic milieu on the units and proactive, positive interventions to prevent and de-escalate crises. 2. Develop and implement a system to adequately monitor and track this requirement.
h.iii	positive behavior support principles.	<p>Findings: MSH reported 41% compliance with this requirement. MSH reported that there were an insufficient number of PBS instructors as well as poor nursing staff attendance at the PBS training. From my review, there is no system in place to ensure that nursing staff attend this training requirement.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that Program Directors are held responsible for any nursing staff, including psychiatric technicians, who do not attend scheduled PBS training. 2. Develop and implement a system to ensure that nursing staff attend PBS training. 3. Continue to monitor and track attendance at PBS training.
i	Each State hospital shall ensure that, prior to assuming their duties and on a regular basis thereafter, all staff responsible for the administration of medication has successfully completed competency-based training on the completion of the MTR and the controlled medication log.	<p>Findings: MSH reported 100% compliance for nursing orientation and 51% compliance for NAU class. Nursing reported that a system was developed to ensure the mandatory trainings are completed and maintained in the training database. However, tracking and follow-up by programs is inadequate.</p>

		<p>Compliance: Partial.</p> <p>Recommendations: Assign responsibility and accountability at the program level for tracking and ensuring mandatory training and competency validation.</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: Interviewed Mari Cobb, Chief of Rehabilitation Services. Interviewed Joellen Arce, RN. Interviewed Rommel Dizon, DPT. Interviewed Meseret Seyoum, OT. Interviewed Edward Arguijo, SLP Reviewed Occupational Therapy Manual. Reviewed Table of Organization for Committee Structure. Reviewed Executive Branch Organization Chart. Reviewed Organizational Chart for Clinical Services. Reviewed Organizational Chart for Administrative/Support Services. Reviewed Organizational Chart for Medical Services Department. Reviewed Speech Pathology Manual. Reviewed MSH Rehabilitation Services Manual. Reviewed Physical Therapy Manual Reviewed Integrated Rehabilitation Therapy Assessment. Reviewed Comprehensive Evaluation in Recreational Therapy (CERT). Reviewed AD Required Time Frame for Patient Record Documentation. Reviewed Rehabilitation Therapy Documentation Audit. Reviewed charts for RC, GW, BB, CL, GA, JS, CC, DG, AM, LW, EG, JC, HN, FG, AM, FA, SB, PC, RT, VK, AD, JP, HG. Reviewed list of individuals with adaptive equipment. Reviewed list of individuals at risk for choking. Reviewed list of individuals at risk for dysphagia and aspiration. Reviewed list of individuals with hearing aids.</p>

		<p>Observed individuals in wheelchairs on units 418 and 419.</p> <p>Observed mealtime for Program 1.</p> <p>Reviewed OT and PT caseloads.</p> <p>Reviewed OT, PT, and Speech assessments.</p> <p>Reviewed bed bound client charts.</p> <p>Received report on individuals during walking rounds on unit 418 and 419.</p>
a	Each State hospital shall develop and implement policies and procedures, consistent with generally accepted professional standards of care, related to the provision of rehabilitation therapy services that address, at a minimum:	<p>Compliance: Partial.</p>
a.i	the provision of direct services by rehabilitation therapy services staff; and	<p>Findings: MSH's rehabilitation therapy services policies and procedures do not include the principles and language of the Wellness and Recovery Model, psychiatric rehabilitation, or principles of recovery. In addition, OT, PT, and Speech Therapy are not integrated into the Rehabilitation Department.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Revise policies and procedures to include principles and language of the Wellness and Recovery Model, psychiatric rehabilitation, and recovery principles. 2. Integrate OT, PT, and Speech Therapy into the Rehabilitation Department as well as into the WRP and team process.
a.ii	the oversight by rehabilitation therapists of individualized physical therapy programs implemented by nursing staff.	<p>Findings: There is no oversight provided by the specialty therapies (OT, PT, Speech Therapy) of individualized programs that are implemented by nursing staff.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a system to provide regular oversight by rehabilitation therapists to nursing staff implementing

		<p>individualized PT programs.</p> <p>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.</p>
b	<p>Each State hospital shall provide competency-based training to nursing staff, as appropriate, on the use and care of adaptive equipment, transferring, and positioning, as well as the need to promote individuals' independence.</p>	<p>Findings: MSH reports that informal training is taking place. However, it is rarely documented and is not competency-based.</p> <p>There is no system in place to monitor this requirement.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a system to provide and document competency-based training on 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>Findings: From my review, there is no system in place to ensure compliance with the key elements of this requirement. As mentioned in the Rehabilitation Therapy Assessment section of this report, there are many unmet therapy needs at MSH. In addition, there is no system in place to review the adequacy of the specialty therapies (OT, PT, Speech Therapy).</p> <p>Compliance: Non-compliance.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a system to adequately monitor this

		<p>requirement.</p> <p>2. See Recommendations for Rehabilitation Therapy Assessments.</p>
d	<p>Each State hospital, consistent with generally accepted professional standards of care, shall ensure that each individual who requires adaptive equipment is provided with equipment that meets his/her assessed needs and promotes his/her independence, and shall provide individuals with training and support to use such equipment.</p>	<p>Findings: There is no monitoring system in place to ensure compliance with the key elements of this requirement. For example, there were significant inconsistencies regarding the number of individuals who have a risk for aspiration. Dietary reported there were only 2 individuals in the facility with dysphagia while another list was generated later in the week that included 104 individuals. In addition, there is no formal tracking system in place to ensure that all adaptive equipment is available, in appropriate working condition, and is being cleaned in a regular basis.</p> <p>Compliance: Non-compliance.</p> <p>Recommendation: Develop and implement a system to monitor the key elements of this requirement.</p>
5	Nutrition Services	
	<p>Each State hospital shall provide the individuals it serves, particularly those experiencing weight-related problems, adequate and appropriate dietary services consistent with generally accepted professional standards of care.</p>	<p>Methodology: Interviewed Mary Christine Marshall, Director of Dietetics. Reviewed Nutrition Care Monitoring Tool (NCMT). Reviewed Nutrition Care Process (NCP). Reviewed Department of Dietetics Policy and Procedure Manual. Reviewed NST acuity and indicators form. Reviewed Nutritional Screening/High Risk Patients policy. Reviewed Indicators For Nutritionally High Risk Patients. Reviewed AD Patient Meal Service and Nutritional Care. Reviewed NP Height/Weight/BMI/Waist Circumference. Reviewed NP Dysphagia/Choking Assessment. Reviewed NP Foreign Body Airway Obstruction Management/Choking.</p>

		<p>Reviewed list of residents with dysphagia. Reviewed AD Wellness and Recovery. Reviewed Guidelines For The Nutritional Management Of Patients At Risk of Choking And/Or Aspiration/Aspiration Pneumonia. Reviewed Dysphagia/Choking Screening. Reviewed Dysphagia Program. Reviewed MSH Individual Training Reports. Reviewed MSH Professional Education Training/Nursing Education. Reviewed Enteral Nutrition Support policy. Reviewed dietary data provided by MSH. Reviewed charts of 23 individuals (RC, GW, BB, CL, GA, JS, CC, DG, AM, LW, EG, JC, HN, FG, AM, FA, SB, PC, RT, VK, AD, JP and HG).</p>
a	<p>Each State hospital shall modify policies and procedures to require that the therapeutic and rehabilitation service plans of individuals who experience weight problems and/or related health concerns include adequate strategies and methodologies to address the identified problems and that such strategies and methodologies are implemented in a timely manner, monitored appropriately, and revised, as warranted, consistent with generally accepted professional standards of care.</p>	<p>Findings: MSH reported that the Department of Dietetics Weight Management Protocol/Procedure has been approved by the Patient Care Committee. However, no data was submitted to address this requirement.</p> <p>Compliance: Non-compliance.</p> <p>Recommendations: Develop and implement a system to monitor this requirement.</p>
b	<p>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>	<p>Findings: There is no system in place that ensures 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> <p>A statewide training tool has not been completed addressing this requirement.</p>

		<p>Compliance: Non-compliance.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a monitoring system to 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. 2. Develop and implement a statewide tool for the training of staff regarding this requirement.
c	<p>Each State hospital shall develop and implement policies and procedures to address the needs of individuals who are at risk for aspiration or dysphagia, including but not limited to, the development and implementation of assessments and interventions for mealtimes and other activities involving swallowing.</p>	<p>Findings: The current MSH policies and procedures regarding risk of aspiration and dysphagia are inadequate to guide the provision of safe care to this population. The SLP, OT, PT, nurses, and other disciplines have little experience and expertise in this particular area. There is no system in place to ensure that a comprehensive, integrated, 24-hour dysphagia care plan is developed and implemented.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that this requirement is met. 2. Revise policies and procedures in accordance with generally accepted standards of practice regarding risk of aspiration/dysphagia. 3. Develop and implement 24-hour, individualized dysphagia care plans. 4. Provide competency-based training to staff regarding risk of aspiration/dysphagia. 5. Provide competency-based training on individualized, 24-hour

		<p>dysphagia care plans to staff working with individuals at risk of aspiration/dysphagia.</p> <p>6. 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>Findings: MSH has provided some training regarding aspiration and dysphagia, however, it has not been adequate or competency-based.</p> <p>Compliance: Non-compliance.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure staff competency-based training regarding the implementation of this requirement. 2. 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>Findings: The current policies and procedures at MSH does not address the key elements of this requirement.</p> <p>Compliance: Non-compliance.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Revise policies and procedures to reflect key elements of this requirement. 2. Develop and implement a system to monitor this requirement.
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</p>	<p>Methodology: Interviewed Harold Plon, PharmD. Interviewed Glen Itow, PharmD.</p>

	develop and implement policies and procedures that require:	<p>Interviewed Quydh-NGA Ton-Nu, PharmD. Reviewed Pharmacy Policy and Procedure Manual. Reviewed Pharmacy job descriptions. Reviewed New Medication Review tool. Reviewed pharmacy raw data provided by MSH. Reviewed Microsoft Access Client Information. Reviewed New Medication Review Tally Sheets.</p>
a	Upon the prescription of a new medication, pharmacists to conduct reviews of each individual's medication regimen and, as appropriate, make recommendations to the prescribing physician about possible drug-to-drug interactions, side effects, and need for laboratory work and testing; and	<p>Findings: There are currently 16 pharmacists at MSH. In addition, there are 13 pharmacy techs.</p> <p>MSH reported 100% compliance for medication reviews, 100% compliance with drug-drug interactions, 40% compliance for side effects, 0% compliance for needed lab work.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Complete and implement an electronic system for documentation. 2. Provide IT assistance to pharmacy regarding electronic database and data collection systems. 3. Ensure pharmacy staff competency regarding 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>Findings: There is no system in place to ensure that physicians considered pharmacists' recommendations, and for any recommendations not followed, documented in the individual's medical record an adequate clinical justification.</p> <p>Compliance: Non-compliance.</p>

		<p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement policies and procedures in collaboration with pharmacy and medical/psychiatry to address this requirement. 2. Assign responsibility and accountability to medical/psychiatry for plans of corrections for problems identified. 3. Develop and implement a monitoring system for this requirement.
7	General Medical Services	
		<p>Methodology:</p> <p>Interviewed Vinh Bach, M.D., Program Director, Medical Services. Interviewed Joellyn Arce, R.N., Supervising Registered Nurse and Program Assistant, Medical Services. Reviewed Medical Emergency Response Work Sheet. Interviewed Chi Vu, M.D. staff physician. Interviewed Bhaviesh Shah, M.D., Staff Physician. Reviewed Medical Emergency Response Work Sheet. Reviewed AD #3304 regarding Medical Emergencies-Ambulance Service and Paramedic Unit (PMU). Reviewed AD #1050 regarding Medical Clinic Services. Reviewed AD #3106 regarding Acute Medical Care Clinics. Reviewed AD # 0004 regarding Physicians of the day (P.O.D). Reviewed AD # 3112 regarding Podiatry Clinic. Reviewed AD #3103 regarding Dental Clinic. Reviewed AD #3261 regarding Referral to Community Medical Facilities. Reviewed AD #1052 regarding Physical, Occupational and speech therapy. Reviewed Duty Statement regarding Medical Consultants (Program Physicians). Reviewed Duty Statement regarding the role of physicians in the admission suite. Reviewed Duty Statement regarding physician officer of the day (POD).</p>

		<p>Reviewed medical Quality Management monitors-Urgent and Emergent care.</p> <p>Reviewed department of medicine meeting minutes (May 10, 2006 and July 19, 2006).</p> <p>Reviewed Quality of Care Monitoring Instrument for Hypertension and summary data.</p> <p>Reviewed Quality of care monitoring for Diabetes Mellitus and summary data.</p> <p>Reviewed Quality of care Monitoring for Asthma/COPD.</p> <p>Reviewed Initial Admission Assessment Monitoring Form and summary data.</p> <p>Reviewed Quality Assurance Monitor regarding Radiology.</p> <p>Reviewed Quality Assurance Monitor regarding EKG and EEG studies.</p> <p>Reviewed charts of four individuals (CG, TP, NK and JJM).</p> <p>Reviewed List of individuals requiring hospitalization, E.R. care and/or medical emergency response.</p> <p>Reviewed Physical Health trigger summary data (January-June 2006).</p>
<p>a</p>	<p>Each State hospital shall provide adequate, appropriate, and timely preventive, routine, specialized, and emergency medical care to all individuals in need of such services, consistent with generally accepted professional standards of care. Each State hospital shall ensure that individuals with medical problems are promptly identified, assessed, diagnosed, treated, monitored and, as monitoring indicates is necessary, reassessed, diagnosed, and treated, consistent with generally accepted professional standards of care.</p>	<p>Findings:</p> <p>The medical services employ 17 full-time physicians; eight are board-certified in internal medicine or family practice. All physicians are licensed and have completed at least one year of internship in medicine. The physicians provide regular coverage of each program as well as on-call medical coverage of the facility at all times. The on-call coverage is provided by a designated program physician from 8:30 am to 4:30 pm. Three full-time physicians ensure on-call coverage after hours.</p> <p>The emergency medical response at MSH is provided by a team of paramedics working for the fire department at Norwalk and the response is limited to first aid/basic CPR and transfer to regional community hospital, usually Norwalk Community Hospital. The facility has procedures that address some aspects of the medical emergency response.</p>

		<p>In addition to the medical service staff physicians, MSH has contractual arrangements with a variety of consultants who provide on-site specialty clinics. These specialty clinics together with the facility's regular clinics include cardiology, podiatry, neurology, hypertension, diabetes, asthma/COPD, dermatology, nephrology/urology, ophthalmology, optometry, physical therapy, EKG/EEG, speech therapy, dental and public health/viral clinics.</p> <p>Individuals who require a level of care not available at MSH are transferred to USC Medical Center except for Orange County individuals who are sent to UCI medical center.</p> <p>At this time, the medical service at MSH has adequate staffing levels and a range of consultation services and contractual arrangements that can meet the needs of the individuals served.</p> <p>The facility has conducted self-monitoring to evaluate its compliance this requirement. The process included:</p> <ol style="list-style-type: none"> 1. A review of 24 charts (during May through July 2006) by peers using the Quality Management Monitor for Non urgent Medical Conditions. The following is an outline of the relevant data, including indicators and compliance rates: <ol style="list-style-type: none"> a) "Was the patient seen within two hours: 91%;" b) "Was an appropriate history documented: 91%;" c) "Was an appropriate physical examination performed and documented: 91.3%;" d) "Was an appropriate differential diagnosis generated: 100%;" e) "If there was tissue damage, was tetanus status ascertained: 67%;" f) "If patient suffered human bite or exposure to bloody/body fluids was HIV and hepatitis screening
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		<p>performed: N/A;</p> <p>g) "Were appropriate diagnostic steps undertaken: 94.4%;" and</p> <p>h) "Was medical care adequate and appropriate: 96%."</p> <p>2. A review of 16 charts (during January through July 2006) by peers using the Quality Management Monitor for Emergencies (life threatening incidents). The following is an outline of the relevant data, including indicators and compliance rates:</p> <p>a) "Did the ambulance/paramedics arrive within fifteen minutes: 92%;"</p> <p>b) "Was CPR initiated: 18.7%;"</p> <p>c) "Was AED (automatic external defibrillator) performed: 12.5%;" and</p> <p>d) "If the patient was transferred to the hospital, was it timely & appropriate: 75%."</p> <p>3. A review of 79 charts of individuals diagnosed with hypertension (during June and August 2006). This review was conducted by Health Services Specialists to assess quality of care, including medications, dietary considerations, etc. An overall compliance rate of 70% was reported.</p> <p>4. A review of 105 charts of individuals diagnosed with diabetes mellitus to assess overall management. Health Services Specialists performed this review (April and August 2006) and found overall compliance rate of 78%.</p> <p>In addition, MSH also has monitoring data based on reviews of the management of asthma/COPD, frequency of hospitalizations, missed clinic appointments and timely reporting and quality of Xrays, EKG and EEG studies. As mentioned under section D.1.C.i, the facility utilized the Initial Admission Medical Assessment Monitoring Form and found 100% compliance rates (this monitor's findings did not corroborate this rate).</p>
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		<p>improve integration of medical and mental health care.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement policy and procedure to codify facility's standards and expectations regarding the areas outlined above. 2. Ensure that monitoring instruments are aligned with the policy and procedure and that the data address not only timeliness and completeness of medical assessments but also quality of assessments and management interventions. 3. Ensure easy access by physicians to the laboratory information system, radiology data/reports, chart notes and consultation reports. 4. Same as in C.1.c.i
b	Each State hospital shall develop and implement protocols and procedures, consistent with generally accepted professional standards of care, that:	<p>Compliance: Partial.</p>
b.i	require the timely provision of initial and ongoing assessments relating to medical care, including but not limited to, vision care, dental care, and laboratory and consultation services;	<p>Findings: As above.</p> <p>Recommendations: As above.</p>
b.ii	require the timely provision of medical care, including but not limited to, vision care, dental care, and laboratory and consultation services; timely and appropriate communication between nursing staff and physicians regarding changes in an individual's physical	<p>Findings: The facility utilized the quality assurance monitor regarding radiology to assess the timeliness of obtaining STAT X-rays within one hour. The data show compliance rates of 45% in April, 81% in May and 100% in June.</p>

	status; and the integration of each individual's mental health and medical care;	<p>The facility has data that indicates 100% compliance with the timely reporting of STAT EKGs (physician notification within 30 minutes) and routine EKGs and EEGs (January to August 2006).</p> <p>Recommendations: As above.</p>
b.iii	define the duties and responsibilities of primary care (non-psychiatric) physicians;	<p>Findings: The current medical staff duty statement outlines the duties and responsibilities, but does not clearly or adequately address the standards and expectations in the specific areas outlined in F.7.a.</p> <p>Recommendations: Ensure that the duty statement outlines the performance standards and expectations as above.</p>
b.iv	ensure a system of after-hours coverage by primary care physicians with formal psychiatric training (i.e., privileging and proctorship) and psychiatric backup support after hours; and	<p>Findings: The current system of after-hours coverage by primary care physicians appears to be adequate regarding physical health needs of the individuals. However, the facility does not provide psychiatric on-site coverage for mental health emergencies and is yet to implement competency-based training of on-site physicians in the assessment and management of psychiatric emergencies</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement competency-based training curriculum in psychiatric emergencies for on-site primary care physicians. 2. The above training must comport with current generally accepted standards and be sufficient to ensure the safety of individuals during after-hours.
b.v	endeavor to obtain, on a consistent and timely basis, an individual's medical records after the individual is	<p>Findings: At present, MSH does not have a tracking system that identifies</p>

	treated in another medical facility.	<p>expectations regarding timeliness and content of needed documentation.</p> <p>Recommendations: Develop and implement adequate tracking system.</p>
c	Each State hospital shall ensure that physicians monitor each individual's health status indicators in accordance with generally accepted professional standards of care, and, whenever appropriate, modify their therapeutic and rehabilitation service plans to address any problematic changes in health status indicators.	<p>Findings: As mentioned in section C.2., this monitor's reviews indicate that, in general, the foci of hospitalization, objectives and interventions are not modified to reflect changes in the physical status of individuals. This deficiency was noted in the services provided to individuals suffering from cognitive disorders, weight changes, substance abuse, seizure disorders.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement monitoring and tracking instruments to ensure that the foci of hospitalization address current assessed medical needs and that foci, objectives and interventions are modified in a timely basis to address the changes in the physical status of the individuals. 2. Develop and implement formalized mechanisms to improve integration of medical staff into the interdisciplinary functions of the WRP.
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>Findings: As mentioned earlier, the facility monitors hospital transfers, missed clinic appointments and management of individuals diagnosed with hypertension, diabetes mellitus and asthma/COPD. Although MSH has instituted a number of process improvements in the medical service, the facility does not have a formalized data-driven system that evaluates health care outcomes for the individuals and process outcomes for the</p>

		<p>medical service.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a formalized physician peer review system that utilizes indicators aligned with the standards and expectations outlined in F.7.a. 2. 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. Expedite efforts to automate data systems to facilitate data collection and analysis.
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: Interviewed Lorraine Clinton, PHN. Interviewed Charlene Hooper, PHN. Dr. Bach present for a portion of the interviews. Reviewed Infection Control Manual. Reviewed California Department of Health Services Guidelines. Reviewed JCAHO Guidelines. Reviewed AD Infection Control Program. Reviewed MSH Public Health Protocol Guidelines For Policies And Procedures For Infection Control. Reviewed MSH Public Health Protocol for Gastroenteritis. Reviewed Guidelines for Confirmation of Foodborne-Disease Outbreaks. Reviewed MSH information sheet regarding Hepatitis A. Reviewed MSH Public Health Protocol Care And Treatment Of Patients</p>

		<p>With HIV Disease.</p> <p>Reviewed Steps of an Outbreak Investigation.</p> <p>Reviewed MSH information sheet regarding Surveillance, Prevention, and Control of Infection.</p> <p>Reviewed Guide to California's HIV/AIDS Laws, 2004.</p> <p>Reviewed MSH Types of Skin and Soft Tissue Infection 2006-2007.</p> <p>Reviewed Infection Report form.</p> <p>Reviewed Non adherence to standard precautions and transmission based precautions audit form.</p> <p>Reviewed Hand washing Survey tool.</p> <p>Reviewed Report of Employee Infections tool.</p> <p>Reviewed Public Health Survey tool.</p> <p>Reviewed MSH's Known Event of Sexual Activity report for May 2005.</p> <p>Reviewed Infection Control Committee minutes for February 22, 2006 and March 23, 2006.</p>
a	Each State hospital shall establish an effective infection control program that:	<p>Compliance:</p> <p>Non-compliance.</p>
a.i	actively collects data regarding infections and communicable diseases;	<p>Findings:</p> <p>MSH provided no data regarding the requirements for Infection Control.</p> <p>In addition, there were several disciplines that had outdated policies regarding Infection Control: Medical, General Supply, EEG/EKG, PT, Patient Clinic, Speech Therapy, Radiology, Pharmacy, Laundry, Rehabilitation, Dietary, and Plant Operations.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a monitoring system for the key elements of these requirements. 2. Develop and implement statewide monitoring instruments to

		<p>monitor the key elements for Infection Control.</p> <p>3. Provide training on the above recommendations to Infection Control staff.</p> <p>4. Revise policies and procedures to reflect key elements in the requirements for Infection Control.</p> <p>5. Review and update disciplines Infection Control policies.</p>
a.ii	assesses these data for trends;	<p>Findings: MSH provided no data regarding the EP requirements for Infection Control.</p> <p>Recommendations: Same as above.</p>
a.iii	initiates inquiries regarding problematic trends;	As above.
a.iv	identifies necessary corrective action;	As above.
a.v	monitors to ensure that appropriate remedies are achieved; and	As above.
a.vi	integrates this information into each State hospital's quality assurance review.	As above.
9	Dental Services	
	Each State hospital shall provide individuals with adequate, appropriate and timely routine and emergency dental care and treatment, consistent with generally accepted professional standards of care.	<p>Methodology: Interviewed Toni Nguyen, DDS. Interviewed John Herdeg, DDS. Reviewed charts of 23 individuals (RC, GW, BB, CL, GA, JS, CC, DG, AM, LW, EG, JC, HN, FG, AM, FA, SB, PC, RT, VK, AD, JP and HG). Reviewed MSH Dental Chart Review data. Reviewed Dental Antibiotic log. Reviewed MSH Department of Medicine Medical Staff Audit form and</p>

		<p>data. Reviewed Monthly Dental Clinic Report March-August 2006. Reviewed Keys to Dental Charting. Reviewed Dental Record form. Reviewed MSH Dental Monitoring Plan. Reviewed Residents Admit/Exam Records. Reviewed MSH Dental Self-Assessment Guide. Reviewed Dental log of incomplete appointments.</p>
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>Findings: MSH has 2 staff dentists and 2 dental assistants. The ratio of dentist to patient is 1:500. There is no position at MSH for a Chief dentist, which serves the role of representation for the dental staff. In addition, there is no clerical staff in the dental department to assist with data collection and data entry. Consequently, the staff dentists have had to develop and implement a monitoring system, which has taken time away from providing services to the residents at MSH. The normal waiting time for a dental appointment was from 2-3 weeks. Currently, it is now 7 to 8 weeks due to the data collection and monitoring done solely by the staff dentists.</p> <p>MSH reported 81% compliance with timeliness of 90 day/annual exams. However, the data for 90 day and annual was not separated out to indicate compliance for each of these timeframes. In addition, MSH reported that 100% of emergency referrals were seen within the timeframes as requested by the referring physician.</p> <p>There is no policy addressing after-hours emergency dental care.</p> <p>Data is compiled by hand since most of the dental record system is not automated.</p>

		<p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Evaluate the need for additional dentists, dental auxiliary staff, a Chief dentist position, and clerical staff for the dental department. 2. Separate data for 90 day and annual examinations. 3. Develop and implement a policy to address the management of after-hours dental emergencies. 4. Obtain a dental management software package to reduce time spent on record keeping and to ensure accurate data.
b	Each State hospital shall develop and implement policies and procedures that require:	<p>Compliance: Partial.</p>
b.i	comprehensive and timely provision of dental services;	<p>Findings: No data were provided regarding policies and procedures as required by this cell.</p> <p>Recommendations: Review and revise policies and procedures as need to address this requirement.</p>
b.ii	documentation of dental services, including but not limited to, findings, descriptions of any treatment provided, and the plans of care:	<p>Findings: MSH reported 100% compliance.</p> <p>The dental information kept in the resident's charts is not consistent with the information kept in the dental department. If charts are not brought to the appointments, information regarding dental services is not accurately reflected.</p>

		<p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that dental information contained in resident's records is accurate and up to date. 2. Ensure that staff brings resident's records to all dental appointments.
b.iii	use of preventive and restorative care whenever possible; and	<p>Findings: MSH reported 71% compliance for preventative and restorative care annually. Problems are diagnosed during the routine exam, but due to the limited manpower, the dental problems are not addressed in a timely manner. It was reported that 30-45% of time is spent on dental exams; 30-40% is spent on preventative dental care and less than 25% is devoted to restorative care, oral surgery, endodontics, and periodontics.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Increase the number of dental staff to provide appropriate and timely services. 2. Continue to monitor this requirement.
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: MSH reported 100% compliance that extraction cases had xray and/or written justification for the extraction.</p> <p>Documentation in the resident's records was not consistent with documentation in the dental records kept in the dental department. However, justification was present in the dental records in the department.</p> <p>Recommendation: Develop and implement a system to ensure that dental information contained in resident's records is accurate and up to date.</p>

c	<p>Each State hospital shall ensure that dentists demonstrate, in a documented fashion, an accurate understanding of individuals' physical health, medications, allergies, and current dental status and complaints.</p>	<p>Findings: There is no monitoring instrument that adequately addresses this requirement.</p> <p>MSH reported that clinicians demonstrate understanding of the residents' medical conditions by prescribing appropriate medications when necessary. The facility's monitoring indicator should reflect that the dentists have reviewed the medical diagnoses and that the diagnoses are documented on the dental assessments.</p> <p>There was no data indicating that this requirement was being monitored.</p> <p>MSH did report 87% compliance that reviewed charts had medical findings the appropriate area.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a monitoring instrument that adequately addresses this requirement. 2. Develop and implement a system to monitor this requirement.
d	<p>Each State hospital shall ensure that transportation and staffing issues do not preclude individuals from attending dental appointments, and individuals' refusals are addressed to facilitate compliance.</p>	<p>Findings: MSH reported that staffing issues from the units is problematic. They reported 17% of canceled appointments were due to lack of 1:1 staff and no charts brought to the clinic with the patients. In addition, 6% of missed appointments were due to the wheelchair van not being available for use.</p> <p>Compliance: Partial.</p>

		<p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that adequate staffing and transportation is available for residents to attend their dental appointments. 2. Improve the communication between the unit staff, clinical scheduling coordinator, and dental assistants to ensure residents are available for their dental appointments.
<p>e</p>	<p>Each State hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to overcome individual's refusals to participate in dental appointments.</p>	<p>Findings:</p> <p>MSH reported that the current procedure for refusals for dental services included after 3 consecutive refusals, the resident's name is given to the Director of Medical Services in the monthly report and a list is forwarded to the unit supervisor to share with the IDTs. However, there is no system in place to monitor and track actions taken by the IDTs.</p> <p>The dental department has recently developed a monitoring tool to track chronic refusals, date sent to the unit IDTs, date received a response from unit, and results of interventions (positive or negative). There has been little to no response from the units regarding follow-up regarding the refusals.</p> <p>Compliance:</p> <p>Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a system to monitor and track interventions and outcomes for dental refusals. 2. Develop and implement a facility-wide system to facilitate communication with dental and the Wellness and Recovery teams regarding individualized strategies to address refusals of dental appointments and treatments.

10	Special Education	
	<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: Attended MSH presentation to DOJ team (September 18, 2006). Reviewed MSH EP, Section F.10, A-G. Reviewed IEPs (JT, ES, VC, FK, SF, and DH) (September 18). Reviewed Psycho Educational Assessments (DH, SF, JT, and ES). Interviewed Mishelle Ross, Project Manager, and Jennifer Miller, Principal (September 18). Observed classroom instruction (Tiffany Bowers; September 18). Interviewed Tiffany Bowers, Teacher (September 18). Interviewed Ronald Williams, Teacher (September 18). Observed classroom instruction (Ronald Williams, Tiffany Bowers, and William Barnhart, September 19). Reviewed existing assessment tools that are used to monitor IEP compliance. Interviewed Marilu Tiberi-Vibra, Assistant Chief, Central Program Services (September 19). Reviewed credentials of teachers.</p>
a	<p>Each State hospital shall develop and implement uniform systems for assessing students' individual educational needs and monitoring their individual progress.</p>	<p>Findings: MSH has developed assessment tools for documenting compliance regarding IEPs, Psycho Educational Assessments, and other components of the Individuals with Disabilities Education Act. While the available data from these tools is helpful in establishing baseline levels of functioning, the tools at times are redundant and do not produce data that will allow for progress monitoring. In addition, the student records are incomplete, with missing data throughout. Finally, there were inconsistencies in timelines of communication between staff and families.</p> <p>The new Principal for the school, Jennifer Miller, indicated that a system will be put in place that allows progress monitoring of student</p>

		<p>achievement as well as tying classroom instruction to the goals and objectives of students' IEPs.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 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 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. 4. 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. 5. Use behavioral data to modify instruction to better meet students' needs. 6. Provide training to teachers and staff in the use of Excel to organize and graph academic and behavioral data.
<p>b</p>	<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 <i>et seq.</i> (2002) ("IDEA").</p>	<p>Findings: The review of IEPs and Psycho Educational Assessments yielded both some strengths and weaknesses, although the strengths tended to be randomly distributed while the weaknesses appeared more prevalent. Specific areas of concern include, but are not limited to: (a) IEP goals and objectives not being measurable and/or with inappropriate criteria for mastery (e.g., 50% compliance on audit item regarding having measurable goals and objectives, both academic and functional), (b) including parents in the IEP process, (c) having signed documentation that parents consented to Psycho Educational Assessment procedures</p>

		<p>(e.g., 50% compliance on audit item regarding assessment plan signed by the parent before assessments conducted), (d) providing appropriate present levels of performance, in multiple domains, in both IEP and Psycho Educational Assessment (e.g., 33% compliance on audit item regarding IEP including present levels of performance), (e) having complete IEP document on file (33% of files reviewed did not include current, complete IEP), (f) completing triennial evaluations within the prescribed timeline (e.g., 50% of files reviewed did not complete triennial evaluations within prescribed timeline), (g) multiple problems with consent timeline, (h) having the same goals, objective, and criteria on successive IEPs (e.g., ES & JT).</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Provide training to teachers and staff to ensure that IEP 2. goals and objectives are measurable and related to assessment 3. data. 4. Utilize the Individual Education Plan Meeting Audit form to both help structure meetings as well as documenting critical components. 5. Collaborate with families in establishing meeting times rather than informing them when meetings will occur. 6. Have signed parental consent documentation prior to performing assessment procedures. 7. Ensure that present levels of performance, in both academic and behavioral domains, are included in IEPs and Psycho Educational Assessments.
c	Each State hospital shall ensure that teachers providing instruction to students at each State hospital have completed competency-based training regarding teaching	<p>Findings: Of the three teachers with primary instructional responsibilities at MSH, one is fully credentialed (RW), one's application for credentials is</p>

	<p>and academic instruction, behavioral interventions, monitoring of academic and behavioral progress and incident management and reporting.</p>	<p>pending (WB), and one (TB) is licensed as an emergency substitute.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Provide necessary supports to ensure that third teacher is fully credentialed. 2. 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). 3. Provide support to teachers and support staff to pursue professional development opportunities (e.g., graduate coursework, reputable workshops, etc.) 4. Provide training to volunteers on specific skills that might support student learning (e.g., reading strategies, comprehension strategies, etc.)
<p>d</p>	<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>Findings: The review of IEPs, classroom observations, and staff interviews suggest a need to systematically collect and use student data to better inform instructional decisions. IEP goals and objectives are not specific and measurable. There is also a need to include more functional skills in both IEPs and daily instruction- for example, students should be taught self-determination skills and useful, relevant vocational skills that can support them as they transition into adulthood and independence. Vocational goals and objectives on IEPs, when present, appeared to be afterthoughts and not specifically associated with students' preferences and goals. A potential strength of the school is the large</p>

		<p>number of elderly volunteers available to work with students, and volunteers and students appear to have strong, supportive relationships. At the same time, on several occasions volunteers appeared unsure of what to do and were not being utilized sufficiently. Finally, while school is scheduled to begin each day at 8:30, on the morning the monitor was present the students didn't arrive until 8:45; if this is a common occurrence the accumulated loss of instructional time over a school year is substantial and unacceptable.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Use CBM data to modify instruction to better meet students' needs. 2. Create and conduct CBMs that relate directly to students' annual goals, particularly in the areas of reading, math, and writing. 3. 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. 4. Use behavioral data to modify instruction to better meet students' needs. 5. Include a measurable annual goal and short-term objectives for every student in the domain of self-determination. 6. Include a measurable annual goal and short-term objectives for every student in the domain of vocational skills. 7. Provide training to volunteer staff, particularly in the area of tutoring skills.
e	Each State hospital shall provide appropriate literacy instruction, consistent with generally accepted professional standards of care, for students who show deficits in one or	<p>Findings: The review of IEPs, Psycho Educational Assessments, and classroom observations indicated several areas in need of improvement. First,</p>

	<p>more common areas of reading (e.g., decoding or comprehending).</p>	<p>while Psycho Educational Assessments indicate literacy deficits for the majority of students, appropriate present levels of performance were not included in the reports (e.g., 2 of 3 files included present levels of performance, 3 files were incomplete). Meanwhile, only 33% of the IEP files reviewed indicate a direct relationship between assessment findings and IEP goals and objectives. There appears to be no systematic curriculum or instructional methods in place for remediating students' literacy deficits.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Provide word recognition instruction using direct instruction. 2. Provide fluency instruction using methods with a research base such as reciprocal peer tutoring, and repeated readings. 3. 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. 4. Provide writing instruction using methods with a research base such as brainstorming, prewriting, editing, and conferencing. 5. Create and conduct CBMs that relate directly to students' annual goals, particularly in the areas of reading and writing. 6. Demonstrate use of CBM data to modify instruction to better meet students' needs. 7. Include a measurable annual goal and short-term objectives for every student in the domain of literacy. 8. Provide training to volunteer staff, particularly in the area of tutoring skills in reading.
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<p>f</p>	<p>Each State hospital shall on admission and as statutorily required thereafter, assess each student's capacity to participate, with appropriate supports and services, in an integrated, non-institutional, education environment, and provide access to an integrated education environment for those students who can participate in one with appropriate supports and services.</p>	<p>Findings: There are significant limitations in the documentation reviewed, as well as interviews with staff, in this area. None of the IEPs reviewed (0%) included an explanation or documentation of either (a) the extent to which students will participate with non-disabled students in non-institutional educational environments, or (b) whether the proposed IEP can be met by a community school placement. While recently a representative from the local school district (Whittier) has been attending IEP meetings, there does not appear to be a plan in place for providing access to integrated educational environments for those students who would benefit from this opportunity, nor does there appear to have been any students to which this opportunity was afforded.</p> <p>Compliance: Non-compliance.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that upon admission and yearly thereafter the IEP team will assess each student's capacity to participate, with appropriate supports and services, in an integrated, non-institutional educational environment. 2. Ensure that all IEP meetings discuss non-institutional educational environments as options for all students. 3. Ensure that IEP documents an explanation of the extent to which the student will participate with non-disabled peers. 4. Develop a plan with the local school district for providing educational services in non-institutional settings, with appropriate supports and services.
<p>g</p>	<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</p>	<p>Findings: There are significant limitations in the documentation reviewed, as well as interviews with staff, in this area. None (0%) of the reviewed IEPs</p>

	<p>and clinical status.</p>	<p>documented that the IEP team considered the full continuum of educational services available to students. While the educational settings at MSH may well be the most appropriate setting for many, if not most, of the students at MSH, it is apparently the only educational setting available to these students. Again, while recently a representative from the local school district (Whittier) has been attending IEP meetings, there does not appear to be a plan in place for providing access to least restrictive educational environments.</p> <p>Compliance: Non-compliance.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that all IEP meetings discuss the least restrictive environment for all students. 2. Ensure that the IEP documents an explanation of the extent to which the student will participate with non-disabled peers. 3. Develop a plan with the local school district for providing educational services in non-institutional setting, with appropriate supports and services.
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G	Documentation		
		<p>Summary of Progress:</p> <ol style="list-style-type: none"> 1. The DMH WRP manual includes criteria for the proper documentation of the main components of the new WRP model. 2. MSH has implemented the formats for the admission and integrated psychiatric assessments. 3. MSH has implemented the formats for the master WRP and for the WRP reviews at seven-days, 14 days, quarterly, monthly and annual intervals. 4. MSH has adequate requirements regarding the timeliness and completeness of psychiatric progress reviews and inter-unit transfer assessments. 5. MSH has identified a self-assessment process and identified a variety of patterns that require performance improvement in the documentation of assessments, reassessments and WRP. 	
	<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 clinically relevant information remains readily accessible.</p>	<p>Findings:</p> <p>The previously mentioned findings of deficiencies in the documentation of admission and integrated assessments (D.1. through D.7) and the main components of integrated therapeutic and rehabilitation services (C.2.b through C.2.i) and specific therapeutic and rehabilitation services (F.1 through F.7) indicate that the documentation of these systems is generally inadequate.</p> <p>Compliance:</p> <p>Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Revise, update, and implement policies and procedures related to documentation to include specific criteria required. 2. Develop and implement a system to monitor and track the quality of documentation addressing the required elements in the Plan. 	

		3. Provide on-going training regarding documentation requirements.
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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 has adopted the Wellness and Recovery Model to guide its provision of services to individuals with serious mental illness. 2. MSH has begun to identify needed revisions in its policies and procedures regarding seclusion, restraints, PRN and /stat medications to ensure compliance with the EP. 3. Monitoring systems are currently being put in place to ensure that proper procedures are being implemented. 4. MSH is committed to decreasing the use of seclusion/restraints and PRN and Stat medications. 5. MSH is beginning to identify some of its deficits through the process of self-assessment. 6. Many of the MSH staff members are invested in making the needed changes to enhance the lives of the individuals residing at MSH.
	<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>Reviewed Seclusion/Restraint Review form. Reviewed 24 Hour Medication Audit form. Reviewed Special Order for Seclusion or Behavioral Restraint. Reviewed AD #3306 regarding Behavioral Seclusion or Restraint. Reviewed NP regarding Behavioral Seclusion Restraint. Reviewed NP regarding Application of Mechanical Restraints and/or Seclusion. Reviewed NP regarding Prevention and Management of Assaultive Behavior. Reviewed charts of 12 individuals (SF, SM, SW, AM, VV, KO, DH, ML, AF, RC, NR and CD). Reviewed HSS Seclusion and Restraint audit data for March-August 2006.</p>

1	<p>Each State hospital shall revise, as appropriate, and implement policies and procedures regarding the use of seclusion, restraints, psychiatric PRN medications, and Stat Medications consistent with generally accepted professional standards of care. In particular, the policies and procedures shall expressly prohibit the use of prone restraints, prone containment and prone transportation and shall list the types of restraints that are acceptable for use.</p>	<p>Findings: Currently, prone containment is being taught in the statewide training program regarding management of aggressive behavior. The statewide taskforce is revising the curriculum to make it more recovery-focused, population specific, and include aggression reduction strategies by early interventions and verbal de-escalation.</p> <p>In addition, the use of prone restraints is included in some of the MSH ADs and policies. There was no indication that MSH was in the process of reviewing and revising their policies to exclude the use of prone restraints.</p> <p>Compliance: Non-compliance.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Revise the statewide training program to prohibit the use of prone restraints, prone containment, and prone transportation. 2. Review and revise policies and procedures that currently allow the use of prone restraints. 3. Prohibit the use of prone restraints, prone containment, and prone transportation immediately.
2	<p>Each State hospital shall ensure that restraints and seclusion:</p>	<p>Compliance: Partial.</p>
a	<p>are used in a documented manner and only when individuals pose an imminent danger to self or others and after a hierarchy of less restrictive measures has been considered in a clinically justifiable manner or exhausted;</p>	<p>Findings: MSH reported 98% compliance that least restrictive interventions are documented and 99% compliance with behavioral justification of the use of restraints.</p>

		<p>This monitor's review showed that the documentation regarding use of least restrictive interventions consisted of merely a check mark in the appropriate box on the restraint form. However, I found no supporting documentation to support that other interventions were tried prior to the use of restraints. My compliance rating is 0% for this element because of a lack of adequate documentation.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a system to adequately document the use of least restrictive measures prior to the implementation of restraints. 2. Ensure that policies and procedures include implementing seclusion and restraints only after a hierarchy of less restrictive measures have been considered in a clinically justifiable manner or exhausted with supporting documentation to be logged in the medical record.
b	are not used in the absence of, or as an alternative to, active treatment, as punishment, or for the convenience of staff;	<p>Findings: MSH does not have a monitoring system in place for the key elements of this requirement.</p> <p>Recommendation: Develop and implement a system to monitor the key elements of this requirement.</p>
c	are not used as part of a behavioral intervention; and	<p>Findings: MSH does not have a monitoring system in place for the key elements of this requirement.</p> <p>From my review of WRPs for 12 individuals, I did not find indications that seclusion and/or restraints were used as part of a behavioral intervention.</p>

		<p>Recommendations: Develop and implement a system to monitor his requirement.</p>
d	are terminated as soon as the individual is no longer an imminent danger to self or others.	<p>Findings: MSH reported 100% compliance with this requirement. However, from my review of the data, the facility monitoring indicator did not adequately meet the requirement.</p> <p>Recommendation: Ensure accurate interpretation of compliance data.</p>
3	Each State hospital shall comply with 42 C.F.R. § 483.360(f), requiring assessments by a physician or licensed clinical professional of any individual placed in seclusion or restraints within one hour. Each State hospital shall also ensure that any individual placed in seclusion or restraints is continuously monitored by a staff person who has successfully completed competency-based training on the administration of seclusion and restraints.	<p>Findings: MSH data indicated 97% compliance with individuals being seen within an hour by a physician or RN while in seclusion/restraints. However, the raw data provided by MSH indicated that the percentage should be lower. In addition, the MSH data did not address the requirement regarding Psychiatric Technician Assistants (PTAs) having completed competency-based training for the restraint/seclusion class. The data from MSH does not address all the key elements of this requirement regarding continuous monitoring by competency-based trained staff.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a system to monitor and ensure compliance with all elements of this requirement. 2. Ensure accurate interpretation of data.
4	Each State hospital shall ensure the accuracy of data regarding the use of restraints, seclusion, psychiatric PRN medications, or Stat medications.	<p>Findings: MSH has designated a time frame of 1.5 days for PRN, STAT, and seclusion and restraints data entry. The data indicated that MSH averaged 1.7 days for PRN and STAT medication data entry and 5.7</p>

		<p>days for S/r data entry.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Improve timeliness of data entry for PRN, STAT medication and Seclusion/Restraint data entry. 2. Identify problems with timeliness of data entry and develop and implement a plan of correction. 3. Data should be entered in real time.
<p>5</p>	<p>Each State hospital shall revise, as appropriate, and implement policies and procedures to require the review within three business days of individuals' therapeutic and rehabilitation service plans for any individuals placed in seclusion or restraints more than three times in any four-week period, and modification of therapeutic and rehabilitation service plans, as appropriate.</p>	<p>Findings: MSH has identified deficits in their policies and procedures regarding this requirement. They are in the process of revising the appropriate policies and procedures.</p> <p>In addition, there is no documentation in the individual's chart or WRP of a review within three business days of an individual being placed in seclusion or restraints more than three times in any four-week period, and modification of their WRP, as appropriate.</p> <p>Compliance: Non-compliance.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Revise appropriate policies and procedures to ensure compliance with this requirement. 2. Develop and implement a monitoring system to ensure that there is 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.

6	Each State hospital shall develop and implement policies and procedures consistent with generally accepted professional standards of care governing the use of psychiatric PRN medication and Stat medication, requiring that:	Compliance:
a	such medications are used in a manner that is clinically justified and are not used as a substitute for adequate treatment of the underlying cause of the individual's distress.	<p>Findings: The findings in D.1.f, F.1.b and F.3.a.i through F.3.a.iii indicate that the use of PRN and Stat medication does not conform to the requirements of the EP. At this time, MSH does not have a policy/procedure or any formalized system to ensure appropriate use.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Same as in D.1.b. 2. Same as in F.1.b. 3. Same as in F.3.a.i through F.3.a.iii. 4. Develop and implement policy/procedure to outline facility's standards regarding PRN/Stat medication use consistent with the requirements of the EP. 5. Develop and implement triggers for review and follow through by medical and nursing leadership.
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>Findings: MSH reported 99.6% compliance. However, the 24-hour Medication Audit does not accurately monitor the key element of this requirement.</p> <p>Recommendations: Develop and implement a monitoring instrument to accurately monitor this requirement.</p>

e	<p>A psychiatrist conducts a face-to-face assessment of the individual within 24 hours of the administration of a Stat medication. The assessment shall address reason for Stat administration, individual's response, and, as appropriate, adjustment of current treatment and/or diagnosis.</p>	<p>Findings: MSH does not monitor this requirement as stated.</p> <p>Findings by this monitor (FD.1.b and F.1.b) indicate that MSH is not in compliance with this requirement.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a monitoring instrument to address this requirement. 2. Same as in recommendations 1 though 3 in H.6.a.
7	<p>Each State hospital shall ensure that all staff whose responsibilities include the implementation or assessment of seclusion, restraints, psychiatric PRN medications, or Stat medications successfully complete competency-based training regarding implementation of all such policies and the use of less restrictive interventions.</p>	<p>Findings: MSH does not have a monitoring system in place for this requirement. In addition, there has been no competency-based training for each of the applicable policies. MSH provided a list of staff members who are out of compliance with the management of aggressive behavior training. The list consisted of 102 pages of staff names.</p> <p>Compliance: Noncompliance.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement competency-based training on this requirement. 2. Develop and implement a monitoring instrument to accurately monitor this requirement. 3. Develop and implement a system to ensure that staff completes the required mandatory training for PMAB.
8	<p>Each State hospital shall:</p>	<p>Compliance: Non-compliance.</p>

a	develop and implement a plan to reduce the use of side rails as restraints in a systematic and gradual way to ensure individuals' safety; and	<p>Findings: MSH does not have a monitoring system in place for the key elements of this requirement.</p> <p>In addition, the facility has only recently begun to look at the issue of the use of side rails but has not developed or implemented a plan to reduce their use.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. 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 monitoring instrument to accurately monitor the key element of this requirement.
b	ensure that, as to individuals who need side rails, their therapeutic and rehabilitation service plans expressly address the use of side rails, including identification of the medical symptoms that warrant the use of side rails, methods to address the underlying causes of such medical symptoms, and strategies to reduce the use of side rails, if appropriate.	<p>Findings: MSH does not have a monitoring system in place for the key elements of this requirement.</p> <p>As mentioned above, MSH has recently begun to address the issue of side rails. However, there has been no system developed and implemented in accordance with the EP.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. 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. 2. Develop and implement an instrument to accurately 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 skeleton of an incident monitoring system that identifies some variables, but does not presently produce reports on a regular basis. 2. MSH has made a commitment to have Special Investigators and Hospital Police investigate allegations of abuse/neglect. 3. The hospital is taking measures to actively solicit the opinions of individuals concerning the quality of their lives. 4. The hospital has gathered trigger data that is being used to inform participants of the weekly trigger Meeting so that they can assist their colleagues in planning for individuals. 5. The hospital has an Environment of Care (EOC) team that inspects units on a rotating basis. Units will be initiating daily and monthly unit reviews of the environment and attention to individual's personal needs.
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>Interviewed M. Nunley, Standards Compliance Director. Interviewed M. Grando, Nurse Coordinator. Interviewed A. Hendricks, Coordinator of Nursing Services. Interviewed B. Hudson, Special Investigator. Interviewed K. Keyes, Training Officer. Interviewed M. Murray, Patient Rights Advocates' Office. Interviewed H. Mears, Chief of Hospital Police. Interviewed D. Bates, Human Resources Director. Interviewed two unit staff. Reviewed incident log. Reviewed 23 abuse/neglect and sexual contact investigation reports. Reviewed four death reports.</p>

a	Each State hospital shall review, revise, as appropriate, and implement incident management policies, procedures and practices that are consistent with generally accepted professional standards of care. Such policies, procedures and practices shall require:	Compliance: Partial.
a.i	that each State hospital not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of individuals;	<p>Findings: MSH has Administrative Directives stating that abuse and neglect will not be tolerated and that require that staff report abuse and neglect. AD 33.08 states that the hospital has zero tolerance for abuse and neglect. AD 3308.3 requires that any employee having any information of any act of patient abuse shall report it verbally to the Program Management Team and then complete an SIR (incident form) before the end of the shift. The responsibility to report is also referenced in AD 2001, Orientation for New Employees. In conversations with two staff in which I posed a scenario describing mild abuse and neglect, both staff indicated that they would speak with the offending staff member and explain what he did was wrong, but neither mentioned that she would complete an incident report. One of the staff has been at the facility for seven years and has never completed an incident report.</p> <p>Recommendation: 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>
a.ii	identification of the categories and definitions of incidents to be reported, and investigated; immediate reporting by staff to supervisory personnel and each State hospital's executive director (or that official's designee) of serious incidents, including but not limited	<p>Findings: The incident reporting form in state-wide use needs to be revised. Specific attention needs to be paid to the definitions of sexual activity, a space needs to be provided for notification of the Department of Children and Family Services of child abuse allegations,</p>

	<p>to, death, abuse, neglect, and serious injury, using standardized reporting across all settings, including school settings;</p>	<p>and the roles of individuals and staff in an incident need to be clarified.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Revise the incident reporting form to specifically address sexual abuse (staff to individual sexual contact regardless of whether coercion is present). 2. Revise the other definitions related to sexual contact. 3. Clarify roles as designated on the reporting form. 4. Provide a space to document notification of child abuse allegations.
<p>a.iii</p>	<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>Findings: In all of the 17 investigations of abuse and neglect reviewed, the alleged perpetrator was removed from contact with the individual until the investigation was concluded. In one investigation reviewed [NR, 3/15/06], the staff members failed to secure medical evaluation for the individual.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. 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. 2. Continue current practice of removing alleged perpetrators from contact with individuals until the investigation is closed.
<p>a.iv</p>	<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>Findings: Present A/N training is grossly inadequate. Nursing staff receives 30 minutes of this training at orientation. Non-nursing staff receives even less—approximately 10 minutes of training given by the hospital police as one of several subjects in a 30 minute period.</p> <p>The hospital plans to increase A/N training for nursing staff at</p>

		<p>orientation to three hours within the next month. Annual refresher training will also be increased, but the amount of time has not yet been determined. [I suggested that the training include a presentation by individuals. This would be consistent with the hospital's First Amendment Due Process initiative.]</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Continue with plans to increase orientation and annual refresher abuse and neglect training for nursing staff. 2. Increase orientation and annual refresher training for non-nursing personnel.
<p>a.v</p>	<p>notification of all staff when commencing employment and adequate training thereafter of their obligation to report abuse or neglect to each State hospital and State officials. All staff persons who are mandatory reporters of abuse or neglect shall sign a statement that shall be kept with their personnel records evidencing their recognition of their reporting obligations. Each State hospital shall not tolerate any mandatory reporter's failure to report abuse or neglect;</p>	<p>Findings:</p> <p>Since March 2006, the hospital has kept a monthly log of all newly hired staff. This log includes the date the individual signed the Mandatory Reporter form. These documents show that all staff signed the form on the date of hire.</p> <p>In August the hospital conducted an audit of 1577 personnel files and found that 24% lacked the Mandated Reporter form. At the time of our tour, approximately 45% were still outstanding.</p> <p>There is one case presently under review where a staff member failed to report an allegation of abuse. [The staff member wrote a note but did not complete an incident report and the allegation was not addressed until the individual make the allegation again to the Patient Rights Advocate.] The investigator of the abuse allegation failed to interview the staff member who received the initial allegation and failed to initiate any action to investigate the failure to report. The lack of an interview and failure to report were identified during the review process.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Continue to secure the missing forms.

		<ol style="list-style-type: none"> 2. Continue the monthly log—either paper or computer. 3. During investigations, ask individuals to whom they made the first report of the allegation.
<p>a.vi</p>	<p>mechanisms to inform individuals and their conservators how to identify and report suspected abuse or neglect;</p>	<p>Findings: Individuals and their personal conservators are given a booklet (available in English and Spanish), entitled "Mental Health Patients' Rights", that explains their rights and provides the toll-free number of the Patient Rights Advocate. A similar booklet is available for minors.</p> <p>In addition the Patient Rights Advocate gives each newly admitted individual a folder that explains the Protection and Advocacy Program and clearly outlines how to make a complaint.</p> <p>In a review of three records, the individuals in each case had signed a statement acknowledging receipt of rights information on admission. In only one of the records was this statement signed again the following year.</p> <p>Recommendation: 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>a.vii</p>	<p>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>	<p>Findings: In each of the units I toured there was a large framed poster stating individuals' rights with the phone number (toll-free) of the Patient Rights Advocate and other numbers for pursuing a complaint in English and Spanish.</p> <p>In a survey conducted with the assistance of the Individual Council, 80% of the respondents indicated that they would report an allegation of abuse/neglect.</p>

		<p>Recommendation: Add the name of the Patient Rights Advocate when one is hired.</p>
a.viii	<p>procedures for referring, as appropriate, allegations of abuse or neglect to law enforcement; and</p>	<p>Findings: AD # 3309 requires that crimes and individual deaths, abuse of individuals and employee misconduct will be investigated by hospital police. Persons alleging rape are taken to outside hospitals and law enforcement is notified.</p> <p>Recommendation: Ensure that hospital police receive notification of allegations of abuse and neglect ASAP so that an investigation can begin in a timely manner.</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>Findings: AD # 2010 "Prohibition from Retaliation Against Persons who Report Illegal Acts (September 2006)" states the right of employees to report improper and illegal acts, be free from retaliation for doing so, and provides procedures for filing a grievance.</p> <p>There have been no reported cases of retaliation for reporting.</p> <p>Recommendation: Continue current practice.</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>
b.i	<p>require investigations of all deaths, as well as allegations of abuse, neglect, serious injury, and theft.</p>	<p>Findings: Prior to the May 1, 2006 decision to have hospital police and Special</p>

	<p>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>Investigators investigate allegation of abuse and neglect, these investigations were conducted by program staff, and the investigation reports were reviewed by the Special Investigators. This practice jeopardized the objectivity of the investigation, as programs had an interest in returning staff members to work as quickly as possible. The May decision ensures the investigation of these allegations by hospital police who have no reporting obligations to the program. It has not yet been determined who will investigate serious injuries.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that the hospital police receive timely notification of allegations. 2. Determine a method for ensuring that trained investigators investigate serious injuries. 3. Encourage and train the investigators of serious injuries to consult physicians and other clinicians as necessary to ensure a comprehensive and accurate investigation.
<p>b.ii</p>	<p>ensure that only the State Hospital staff who have successfully completed competency-based training on the conduct of investigations be allowed to conduct investigations of allegations of petty theft and all other unusual incidents;</p>	<p>Findings: All thefts and other crimes are to be investigated by the hospital police. I have no direct knowledge of the quality of these investigations.</p> <p>Recommendation: Continue current practice.</p>
<p>b.iii</p>	<p>investigations required by paragraph I.1.b.i, (above) provide for the safeguarding of evidence;</p>	<p>Findings: In several of the investigations reviewed, photographs were properly labeled and included in the investigation file. I reviewed no investigations that required the securing of other evidence.</p>

		<p>Recommendation: Continue current practice.</p>																																				
<p>b.iv</p>	<p>investigations required by paragraph I.1.b.i, (above) require the development and implementation of standardized procedures and protocols for the conduct of investigations that are consistent with generally accepted professional standards. Such procedures and protocols shall require that:</p>	<p>Findings: Nine of the 23 investigations reviewed contained an element that did not meet professional standards, as documented below.</p> <table border="1" data-bbox="1012 488 1898 1391"> <thead> <tr> <th data-bbox="1012 488 1157 565">Individual</th> <th data-bbox="1157 488 1360 565">Date/Incident</th> <th data-bbox="1360 488 1898 565">Problem</th> </tr> </thead> <tbody> <tr> <td data-bbox="1012 565 1157 641">NR</td> <td data-bbox="1157 565 1360 641">3/15/06</td> <td data-bbox="1360 565 1898 641">Did not identify the failure to obtain medical attention.</td> </tr> <tr> <td data-bbox="1012 641 1157 717"></td> <td data-bbox="1157 641 1360 717"></td> <td data-bbox="1360 641 1898 717">Did not identify failure to report injury on incident reporting form.</td> </tr> <tr> <td data-bbox="1012 717 1157 794">MP</td> <td data-bbox="1157 717 1360 794">3/22/06</td> <td data-bbox="1360 717 1898 794">Did not separate witnesses and conduct separate interviews.</td> </tr> <tr> <td data-bbox="1012 794 1157 870">AR</td> <td data-bbox="1157 794 1360 870">4/11/06</td> <td data-bbox="1360 794 1898 870">Failure to interview staff who received the allegation from the individual.</td> </tr> <tr> <td data-bbox="1012 870 1157 946"></td> <td data-bbox="1157 870 1360 946"></td> <td data-bbox="1360 870 1898 946">Failure to take action at the time re: the failure to file an incident report.</td> </tr> <tr> <td data-bbox="1012 946 1157 1023">SF</td> <td data-bbox="1157 946 1360 1023">4/4/06</td> <td data-bbox="1360 946 1898 1023">Failure to reconcile disparate accounts of witnesses.</td> </tr> <tr> <td data-bbox="1012 1023 1157 1099"></td> <td data-bbox="1157 1023 1360 1099"></td> <td data-bbox="1360 1023 1898 1099">Failure to consider the possibility of neglect.</td> </tr> <tr> <td data-bbox="1012 1099 1157 1175">CG & JS</td> <td data-bbox="1157 1099 1360 1175"></td> <td data-bbox="1360 1099 1898 1175">Failure to secure assistance from clinical/medical staff.</td> </tr> <tr> <td data-bbox="1012 1175 1157 1252">DG</td> <td data-bbox="1157 1175 1360 1252">7/4/06</td> <td data-bbox="1360 1175 1898 1252">Failure to reconcile disparate accounts of witnesses</td> </tr> <tr> <td data-bbox="1012 1252 1157 1328">AM</td> <td data-bbox="1157 1252 1360 1328">5/1/06</td> <td data-bbox="1360 1252 1898 1328">Failure to look for other individuals who may have been witnesses.</td> </tr> <tr> <td data-bbox="1012 1328 1157 1391">PH</td> <td data-bbox="1157 1328 1360 1391">6/15/06</td> <td data-bbox="1360 1328 1898 1391">Did not date and sign investigation report.</td> </tr> </tbody> </table>	Individual	Date/Incident	Problem	NR	3/15/06	Did not identify the failure to obtain medical attention.			Did not identify failure to report injury on incident reporting form.	MP	3/22/06	Did not separate witnesses and conduct separate interviews.	AR	4/11/06	Failure to interview staff who received the allegation from the individual.			Failure to take action at the time re: the failure to file an incident report.	SF	4/4/06	Failure to reconcile disparate accounts of witnesses.			Failure to consider the possibility of neglect.	CG & JS		Failure to secure assistance from clinical/medical staff.	DG	7/4/06	Failure to reconcile disparate accounts of witnesses	AM	5/1/06	Failure to look for other individuals who may have been witnesses.	PH	6/15/06	Did not date and sign investigation report.
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		AG	3/28/06	Did not interview alleged perpetrator.
b.iv.1	investigations commence within 24 hours or sooner, if necessary, of the incident being reported	<p>Recommendation: 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: Prior to May 2006, investigations were often begun within 24 hours because they were completed at the program level. Since the May decision to use hospital police and Special Investigators, some investigations have not been initiated within 24 hours. This is due, at least in part, to the shortage of investigators. When two investigators are hired in the next 3-4 months, this should ease the situation.</p> <p>Recommendation: 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>		
b.iv.2	investigations be completed within 30 business days of the incident being reported, except that investigations where material evidence is unavailable to the investigator, despite best efforts, may be completed within 5 business days of its availability;	<p>Findings: Eleven of the 17 abuse investigations reviewed (65%) were completed within 30 days. The hospital self-assessment of 25 cases yielded an 80% rate of completion within 30 days. I do not find these results incompatible.</p> <p>There is a significant delay in the hospital police investigation of deaths because autopsies are not made available. For example, EG died in April 2006 and the investigation is still open because the hospital has not received the autopsy.</p> <p>Recommendations: 1. Ensure that hospital police receive timely notification of an</p>		

		<p>allegation, as this will maximize the chance of completion within 30 days.</p> <p>2. 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>
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>Findings: All investigations resulted in a written report that included a summary of the investigation and in some instances recommendations for corrective actions. In one incident, PH [6/15/06] there was written documentation that corrective actions had been implemented. The investigations completed by the program were sometimes cursory and amounted to a description of the allegation, a recounting of the staff's denial and a conclusion that the allegation could not be substantiated.</p> <p>Recommendation: 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>
b.iv.3(i)	<p>each allegation of wrongdoing investigated;</p>	<p>Findings: The investigations reviewed all contained a statement of the allegation of wrongdoing under investigation.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Continue current practice. 2. Same as b.iv.3.
b.iv.3(ii)	<p>the name(s) of all witnesses;</p>	<p>Findings: The names of all witnesses interviewed were identified in the investigation reports reviewed. However, in some relevant cases there</p>

		<p>was no attempt to find additional persons who may have seen or heard an incident. For example, in the 4/4/06 allegation involving SF, seven youths were in the mall room when the horseplay began and the pants-pulling incident occurred, but all were not interviewed.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Document attempts to find individuals who may be witnesses to an incident. 2. Interview all staff on duty at the time.
b.iv.3(iii)	the name(s) of all alleged victims and perpetrators;	<p>Findings: All investigations reviewed identified the names of alleged victims and perpetrators. This finding is consistent with the hospital's self-assessment.</p> <p>Recommendation: Continue current practice.</p>
b.iv.3(iv)	the names of all persons interviewed during the investigation;	<p>Findings: All investigations reviewed included the names of all persons interviewed. This finding is consistent with the hospital's self-assessment.</p> <p>Recommendation: Continue current practice.</p>
b.iv.3(v)	a summary of each interview;	<p>Findings: Each investigation reviewed contained a summary of each interview, however in some of the investigations done by the program, summaries of interviews were very sparse and there was little or no probing to determine why staff saw and heard nothing. See incident described in b.iv.3(ii)</p>

		<p>Recommendations:</p> <ol style="list-style-type: none"> 1. Identify interview questions and answers. 2. Question and document where staff was when the incident occurred and why they could not see or hear what was occurring.
b.iv.3(vi)	a list of all documents reviewed during the investigation;	<p>Findings:</p> <p>The investigations reviewed did not list the documents reviewed. In some instances, for example, in the allegation charging the misuse of PRNS and STAT medications [CG and JS, 7/11/06] the investigator should have reviewed documentation of the use of these medications, asking for assistance from medical/clinical staff as needed, but he did not.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Review relevant documents, copy relevant portions that are critical to the findings and outcome. 2. Identify documents reviewed on the cover page of the investigation.
b.iv.3(vii)	all sources of evidence considered, including previous investigations and their results, involving the alleged victim(s) and perpetrator(s);	<p>Findings:</p> <p>Some investigations included very specific information regarding the allegation history of the individual, such as in the incident involving JW [4/13/06] where the investigation cites "52 attempts to get staff fired between 12/30/06 and 4/13/06." In other instances the investigator made a generalized statement about the individual's history of making false allegations. Good investigations in this regard contained a notation indicating that the individual had or did not have a treatment objective directed at false allegations.</p> <p>Though less common, some investigations noted the perpetrator's incident history, but in all instances it was to cite the fact that the staff member had not been involved in an allegation.</p>

		<p>Recommendations:</p> <ol style="list-style-type: none"> 1. Continue to review WRPs for relevant treatment objectives. 2. Avoid general statements with no objective data that claim an individual is not credible. 3. 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.
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>Findings:</p> <p>The investigations reviewed included the investigator's findings in support of the outcome (substantiation or lack of substantiation), but the summary of findings to support the conclusion was often a repeat of the list of findings copied from a previous page. As noted above, investigator's need to be more conscious of staff's programmatic responsibilities. In the investigation involving SF, the sexual horseplay occurred in a mall room where there was no supervision of the seven youths. Beyond stating that staff should be more attentive and not leave individuals in the room alone, the investigator took no actions to identify the staff person who should have been in the room and determine why he/she was not.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Identify the location and activities of all staff when investigating an incident. 2. Write a clear and concise statement of findings that supports the conclusion.
a.iv.3(ix)	the investigator's reasons for his/her conclusions, including a summary indicating how potentially conflicting evidence was reconciled; and	<p>Findings:</p> <p>In two of the cases reviewed, the investigator failed to reconcile conflicting evidence. In the case cited above involving SF, both boys who were allegedly trying to grope SF and pull down her pants denied doing so, but one said the other was engaging in these behaviors. There was no attempt to reconcile the accounts by interviewing the</p>

		<p>other youths in the room. In an incident involving DG (7/12/06) an individual alleged that a staff member held a pillowcase tightly over DG's head to keep him from spitting as he was escorted down the hall by several staff. The accused staff member denied the allegation and said, instead, that she held a small sheet in front of (but never touching) his face. No staff member saw the pillowcase or the sheet, not even those the alleged staff member said assisted in the escort. There was no attempt by the investigator to reconcile the differences in the interviews.</p> <p>Recommendation: Deal with the problem of conflicting evidence by doing second interviews.</p>
<p>b.iv.4</p>	<p>staff supervising investigations review the written report, together with any other relevant documentation, to ensure that the investigation is thorough and complete and that the report is accurate, complete, and coherent. Any deficiencies or areas of further inquiry in the investigation and/or report shall be addressed promptly. As necessary, staff responsible for investigations shall be provided with additional training and/or technical assistance to ensure the completion of investigations and investigation reports consistent with generally accepted professional standards of care.</p>	<p>Findings: The review process for investigations is extensive and provides for input from the staff working with the individual through to the Medical Director and the Executive Director. It has the potential to identify individual-specific recommendations and systemic recommendations.</p> <p>Recommendation: Same as in b.iv.</p>
<p>c</p>	<p>Each State Hospital shall ensure that whenever disciplinary or programmatic action is necessary to correct a situation or prevent reoccurrence, each State hospital shall implement such action promptly and thoroughly, and track and document such actions and the corresponding outcomes.</p>	<p>Findings: The investigations I reviewed revealed some evidence that necessary disciplinary and programmatic actions are taken. In two of the investigations I reviewed, recommendations were made for retraining of staff members. As the result of the findings of another investigation, one staff member was disciplined with a one step</p>

		<p>reduction in salary for nine months. And in another case, which I did not review, a cleaner was terminated for being in an individual's bedroom when she was lying on the bed in her underwear. Because the hospital cannot produce a list of substantiated cases, it is not possible to follow disciplinary matters without reading every case.</p> <p>Some investigations recommended programmatic corrective actions and in one instance PH (6/15/06) there was written documentation that the programmatic corrective action was implemented. The identification of programmatic recommendations is an area that requires additional attention and should be discussed by the investigation reviewers.</p> <p>There is a log that tracks currently open Adverse Actions against specific staff members. There is no log with historical data, however, so one cannot look for patterns and trends.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop the capacity to identify the outcome of each investigation and provide this in a monthly report, along with incident type and location as a start for tracking patterns and trends. 2. As Adverse Action cases are closed, either keep them on the log with the closing date noted or keep a separate log.
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: Non-compliance.</p>
d.i	type of incident;	<p>Findings: MSH is not presently using incident data to identify high-risk</p>

		<p>individuals and situations and to protect individuals from harm. MSH does not have a system that tracks and trends incidents and regularly produces reports identify these.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Identify those elements that the data base 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. 2. Later display this information in a meaningful form that will facilitate the identification of patterns and trends.
d.ii	staff involved and staff present;	<p>Findings:</p> <p>The investigations reviewed identified the staff members involved in the incident. As noted earlier, the investigations often did not identify all staff present. Also noted earlier, definitions of the roles of individuals (as indicated on the incident reporting form) need to be clarified, as the victim is sometimes coded as "involved" rather than as "victim." There were seven of these kinds of errors among the 54 incidents on the Abuse and Neglect Database log.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Account for all staff present in investigation reports. 2. Clarify roles on the incident reporting form. 3. Update the data regularly (weekly) to maintain its integrity and usefulness.
d.iii	individuals directly and indirectly involved;	<p>Findings: Same as d.ii</p> <p>Recommendations: Same as d.ii.</p>

d.iv	location of incident;	<p>Findings: It is unclear whether the database in identifying the unit, is identifying the unit where the incident occurred or where the individual resides. Location of the incident is included on the incident reporting form, and should be in the database at some point.</p> <p>Recommendation: Ensure that the database can identify where the incident took place.</p>
d.v	date and time of incident;	<p>Findings: The incident database can identify the date of the incident, but not the time.</p> <p>Recommendation: Same as d.i.</p>
d.vi	cause(s) of incident; and	<p>Findings: The incident database cannot identify the cause of an incident. There is no information on the incident reporting form that provides the cause of the incident.</p> <p>Recommendation: Consider during the review of the incident reporting form if the broad incident types could be reworded to provide cause.</p>
d.vii	outcome of investigation.	<p>Findings: All of the investigations reviewed included identification of the outcome/conclusion of the investigation.</p> <p>Recommendation: See b.iv.3(viii)</p>

e	<p>Each State hospital shall ensure that before permitting a staff person to work directly with any individual, each State hospital shall investigate the criminal history and other relevant background factors of that staff person, whether full-time or part-time, temporary or permanent, or a person who volunteers on a regular basis. Facility staff shall directly supervise volunteers for whom an investigation has not been completed when they are working directly with individuals living at the facility. The facility shall ensure that a staff person or volunteer may not interact with individuals at each State hospital in instances where the investigation indicates that the staff person or volunteer may pose a risk of harm to such individuals.</p>	<p>Findings: Since March 2006, MSH has been keeping a monthly log of all newly hired staff that indicates the date the hospital received the finger print clearance. In each case, clearance was received prior to the staff member's hire date.</p> <p>In addition, a New Hire Cover Sheet for each employee tracks the fingerprint clearance date, date of physical, and professional license check, among other information. According to the HR Director, all staff who regularly volunteers at the hospital undergo the same background check as prospective staff. One-time volunteers sign a statement acknowledging their role, and they are under the supervision of staff while they are in the hospital.</p> <p>Compliance: Partial.</p> <p>Recommendation: Continue current practice.</p>
2	<p>Performance Improvement</p>	
	<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: Interviewed K. Layman, Treatment Enhancement Coordinator. Interviewed M. Nunley, Standards Compliance Director. Reviewed trigger information concerning specific individuals. Reviewed aggregate trigger information. Attended Trigger Meeting on September 21, 2006.</p>

	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;	Findings: The hospital is able to collect data on all of the trigger items—medical and non-medical. It has recognized shortcomings in the collection of some of the data and questions the accuracy of the data. At the time of our tour, the data for August (month 3) became available. Recommendation: Continue to refine the collection of data and check on accuracy.
a.ii	establishment of triggers and thresholds that address different levels of risk, as set forth in Appendix A; and	Findings: Same as a.i. This monitor commends the decision to modify the trigger dealing with abuse and neglect to eliminate the requirement for an injury. Recommendations: Same as a.i.
a.iii	identification of systemic trends and patterns of high risk situations.	Findings: Since data for the third month only became available during our tour, it would be premature for the hospital to be identifying patterns and trends of high-risk situations. The data is identifying individuals with high-risk behaviors. This information is shared with the unit and may be discussed in the weekly Trigger Meetings.

		<p>Recommendation: Continue to refine data collection methods to improve accuracy, so that trending and pattern data, when produced, will be useful.</p>
b	Mechanisms for timely interventions and other corrective actions by teams and disciplines to prevent or minimize risk of harm to individuals. These mechanisms shall include, but not be limited to:	<p>Compliance: Partial.</p>
b.i	a hierarchy of interventions by clinical teams that correspond to triggers and thresholds;	<p>Findings: The hospital has created a hierarchy of responses to the non-medical triggers. This form is sent to the unit with the information that indicates that an individual has reached a trigger. The unit is supposed to indicate on the form the intervention it is implementing and return it to Standards Compliance. This process had only been in effect 7-10 days when we were on site.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Continue work on procedures for the return of the response forms. 2. Adopt guidelines for the monitoring the implementation of a sample of the response forms.
b.ii	timely corrective actions by teams and/or disciplines to address systemic trends and patterns;	<p>Findings: Same as a.iii.</p> <p>Recommendations: Same as a.iii and b.i.</p>
b.iii	formalized systems for the notification of teams and needed disciplines to support appropriate interventions and other corrective actions;	<p>Findings: Same as b.i. In addition to the process described, some cases are discussed at the weekly Triggers Meeting. If an individual is discussed there, his /her medications are projected on a screen, along with the individual's trigger history in an effort to assist colleagues to more</p>

		<p>confidently make suggestions to the presenting physician.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Continue the current practice of alerting units when an individual has reached a trigger. 2. Continue to provide the individual's trigger history on the alert and at the Trigger Meetings.
b.iv	<p>formalized systems for feedback from teams and disciplines to the standards compliance department regarding completed actions; and</p>	<p>Findings: As noted above, the system for the use of the hierarchy response forms and the expectation that they will be completed and returned to Standards Compliance had only just been initiated at the time of our tour. The hospital is working on plans to track and encourage compliance.</p> <p>Recommendation: Continue with plan to increase compliance with the return of the response forms.</p>
b.v	<p>monitoring and oversight systems to support timely implementation of interventions and corrective actions and appropriate follow up.</p>	<p>Findings: Eventually a monitoring component will be added to ensure the implementation of the response described. This will be done on a sampling basis.</p> <p>Recommendation: Continue with plans for the full development of the trigger identification, response and oversight system.</p>
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>Findings: The facility's ability to capture data on many non-medical and medical variables is noteworthy. The hospital identified in its self-assessment collection methods that need revision and data accuracy that needs to be improved. Some staff members could not explain their data and</p>

		<p>some did not know how it was gathered. Still others said it was simply erroneous.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Provide more discipline/area-specific training to staff on methods for collecting their data and ensuring its accuracy. 2. Test to be sure staff members understand what they have been taught, so that they can help improve the process.
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: Interviewed C. Lusch, Hospital Administrator. Had brief conversation with two members of the EOC inspection team. Reviewed inspection records. Inspected five units.</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>Findings: The hospital has identified the bathroom partitions as suicide hazards and has requested capital funds to replace them. It hopes to receive these funds in the next fiscal year. In the meantime, the hospital has made a programmatic change requiring that all bathrooms and bedrooms be locked during meals and smoking breaks, when staff is leaving the unit. The facility has also identified atmospheric vacuum breakers (L-shaped pipes near the shower heads in some tub rooms) as suicide hazards and has received funding to remove them. This work has begun.</p> <p>During my tour, I found conduits that were not flush against the wall.</p>

		<p>In addition to the inspections provided by the EOC team on a rotating basis, beginning shortly units will be reviewing their own environmental conditions monthly and conducting a walk-through daily.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Continue to remove the atmospheric vacuum breakers. 2. Review conduits in all units and address any gaps from the wall. 3. Remind staff of the importance of accurate counts when individuals are leaving the unit, lest someone get locked into a bedroom or bathroom. 4. Complete the development of tools for the daily walk-through and the monthly self-inspections.
<p>b</p>	<p>All areas of the hospital that are occupied by individuals being served have adequate temperature control and deviations shall be promptly corrected;</p>	<p>Findings: The temperature of the units I visited was comfortable. Several units had instructions posted for taking care of individuals in very warm weather. The water temperature in some of the sinks in the bathrooms on CT-East and West was 130 degrees. Staff reported that the alarm that should sound when water temperature exceeds 125 degrees did not function.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Check the water temperature and make required adjustments, including to the alert system. 2. Include a review of water temperature on the monthly in-house environmental reviews.

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>Findings: Although the hospital has a list of individuals who are incontinent, only the SNF has written procedures for the care of these individuals.</p> <p>Compliance: Partial.</p> <p>Recommendation: Create individual incontinent 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>
d	<p>Each State hospital thoroughly reviews and revises, as appropriate, its policy and practice regarding sexual contact among individuals served at the hospital. Each State hospital shall establish clear guidelines regarding staff response to reports of sexual contact and monitor staff response to incidents. Each State hospital documents comprehensively therapeutic interventions in the individual's charts in response to instances of sexual contact; and</p>	<p>Findings: The hospital presently does not have a written policy addressing consensual sexual activity among adults, except for AD 3305, which aims primarily to ensure that the activity is consensual. In one investigation reviewed, JS and JA (February 27, 2006), the individuals were told that sexual activity "is not acceptable behavior on the unit." In the sexual contact investigations reviewed, the individuals were all counseled about STDs.</p> <p>Compliance: Partial.</p> <p>Recommendation: 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>
e	<p>Each State hospital develops and implements clear guidelines stating the circumstances under which it is</p>	<p>Findings: Presently the hospital does not use untrained staff in capacities, e.g. as</p>

	<p>appropriate to utilize staff that is not trained to provide mental health services in addressing incidents involving individuals. Each State hospital ensures that persons who are likely to intervene in incidents are properly trained to work with individuals with mental health concerns.</p>	<p>mall instructors, where they would be responding to incidents. If non-nursing and other untrained staff should begin to provide mall instruction, the hospital will need to develop a training curriculum for them.</p> <p>Compliance: Partial.</p> <p>Recommendation: Develop a training curriculum for the situations described, as the need arises.</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 is making an earnest effort to solicit the opinions of individuals about issues central to their life at the hospital. This effort is being supported by the Individual Council. 2. The hospital has an active Individual Council that meets monthly and keeps meeting minutes. It is working with administration on identifying issues and addressing them.
	<p>Each State hospital unconditionally permits individuals to exercise their constitutional rights of free speech, including the right to petition the government for redress of grievances without State monitoring, and provides them due process.</p>	<p>Methodology: Interviewed Kenneth Layman, Treatment Enhancement Coordinator Reviewed minutes of the Individual Council Meetings Reviewed results of the Individual Council Survey on First Amendment and Due Process.</p>
		<p>Findings: The results of the First Amendment and Due Process Survey were coming in at the time of the tour. The hospital has acknowledged that some of the results identify issues that need to be addressed. Some results include:</p> <ul style="list-style-type: none"> 65 % of respondents feel safe. 69% would judge the environment neat and clean. 50% of respondents believe the grievance process works. 80% said they would report abuse or neglect. 51% have been placed in restraint or seclusion. 50% say they have been placed in restraint or seclusion as punishment. <p>A Hospital Safety Survey was distributed to individuals in mall groups. 180 individuals participated. 65% reported feeling safe on the unit. 43% reported being the victim of physical assault at the hospital. 59% believe staff knows how to prevent individuals from hurting one</p>

		<p>another. The hospital plan to have a Safety Team composed of individuals, line staff, administrators and hospital police to address issues raised by the surveys.</p> <p>Compliance: Partial.</p> <p>Recommendation: Continue to engage in an authentic dialogue with the Individual Council over the issues raised by these surveys.</p>
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