

REPORT 3

NAPA STATE HOSPITAL

July 23-27, 2007

**THE HUMAN POTENTIAL CONSULTING GROUP
ALEXANDRIA, VIRGINIA**

NOTE

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

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

Table of Contents

	Introduction	1
C	Integrated Therapeutic and Rehabilitation Services Planning	19
	1. Interdisciplinary Teams	19
	2. Integrated Therapeutic and Rehabilitation Service Planning (WRP)	40
D	Integrated Assessments	112
	1. Psychiatric Assessment and Diagnoses	113
	2. Psychological Assessments	142
	3. Nursing Assessments	162
	4. Rehabilitation Therapy Assessments	175
	5. Nutrition Assessments	193
	6. Social History Assessments	209
	7. Court Assessments	215
E	Discharge Planning and Community Integration	223
F	Specific Therapeutic and Rehabilitation Services	242
	1. Psychiatric Services	242
	2. Psychological Services	273

	3. Nursing Services	310
	4. Rehabilitation Therapy Services	337
	5. Nutrition Services	350
	6. Pharmacy Services	357
	7. General Medical Services	361
	8. Infection Control	372
	9. Dental Services	377
G	Documentation	391
H	Restraints, Seclusion and PRN and Stat Medication	393
I	Protection from Harm	411
	1. Incident Management	412
	2. Performance Improvement	447
	3. Environmental Conditions	457
J	First Amendment and Due Process	464

Introduction

A. Background Information

The evaluation team, consisting of the Court Monitor (Mohamed El-Sabaawi, MD) and four expert consultants (Vicki Lund, PhD, MSN, ARNP; Ramasamy Manikam, PhD; Elizabeth Chura, MSRN; and Monica Sage, OTR/L) visited Napa State Hospital (NSH) from July 23 to 27, 2007 to evaluate the facility's progress regarding compliance with the Enhancement Plan (EP). The evaluators' objective was to develop a detailed assessment of the status of compliance with all action steps of the EP.

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

1. The methodology of evaluation, summarized in one cell at the beginning of each section or major subsection (C1, C2, D1 through D.7, E, F1 through F 10, G, H., I and J);
2. 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 and clinical staff and some

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

C. Statistical Reporting

NSH has actively sought opportunities to measure its processes and results and provided the monitoring team with monitoring data that illustrated its work in this regard. This information can be a very helpful complement to the monitors' reviews and empirical observations. In addition to continuing and refining its monitoring work (for example by ensuring that total target population are accurately defined and that sample sizes have statistical significance and are relatively consistent over time), the monitor would encourage the facility to feel free to develop what it believes are the most relevant and usable forms of reporting its measurements, recognizing that not all data lends itself to a single standard format.

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

Abbreviation	Definition
N	Total target population
n	Target population reviewed
%S	Sample size; target population reviewed (n) divided by total target population (N), multiplied by 100
%C	Compliance rate

In some cases, data that was characterized by NSH as N, n or %S did not comport with the above definitions and has been recharacterized in this report, usually by naming the process or group that was audited/monitored.

D. Findings

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

1. Key Indicator Data

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

- a.) The key indicator data provide a global assessment of and insights into the clinical and process outcomes of the facility over time. These types of data form a foundation for identifying and potentially prioritizing needed performance improvement at any medical facility and should not be seen as just another requirement of the EP.
- b.) NSH has now collected 16 months (April 2006 through July 2007) of many of the key indicator data series. This amount of data can now help the facility as well as the monitor begin to move beyond interpretations that were necessarily tentative due to lack of sufficient longitudinal data.
- c.) The data suggests several positive trends, including:
 - a. Most notably, a sustained decline in the use of PRN medications.
 - b. A decline in the incidence of close observation, assuming that this trend is a result of more effective management of individuals' needs rather than from failure to engage in close observation when called for.
 - c. An apparent downtrend in the number of incidents in which individuals test positive for street drugs.
 - d. A near-term decline in the number of individuals experiencing repeated episodes of restraint.
 - e. While six months of data are not a sufficient foundation for firm conclusions, there has been a decrease in the number of Stat medications administered.
- d.) The key indicator data reveals trends that should be noted, investigated and explained by the facility. It is unclear whether the trends are in fact trends resulting from clinical activities or if there is variability in data collection that results in the suggestion of a pattern that does not have true significance. Examples include:
 - a. A near-term increase in the number of acts of self-aggression resulting in major injury, acts of aggression to staff resulting in major injury and repeated episodes of aggressive acts; this may be due to a one or a few individuals, but there also may be systemic factors that should be considered, for example co-existence of this trend with a decline in the incidence of close observation.
 - b. A May 2007 spike in allegations of abuse, neglect and/or exploitation.

- c. A June 2007 spike in hospitalization for medical issues; this indicator is ordinarily variable from month to month and can vary based on individual population as well, but systemic issues should be considered.
 - d. The number of individuals prescribed the older anticonvulsant phenytoin has risen; this trend should be evaluated and justified.
 - e. NSH reports few medication variances for any reasons other than administration and documentation, and even these may be low. Medication variances happen even with the most skilled and seasoned staff and it is essential that they are captured and analyzed so that risks can be mitigated to the extent possible. The monitor's expectation of medication variance, including prescribing variances, is based on realism, not on any judgment about the skill and seasoning of the medical staff.
- e.) NSH still is not reporting on 15 key indicators; while staff shortages and lack of complete automation can preclude full data collection and reporting, it is important for the facility to make every effort to capture all the data. This is not for the Court Monitor's sake but to enhance the facility's own performance improvement practice.

2. Monitoring, Mentoring and Self-Evaluation

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

- a) NSH has continued the process of internal monitoring despite serious and, in some cases, critical shortages of core clinical staff. However, the facility's progress report included examples that demonstrated lack of an adequate understanding of the intent, scope and purposes of the EP. Some section leaders were unable to explain some of their own data, did not have adequate knowledge of what material was presented in the binders that were submitted to the court monitor's team and presented some data that had no clinical relevance, lacked context and/or contained obvious inconsistencies.
- b) The EP is primarily concerned with mechanisms that improve the quality of services provided to the individuals at the state facilities. The implementation of the EP has created requirements for monitoring and data collection by the facilities. Data gathering is by no means an end unto itself nor are the court monitor, his experts or the EP process suggesting that it is a better use of direct care clinicians' time to collect data rather than caring for the individuals. However, a consistent, thorough and reliable data gathering should be performed without taxing direct care resources. This is essential to provide

needed information to assess, strengthen and reinforce services and to enhance awareness by clinicians and managers of practice outcomes and of opportunities to improve these practices.

- c) Despite shortcomings in NSH's progress report, the facility's data in many sections were based on indicators that were well-aligned with requirements of the plan and contained compliance ratings that appeared to have integrity.
- d) The facility's internal 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.
- e) 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. Furthermore, the monitoring data across hospitals should be reviewed quarterly by the State with their Chief CRIPA Consultant so that the aggregate data can be used to enhance the mental health services provided throughout the DMH system.
- f) The California Department of Mental Health (DMH) has made significant progress in streamlining and standardizing monitoring systems across hospitals, especially in the tools that are used to monitor the process and content of the Wellness and Recovery Plan (WRP). The DMH has developed written operational instructions that accompany the WRP monitoring tools. These instructions contain appropriate guidelines regarding the use of each tool.
- g) The DMH should finalize current efforts to streamline and standardize the tools used for disciplinary assessments and services. The current tools that are used to assess psychiatric assessments and reassessments, inter-unit transfer assessments, court assessments, nutrition assessments, high-risk medication uses (PRN medications, benzodiazepines, and anticholinergics) and some aspects of medical service delivery are generally well aligned with requirements of the EP. However, not all the tools address the quality of services or include operational definitions and instructions that can standardize the use within and across the facilities.
- h) 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 of documentation. It is expected that quality indicators change slowly overtime, but the process must be oriented to these indicators from the beginning.
- i) Much work remains to be done to define the total target population (N) and ensure adequate and consistent sample size (%S). The sample size should be 20% of the total population or target population. If the target population is very small (e.g. individuals diagnosed with Tardive Dyskinesia), the total target population should be sampled.
- j) In too many cases, the sample size monitored was far too small to be meaningful and the method of selection was unstated. The sample size must be representative of the total population or subpopulations that are being assessed.

- k) The reliability data on internal monitoring is still insufficient. Approximately 20% of the data collected should be assessed for reliability.
- l) Monitoring is not always undertaken by staff that is trained to competency in the process of monitoring. As mentioned in previous reports, the essence of collecting monitoring data is that it will be closely followed by feedback and mentoring.
- m) Given the amount of monitoring that is required, the tools and data collection must be automated.
- n) The facilities are encouraged to provide their data in Excel spreadsheets. These are generally preferable to Word documents for reporting data as they provide ample room for text and also can be used to double-check calculations.

3. Implementation of the EP

- a) Structure of current and planned implementation:
 - i. During this review period, NSH has made progress in a few areas, including nutritional assessments and services, infection control, psychiatric occupational therapy, speech language pathology and art therapy.
 - ii. NSH appears to be on the right track in the area of court assessments.
 - iii. NSH has developed a new structure for risk management, including triggers and levels of interventions. This system is very promising, but it has yet to be implemented.
 - iv. Overall, however, NSH has fallen to the same level of services that was evident in the baseline assessment and in some areas the facility has fallen further behind.
 - v. The staffing shortages that were highlighted in the last review have, in general, worsened (despite increased allocations for many of these positions). This has been a major barrier towards implementation of the EP. However, some of the deficiencies in the implementation appear to transcend the issue of shortages.
 - vi. NSH has experienced recent and necessary changes in all key administrative positions in the facility, including Executive Director, Hospital Administrator and Clinical Administrator. In addition, the facility has had an Acting Medical Director for much of this review period. **A change of this magnitude would require time to effect improvements in the facility's efforts to comply with the EP.**
 - vii. There does not appear to be much accountability in the system in reference to compliance with the EP. The new administrative leadership needs to make serious efforts to address and correct this barrier.
 - viii. The Medical Staff is currently hampered by staffing shortages in addition to the lack of a dedicated position of Chief of Psychiatry. During the last review, this monitor made a recommendation to fill the position of Chief of Psychiatry promptly, but this has yet to occur. This position is essential to facilitate compliance.

- ix. The position of Chief of Psychiatry must have authority and responsibility regarding the clinical assignments of staff psychiatrists, the assignment and of senior psychiatrists (yet to be recruited) to various mentoring and monitoring functions, the supervision of all psychiatrists and the responsibility for compliance with the EP in the areas of psychiatric assessments/services and leadership of the WRPTs.
 - x. The facility needs to strengthen its current WRP training by significantly increasing the training sessions. Discipline seniors should be trained to not only monitor, but also mentor clinicians in their areas. The WRPTs need to work with dedicated trainers who can provide feedback and teaching on an ongoing basis.
 - xi. As mentioned in the previous reports, the DMH-approved monitoring system has the potential to demonstrate the effectiveness of the recovery-oriented psychiatric rehabilitation of the individuals served in the DMH forensic hospitals.
 - xii. The current implementation of the matrix model at all the DMH facilities has hindered compliance with the EP. This has resulted in the clinical chiefs having the responsibility but not the authority to implement and produce the outcomes expected by the EP.
 - xiii. Given that the EP provides the basis for mental health services delivered in all state DMH facilities, it is the monitor's recommendation that the DMH seriously consider standardizing Administrative Directives that impact these services across all hospitals.
- b) Function of current and planned implementation:
- i. NSH has yet to make progress in the process and content of Wellness Recovery Planning.
 - ii. Although there is an excellent manual of WRP, the implementation of many of the principles and practice requirements remains generally inadequate. The facility needs to increase and focus its training sessions on proper implementation of this manual
 - iii. This monitor's observations of team meetings and review of charts showed evidence of significant deficiencies that must be corrected to achieve momentum in the path toward compliance. The deficiencies outlined in section C.1. are reiterated here:
 - The schedules of some meetings were changed without notification of the facility administration.
 - Some conferences did not start on time for no apparent reason.
 - Most team meetings did not include some core team members.
 - Most meetings were conducted without evidence of who the team leader was.
 - Some team members left the conference during the discussion without adequate reason.
 - Some team members engaged in sidebar conversations while the individual was present in the conference.
 - Almost all the teams failed to review/discuss their assessments prior to the arrival of the individual.

- Most teams spent much time during the meeting to conduct assessments and mental status examination of the individual.
 - Most teams failed to adequately update the present status section of the case formulation.
 - The review/update of diagnosis and foci of hospitalization were generally not informed by a discussion/analysis of assessments, case formulation and/or progress in Mall groups.
 - There was no mechanism to adequately review progress in Mall groups.
 - In general, the review of the objectives and interventions began too late in the meetings.
 - Some teams developed objectives that were not attainable for the individual.
 - Too many objectives were not behavioral, measurable and/or appropriately linked to the individual's stage of change.
 - Too many interventions lacked specificity as to who will do what to assist the individual in achieving the objectives.
 - The revisions of foci, objectives and/or interventions did not reflect important changes in the individual's status, including important medical needs and the use of seclusion/restraints.
- iv. Functional outcomes of the current structural changes have yet to be identified and implemented to guide further implementation.
- v. NSH has yet to implement a system to ensure linkage between interventions provided at the PSR Mall and objectives outlined in the WRP.
- vi. A well-functioning PSR Mall that meets the specific needs of the individuals is the centerpiece of the Wellness and Recovery Planning model. Progress remains to be made towards this goal, specifically in the areas of:
- i. **Mall hours:** The number of hours of Psychosocial Rehabilitation Mall (PSR) services (i.e., group facilitation or individual therapy) provided by the various disciplines, administrative staff, and others is currently minimal. The following table provides the minimum average number of hours of Mall services that DMH facilities should provide:

Required PSR MALL Hours as Facilitators or Co-Facilitators		
	Admissions Staff	Long-Term Staff
Psychiatry	4	8
Psychology	5	10
SW	5	10

RT	7	15
RN	6	12
PT	6	12
FTE Mall staff	20 hours as Mall group facilitator	
Other hospital staff	As determined locally at each hospital	

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

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

- ii. **Progress notes:** None of the monitored facilities has a system that requires providers of Mall groups and individual therapy to complete and make available to each individual's Wellness and Recovery Planning Team (WRPT), the DMH-approved PSR Mall Facilitator Monthly Progress Note prior to regularly scheduled WRPCs. Without the information in the monthly progress notes, the WRPT has almost no data on which to base the revisions of an individual's objectives and interventions. This is unacceptable and not aligned with the requirements as stated in the DMH WRP Manual. All hospitals must fully implement the PSR Mall Facilitator Monthly Progress Note in their PSR Malls for all groups and individual therapies no later than October 1, 2007.
- iii. **Cognitive screening for PSR Mall groups:** PSR Mall groups should be presented in terms of the cognitive levels of the individuals at the hospital. Individuals can be stratified at three cognitive levels: (a) advanced (above average), (b) average, and (c) challenged (below average). A cognitive screening protocol, utilizing generally accepted testing methods, can be used to determine these levels for those individuals whose primary or preferred language is English.

The cognitive screening protocol will also provide information for the team psychologist to determine whether a referral to the DCAT and/or neuropsychological service is required. All State hospitals must ensure that no later than January 1, 2008, cognitive screening has been completed for all individuals and that their Mall groups are aligned with their cognitive level.

- iv. **PSR Mall, Vocational Services and Central Program Services (CPS):** The DMH facilities have made some progress toward developing a centralized PSR Mall service under the direction of the PSR Mall Director. However, not all services have been incorporated in the PSR Mall system, e.g., vocational services and CPS. All facilities must ensure that no later than January 1, 2008, there is a single unified PSR Mall system that incorporates all psychosocial rehabilitation services that are included in the individuals' WRPs.
- v. **Virtual PSR Mall:** Those facilities that have individuals who are civilly committed, and who have no legal barriers to attending rehabilitation and skills training groups in the community, should provide those individuals with that opportunity. These groups should be included as a part of a virtual PSR Mall. The WRPs of these individuals should include specific reference to community PSR Mall groups in the interventions. This service should be available to this group of individuals no later than January 1, 2008.

4. Staffing

The NSH staffing table below shows the staffing pattern at the hospital as of June 30, 2007. These data were provided by the California DMH. The table shows that there continues to be severe shortages of staff in several core clinical disciplines: staff psychiatrists, senior psychiatrists, staff psychologists, senior psychologists, staff physicians and surgeons, pharmacists, social workers, rehabilitation therapists and clinical dieticians. In general, these shortages have worsened since the last review (despite increased allocations by the state for many of these positions). As mentioned in the monitor's previous reports, these shortages can negatively affect service delivery and the safety and security of individuals and staff. The shortages of psychiatrists, psychologists, pharmacists and rehabilitation therapists have had direct negative impact on the facility's compliance with requirements of the EP.

Napa State Hospital Vacancy Totals As of 6/30/07				
Identified Clinical Positions	Allocated Positions	Filled Positions	Vacant Positions	Vacancy Rate
Assistant Coordinator of Nursing Services	5.00	5.00	0.00	0%
Assistant Director of Dietetics	3.00	3.00	0.00	0%
Audiologist I	0.00	0.00	0.00	NA
Chief Dentist	1.00	1.00	0.00	0%
Chief Physician & Surgeon	1.00	1.00	0.00	0%
Chief, Central Program Services	0.00	0.00	0.00	NA
Clinical Dietician/Pre-Reg. Clin. Dietician	10.00	4.50	5.50	55%
Clinical Laboratory Technologist	4.00	4.00	0.00	0%
Coordinator of Nursing Services	1.00	0.00	1.00	100%
Coordinator of Volunteer Services	1.00	1.00	0.00	0%
Dental Assistant	3.00	2.00	1.00	33%
Dental Hygienist	1.00	0.00	1.00	100%
Dentist	2.00	1.50	0.50	25%
Dietetic Technician	0.00	0.00	0.00	NA
E.E.G. Technician	0.00	0.00	0.00	NA
Hospital Police Lieutenant	4.00	4.00	0.00	0%
Hospital Police Officer	85.00	75.00	10.00	12%
Hospital Police Sergeant	11.00	9.00	2.00	18%
Hospital Worker	5.00	5.00	0.00	0%
Health Record Technician	15.00	10.00	5.00	33%

**Napa State Hospital Vacancy Totals
As of 6/30/07**

Identified Clinical Positions	Allocated Positions	Filled Positions	Vacant Positions	Vacancy Rate
Health Services Specialist	30.00	26.00	4.00	13%
Institution Artist Facilitator	1.00	1.00	0.00	0%
Licensed Vocational Nurse	52.00	46.30	5.70	11%
Medical Technical Assistant	0.00	0.00	0.00	NA
Nurse Instructor	9.00	6.00	3.00	33%
Nurse Practitioner	7.00	2.00	5.00	71%
Nursing Coordinator	7.00	7.00	0.00	0%
Office Technician	36.50	38.80		NM
Pathologist	1.00	0.00	1.00	100%
Pharmacist I	13.50	6.00	7.50	56%
Pharmacist II	2.00	1.00	1.00	50%
Pharmacy Services Manager	1.00	1.00	0.00	0%
Pharmacy Technician	15.00	12.90	2.10	14%
Physician & Surgeon	23.00	14.90	8.10	35%
Podiatrist	1.00	1.00	0.00	0%
Pre-licensed Pharmacist	0.00	0.00	0.00	NA
Pre-licensed Psychiatric Technician	4.00	4.00	0.00	0%
Program Assistant	7.00	4.00	3.00	43%
Program Consultant (RT, PSW, Psych)	2.00	2.00	0.00	0%
Program Director	7.00	5.00	2.00	29%
Psychiatric Social Worker	73.80	56.60	17.20	23%

**Napa State Hospital Vacancy Totals
As of 6/30/07**

Identified Clinical Positions	Allocated Positions	Filled Positions	Vacant Positions	Vacancy Rate
Psychiatric Nursing Education Director	1.00	1.00	0.00	0%
Psychiatric Technician	282.00	280.30	1.70	1%
Psychiatric Technician Trainee	0.00	0.00	0.00	NA
Psychiatric Technician Assistant	317.00	304.10	12.90	4%
Psychiatric Technician Instructor	2.00	2.00	0.00	0%
Psychologist-HF, (Safety)	63.20	51.30	11.90	19%
Public Health Nurse II/I	1.00	1.00	0.00	0%
Radiologic Technologist	2.00	2.00	0.00	0%
Registered Nurse	322.00	313.00	9.00	3%
Reg. Nurse Pre Registered	1.00	1.00	0.00	0%
Rehabilitation Therapist	84.40	53.00	31.40	37%
Special Investigator	5.00	2.00	3.00	60%
Speech Pathologist I	0.00	0.00	0.00	NA
Sr. Clinical Laboratory Technologist	2.00	1.00	1.00	50%
Sr. Psychiatrist	15.30	1.00	14.30	93%
Sr. Psychologist	16.00	0.00	16.00	100%
Sr. Psych Tech(Safety)	61.00	59.00	2.00	3%
Sr. Radiologic Technologist (Specialist)	0.00	0.00	0.00	NA
Sr. Voc. Rehab. Counselor/Voc. Rehab. Counselor	1.00	1.00	0.00	0%
Staff Psychiatrist	71.70	36.00	35.70	50%
Supervising Registered Nurse	19.00	16.00	3.00	16%

Napa State Hospital Vacancy Totals As of 6/30/07				
Identified Clinical Positions	Allocated Positions	Filled Positions	Vacant Positions	Vacancy Rate
Teacher-Adult Educ./Vocational Instructor	8.50	6.00	2.50	29%
Teaching Assistant	0.00	0.00	0.00	NA
Unit Supervisor	29.00	26.00	3.00	10%
Vocational Services Instructor	2.00	2.00	0.00	0%

NA = not applicable and applies to positions without allocations; NM = not meaningful

As mentioned in earlier reports, the staffing shortages at the DMH facilities have reached levels that may threaten the safety and security of individuals and staff. The recent timely and decisive actions by the DMH to address the pay differential between the mental health facilities and the California Department of Corrections and Rehabilitation (CDCR) have the potential of resolving this crisis and reversing the negative impact on its mental health institutions.

In order to meet the Enhancement Plan requirements, the overall numbers of nursing staff must increase and the skill mix be expanded. The facility needs sufficient numbers of direct service nursing staff to provide a minimum of 5.5 nursing care hours per patient day (NCHPPD) on all units. If any individual on the unit is on 1:1 observation, an additional staff member should be added to each shift for the period of time an individual is on 1:1 observation, and this additional staff member would not be counted in the overall NCHPPD.

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

Psychiatric Mental Health Advanced Practice Nurses and/or Clinical Nurse Specialists should be actively recruited to develop a program and provide education for psychiatric mental health nursing. Within the first 90 days of employment, any nurse who does

not have previous experience in psychiatric mental health nursing should be required to complete a basic psychiatric mental health nursing review course.

E. Monitor's Evaluation of Compliance

The status of compliance is assessed considering the following factors:

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

A finding of partial compliance indicates that the facility has taken steps that are oriented toward achieving compliance with a particular requirement of the EP but is not yet achieving results that substantially comply with EP requirements. Additionally, in some instances the Court Monitor has rendered a finding of partial compliance despite monitoring data that would appear to suggest non-compliance. This is because in some cases, the facility uses a monitoring indicator with multiple underlying requirements and an all-or-none scoring protocol. For example, a monitoring indicator may have ten underlying requirements and the facility may meet nine of the requirements, but receive a score of 0% compliance for falling short on one of the ten indicators.

F. Next Steps

1. The Court Monitor's team's schedule for the next six months is as follows:
 - a) Metropolitan State Hospital: August 27-31, 2007
 - b) Atascadero State Hospital: October 15-19, 2007
 - c) Patton State Hospital: November 26-30, 2007

2. The Court Monitor's team will reevaluate NSH January 28 to February 1, 2008.
3. All compliance reports should be reviewed and utilized, as applicable, by all facilities to guide implementation efforts regardless of the schedule of facility-specific assessments.

Sec.	Enhancement Tasks	
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 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.	

Section C: Integrated Therapeutic and Rehabilitation Services Planning

C	Integrated Therapeutic and Rehabilitation Services Planning	
	<p>Each State hospital shall provide coordinated, comprehensive, individualized protections, services, supports, and treatments (collectively "therapeutic and rehabilitation services") for the individuals it serves, consistent with generally accepted professional standards of care. In addition to implementing the therapeutic and rehabilitation planning provisions set forth below, each State hospital shall establish and implement standards, policies, and practices to ensure that therapeutic and rehabilitation service determinations are consistently made by an interdisciplinary team through integrated therapeutic and rehabilitation service planning and embodied in a single, integrated therapeutic and rehabilitation service plan.</p>	<p>Summary of Progress:</p> <ol style="list-style-type: none"> 1. NSH recently adopted and began to implement the WRP training curriculum established at MSH. 2. NSH has continued efforts to implement all schedules of the WRPs and to monitor this implementation despite shortages in core clinical staff. 3. NSH has increased training sessions provided to WRPTs despite psychology vacancies resulting in loss of most members of the WRP training team. 4. NSH has developed the final portion of the curriculum for the treatment of substance abuse. The curriculum is aligned with the Trans-theoretical Model of the Stages of Change and with current literature by the US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment. 5. NSH has continued to monitor its implementation of the EP. Despite many methodological shortcomings, the facility's ratings of compliance appeared to have integrity. 6. NSH has implemented the new Clinical Chart Auditing process. The indicators are aligned with EP requirements and the tool represents improved clinical input in the process of internal monitoring.
C.1	Interdisciplinary Teams	
	<p>The interdisciplinary team's membership shall be dictated by the particular needs and strengths of the individual in the team's care. At a minimum, each State Hospital shall ensure that the team shall:</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Carmen Caruso, Clinical Administrator 2. Regina Ott, Director, CPS 3. Cindy Black, Standards Compliance Director 4. Gregory Leonard, Psych. Tech., Standards Compliance department <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Documentation of WRP Consultation Group meetings from January to June 2007

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<ol style="list-style-type: none"> 2. Memorandum from Executive Director (March 20, 2007) regarding WRP Nursing Interventions Training Plan 3. WRP Nursing Interventions Training Objectives 4. WRP Training Curriculum: Engagement Module 5. WRP Training Curriculum: Case Formulation Module 6. WRP Training Curriculum: Foci and Objectives Module 7. WRP Knowledge Assessment Post Test 8. Administrative Directive (AD) #785, Wellness and Recovery Plan (WRP) 9. Draft Medical Staff Manual (revised July 5, 2007) 10. WRP Observation Monitoring Form 11. WRP Observation Monitoring Form Instructions 12. WRP Observation Monitoring summary data (January to June 2007) 13. WRP Chart Audit Form 14. WRP Chart Audit Form Instructions 15. WRP Clinical Chart Auditing Form 16. WRP Clinical Chart Auditing Form Instructions 17. WRP Chart Auditing summary data (January to June 2007) 18. Psychology Assessment Monitoring Form 19. Psychology Assessment Monitoring Form Instructions 20. Admission psychiatry, initial medical, admission nursing and integrated nursing assessments summary data (January to June 2007) 21. WRPC/Consistent Enduring Team (CET) Attendance Monitoring Form 22. WRPC/Consistent Enduring Team (CET) Attendance Monitoring summary data (January to June 2007) <p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. WRPT meeting (Program III unit T-16) for monthly review of MB and EVH. 2. WRPT meeting (Program II, unit T-17) for quarterly review of GP. 3. WRPT meeting (Program I, unit T-5) for annual review of DM. 4. WRPT meeting (Program V, unit Q-5) for biweekly review of SB.
--	--	---

Section C: Integrated Therapeutic and Rehabilitation Services Planning

<p>C.1.a</p>	<p>Have as its primary objective the provision of individualized, integrated therapeutic and rehabilitation services that optimize the individual's recovery and ability to sustain himself/herself in the most integrated, appropriate setting based on the individual's strengths and functional and legal status and support the individual's ability to exercise his/her liberty interests, including the interests of self determination and independence.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Implement the revised DMH WRP manual.</p> <p>Findings: The revised DMH WRP Manual has been implemented.</p> <p>Recommendation 2, February 2007: Continue training provided to WRP trainers and documentation of training to competency.</p> <p>Findings: The WRP Consultation Group, led by the Treatment Enhancement Coordinator (TEC), has been meeting on a weekly basis to implement this recommendation. The membership of this group has been essentially the same since last review. The TEC has facilitated 20 additional hours of training during this review period. However, the number of WRP program trainers has decreased due to departure of three psychologists. At this time, only one and a half FTE psychologists are dedicated as program trainers. Competency is currently based on a score of 100% on the WRP Knowledge Assessment Post Test (may include remediation). The facility did not provide documentation of training to competency as recommended.</p> <p>In March 2007, the facility prioritized nursing interventions that address high-risk factors (e.g. aggression) in their WRP training. The TEC developed a lesson plan derived from the WRP Manual and a new post-test regarding this training. Nursing Coordinators were identified as WRP Trainers for nursing staff in March, 2007. These coordinators have been consistently attending the WRP Consultation Group trainings and served as co-trainers of the WRP Nursing Intervention training. This has resulted in 91% (N=654) of all nursing staff being trained (RN/LVN/PT). However, the facility has yet to provide documentation of training to competency.</p>
--------------	---	--

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>Recommendation 3, February 2007: Increase training sessions to all members of the WRPTs and provide documentation of training to competency.</p> <p>Findings: NSH has increased training sessions by 40.5 hours from January to June 2007 despite loss of psychology WRP trainers. NSH used the WRP Knowledge assessment post-test developed at MSH. As mentioned above, NSH did not provide documentation of training to competency.</p> <p>Recommendation 4, February 2007: Ensure that all WRPTs at the facility receive the same level of training.</p> <p>Findings: NSH has adopted the WRP training curriculum developed by MSH, including Engagement, Case Formulation and Foci and Objectives Modules. The DMH WRP Manual and the WRP Training curriculum are the only sources of training materials for all WRPTs.</p> <p>Recommendation 5, February 2007: Establish new employee WRP training (for non-nursing disciplines).</p> <p>Findings: New Employee WRP training for non-nursing disciplines has been established effective July 3, 2007 (WRP Training Database Course Code #6017-11).</p> <p>Recommendation 6, February 2007: Utilize the review questions listed for each chapter of the DMH WRP manual in the WRP competency evaluation.</p>
--	--	--

		<p>Findings: NSH has implemented this recommendation. The WRP Knowledge Assessment Post Test has been aligned with the review questions.</p> <p>Recommendation 7, February 2007: Ensure that the AD regarding WRP is aligned with the revised DMH WRP manual.</p> <p>Findings: NSH has yet to implement this recommendation.</p> <p>Other findings: Since the last review, NSH has continued internal monitoring to assess compliance with this section of the EP. A total of 13 auditors affiliated with the standards compliance department participate in this monitoring. In April 2007, the State's training consultant conducted inter-reliability evaluation of a number of these auditors that varied from three to 13. All the auditors evaluated met the target of at least 90% reliability. The following table illustrates the data:</p> <table border="1" data-bbox="884 857 1646 1084"> <thead> <tr> <th data-bbox="884 857 1236 971">Monitoring Instrument</th> <th data-bbox="1236 857 1409 971"># of Auditors Evaluated</th> <th data-bbox="1409 857 1646 971"># of auditors that met >90% Reliability</th> </tr> </thead> <tbody> <tr> <td data-bbox="884 971 1236 1008">WRP Chart Audit</td> <td data-bbox="1236 971 1409 1008">13</td> <td data-bbox="1409 971 1646 1008">13</td> </tr> <tr> <td data-bbox="884 1008 1236 1045">WRP Clinical Chart Audit</td> <td data-bbox="1236 1008 1409 1045">10</td> <td data-bbox="1409 1008 1646 1045">10</td> </tr> <tr> <td data-bbox="884 1045 1236 1084">WRP Observation Audit</td> <td data-bbox="1236 1045 1409 1084">3</td> <td data-bbox="1409 1045 1646 1084">3</td> </tr> </tbody> </table> <p>NSH has data showing the average sample sizes that have been monitored using the above three instruments for each WRP schedule between January and June 2007. The data summarized in the tables below show that the sample sizes have been well below the recommended 20%.</p>	Monitoring Instrument	# of Auditors Evaluated	# of auditors that met >90% Reliability	WRP Chart Audit	13	13	WRP Clinical Chart Audit	10	10	WRP Observation Audit	3	3
Monitoring Instrument	# of Auditors Evaluated	# of auditors that met >90% Reliability												
WRP Chart Audit	13	13												
WRP Clinical Chart Audit	10	10												
WRP Observation Audit	3	3												

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<table border="1"> <thead> <tr> <th>7- Day WRP</th> <th>Average Sample Size (%)</th> </tr> </thead> <tbody> <tr> <td>WRP Clinical Chart Audit</td> <td>3</td> </tr> <tr> <td>WRP Chart Audit</td> <td>5</td> </tr> <tr> <td>WRP Observation Audit</td> <td>2</td> </tr> </tbody> </table> <table border="1"> <thead> <tr> <th>Bi-Weekly WRP</th> <th>Average Sample Size (%)</th> </tr> </thead> <tbody> <tr> <td>WRP Clinical Chart Audit</td> <td>0</td> </tr> <tr> <td>WRP Chart Audit</td> <td>11</td> </tr> <tr> <td>WRP Observation Audit</td> <td>4</td> </tr> </tbody> </table> <table border="1"> <thead> <tr> <th>Monthly WRP</th> <th>Average Sample Size (%)</th> </tr> </thead> <tbody> <tr> <td>WRP Clinical Chart Audit</td> <td>0</td> </tr> <tr> <td>WRP Chart Audit</td> <td>6</td> </tr> <tr> <td>WRP Observation Audit</td> <td>3</td> </tr> </tbody> </table> <table border="1"> <thead> <tr> <th>Quarterly WRP</th> <th>Average Sample Size (%)</th> </tr> </thead> <tbody> <tr> <td>WRP Clinical Chart Audit</td> <td>4</td> </tr> <tr> <td>WRP Chart Audit</td> <td>11</td> </tr> <tr> <td>WRP Observation Audit</td> <td>10</td> </tr> </tbody> </table> <table border="1"> <thead> <tr> <th>Annual WRP</th> <th>Average Sample Size (%)</th> </tr> </thead> <tbody> <tr> <td>WRP Clinical Chart Audit</td> <td>1</td> </tr> <tr> <td>WRP Chart Audit</td> <td>5</td> </tr> <tr> <td>WRP Observation Audit</td> <td>1</td> </tr> </tbody> </table>	7- Day WRP	Average Sample Size (%)	WRP Clinical Chart Audit	3	WRP Chart Audit	5	WRP Observation Audit	2	Bi-Weekly WRP	Average Sample Size (%)	WRP Clinical Chart Audit	0	WRP Chart Audit	11	WRP Observation Audit	4	Monthly WRP	Average Sample Size (%)	WRP Clinical Chart Audit	0	WRP Chart Audit	6	WRP Observation Audit	3	Quarterly WRP	Average Sample Size (%)	WRP Clinical Chart Audit	4	WRP Chart Audit	11	WRP Observation Audit	10	Annual WRP	Average Sample Size (%)	WRP Clinical Chart Audit	1	WRP Chart Audit	5	WRP Observation Audit	1
7- Day WRP	Average Sample Size (%)																																									
WRP Clinical Chart Audit	3																																									
WRP Chart Audit	5																																									
WRP Observation Audit	2																																									
Bi-Weekly WRP	Average Sample Size (%)																																									
WRP Clinical Chart Audit	0																																									
WRP Chart Audit	11																																									
WRP Observation Audit	4																																									
Monthly WRP	Average Sample Size (%)																																									
WRP Clinical Chart Audit	0																																									
WRP Chart Audit	6																																									
WRP Observation Audit	3																																									
Quarterly WRP	Average Sample Size (%)																																									
WRP Clinical Chart Audit	4																																									
WRP Chart Audit	11																																									
WRP Observation Audit	10																																									
Annual WRP	Average Sample Size (%)																																									
WRP Clinical Chart Audit	1																																									
WRP Chart Audit	5																																									
WRP Observation Audit	1																																									

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>Observations of WRPCs (see C.1.e below) and chart reviews (see section C.2) by this monitor show that, since the last review, NSH has made little progress in approaching compliance with the EP requirements in C.1.a through C.1.f.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Expedite recruitment of senior psychiatrists and senior psychologists to provide additional training and peer mentoring. 2. Continue training provided to WRP trainers and provide documentation of training to competency. 3. Increase training sessions to all members of WRPTs (including nursing) and provide documentation of training to competency. 4. Implement the New Employee training for non-nursing disciplines. 5. Align the AD regarding WRP with the WRP Manual.
C.1.b	Be led by a clinical professional who is involved in the care of the individual.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Continue to monitor presence of team leaders and aggregate data regarding coverage of the leader role.</p> <p>Findings: Using the WRP Process Observation Monitoring, NSH assessed its compliance with this requirement (January to June 2007). Based on an average sample size of 1%, the facility reported an average compliance rate of 53%. This monitoring is based on the presence of rather than participation by the team leader. Due to an increase in psychiatry vacancies, psychologists have served as the identified team leader at many WRP conferences.</p>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

	<p>Recommendation 2, February 2007: Standardize the current WRP Conferences Monitor Report for statewide use.</p> <p>Findings: The DMH has modified the process observation, chart audit and case formulation (now incorporated in the DMH WRP Clinical Chart Auditing Form) monitoring instruments. These monitoring instruments have been standardized statewide. Each form is now accompanied by instructions that provide clear and adequate definitions of the appropriate operational components of each item.</p> <p>Recommendation 3, February 2007: Develop and implement a monitoring tool to assess proper participation by the team leader in the WRP conferences.</p> <p>Findings: NSH has yet to address this recommendation. The facility reported that the shortage of psychiatrists has been the main barrier. The revised DMH WRP Manual specifies the functions of the team leader as aligned with requirements of the EP.</p> <p>Recommendation 4, February 2007: Develop and implement a peer mentoring system to ensure competency in team leadership skills.</p> <p>Findings: NSH has yet to implement this recommendation. The draft Medical Staff Manual assigns Senior Psychiatrists and Senior Psychologists the responsibility of mentoring peers to ensure their competency as team leaders (see Section VI.D.5, pg#21). However, most of these positions have yet to be filled. In the interim, effective August 1, Dr. Scott Sutherland will assume the new position of Acting Chief of Psychiatry and will begin providing peer mentoring. Dr. Anne Hoff and Dr. Kathleen Patterson, Senior Psychologists are currently providing peer mentoring</p>
--	--

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>to unit psychologists on a monthly basis. The facility has plans to develop a formalized peer mentoring system, with projected implementation date by October 1, 2007.</p> <p>Recommendation 5, February 2007: The revised Psychiatric Physician Manual should address the leader's responsibility to ensure a sequence of tasks that facilitates WRP as well as proper participation by individuals in the WRPCs.</p> <p>Findings: The Medical Staff Manual has been revised to include the team leader's responsibilities to ensure a sequence of tasks that facilitates WRP as defined in the DMH WRP Manual, March 2007 (Section VI.D.1-5, Pg #20).</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Same as recommendations 1-3 under C.1.a. 2. Monitor the presence and participation by team leaders in the WRPCs using a statewide standardized instrument. 3. Develop and implement a peer mentoring system to ensure competency in team leadership skills. 4. Finalize the draft Medical Staff Manual.
C.1.c	Function in an interdisciplinary fashion.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Use the WRP Process Observation Form to assess team functions at the 7-day and 14-day conferences.</p>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>Findings: NSH has implemented this recommendation.</p> <p>Recommendation 2, February 2007: Continue to monitor all WRPCs regarding this requirement.</p> <p>Findings: NSH has data that indicate partial implementation of this recommendation. The facility used the WRP Observation Monitoring Form to assess compliance. Reviewing an average sample size of 1%, the facility reported mean compliance rates of 0% for each of the 7-day (January and May 2007) and 14 day (April to June 2007) WRPCs. The facility has additional data regarding the monthly WRPCs (January to June 2007), but the average sample size was less than 1%.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Same as recommendations 1-3 under C.1.a. 2. Monitor adequate sample of all schedules of the WRP conferences.
C.1.d	Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary, and appropriate psychiatric and medical care.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Resume the practice of surveying team members once adequate training has been provided to the team leaders.</p> <p>Findings: NSH has yet to implement this recommendation.</p> <p>Recommendation 2, February 2007: Implement the DMH WRP Clinical Chart Auditing Form.</p>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>Findings: NSH has implemented this recommendation. Using this audit, the facility reviewed an average sample size of 15% of quarterly WRPCs (January to June 2007). Based on auditing instructions that are appropriate to the interdisciplinary process of team functioning, the facility reported mean compliance rate of 1%.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Same as recommendations #1-3 under C.1.a. 2. Resume the practice of surveying team members once adequate training has been provided to the team leaders. 3. Continue using the WRP Clinical Chart Auditing Form and ensure adequate sample sizes.
C.1.e	<p>Ensure that each member of the team participates appropriately in competently and knowledgeably assessing the individual on an ongoing basis and in developing, monitoring, and, as necessary, revising the therapeutic and rehabilitation services.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Ensure recruitment of needed senior clinicians.</p> <p>Findings: NSH has maintained staffing of two acting Senior Psychologists and added one acting Senior Social Worker. The facility has yet to recruit needed senior clinicians, including psychiatrists. A high rate of vacancies in almost all clinical disciplines has precluded assignment of direct care providers to supervising positions. The facility has identified the pay scale in DMH for senior clinicians as the main barrier. Efforts are underway to resolve this issue. According to the facility administration, recent announcements regarding improved pay status for senior clinicians have resulted in successful recruitment for several new positions,</p>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>both as contractors and employees (scheduled to begin employment July 17, 2007). The facility expects to be able to select candidates for senior psychiatrists, psychologists, social workers and rehabilitation therapists and to fill vacancies prior to the next review.</p> <p>Recommendation 2, February 2007: Finalize and implement the new audit regarding quality of assessments for all disciplines.</p> <p>Findings: Medical staff, Nursing and Rehabilitation Therapy Services monitors are still in development within the statewide process. The Psychology assessment monitoring form has been approved for statewide use and implemented July 2, 2007. The tool adequately addresses the quality of assessments. The Nutrition monitor has been completed and approval is in process, with an anticipated implementation later in July, 2007. The Social Work assessment and monitoring tools are still in development, with anticipated completion in August 2007.</p> <p>Nursing, Rehabilitation Therapy Services and Medical Staff monitors are still in development within the statewide process.</p> <p>Recommendation 3, February 2007: Continue to monitor this requirement using process observation.</p> <p>Findings: NSH used the Observation Monitoring tool (January to June 2007) to review a sample of 1% of WRPCs. A mean compliance rate of 3% was reported. This rate reflected compliance with the form instructions that are focused on the interdisciplinary process of reviewing assessments during the team meetings.</p> <p>Recommendation 4, February 2007: Assess and correct factors related to low compliance with this requirement.</p>
--	--	---

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>Findings: The WRP Consultation Group has reportedly addressed this recommendation but compliance remains low. The facility anticipates progress when senior clinicians are hired and begin to participate in mentoring and training of WRPTs, particularly team leaders.</p> <p>Other findings: The WRPCs observed (and chart reviews) by this monitor still revealed a general pattern of process and content deficiencies that preclude adequate compliance with requirements of the EP in sections C.1 and C.2. The following are specific examples of these deficiencies:</p> <ol style="list-style-type: none">1. The schedules of some meetings were changed without notification of the facility administration.2. Some conferences did not start on time for no apparent reason.3. Most team meetings did not include some core team members.4. Most meetings were conducted without evidence of who the team leader was.5. Some team members left the conference during the discussion without adequate reason.6. Some team members engaged in sidebar conversations while the individual was present in the conference.7. Almost all the teams failed to review/discuss their assessments prior to the arrival of the individual.8. Most teams spent much time during the meeting to conduct assessments and mental status examination of the individual.9. Most teams failed to adequately update the present status section of the case formulation.10. The review/update of diagnosis and foci of hospitalization were generally not informed by a discussion/analysis of assessments, case formulation and/or progress in Mall groups.11. There was no mechanism to adequately review progress in Mall groups.
--	--	---

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>12. In general, the review of the objectives and interventions began too late in the meetings.</p> <p>13. Some teams developed objectives that were not attainable for the individual.</p> <p>14. Too many objectives were not behavioral, measurable and/or appropriately linked to the individual's stage of change.</p> <p>15. Too many interventions lacked specificity as to who will do what to assist the individual in achieving the objectives.</p> <p>16. The revisions of foci, objectives and/or interventions did not reflect important changes in the individual's status, including important medical needs and the use of seclusion/restraints.</p> <p>The above deficiencies indicate that the WRPTs have yet to implement the principles and practice recommendations included the DMH WRP Manual.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Expedite recruitment of needed senior clinicians. 2. Finalize and implement the new audits that address quality of assessments for all disciplines. 3. Ensure that WRP training/mentoring corrects all the specific deficiencies outlined by this monitor above. 4. Continue to monitor this requirement using process observation.
C.1.f	<p>Ensure that assessment results and, as clinically relevant, consultation results, are communicated to the team members, along with the implications of those results for diagnosis, therapy and rehabilitation by no later than the next review.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Continue to monitor this requirement using process observation.</p> <p>Findings: Using the WRP Observation Monitoring form, NSH reported mean compliance rate</p>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>of 14% based on an average sample size of 1% (January to June 2007).</p> <p>Recommendation 2, February 2007: Assess and correct factors related to low compliance rates.</p> <p>Findings: WRP Consultation Group has provided training regarding this requirement, but the facility acknowledges that the current shortage of clinical staff has precluded adequate compliance.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to monitor this requirement using adequate sample size. 2. Same as recommendation #3 above.
C.1.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>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Assess and correct factors related to the shortage of staff needed to implement the EP</p> <p>Findings: Same as in findings under recommendation #1 of C.1.e.</p> <p>Recommendation 2, February 2007: Ensure that all assessments are completed on all units as per the schedule established in the DMH WRP manual.</p> <p>Findings: NSH used the Observation Monitoring Form (January to June 2007) and reviewed</p>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>an average sample size of 1%. A compliance rate of 0% was reported regarding the identification by the team of someone to be responsible for this requirement of the EP. The facility anticipates that the scheduling and coordination of assessments, meetings and progress reviews will be enhanced by the introduction of the WaRMSS WRP Module. This module is expected to facilitate determination of when WRPCs are scheduled and identification of individuals due for specific types of conferences.</p> <p>The facility has monitored the timeliness of admission psychiatry assessments, initial medical assessments and admission and integrated nursing assessments. Using. The following table summarizes the average sample sizes and compliance rates for each type of assessment (January to June 2007):</p> <table border="1" data-bbox="884 670 1869 865"> <thead> <tr> <th>Assessment</th> <th>%S</th> <th>%C</th> </tr> </thead> <tbody> <tr> <td>Admission Psychiatry</td> <td>23</td> <td>87</td> </tr> <tr> <td>Initial Medical</td> <td>23</td> <td>79</td> </tr> <tr> <td>Admission Nursing</td> <td>85</td> <td>30</td> </tr> <tr> <td>Integrated Nursing</td> <td>84</td> <td>39</td> </tr> </tbody> </table> <p>Recommendation 3, February 2007: Ensure that WRPs are completed and reviewed as per the schedule established in the DMH WRP manual</p> <p>Findings: NSH has yet to fully implement this recommendation. At this time, only one unit (A-9) has implemented the required conference schedule for the first 60 days. The A-WRP is completed on admissions to units A-9 and T-3 and in Program V. The monthly reviews of the WRP are held on three units (T-3, T-16 and Q-9). The quarterly and annual reviews are completed by all WRPTs at the facility.</p> <p>Recommendation 4, February 2007: The State must address factors related to recruitment and retention of needed</p>	Assessment	%S	%C	Admission Psychiatry	23	87	Initial Medical	23	79	Admission Nursing	85	30	Integrated Nursing	84	39
Assessment	%S	%C															
Admission Psychiatry	23	87															
Initial Medical	23	79															
Admission Nursing	85	30															
Integrated Nursing	84	39															

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>staff.</p> <p>Findings: Same as in findings under recommendation #1 of C.1.e.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Utilize the WaRMSS WRP Module to facilitate scheduling and coordination of assessments, WPRT meeting and progress reviews. 2. Ensure that all assessments are completed on all units as per the schedule established in the DMH WRP manual. 3. Ensure that WRPs are completed and reviewed as per the schedule established in the DMH WRP manual. 4. Same as recommendation #1 of C.1.e.
C.1.h	<p>Consist of a stable core of members, including at least the individual served; the treating psychiatrist, treating psychologist, treating rehabilitation therapist, the treating social worker; registered nurse and psychiatric technician who know the individual best; and one of the individual's teachers (for school-age individuals), and, as appropriate, the individual's family, guardian, advocates, attorneys, and the pharmacist and other staff.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Assess and correct factors related to low compliance rates.</p> <p>Findings: NSH reported that high vacancy rates in Psychiatry, Psychology, Social Work, and Rehabilitation Therapy are the major barriers to implementation at this time. As mentioned earlier, corrective actions are underway.</p> <p>Recommendation 2, February 2007: Complete the process of monitoring the attendance by core team membership.</p> <p>Findings: NSH has made progress in the implementation of this recommendation. The</p>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>facility used the WRPC/CET Attendance Monitoring Form to assess compliance with this requirement. Based on monitoring of an average sample size of 1% (January to June 2007), the facility reported the following attendance rates for each core member:</p> <table border="1" data-bbox="884 375 1478 607"> <tr> <td>Individual</td> <td>86%</td> </tr> <tr> <td>Physician (Psychiatrist)</td> <td>69%</td> </tr> <tr> <td>Social Worker</td> <td>89%</td> </tr> <tr> <td>Rehabilitation Therapist</td> <td>83%</td> </tr> <tr> <td>Registered Nurse</td> <td>85%</td> </tr> <tr> <td>Psychiatric Technician</td> <td>3%</td> </tr> </table> <p>The facility anticipates that the sample size will significantly increase in the future as a result of automation via the WaRMSS WRP Module.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Address and correct factors related to low attendance rates of Psychiatric technicians. 2. Continue to monitor attendance by all core members of the WRPTs. 3. Utilize the WaRMSS WRP Module to ensure adequate sample size. 	Individual	86%	Physician (Psychiatrist)	69%	Social Worker	89%	Rehabilitation Therapist	83%	Registered Nurse	85%	Psychiatric Technician	3%
Individual	86%													
Physician (Psychiatrist)	69%													
Social Worker	89%													
Rehabilitation Therapist	83%													
Registered Nurse	85%													
Psychiatric Technician	3%													
C.1.i	<p>Not include any core treatment team members with a case load exceeding 1:15 in admission teams (new admissions of 90 days or less) and, on average, 1:25 in all other teams at any point in time.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Same as in C.1.h.</p> <p>Findings: Same as in C.1.h.</p>												

Section C: Integrated Therapeutic and Rehabilitation Services Planning

Other findings:

The facility reported the following numbers and ratios of professionals to individuals by core disciplines (January to June 2007). The data show that the case loads exceed plan requirements for all disciplines in the admissions' units and for physicians and psychologists in the long-term units.

Professional/Individuals (numbers) by Month:

	Jan	Feb	Mar	April	May	June	Mean
ADMISSIONS							
MD	2.5/129	1.25/126	1.25/123	1.25/120	1.25/126	1.25/126	1.5/125
PhD	4/129	2/126	2/123	2/120	2/126	2/126	2/125
SW	4/129	2/126	2/123	2/120	2/126	2/126	2/125
RT	3/129	2/126	2/123	2/120	2/126	2/126	2/125
RN	3/129	1/126	1/123	1/120	1/126	1/126	1/125
PT	3/129	0/126	0/123	0/120	0/126	0/126	1/125
LONG-TERM CARE							
MD	32/1045	28/1037	26/1040	27/1032	28/1032	24/1029	28/1036
PhD	37/1045	39/1037	38/1040	36/1032	38/1032	38/1029	38/1036
SW	52/1045	53/1037	52/1040	49/1032	50/1032	49/1029	51/1036
RT	48/1045	49/1037	48/1040	52/1032	48/1032	45/1029	49/1036
RN	49/1045	52/1037	51/1040	51/1032	50/1032	50/1029	51/1036
PT	45/1045	50/1037	50/1040	49/1032	49/1032	49/1029	49/1036

Section C: Integrated Therapeutic and Rehabilitation Services Planning

Professional/Individual (ratios) by Month							
	Jan	Feb	Mar	April	May	June	Mean
ADMISSIONS							
MD	1:52	1:101	1:98	1:96	1:101	1:101	1:92
PhD	1:32	1:63	1:62	1:60	1:63	1:63	1:57
SW	1:32	1:63	1:62	1:60	1:63	1:63	1:57
RT	1:43	1:63	1:62	1:60	1:63	1:63	1:59
RN	1:43	1:126	1:123	1:120	1:126	1:126	1:111
PT	1:43	0:126	0:123	0:120	0:126	0:126	0:111
LONG TERM CARE							
MD	1:33	1:37	1:40	1:38	1:37	1:42	1:38
PhD	1:28	1:27	1:28	1:29	1:27	1:27	1:28
SW	1:20	1:20	1:20	1:21	1:21	1:21	1:21
RT	1:22	1:21	1:22	1:20	1:22	1:23	1:21
RN	1:21	1:20	1:20	1:20	1:21	1:21	1:21
PT	1:23	1:21	1:21	1:21	1:22	1:25	1:21
<p>As mentioned earlier, the primary barrier to compliance has been staff shortages and corrective actions are underway.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Expedite recruitment efforts to ensure compliance with this requirement of the EP.</p>							

Section C: Integrated Therapeutic and Rehabilitation Services Planning

<p>C.1.j</p>	<p>Not include staff that is not verifiably competent in the development and implementation of interdisciplinary wellness and recovery plans.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Continue and strengthen training to all WRPT leaders and members regarding development and implementation of the WRP.</p> <p>Findings: Same as in C.1.a.</p> <p>Recommendation 2, February 2007: Include WRP training in new employee orientation and in the proctoring and mentoring of new employees during their first year of employment.</p> <p>Findings: NSH has yet to implement this recommendation.</p> <p>Recommendation 3, February 2007: Same as in C.1.a, recommendation #6.</p> <p>Findings: Same as in C.1.a.</p> <p>Compliance: Partial.</p> <p>Current recommendations: Same as in C.1.a through C.1.f.</p>
--------------	---	--

Section C: Integrated Therapeutic and Rehabilitation Services Planning

C.2	Integrated Therapeutic and Rehabilitation Service Planning (WRP)	
	<p>Each State hospital shall develop and implement policies and protocols regarding the development of therapeutic and rehabilitation service plans, referred to as "Wellness and Recovery Plans" [WRP]) consistent with generally accepted professional standards of care, to ensure that:</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Scott Sutherland, MD, Chief of Psychiatry, Co-chair Behavioral Consultation Committee 2. Tony Rabin, PhD, Mall Director 3. Cathy Michaels, Assistant Chief, Central Program Services 4. Regina Ott, Director, CPS 5. Carmentica R. Jose, MD, Staff Psychiatrist 6. Emmanuel Obanor, DO, PharmD, Staff Physician 7. Individuals AL (through interpreter) and DT 8. Kathleen Patterson, PhD, Interim Senior Supervising Psychologist 9. Ann Hoff, PhD, Interim Senior Supervising Psychologist 10. Nicole Aviles-Galberth, PhD, BY CHOICE Coordinator 11. Donna Robeson, LCSW, DCAT member 12. Saeed Elmi, PT, DCAT member 13. Cynthia Morgan, RN, DCAT member 14. Robin Rogers, OT, DCAT member 15. Barry Wagener, RN, PBS team member 16. Linda Monahan, PT, PBS team member 17. Kelley Jarrett, PT, PBS team member 18. Shirley Duran, Data Technician, PBS team member 19. Wendy Hatcher, PsyD, Psychologist, PBS team member 20. Sue Silverman, PT, PBS team member 21. Coral Parrish, RN, PBS team member 22. Darrel Bailey, PT, PBS team member 23. Patricia White, PhD, Psychologist, PBS team member 24. Shoko Kokubun, Psychology Intern, PBS team member 25. Jeff Barnes, PT, PBS team member 26. Jessica Michaelson, PsyD, Psychologist, PBS team member

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>27. Herman Mercado, RN 28. Jason Bermack, M.D., PhD 29. Kathrin Capeto, CSW 30. Kristin Menne, ATR-BC 31. Carmen Caruso, Clinical Administrator 32. Sophie Tramel, PT, BY CHOICE Store 33. Jeffrey Salcedo, PTA 34. Karen Zanetell, Chief of Rehabilitation Services 35. Odie Ashford, Interpreter 36. Imelda Catacuten, PT 37. Julie Winn, PsyD, Psychologist 38. Bruce Bugbee, Unit Supervisor 39. Luesilvia Smith, PTA 40. Sharon Sanguinetti, RN 41. Gregory Leonard, PT</p> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Charts of 62 individuals (ACB, AG, AL, AR, AS, AT, BN, BS, BT, CAB, CC, CH, CR, DC, DK, DPD, EA, EER, EH, EM, ERC, EV, FK, GB, GS, HA, HT, JA, JB, JC, JD, JP, JS, JTF, KW, LTH, LK, LP, LT, MB, MER, MN, MP, MW, NB, PH, RAE, RAH, RP, RT, RWV, SB, SBC, TA, TCG, TM, TQ, TX, VH, WGS, WQ, and WTZ) 2. Behavior Guidelines of 17 individuals (FC, SB, JP, JC, DG, RB, NF, ST, DR, PB, BN, LT, MW, MP, JB, JM, and DC) 3. Crisis Intervention Plans of three individuals (JB, DC, and CC) 4. Positive Behavior Support Plans of five individuals (CC, BN, HS, AL, and CH) 5. NSH WRP Training Database 6. WRP Training Curriculum: Engagement Module 7. WRP Training Curriculum: Case Formulation Module 8. WRP Training Curriculum: Foci and Objectives Module 9. WRP Observation Monitoring summary data (January to June 2007) 10. WRP Chart Audit summary data (January to June 2007) 11. Admission Audit Form
--	--	---

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<ol style="list-style-type: none"> 12. Admission Audit summary data (January to June 2007) 13. Clinical Chart Auditing summary data (January to June 2007) 14. Substance Abuse Checklist 15. Substance Abuse Checklist summary data (April 2007) 16. WRP Mall Alignment Monitoring Form 17. WRP Mall Alignment Monitoring summary data (June 2007) 18. AD #885, Psychosocial Rehabilitation (Malls & Enrichment) Schedules 19. Summary of MAPP data regarding averages of active treatment hours scheduled and attended 20. Substance Recovery Maintenance, the Third and Final Portion of NSH's Curriculum for the Treatment of Substance Abuse 21. Enhancing Motivation for Change, In-service Training by US Department of health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Substance Abuse Treatment 22. Program IV Admission orientation Flowsheet 23. Sample of Wellness and Recovery Orientation post-tests for lesson I 24. NSH 12-week lesson plan regarding Medication Education 25. Sample of literature used at NSH for medication education 26. DMH WRP/MALL Alignment Check Protocol 27. DMH Mall Alignment Monitoring Form Instructions 28. DMH PSR Mall Note 29. PSR Mall Note Instructions 30. Mall Provider List 31. Psychosocial Rehabilitation Mall Manual 32. PRS Mall Facilitator Monthly Progress Note Instructions 33. PSR Mall Facilitator Monthly Progress Notes (CB and SJ) 34. Therapeutic Milieu Observation Form 35. List of Credentials of Rehabilitation Therapists 36. List Verifying Mall Facilitator Competency 37. Facilitating Wellness Group Post-Test 38. Family/ Individual Psychotherapy Monitor 39. Family/Individual Psychotherapy Monitor Worksheet
--	--	---

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>40. NSH Mall Manual 41. Summary of Provider Hours of Active Treatment 42. NSH EP Progress Report, July 2007 43. Twelve Week Lesson Plan -Wellness Recovery Action Plan 44. List of PBS-BCC checklists 45. Weekly Mall Group Activity Schedules 46. Mall Group Activity Lesson Plans 47. List of Individual Hours of Mall Activity 48. Enrichment Activity List 49. List of Psychologists with Substance Abuse Treatment Privileges 50. BCC Meetings Attendance Record 51. BCC Meeting Minutes 52. Procedural Steps for Behavioral Consultation Committee Form 53. Positive Behavior Support Manual, Draft, 2007 54. PBS Training Roster 55. Psychologists Training Roster 56. BY CHOICE Individual Satisfaction Survey Form 57. BY CHOICE Red List (choking, allergy, diabetes) 58. BY CHOICE Inventory List 59. BY CHOICE Inventory Check Sheet 60. List of Enrichment Activities 61. List of Scheduled vs Attended Mall Activities 62. Summary of Provider Hours of Active Treatment, MAPP report, May, 2007 63. Enrichment/Leisure Activity Schedule 64. Substance Abuse Checklist 65. Mall progress notes (CB, WH, and SJ) 66. AD #853 (Cognitive Screening), AD #885 (Psychosocial Rehabilitation, Malls and Enrichment, Schedules)</p> <p><u>Observed:</u> 1. WRPT meeting (Program III Unit T-16) for monthly review of MB and EVH 2. WRPT meeting (Program II, Unit T-17) for quarterly review of GP</p>
--	--	---

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<ol style="list-style-type: none"> 3. WRPT meeting (Program I, Unit T-5) for annual review of DM 4. WRPT meeting (Program V, Unit Q-5) for biweekly review of SB 5. WRPT meeting (Program V, Unit Q-6) for review of WB 6. WRPT meeting (Program V, Unit Q-9) for review of MG 7. Mall Groups (Coping Skills/Money Management, Coping Skills/Karaoke (A-4), Wellness and Recovery Action Plan 8. Individuals AL, WR, MG, and WB
C.2.a	<p>Individuals have substantive input into the therapeutic and rehabilitation service planning process, including but not limited to input as to mall groups and therapies appropriate to their WRP.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation 1, February 2007: Continue WRP training that focuses on the process of engaging the individual in providing substantive input.</p> <p>Findings: In June 2007, NSH implemented the Engagement Module developed at MSH as part of the WRP Training Curriculum. The WRP consultation group provided one hour training session to the WRP trainers regarding the engagement of individuals. The WRPTs have yet to receive training in this area.</p> <p>Using the Observation Monitoring Form, the facility has monitoring data (January to June 2007) based on an average sample of 1%. The data showed mean compliance rate of 6% with this requirement of the EP.</p> <p>Recommendation 2, February 2007: Address and correct factors related to low compliance with this requirement.</p> <p>Findings: The facility did not provide data specific to this recommendation.</p> <p>Compliance: Partial.</p>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue WRP training that focuses on the process of engaging the individual in providing substantive input. 2. Address and correct factors related to low compliance with this requirement.
C.2.b	Therapeutic and rehabilitation service planning provides timely attention to the needs of each individual, in particular:	Please see sub-cells for compliance findings.
C.2.b.i	initial therapeutic and rehabilitation service plans (Admission-Wellness and Recovery Plan ("A-WRP") are completed within 24 hours of admission;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Continue implementation of the A-WRP within the first 24 hours of the admission.</p> <p>Findings: At this time, all teams on nine units are implementing this requirement. These units are A-9 (individuals under LPS conservatorship), T-3 (long-term unit) and Program 5 (seven units for individuals deemed incompetent to stand trial). The implementation of this requirement has depended, to a large extent, on the teams' staffing levels, with those teams that meet the required staff-to-individual ratio of 1:15 (as in unit A-9) being more likely to have implemented the requirement.</p> <p>Recommendation 2, February 2007: Monitor implementation of the A-WRP within 24 hours of all admission.</p> <p>Recommendation 3, February 2007: Ensure that monitoring of the A-WRP includes 20% sample of all admissions.</p> <p>Findings: NSH used the Chart Audit Form to monitor compliance. Reviewing an average sample size of 31% (January to June 2007)), the facility reported mean compliance rate of less than 1%. This sample was based on all monthly admissions</p>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>and not limited to the units that have implemented this recommendation.</p> <p>Other findings: This monitor reviewed eight randomly selected charts of individuals (RAH, LTH, EER, ERC, TA, JTF, JP and JA) who were admitted to the facility during this review period. The review showed compliance in four charts (LTH, TA, JTF and JP) and non-compliance in four (RAH, EER, ERC and JA).</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue implementation of the A-WRP within the first 24 hours of the admission. 2. Provide data on the number of admission teams that have yet to implement this requirement. 3. Continue to monitor implementation of the A-WRP within 24 hours of all admissions, using at least a 20% sample.
C.2.b.ii	<p>master therapeutic and rehabilitation service plans ("Wellness and Recovery Plan" (WRP)) are completed within 7 days of admission; and</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1, 2 and 3, February 2007:</p> <ol style="list-style-type: none"> 1. Implement master WRPs within seven days of admission in all units. 2. Monitor the implementation of the master WRP within seven days of all admissions. 3. Ensure that monitoring of the master WRP includes a 20% sample of all admissions. <p>Findings: The facility did not have sufficient data based on the Chart Audit Form, but was able to present information from its admission audit system. This audit is intended to review 100% of the charts, but the data are based on an average</p>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>sample size of 35% (January to June 2007). The data showed mean compliance rate of 8% with this requirement of the EP.</p> <p>Recommendation 4, February 2007: Implement the DMH Clinical Chart Auditing Form.</p> <p>Findings: NSH has implemented this recommendation, but no data were provided regarding results of this process.</p> <p>Other findings: This monitor's review of the above-mentioned eight charts showed non-compliance in four (RAH, EER, ERC and JA), compliance in three (TA, JTF and JP) and incomplete implementation in one (LTH).</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Implement master WRPs within seven days of admission in all units. 2. Monitor the implementation of the master WRP within seven days of all admissions based on at least 20% sample.
C.2.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>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Implement the required WRP conference schedule on all admission and long-term teams.</p> <p>Findings: Currently, only one admission team (A-9) has implemented this requirement. The other teams on admission units (two teams on unit T-3) were discontinued in February 2007 due to substantial shortage of psychiatrists. The facility has admission teams on long-term units but these teams have yet to implement the required conference schedule. The facility anticipates that the introduction of</p>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>the WaRMSS WRP Module will facilitate the transition to the required schedules on all units. The module implementation includes improved method for tracking scheduled conferences. The facility has a projected implementation data in the fall of 2007.</p> <p>Recommendation 2, February 2007: Monitor the implementation of the required WRP conference schedule on all admission and long-term teams.</p> <p>Recommendation 3, February 2007: Ensure that monitoring of the WRP reviews includes a 20% sample of all admissions.</p> <p>Findings: Using the Chart Audit Form, NSH has monitoring data (January to June 2007) based on average sample size of 10%. A mean compliance rate of 4% was reported.</p> <p>Recommendation 4, February 2007: Implement the DMH Clinical Chart Auditing Form.</p> <p>Findings: NSH has implemented this recommendation, but no data were provided regarding results of this process.</p> <p>Other findings: Reviewing eight charts, this monitor found partial compliance in four (RAH, ERC, TA and JP), non-compliance in three (LTH, EER and JA) and compliance in one (JTF).</p> <p>Compliance: Partial.</p>
--	--	---

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Implement the required WRP conference schedule on all admission and long-term teams. 2. Monitor the implementation of the required WRP conference schedule on all admission and long-term teams, using at least 20% sample.
C.2.c	<p>Treatment rehabilitation and enrichment services are goal-directed, individualized, and informed by a thorough knowledge of the individual's psychiatric, medical, and psychosocial history and previous response to such services;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Continue training of WRPTs to ensure that:</p> <ul style="list-style-type: none"> • The case formulation includes appropriate review and analysis of assessments to identify the individual's needs in the psychiatric, medical and psychosocial domains, and • Foci of hospitalization addresses all identified needs of the individual in the above domains. <p>Findings: The WRP Consultation Group has met weekly (January - June, 20 hrs) to coordinate training on items (a) and (b) above. The group has adopted the WRP Training Curriculum (Case Formulation and Foci & Objectives Modules) that was developed at MSH. However, the group has yet to implement training based on these modules.</p> <p>Recommendation 2, February 2007: 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 their treatment), psychiatric status (and its treatment) and psychosocial functioning of the individual.</p>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>Findings: The facility used the Clinical Chart Audit to assess compliance. The monitoring indicator (<i>when seizure disorder is identified, it is written in Focus 6, and has at least one objective with appropriately linked intervention</i>) is appropriate to the recommendation. The facility's data (0% compliance) are based on a review of only one chart in May 2007.</p> <p>Recommendation 3, February 2007: 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.</p> <p>Findings: The Clinical Chart Auditing Form has a monitoring indicator (<i>when cognitive disorders are identified on Axis III, it is written in Focus I and has at least one objective with an appropriately linked intervention</i>) that is appropriate to this recommendation. NSH has yet to review charts using this audit. This form also has another appropriate indicator (<i>when mental retardation is identified on Axis II, all interventions are aligned with the cognitive functioning level of the individual</i>). Using this indicator, the facility reviewed one chart in May 2007 and found 0% compliance.</p> <p>Recommendation 4, February 2007: 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.</p> <p>Findings: NSH used three monitoring instruments to assess compliance. The following is a summary of the facility's data, including the name of each tool, sample size and months of monitoring. The monitoring indicator and corresponding compliance rates are identified. The indicators used are appropriate to the recommendation,</p>
--	--	---

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>but the indicators on the Chart Audit Form tend to overlap with the other two instruments. The sample size on the Clinical Chart Audits (17%) was based on an inaccurate calculation of the total target population (N), which should be calculated as the total number of individuals with substance use disorders.</p> <p>Clinical Chart Auditing Form (average sample size: 17%, January to June 2007): <i>When substance abuse is identified on Axis I, it is written in Focus 5, and has at least one objective with an appropriately linked intervention: 0%.</i></p> <p>Chart Audit Form (sample size: 9%, April 2007):</p> <ol style="list-style-type: none"> 1. <i>The WRP includes all objectives from the individual's current stage of change (SOC) or readiness for rehabilitation, to the maintenance stage for each focus of hospitalization, as clinically appropriate: 6%.</i> 2. <i>When substance abuse is diagnosed on Axis I it is documented in Focus 5 and there is at least one objective and intervention : 52%</i> <p>Substance Abuse Checklist (sample size: 2%, April 2007):</p> <ol style="list-style-type: none"> 1. <i>Substance Abuse Diagnosis is identified in Axis I: 76%.</i> 2. <i>Substance abuse is identified in the 6 - Ps: 83%.</i> 3. <i>There is an Objective and corresponding Intervention under FOCI #5 - Substance Abuse: 86%.</i> 4. <i>Individual's current Stage of Change is identified in the WRP: 77%.</i> 5. <i>Identified Stage of Change is consistent with corresponding Objective(s) and Intervention(s) under FOCI #5: 40%.</i> <p>Other findings: NSH used the Clinical Chart Auditing form to assess compliance with this requirement of the EP. The facility reviewed an average sample size of 46%, but the target population (N) was limited to all first quarterly WRPs completed. This process resulted in a mean compliance rate of 2%, based on an indicator that is appropriate to the requirement. The following is the indicator used:</p>
--	--	---

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p><i>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.</i></p> <p>Reviews by this monitor of the charts of individuals suffering from a range of disorders revealed a pattern of deficiencies similar to that described in the last report. The following are examples of the deficiencies in each category of these disorders, based on a review of documentation in the WRPs:</p> <ol style="list-style-type: none">1. Seizure disorders:<ol style="list-style-type: none">a. The objectives are unattainable for the individuals (JP and TCG).b. The intervention does not include the correct current medication regimen (JP).c. The interventions fail to include attempts to assess the cognitive/behavioral risks of current medication regimen (phenytoin) and to utilize safer alternatives (MSB, WTZ, HT and DPD).2. Cognitive disorders:<ol style="list-style-type: none">a. The diagnosis of cognitive disorder is not listed on the plan (MER and ACB).b. The focus of hospitalization does not adequately describe the nature of the disorder (RAE).c. The objectives are not behavioral or measurable and the interventions do not specify what staff will do to assist achievement of the objectives (EV).d. The objectives are unattainable, vague and not tailored to specific deficits (WQ).e. The objectives are not related to the focus and the interventions are generic (RAE and TE).3. Substance abuse: See monitor's findings in C.2.o. <p>Compliance: Partial.</p>
--	--	--

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Implement the WRP training curriculum 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. 2. Implement the Clinical Chart Auditing Form, based on at least 20% sample, to ensure that seizure, cognitive and/or substance abuse disorders, if present, are documented as a focus and that individualized and appropriate objectives and interventions are provided. 3. Implement the Substance Abuse Checklist, based on at least 20% sample, in monitoring of substance abuse disorders. 4. The use of the Chart Audit Form to monitor substance abuse disorders is unnecessary.
C.2.d	<p>Therapeutic and rehabilitation service planning is based on a comprehensive case formulation for each individual that emanates from interdisciplinary assessments of the individual consistent with generally accepted professional standards of care. Specifically, the case formulation shall:</p>	<p>Compliance: Partial.</p>
C.2.d.i	<p>be derived from analyses of the information gathered from interdisciplinary assessments, including diagnosis and differential diagnosis;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Same as in C.2.c.</p> <p>Findings: Same as in C.2.c.</p>

		<p>Recommendation 2, February 2007: Continue the case formulation training related to this requirement and ensure that the training includes clinical case examples.</p> <p>Findings: As mentioned earlier, the WRP Consultation Group has adopted the training curriculum developed at MSH. This curriculum includes a Case Formulation Module. The facility did not provide data regarding actual training on this module.</p> <p>Recommendation 3, February 2007: Continue to monitor this requirement and ensure at least 20% sample of the target population.</p> <p>Findings: NSH used the Clinical Chart Auditing Form to assess compliance with this requirement of the EP. The target population was limited to the first quarterly WRPs completed. Reviewing a sample size of 52% of that population (January to June 2007), the facility reported mean compliance rate of 1%.</p> <p>Recommendation 4, February 2007: Address and correct factors related to low compliance.</p> <p>Findings: The facility has yet to implement this recommendation. The anticipated training on the Case Formulation Module should facilitate compliance.</p> <p>Other findings: Chart reviews and team observations by this monitor show the same pattern of deficiencies that was described in the last report. The following is an outline of the deficiencies that must be addressed and corrected in order to achieve substantial compliance with this requirement. These deficiencies address the</p>
--	--	--

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>requirements in C.2.d.i through C.2.d.vi.</p> <ol style="list-style-type: none"> 1. The case formulations are not appropriately completed in the 6-p format. 2. The present status sections do not include sufficient review and analysis of important clinical events that require modifications in WRP interventions. For example, the review of the use of restrictive interventions is either absent or limited to a reiteration of the circumstances that led to this use, without much analysis of contributing factors or review of needed modifications in medication and other interventions in order to reduce the risk. In addition, the individual's progress towards discharge is documented in generic terms, without evidence of discussion by the team regarding the individual's progress in achieving objectives that are stated in terms of what the individual has learned or has yet to learn 3. The linkages within different components of the formulations are often missing. 4. The formulations contain inadequate analysis of assessments and derivation of hypothesis regarding the individual's diagnosis, differential diagnosis, treatment, rehabilitation and enrichment needs. 5. There is inadequate linkage between the material in the case formulations and other key components of the WRP (e.g. foci of hospitalization, life goals, objectives and interventions). <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Same as C.2.c. 2. Implement training on the Case Formulation Module to all WRPTs and ensure that the training includes clinical case examples. 3. Continue to monitor this requirement using the Clinical Chart Audit and ensure at least 20% sample of all WRPS. 4. Address and correct factors related to low compliance
C.2.d.ii	include a review of: pertinent history; predisposing, precipitating and	Current findings on previous recommendations:

Section C: Integrated Therapeutic and Rehabilitation Services Planning

	<p>perpetuating factors; previous treatment history, and present status;</p>	<p>Recommendation, February 2007: Same as above.</p> <p>Findings: Same as above.</p> <p>Other findings: Using the Clinical Chart Audit, NSH reviewed an average sample size of 52% (of all first quarterly WRPs completed) and reported mean compliance rate of 0%.</p> <p>Current recommendations: Same as above.</p>
C.2.d.iii	<p>consider biomedical, psychosocial, and psychoeducational factors, as clinically appropriate, for each category in § [III.B.4.b] above</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Same as above.</p> <p>Findings: Same as above.</p> <p>Other findings: The facility reported mean compliance rate of 0% using the above-mentioned monitoring process.</p> <p>Current recommendations: Same as above.</p>
C.2.d.iv	<p>consider such factors as age, gender, culture, treatment adherence, and medication issues that may affect the outcomes of treatment and</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Same as above.</p>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

	rehabilitation interventions;	<p>Findings: Same as above.</p> <p>Other findings: The facility reported mean compliance rate of 0% using the above-mentioned monitoring process.</p> <p>Current recommendations: Same as above.</p>
C.2.d.v	support the diagnosis by diagnostic formulation, differential diagnosis and Diagnostics and Statistical Manual DSM-IV-TR (or the most current edition) checklists; and	<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Same as in D.1.d.i and D.1.c.iii.</p> <p>Findings: Same as in D.1.d.i and D.1.c.iii.</p> <p>Other findings: The facility reported mean compliance rate of 0% using the above-mentioned monitoring process.</p> <p>Recommendations: Same as above.</p>
C.2.d.vi	enable the interdisciplinary team to reach sound determinations about each individual's treatment, rehabilitation, enrichment and wellness needs, the type of setting to which the individual should be discharged, and the changes	<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Same as above.</p>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

	that will be necessary to achieve discharge.	<p>Findings: Same as above.</p> <p>Other findings: The facility did not present monitoring data regarding this requirement.</p> <p>Current recommendations: Same as above.</p>
C.2.e	The therapeutic and rehabilitation service plan specifies the individual's focus of hospitalization (goals), assessed needs (objectives), and how the staff will assist the individual to achieve his or her goals/objectives (interventions);	<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Same as in C.2.c, C.2.f, C.2.g and C.2.o.</p> <p>Findings: Same as in C.2.c, C.2.f, C.2.g and C.2.o.</p> <p>Other findings: The facility has monitoring data (January to June 2007) based on the Chart Audit. Reviewing an average sample size of 52% of all quarterly WRPs completed (N), the facility reported mean compliance rate of 1%.</p> <p>Compliance: Partial.</p> <p>Current recommendations: Same as in C.2.c, C.2.f, C.2.g and C.2.o.</p>
C.2.f	Therapeutic and rehabilitation service planning is driven by individualized needs, is strengths-based (i.e., builds on an individual's current strengths), addresses	Please see sub-cells for compliance findings.

Section C: Integrated Therapeutic and Rehabilitation Services Planning

	<p>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>C.2.f.i</p>	<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>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Continue training of WRPTs to ensure that objectives and interventions are implemented in accordance with the requirements in the DMH WRP manual.</p> <p>Findings: The facility has adopted the training module on Foci and Objectives that was developed at MSH, but has yet to provide information regarding this specific training. Also, refer to C.1.a for information regarding training of nursing staff, which emphasized goals, objectives and interventions (WRP Training Database Course Code #6017).</p> <p>Recommendation 2, February 2007: Continue to monitor this requirement.</p> <p>Findings: NSH used the Chart Audit and reviewed an average sample size of 11% of the total target population (January to June 2007). A mean compliance rate of 5% was reported regarding this requirement of the EP. The facility also has data based on the Observation Monitoring Form (average sample size of 1% from January to June 2007). The data showed mean rate of 3% regarding compliance with the following indicator:</p> <p><i>The treatment plan includes the individual's strengths related to each enrichment,</i></p>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p><i>treatment, or rehabilitation objective.</i></p> <p>Recommendation 3, February 2007: Address and correct factors related to low compliance with this requirement.</p> <p>Findings: The facility anticipates implementation of this recommendation upon recruitment of senior clinicians.</p> <p>Other findings: This monitor reviewed six charts and found non-compliance in four (JP, LTH, CAB and RWV), compliance in one (TA) and partial compliance in one (ERC).</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue training of WRPTs to ensure that objectives and interventions are implemented in accordance with the requirements in the DMH WRP manual. 2. Continue to monitor this requirement and ensure a sample size of at least 20%. 3. Expedite recruitment of senior clinicians to address and correct factors related to low compliance with this requirement.
C.2.f.ii	<p>ensure that the objectives/ interventions address treatment (e.g., for a disease or disorder), rehabilitation (e.g., skills/supports, motivation and readiness), and enrichment (e.g., quality of life activities);</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Same as above.</p> <p>Findings: Same as above.</p>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>Other findings: NSH has monitoring data from the Chart Audits (January to June 2007). The facility reviewed an average sample size of 11% and reported mean compliance rate of 2%.</p> <p>This monitor found non-compliance in all six charts reviewed (TA, JP, LTH, CAB, RWV and ERC).</p> <p>Compliance: Non-compliance.</p> <p>Current recommendations: Same as above.</p>
C.2.f.iii	write the objectives in behavioral, observable, and/or measurable terms;	<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Same as above.</p> <p>Findings: Same as above.</p> <p>Other findings: Using the above mentioned monitoring process, the facility reported mean compliance rate of 8%.</p> <p>Chart reviews by this monitor showed non-compliance in four charts (TA, JP, LTH and CAB) and partial compliance in two (RWV and ERC).</p> <p>Compliance: Partial.</p>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>Current recommendations: Same as above.</p>
C.2.f.iv	<p>include all objectives from the individual's current stage of change or readiness for rehabilitation, to the maintenance stage for each focus of hospitalization, as clinically appropriate;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Same as above.</p> <p>Findings: Same as above.</p> <p>Other findings: The facility reported mean compliance rate of 10% based on the above-mentioned monitoring process.</p> <p>This monitor found non-compliance in four charts (JP, LTH, RWV and ERC) and compliance in two (TA and CAB).</p> <p>Compliance: Partial.</p> <p>Current recommendations: Same as above.</p>
C.2.f.v	<p>ensure that there are interventions that relate to each objective, specifying who will do what, within what time frame, to assist the individual to meet his/her needs as specified in the objective;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Same as above.</p> <p>Findings: Same as above.</p>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>Other findings: The facility used the above-mentioned Chart Audit process and reported mean compliance rate of 6%.</p> <p>This monitor found non-compliance in five charts (JP, LTH, CAB, RWV and ERC) and compliance in one (TA).</p> <p>Compliance: Partial.</p> <p>Current recommendations: Same as above.</p>
C.2.f.vi	<p>implement interventions appropriately throughout the individual's day, with a minimum of 20 hours of active treatment per week. Individual or group therapy included in the individual's WRP shall be provided as part of the 20 hours of active treatment per week;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Assess and address the factors related to inadequate scheduling by the WRPTs, inaccurate reporting of hours scheduled on the WRP, disconnection between WRP and MAPP data and inadequate participation by individuals.</p> <p>Findings: NSH has partially implemented this recommendation. The facility has revised its AD (#885) regarding Psychosocial Rehabilitation (Malls & Enrichment) Schedules to improve alignment with EP requirements. The facility identified the high percentage of vacancies in all disciplines, except nursing, as the primary contributing factor to lack of programs. In an effort to implement this recommendation, the Mall Director and Clinical Management Team have identified afternoon Mall hours (3:30 - 4:20 and 4:40 - 5:30) to improve compliance, and developed a plan to increase hours of active treatment provided by each discipline based on percentage of vacancies. A group consisting of the Mall Director, Clinical Management Team and Information Systems Director has developed a plan to correct the reporting inaccuracies by establishing a formal reporting process</p>

and regular meeting schedule for all stakeholders to improve communication.

Recommendation 2, February 2007:

Continue efforts to monitor hours of active treatment (scheduled and attended).

Findings:

NSH has made progress in implementing this recommendation. The facility reported data regarding averages of active treatment hours scheduled and attended (per week) for the total census of individuals. The following table summarizes these data. The table shows that the hours scheduled and attended still fall short of requirements of the EP.

	Jan	Feb	Mar	Apr	May	Jun
N	1171	1166	1163	1152	1158	1144
n	1171	1166	1163	1152	1158	1144
% S	100	100	100	100	100	100
Scheduled	8.6	8.2	7.7	8.1	9.2	8.6
Actual	2.3	3.8	3.7	3.8	4.2	3.8

Other findings:

This monitor reviewed five charts (LTH, CAB, RWV, ERC and JA) to determine the number of active treatment hours listed on the most recent WRP and the number of hours scheduled and attended per MAPP. The review shows that WRPs still generally fail to identify the required hours and that inconsistency exists between WRP and MAPP data regarding scheduled hours and actual hours attended.

Individual	Scheduled hours (WRP)	Scheduled hours (MAPP)	Attended hours (MAPP)
LTH	0	5	2
CAB	6	14	11

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<table border="1"> <tr> <td>RWV</td> <td>Unspecified</td> <td>1</td> <td>1</td> </tr> <tr> <td>ERC</td> <td>Unspecified</td> <td>11</td> <td>3</td> </tr> <tr> <td>JA</td> <td>Unspecified</td> <td>18</td> <td>0</td> </tr> </table>	RWV	Unspecified	1	1	ERC	Unspecified	11	3	JA	Unspecified	18	0	<p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Assess and address the factors related to inadequate scheduling by the WRPTs, inaccurate reporting of hours scheduled on the WRP, disconnection between WRP and MAPP data and inadequate participation by individuals. 2. Continue efforts to monitor hours of active treatment (scheduled and attended).
RWV	Unspecified	1	1												
ERC	Unspecified	11	3												
JA	Unspecified	18	0												
C.2.f. vii	<p>maximize, consistent with the individual's treatment needs and legal status, opportunities for treatment, programming, schooling, and other activities in the most appropriate integrated, non-institutional settings, as clinically appropriate; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation 1, February 2007: Monitor 20% sample of civilly committed individuals.</p> <p>Findings: NSH has implemented this recommendation. Based on an average sample size of 31% of the total target population, the facility reported average compliance rate of 3%. Monitoring was conducted between January and June 2007.</p> <p>Recommendation 2, February 2007: Assess and correct factors related to lack of programs.</p> <p>Findings: The facility anticipates implementation of this recommendation upon recruitment of senior clinicians.</p>													

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>Other findings: This monitor reviewed the charts of five civilly committed individuals (TA, JP, JTF, SBC and RET) and found non-compliance in all cases.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue monitoring based on at least 20% sample of civilly committed individuals. 2. Address and correct factors related to lack of programs.
C.2.f. viii	<p>ensure that each therapeutic and rehabilitation service plan integrates and coordinates all services, supports, and treatments provided by or through each State hospital for the individual in a manner specifically responsive to the plan's therapeutic and rehabilitation goals. This requirement includes but is not limited to ensuring that individuals are assigned to mall groups that link directly to the objectives in the individual's WRP and needs.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: 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.</p> <p>Findings: A statewide DMH Mall Alignment Monitoring Form has been approved in June 2007 and implementation began in July 2007.</p> <p>Recommendation 2, February 2007: Revise the WRP/mall alignment check protocol to address this requirement.</p> <p>Findings: NSH has implemented the revised Mall Alignment Monitoring Form to address this recommendation. The form instructions are appropriate to this requirement of the EP. The facility has monitoring data (June 2007) based on a review of five individuals (a sample of .004%). The compliance rate was 0%.</p> <p>Recommendation 3, February 2007: Continue the implementation of electronic progress note documentation by all Mall and individual therapy providers.</p>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>Findings: The Psychosocial Rehabilitation (PSR) Mall Facilitator Monthly Progress Notes were implemented on only three units. An internal audit of individuals' charts on these units found completed notes in seven of the 15 individuals audited. None of the individuals' WRPs cited the information in the progress notes, or appeared to adjust the WRPs in relation to the notes. The facility anticipates that the introduction of the WaRMSS (scheduled to begin in August, 2007) will facilitate implementation in all units.</p> <p>Compliance: Partial.</p> <p>Current 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. Implement the WRP Mall Alignment Check list and improve sample size. 3. Implement electronic progress note documentation by all Mall and individual therapy providers.
C.2.g	Therapeutic and rehabilitation service plans are revised as appropriate to ensure that planning is based on the individual's progress, or lack thereof, as determined by the scheduled monitoring of identified criteria or target variables, consistent with generally accepted professional standards of care. Specifically, the interdisciplinary team shall:	Please see sub-cells for compliance findings.
C.2.g.i	revise the focus of hospitalization, objectives, as needed, to reflect the	Current findings on previous recommendations:

Section C: Integrated Therapeutic and Rehabilitation Services Planning

	<p>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>Recommendation 1, February 2007: Continue training to WRPTs to ensure that foci and objectives are reviewed and revised and that new interventions are developed and implemented as clinically needed.</p> <p>Findings: The WRP training module regarding Foci and Interventions addresses this requirement. The information in C.1.a, C2.f.i and C2.f.v are also relevant to this recommendation.</p> <p>Recommendation 2, February 2007: Continue to monitor this requirement.</p> <p>Findings: NSH used the Observation Monitoring Form (January to June 2007) and reviewed an average sample size of 1%. The mean compliance rate was 4%.</p> <p>Recommendation 3, February 2007: Address and correct factors related to low compliance.</p> <p>Findings: As mentioned in previous cells, the facility anticipates that Supervising Senior Clinicians will be identified as vacancies are filled and that these positions will participate in the training and mentoring needed to improve compliance.</p> <p>Other findings: This monitor reviewed the charts of six individuals and found compliance in three (TA, JP and RWV) and non-compliance in three (LTH, CAB and ERC).</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue training to WRPTs to ensure that foci and objectives are reviewed and revised and that new interventions are developed and implemented as
--	---	---

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>clinically needed.</p> <ol style="list-style-type: none"> 2. Continue to monitor this requirement and ensure a sample size of at least 20%. 3. Expedite recruitment of senior clinicians to address and correct factors related to low compliance.
C.2.g.ii	<p>review the focus of hospitalization, needs, objectives, and interventions more frequently if there are changes in the individual's functional status or risk factors (i.e., behavioral, medical, and/or psychiatric risk factors);</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Same as above.</p> <p>Findings: Same as above.</p> <p>Recommendation 2, February 2007: Revise current monitoring tool to include individuals whose functional status has improved.</p> <p>Findings: The facility has yet to implement this recommendation.</p> <p>Other findings: NSH used Chart Audits (January to June 2007) and reviewed an average sample size of 3%. The mean compliance rate was 14%. The facility presented data based on the Observation Monitoring but the sample size was less than 1% and the data lacked consistency.</p> <p>This monitor reviewed the charts of six individuals who experienced restrictive interventions during this review period (TCG, DC, LK, JB, CLC and BAS). The following deficiencies were noted upon review of the present status section of the WRPs.</p>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<ol style="list-style-type: none"> 1. There is incomplete or no review of the circumstances of the use of seclusion and/or restraints (TCG, LK, CLC and BAS).. 2. There is no review of the treatment provided during these episodes (TCG, LK, JB, CLC and BAS). 3. The plans do not include appropriate modifications in interventions to reduce the risk (TCG, LK, CLC and BAS)). <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Same as above. 2. Monitor individuals whose functional status has improved. 3. Implement the Clinical Chart Auditing tool in monitoring of this requirement.
C.2.g.iii	<p>ensure that the review process includes an assessment of progress related to discharge to the most integrated setting appropriate to meet the individuals assessed needs, consistent with his/her legal status; and</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007 Continue training of WRPTs to ensure consistent implementation of this requirement.</p> <p>Findings: NSH has yet to implement this recommendation.</p> <p>Recommendation 2, February 2007: Continue to monitor this requirement.</p> <p>Findings: NSH has data based on the Observation Monitoring Form (January to June 2007). Reviewing an average sample size of 1%, the facility reported mean compliance rate of 4%.</p> <p>Recommendation 3, February 2007: Address and correct factors related to low compliance.</p>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>Findings: Same as in recommendation #3 in C.2.g.i.</p> <p>Other findings: This monitor reviewed the charts of six individuals (ERC, RWV, TA, JP, LTH and CAB). The following are the two main findings:</p> <ol style="list-style-type: none"> 1. The discharge criteria were not sufficiently individualized in terms of learning outcomes. This was noted in the charts of TA, JP, LTH and CAB. There was compliance in ERC and partial compliance in RWV. 2. There was no documentation of the team's discussion of the individual's progress towards discharge (CAB, RWV and ERC). There was adequate documentation of this discussion in the other three charts. <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue training of WRPTs to ensure consistent implementation of this requirement. 2. Continue to monitor this requirement and ensure a sample size of at least 20%. 3. Expedite recruitment of senior clinicians to address and correct factors related to low compliance.
C.2.g.iv	base progress reviews and revision recommendations on data collected as specified in the therapeutic and rehabilitation service plan.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Same as in C.2.g.i.</p> <p>Findings: Same as in C.2.g.i.</p>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>Recommendation 2, February 2007: Same as in C.2.f.viii.</p> <p>Findings: Same as in C.2.f.viii.</p> <p>Recommendation 3, February 2007: Same as in C.2.f.ii.</p> <p>Findings: Same as in C.2.f.ii.</p> <p>Other findings: NSH has data based on the WRP Observation Audit. Reviewing an average sample of 1% (January to June 2007), the facility reported mean compliance rate of 1%. The facility presented other data that were not relevant to this requirement of the EP.</p> <p>This monitor found non-compliance in all the charts reviewed (TA, JP, LTH, CAB, ERC and RWV).</p> <p>Compliance: Non-compliance.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Same as in C.2.g.i. 2. Same as in C.2.f.viii.
C.2.h	Individuals in need of positive behavior supports in school or other settings receive such supports consistent with generally	Current findings on previous recommendations:

Section C: Integrated Therapeutic and Rehabilitation Services Planning

	<p>accepted professional standards of care.</p>	<p>Recommendation 1, February 2007: Implement the revised AD that allows the PBS Psychologist to write an order for the PBS plan across settings.</p> <p>Findings: NSH has implemented AD #850 (Psychology Services) as of October 26, 2006. PBS psychologists at NSH can write orders for PBS plans across settings.</p> <p>Recommendations 2 and 3, February 2007:</p> <ol style="list-style-type: none"> 2. Ensure that staff in all settings has been trained to competency on all PBS plans. 3. Provide documentation that staff in all treatment settings have been trained to competency on all PBS plans <p>Findings: NSH used item #31 from the DMH Psychology Monitoring Form to evaluate this recommendation, reporting 16% compliance. The table below with its monitoring indicator shows the number of PBS plans available (N), the number of PBS plans reviewed (n), and the percent compliance (%C), is a summary of the facility's data.</p> <p><i>Behavioral interventions are consistently implemented across all settings, including school settings. List of all individuals needing behavioral interventions.</i></p> <table border="1" data-bbox="961 1040 1646 1271"> <thead> <tr> <th></th> <th>Jan</th> <th>Feb</th> <th>Mar</th> <th>Apr</th> <th>May</th> <th>Jun</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>3</td> <td>3</td> <td>3</td> <td>3</td> <td>2</td> <td>2</td> <td></td> </tr> <tr> <td>n</td> <td>3</td> <td>3</td> <td>3</td> <td>3</td> <td>2</td> <td>2</td> <td></td> </tr> <tr> <td>% S</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td></td> </tr> <tr> <td>% C-31</td> <td>33</td> <td>33</td> <td>33</td> <td>0</td> <td>0</td> <td>0</td> <td>16</td> </tr> </tbody> </table> <p>This monitor reviewed three PBS plans (CH, AL, and BN). PBS team members report and available documentation revealed that PBS team members train staff</p>		Jan	Feb	Mar	Apr	May	Jun	Mean	N	3	3	3	3	2	2		n	3	3	3	3	2	2		% S	100	100	100	100	100	100		% C-31	33	33	33	0	0	0	16
	Jan	Feb	Mar	Apr	May	Jun	Mean																																			
N	3	3	3	3	2	2																																				
n	3	3	3	3	2	2																																				
% S	100	100	100	100	100	100																																				
% C-31	33	33	33	0	0	0	16																																			

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>involved in implementing the PBS plans. PBS team members also have worked with staff outside the facility when individuals have been temporarily admitted to hospitals outside the facility (BN and CC). PBS plans generally are not implemented in other settings (Mall groups, vocational settings, and school). Where appropriate, all PBS plans should be implemented across settings where the individual is served and the appropriate staff in those settings should be trained prior to the implementation of the PBS plans.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that staff in all settings has been trained to competency. 2. Provide documentation that staff in all treatment settings have been trained to competency on all PBS plans.
C.2.i	<p>Adequate active psychosocial rehabilitation is provided, consistent with generally accepted professional standards of care, that:</p>	<p>Compliance: Partial.</p> <p>Interview with the Mall Director, review of the Mall Schedules, list of individuals with cognitive disorders, and the hours of Mall attendance summary lists showed that individuals at NSH do not receive adequate psychosocial rehabilitation services. For example, attendance for a randomly chosen week (July 17 to July 23, 2007) showed that attendance for the five programs averaged 2.97 hours (43.35%, range 15% to 77%).</p>
C.2.i.i	<p>is based on the individual's assessed needs and is directed toward increasing the individual's ability to engage in more independent life functions;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Revise all discipline-specific assessments to include a section that states the implications of the assessment for rehabilitation activities.</p>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>Findings: This monitor reviewed discipline-specific assessments and noted that a section on "the implications of the assessment for rehabilitation activities" is included in the Psychology Integrated Assessment, Social Work 30-Day Assessment, Rehabilitation Therapy Integrated Assessment, and the Nursing Integrated Assessment. According to Carmen Caruso, Clinical Administrator, only the psychology assessment has been approved, and the rest are awaiting DMH approval.</p> <p>Recommendation 2, February 2007: Assess the WRP for integration of this element of the assessments into the WRP.</p> <p>Findings: NSH used item #5 of the DMH WRP Chart Audit to address this recommendation, reporting 5% compliance. The table below with its monitoring indicator showing the census at the facility (N), the number of charts audited (n), and the percent compliance (%C) is a summary of the facility's data.</p> <p><i>The team has developed and prioritized reasonable and attainable goals/objectives (e.g. at the level of each individual's functioning) that build on the individual's strengths and address the individual's identified needs, and if any identified needs are not addressed, provide a rationale for not addressing the need.</i></p> <table border="1" data-bbox="884 1094 1824 1286"> <thead> <tr> <th></th> <th>Jan</th> <th>Feb</th> <th>Mar</th> <th>Apr</th> <th>May</th> <th>Jun</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>1171</td> <td>1166</td> <td>1163</td> <td>1152</td> <td>1158</td> <td>1144</td> <td></td> </tr> <tr> <td>n</td> <td>119</td> <td>71</td> <td>124</td> <td>127</td> <td>205</td> <td>120</td> <td></td> </tr> <tr> <td>% S</td> <td>10</td> <td>6</td> <td>10</td> <td>11</td> <td>17</td> <td>10</td> <td></td> </tr> <tr> <td>% C - 5</td> <td>10</td> <td>9</td> <td>4</td> <td>1</td> <td>4</td> <td>2</td> <td>5</td> </tr> </tbody> </table>		Jan	Feb	Mar	Apr	May	Jun	Mean	N	1171	1166	1163	1152	1158	1144		n	119	71	124	127	205	120		% S	10	6	10	11	17	10		% C - 5	10	9	4	1	4	2	5
	Jan	Feb	Mar	Apr	May	Jun	Mean																																			
N	1171	1166	1163	1152	1158	1144																																				
n	119	71	124	127	205	120																																				
% S	10	6	10	11	17	10																																				
% C - 5	10	9	4	1	4	2	5																																			

		<p>Recommendation 3, February 2007: Finalize the Mall Alignment tool to monitor the match between assessed needs in the WRP and the psychosocial services provided.</p> <p>Findings: NSH has finalized and implemented the statewide DMH Mall Alignment Monitoring Form. The form was implemented on July, 2007.</p> <p>Recommendation 4, February 2007: Ensure that there is a match among the WRP plan, Mall activity schedule, and the group individuals attend.</p> <p>Findings: NSH used item #1 (<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</i>) of the DMH Mall Alignment Monitor to address this recommendation, reporting 0% compliance.</p> <p>This monitor reviewed seven charts (LP, LT, JP, TX, JB, AS, and DK). None of them met the criterion to satisfy this recommendation. For example, LP had no activity schedule present in the chart, LT's groups are listed in the WRP but were not found in the schedule, and JP does not have groups mentioned in the WRP's intervention section.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Revise all discipline-specific assessments to include a section that states the implications of the assessment for rehabilitation activities. 2. Assess the WRP for integration of this element of the assessments into the WRP. 3. Ensure that there is a match among the WRP plan, Mall activity schedule, and the group individuals attend.
--	--	---

Section C: Integrated Therapeutic and Rehabilitation Services Planning

<p>C.2.i.ii</p>	<p>Has documented objectives, measurable outcomes, and standardized methodology</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Ensure that the learning outcomes are developed and are stated in measurable terms</p> <p>Findings: NSH used item #3 (<i>Plan has documented objectives, measurable outcomes, and standardized methodology</i>) of the DMH Mall Alignment Monitor) to address this recommendation, reporting 0% compliance.</p> <p>This monitor reviewed seven charts (BS, LP, AS, DK, JB, CH, and CH) to assess if the objectives in the WRPs were written in an objective and measurable manner. One of them (BS) had the objectives written in a way that specifies what the individual will be doing that can be objectively monitored, and the rest did not.</p> <p>Recommendation 2, February 2007: Ensure that the DMH PSR Mall Facilitator Monthly Progress Note is implemented and made available to the teams for tracking outcomes related to the WRP.</p> <p>Findings: NSH has implemented the Monthly Mall Progress Note in three units. NSH audited fifteen charts and noted that only seven of them included Mall progress notes. However, none of the information in those progress notes was included in the individuals' WRPs, and the objectives and interventions were not adjusted as a function of the information contained in the progress notes.</p> <p>This monitor reviewed ten charts (LP, LK, SB, BN, HS, AS, DK, GB, CH, and JB). None of them included any monthly Mall progress notes. There was no mention of a progress note in the Present Status section of the individual's WRP.</p> <p>Tony Rabin, Mall Director, stated that Mall Facilitators need to get the</p>
-----------------	---	---

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>objectives from the individual's WRP for the facilitators to be able to address the individual's needs in the Mall group activities.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that learning outcomes are developed and are stated in measurable terms. 2. Ensure that the DMH PSR Mall Facilitator Monthly Progress Note is implemented and made available to the teams for tracking outcomes related to the WRP.
C.2.i.iii	<p>Is aligned with the individual's objectives that are identified in the individual's Wellness and Recovery Plan</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation 1, February 2007: Ensure that all therapies and rehabilitation services provided in the malls are aligned with the assessed needs of the individuals.</p> <p>Findings: NSH used item #4 (<i>Plan is aligned with the individual's objectives that are identified in the individual's Wellness and Recovery Plan</i>) of the DMH Mall Alignment Monitor Form to address this recommendation, reporting 20% compliance.</p> <p>This monitor reviewed eight charts (LP, JB, AL, CH, GB, DK, AS, and MP). One of them (CH) had objectives and interventions in the WRP that matched with the Mall Catalogue. The remaining seven did not have appropriate milieu interventions for each objective and/or the groups assigned in the WRP did not match with the Mall Catalogue.</p> <p>Recommendation 2, February 2007: Revise and implement the PSR Mall Alignment tool.</p>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>Findings: NSH implemented the revised PSR Mall Alignment tool on June 2007.</p> <p>Current recommendation: Ensure that all therapies and rehabilitation services provided in the malls are aligned with the assessed needs of the individuals.</p>																												
C.2.i.iv	utilizes the individual's strengths, preferences, and interests;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Ensure that the individual's strengths, preferences, and interests are clearly specified in the interventions in the individual's WRP in accordance with the DMH WRP manual.</p> <p>Findings:</p> <p>NSH also used item #7 of the DMH WRP Observation Monitoring Form (<i>The treatment plan includes the individual's strengths related to each enrichment, treatment, or rehabilitation objective</i>) to address this recommendation, reporting 3% compliance. The table below with its monitoring indicator showing the number of WRP conference observed (n) and the percent compliance observed (%C) is a summary of the facility's data.</p> <table border="1" data-bbox="884 1044 1734 1235"> <thead> <tr> <th></th> <th>Feb</th> <th>Mar</th> <th>Apr</th> <th>May</th> <th>Jun</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>n</td> <td>5</td> <td>11</td> <td>16</td> <td>25</td> <td>20</td> <td></td> </tr> <tr> <td>% S</td> <td>0</td> <td>0</td> <td>1</td> <td>2</td> <td>1</td> <td></td> </tr> <tr> <td>% C - 7</td> <td>0</td> <td>9</td> <td>6</td> <td>0</td> <td>0</td> <td>3</td> </tr> </tbody> </table> <p>This monitor reviewed six charts (BS, LK, CH, AL, JB, and MP). One of them (CH) consistently included the individual's strengths for the providers to facilitate the</p>		Feb	Mar	Apr	May	Jun	Mean	n	5	11	16	25	20		% S	0	0	1	2	1		% C - 7	0	9	6	0	0	3
	Feb	Mar	Apr	May	Jun	Mean																								
n	5	11	16	25	20																									
% S	0	0	1	2	1																									
% C - 7	0	9	6	0	0	3																								

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>interventions. The others (BS, LK, AL, JB, and MP) did not include strengths in all the recommended interventions.</p> <p>Recommendation 2, February 2007: Ensure that the group facilitators and individual therapists know and use the individual's strengths, preferences and interests when delivering rehabilitation services.</p> <p>Findings: NSH used item #5 (<i>Provider utilizes the individual's strengths, preferences and interests</i>) of the DMH Mall Alignment Monitor, reporting 20% compliance.</p> <p>According to the Mall Director, facilitators do not always know the individual's focus/foci, objectives, discharge criteria, interventions, or their strengths as there is no system in place to inform the facilitators with the necessary information on the individual. As indicated by this monitor in the findings related to the previous Recommendation 1 above, five of six WRPs failed to include the individual's strengths in their intervention section.</p> <p>Current 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.
C.2.i.v	focuses on the individual's vulnerabilities to mental illness, substance abuse, and readmission due to relapse, where appropriate;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1 and 2, February 2007:</p> <ol style="list-style-type: none"> 1. Address and correct factors related to low compliance with the recommendation to include the individual's vulnerabilities in the case

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>formulation under predisposing, precipitating, and perpetuating factors.</p> <p>2. Present monitoring data regarding the recommendation to include in the present status an update on the current status of these vulnerabilities.</p> <p>Findings: NSH used item #6 (<i>Focuses on the individual's vulnerabilities to mental illness, substance abuse, and readmission due to relapse, when appropriate</i>) of the DMH Mall Alignment Monitor to address this recommendation, reporting 20% compliance.</p> <p>NSH has yet to develop a system to monitor updates of the individual's vulnerabilities in the Present Status section of the individual's WRP.</p> <p>This monitor reviewed nine charts (TQ, TM, KW, EA, AR, JS, RAE, GS, and FK). Three of them (AR, JS, and FK) addressed the individual's vulnerabilities in the case formulation, and six of them (TQ, TM, KW, EA, RAE, and GS) did not.</p> <p>Recommendation 3, February 2007: Implement substance abuse training on all stages of change to all group facilitators.</p> <p>Findings: According to the Mall Director, NSH has developed the necessary material and implemented training of group facilitators on substance abuse on all stages of change. Facilitators have not received training on the Maintenance level because the facilitators have not completed training in the other areas. This monitor reviewed the training schedule, attendance, and post-test documentation conducted on October 19, 2006.</p> <p>Recommendation 4, February 2007: Implement the new curriculum to provide groups on Wellness Recovery Action Plan to all individuals to preempt relapse.</p>
--	--	--

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>Findings: NSH has implemented the curriculum, and individuals are offered the Wellness and Recovery Action Plan group. According to the Mall Director, nine individuals have completed the course and have developed their own Wellness and Recovery Action Plans. Twenty individuals are attending the current group.</p> <p>This monitor observed the Wellness and Recovery Action Plan Group (July 27, 2007, 9.30AM; Unit 15, Program 3). This group was facilitated by John Dickinson, Assistant Chief, Central Program Services. Jackie Bowyer, Psychologist, was part of the team. The group was fully attended and the individuals were focused and attentive during the session. They worked on their own Action Plans when instructed. One of the individuals in the group (JW) was also one of the Co-facilitators. JW was very proud of his role and was actively observing, monitoring, and giving feedback to the other individuals in the group. It appeared from the response of the other individuals to JW, that he was well accepted in his role as co-facilitator. The facilitator was prepared and followed the curriculum.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Address and correct factors related to low compliance with the recommendation to include the individual's vulnerabilities in the case formulation under predisposing, precipitating, and perpetuating factors. 2. Present monitoring data regarding the recommendation to include in the present status an update on the current status of these vulnerabilities. 3. Complete substance abuse training on all stages of change to all group facilitators.
C.2.i.vi	is provided in a manner consistent with each individual's cognitive strengths and limitations;	<p>Current findings on previous recommendations:</p> <p>Recommendations 1-3, February 2007:</p> <ol style="list-style-type: none"> 1. Assess all individuals suspected of cognitive disorders, mental retardation and developmental disabilities and other conditions that may adversely impact an

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>individuals' cognitive status.</p> <ol style="list-style-type: none"> 2. Ensure that individuals' cognitive functioning is taken into consideration when assigning them to activities. 3. Ensure that Mall activities are designed to meet differing cognitive strengths and limitations. <p>Findings: NSH has implemented AD #853 (Cognitive Screen) on January 18, 2007 to align with this recommendation. According to the Mall Director and Clinical Administrator, all individuals receive a cognitive screening upon admission, and further cognitive screening is conducted when there is a change in the individual's functioning.</p> <p>According to the Mall Director, Mall curriculums specify the appropriate cognitive level for participants. The Mall Director chairs a committee to develop groups meeting the needs of individuals with differing cognitive levels of functioning. The DCAT members are offering the SILS (Social and Independent Living Skills) group for individuals with cognitive challenges.</p> <p>Observation of Mall groups, interview of Mall facilitators, and review of Interventions and Mall schedules did not show evidence that this recommendation was fully implemented. There are no levels offered for the same group activity. Facilitators are not certain about the cognitive functioning of individuals in their groups.</p> <p>Recommendation 4, February 2007: Ensure that the WRPTs use the WRP Treatment Activity Request Form when a group is not available that matches the individual's cognitive strengths and limitations.</p>
--	--	---

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>Findings: According to the Mall Director, the WRP Treatment Activity Request Form has been used twice in the last six months but in both cases, the request was not based on the individuals' cognitive levels.</p> <p>Recommendation 5, February 2007: Complete and implement the WRP/mall alignment tool.</p> <p>Findings: NSH has revised and implemented the DMH Mall Alignment Monitoring Form. NSH audited five Mall groups in June 2007, using item #7 (<i>Is provided in a manner consistent with each individual's cognitive strengths and limitations</i>) of the DMH Mall Alignment Monitor, reporting 50% compliance. The completed Mall Alignment Monitoring Form for this item was not made available for review by this monitor.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Assess all individuals suspected of cognitive disorders, mental retardation and developmental disabilities and other conditions that may adversely impact an individuals' cognitive status. 2. Ensure that individuals' cognitive functioning is taken into consideration when assigning them to activities. 3. Ensure that Mall activities are designed to meet differing cognitive strengths and limitations. 4. Ensure that the WRPTs use the WRP Treatment Activity Request Form when a group is not available that matches the individual's cognitive strengths and limitations.
C.2.i.vii	Provides progress reports for review by the Wellness and Recovery Team as part of the Wellness and Recovery Plan review process	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, February 2007:</p> <ol style="list-style-type: none"> 1. Implement the PSR Mall Facilitator Monthly Progress Notes.

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>2. Automate this system to make it feasible for the group facilitators and individual therapists to provide progress reports in a timely manner.</p> <p>Findings: NSH has implemented the Mall Progress Note in three units (A9, T3, and T16). NSH audited fifteen charts and found Mall monthly progress notes in seven of them. However, none of the seven had completed notes for all the months involved.</p> <p>NSH has yet to automate the Monthly Mall Facilitator Progress Note to make it feasible for the group facilitators and individual therapists to provide progress reports in a timely manner. According to the Mall Director, the WaRMSS WRP module, which includes the PSR Mall Facilitator Monthly Progress Notes, is to be implemented in fall 2007.</p> <p>This monitor reviewed five charts (JD, RT, JC, NB, and MB). Mall progress notes were not found in these charts.</p> <p>This monitor reviewed three Mall progress notes (CB, WH, and SJ). The notes were written by Tony Rabin (Facilitator) and Scott Sutherland (Co-Facilitator). The notes were complete and aligned with the WRP/Mall Alignment Check Protocol.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Implement the PSR Mall Facilitator Monthly Progress Notes. 2. Automate this system to make it feasible for the group facilitators and individual therapists to provide progress reports in a timely manner.
C.2.i. viii	is provided five days a week, for a minimum of four hours a day (i.e., two hours in the morning and two hours in the afternoon each weekday), for each	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Ensure that PSR Mall groups are offered for two hours in the afternoon each</p>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

	<p>individual or two hours a day when the individual is in school, except days falling on State holidays;</p>	<p>weekday.</p> <p>Findings: NSH has yet to implement this recommendation. According to the Mall Director, the Clinical Management Team has chosen 3:30PM - 4:20PM and 4:40 - 5:30PM as standard hours for the afternoon Mall time. The new schedule is set to begin on October 1, 2007. However, the Mall Director also stated that Program 4 has chosen to conduct the Mall activities for one hour in the mornings and three hours in the afternoons. These scheduled hours are not aligned with EP requirements.</p> <p>Recommendation 2, February 2007: Mandate that all staff at NSH, other than those who attend to emergency medical needs of individuals, will provide services at the PSR mall. This includes clinical, administrative and support staff.</p> <p>Findings: NSH has yet to mandate that all staff at NSH, other than those needed to attend to individuals' emergency medical needs, provide services at the PSR mall. According to the Mall Director, 36 administrative and support staff are providing at least one hour of Mall services as providers or co-providers.</p> <p>Recommendation 3, February 2007: Ensure that WRPTs use the WRP Treatment Activity Request Form to inform the Mall of needed services.</p> <p>Findings: NSH has begun to use the WRP Treatment Activity Request Form to inform the Mall of needed services. Two WRP teams have used the treatment Activity Request Form in the past six months.</p>
--	---	---

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>Recommendation 4, February 2007: Ensure that the Mall develops the treatment activities that are needed.</p> <p>Findings: NSH has not responded to the two requests received in the last six months. According to the Mall Director, the Mall group requests went unmet due to staffing shortage. The facility has plans to train other providers to be able to meet the requests.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that PSR Mall groups are offered for two hours in the afternoon each weekday. 2. Mandate that all staff at NSH, other than those who attend to emergency medical needs of individuals, will provide services at the PSR mall. This includes clinical, administrative and support staff. 3. Ensure that WRTs use the WRP Treatment Activity Request Form to inform the Mall of needed services. 4. Ensure that the Mall develops the treatment activities that are needed.
C.2.i.ix	is provided to individuals in bed-bound status in a manner and for a period that is commensurate with their medical status;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Ensure that bed-bound individuals receive appropriate services following EP guidelines including hours of services.</p> <p>Findings: NSH reported having four bed-bound individuals in June 2007. The average hours of services provided to these individuals was reported as 1.4 hours per week. Staffing shortage is said to affect the hours of services offered to individuals categorized as bed-bound.</p> <p>This monitor's visit to the Skilled Nursing Unit (SNF) showed that there was no</p>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>bed-bound individual in the facility at this time. The individuals in the unit were ambulatory or wheelchair mobile. This monitor observed a Social Skills through Karaoke group in session. The staff were not able to articulate the social skills targeted using karaoke or what social skills were targeted for certain individuals attending the group.</p> <p>Recommendation 2, February 2007: Implement and document the skills-building activities.</p> <p>Findings: NSH has developed skills-building activities as part of the Mall group curriculum for bed-bound individuals.</p> <p>This monitor reviewed the Weekly Individual Schedule of RE, JC, JW, JM, and CR. CR's weekly schedule (July 9, 2007) showed the following skill-building activities: Reality Orientation and Spiritual Awareness (Monday, 8AM-8.50AM and 10.30AM to 11.20AM), Sensory Stimulation (Tuesday 10.20AM-11.20AM), Communication Skills through Art (Wednesday, 10.30AM - 11.20AM), Coping Skills through Creativity (Friday, 3.30PM-4.20PM).</p> <p>The schedules reviewed by this monitor showed that most bed-bound individuals do not receive four hours of PSR Mall services per day.</p> <p>Current recommendation: Ensure that bed-bound individuals receive appropriate services following EP guidelines including hours of services.</p>
C.2.i.x	routinely takes place as scheduled;	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, February 2007:</p> <ol style="list-style-type: none"> 1. Expand the no-cancellation policy to all Mall groups. 2. Ensure that Mall group activities routinely take place as scheduled.

		<p>Findings: NSH has yet to implement the no-cancellation policy to all groups.</p> <p>This monitor reviewed the Mall cancellation data. The data showed that for the month of June 2007, a total of 323 Mall groups were cancelled across the programs (range 3-82 per program); this amounts to an average of 15.4% cancellation rate (range 1.6%-23.4%). Further review of Mall cancellation data (for week June 4 through June 8, 2007) showed staffing shortage as the primary reason for Mall cancellations. For the week of June 4, 2007, 164 of the 211 groups cancelled were due to staffing/coverage shortage.</p> <p>Recommendation 3, February 2007: Inform the WRPT when an individual is not engaging in the assigned treatment.</p> <p>Findings: NSH does not have a system in place to notify WRPTs when individuals do not regularly engage in assigned treatments.</p> <p>Recommendation 4, February 2007: Develop a plan for engaging the individuals not going to assigned treatment activities.</p> <p>Findings: NSH has chosen to use the BY CHOICE Incentive program, Narrative Restructuring Therapy, and Motivational Interviewing to address this recommendation. According to the Mall Director, the facility is short on staff trained on Restructuring Therapy and Motivational Interviewing. Training is ongoing to increase the number of qualified providers in these areas.</p> <p>NSH did not routinely review data on individuals who did not participate in their assigned treatments. Furthermore, no tracking and monitoring system is in place</p>
--	--	---

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>to evaluate if these individuals are being engaged and by who and where, and what progress they are making. For example, for the week of June 17, 2007, 60 individuals showed zero hours attendance at their assigned treatment sessions. There is no documentation that anything was being done to address this issue with these individuals'.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Expand the no-cancellation policy to all Mall groups. 2. Ensure that Mall group activities routinely take place as scheduled. 3. Inform the WRPT when an individual is not engaging in the assigned treatment. 4. Develop a plan for engaging the individuals not going to assigned treatment activities.
C.2.i.xi	<p>includes, in the evenings and weekends, additional activities that enhance the individual's quality of life; and</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1 and 2, February 2007:</p> <ol style="list-style-type: none"> 1. Plan and organize these activities such that there is minimal interruption, individuals are reinforced to participate regularly in these activities, and as much as possible eliminate competing activities that act as a barrier for individuals to participate in such activities. 2. Increase the number of hours of enrichment activities per individual provided in the evenings and on weekends. <p>Findings:</p> <p>NSH offers enrichment activities to individuals in the evenings and on weekends.</p> <p>This monitor reviewed the Enrichment Activity Rosters and Enrichment Activity Unit Calendars and noted that enrichment activities were being offered throughout the week including weekends.</p> <p>The Mall Director stated that there were no system barriers/ interruptions to</p>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>individuals' participation in the enrichment activities, except for staffing needs (arising from shortage of staffing or coverage due to staff illness/vacation).</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Plan and organize these activities such that there is minimal interruption, individuals are reinforced to participate regularly in these activities, and as much as possible eliminate competing activities that act as a barrier for individuals to participate in such activities. 2. Increase the number of hours of enrichment activities per individual provided in the evenings and on weekends.
C.2.i.xii	<p>is consistently reinforced by staff on the therapeutic milieu, including living units.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Ensure that all WRPs have therapeutic milieu interventions clearly specified in the intervention sections.</p> <p>Findings: NSH reported that Nursing Coordinators conducted a 100% audit of WRPs for the presence of therapeutic milieu interventions. However, no data was produced showing how many individuals had fewer than the required hours of milieu interventions identified in the intervention section of their WRPs.</p> <p>This monitor reviewed the Mall Activity Schedule (June 17 -June 23, 2007). Except for CR, who had 16 hours of scheduled activity, the rest of the individuals had a range of 0-8 hours of scheduled activity, out of the required 20 hours.</p> <p>This monitor reviewed nine charts (BS, LK, CH, AL, HA, MP, GB, DK, and AS). Four of them had no scheduled activity hours (BS, HS, MP, and GB), and the remaining five (LK, CH, AL, DK, and HA) had between one and eight hours of scheduled activity for the week.</p>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>Recommendation 2, February 2007: Ensure that unit staff know what the individuals are learning in the Malls and individual therapies and reinforce their learning in all settings.</p> <p>Findings: NSH audited this recommendation using all 21 items of the Therapeutic Milieu Observation Monitoring Form to address this recommendation. This monitor found items #6, #7, #10, and #21 to be directly relevant to this recommendation. The table below with the monitoring identifiers of these items shows the number of units available for observation (N), the number of units observed (n) and the percent compliance with these items (%C).</p> <p><i>#6: Staff is observed offering praise or positive feedback to individuals.</i></p> <p><i>#7: Staff is heard acknowledging individuals' strengths and abilities.</i></p> <p><i>#12: Staff is observed discussing Mall activities with individuals.</i></p> <p><i>#21: Staff is familiar with individuals' Wellness Recovery Plans.</i></p> <table border="1" style="margin-left: auto; margin-right: auto;"> <thead> <tr> <th></th> <th>Jan</th> <th>Mar</th> <th>Jun</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>29</td> <td>29</td> <td>29</td> <td></td> </tr> <tr> <td>n</td> <td>29</td> <td>29</td> <td>21</td> <td></td> </tr> <tr> <td>% S</td> <td>100</td> <td>100</td> <td>72</td> <td></td> </tr> <tr> <td>% C-</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>#6</td> <td>75</td> <td>71</td> <td>76</td> <td>74</td> </tr> <tr> <td>#7</td> <td>69</td> <td>100</td> <td>90</td> <td>86</td> </tr> <tr> <td>#12</td> <td>10</td> <td>21</td> <td>4</td> <td>11</td> </tr> <tr> <td>#21</td> <td>90</td> <td>90</td> <td>80</td> <td>85</td> </tr> </tbody> </table> <p>This monitor observed one individual (AL). The staff on this unit (Julie Winn,</p>		Jan	Mar	Jun	Mean	N	29	29	29		n	29	29	21		% S	100	100	72		% C-					#6	75	71	76	74	#7	69	100	90	86	#12	10	21	4	11	#21	90	90	80	85
	Jan	Mar	Jun	Mean																																											
N	29	29	29																																												
n	29	29	21																																												
% S	100	100	72																																												
% C-																																															
#6	75	71	76	74																																											
#7	69	100	90	86																																											
#12	10	21	4	11																																											
#21	90	90	80	85																																											

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>Psychologist, and Sharon Sanguinetti, Nurse) were well-informed of the individual's WRP plan and they actively reinforced the individual when they were around him.</p> <p>This monitor interviewed one individual (DT), who stated that certain staff were friendly and would ask about his milieu services and progress, whereas others almost never care about him and do not discuss his WRP.</p> <p>Current 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.
C.2.j	<p>Adequate, individualized group exercise and recreational options are provided, consistent with generally accepted professional standards of care.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Review the developed list for redundancy.</p> <p>Findings: NSH has yet to review and sort out the redundant activities in the Enrichment Activity list.</p> <p>Recommendation 2, February 2007: Continue to provide training to Mall facilitators to conduct the activities appropriately.</p> <p>Findings: NSH has assigned a half-time RT to the Fitness Center. According to the Mall Director, a plan for training providers has been developed and will be conducted as required.</p>

		<p>Recommendations 3 and 4, February 2007:</p> <ol style="list-style-type: none"> 3. Develop a system to track and review individuals' participation in scheduled group exercise and recreational activities. 4. Implement corrective action if participation is low. <p>Findings:</p> <p>NSH has not developed a system to track and review individuals' participation in scheduled group exercise and recreational activities. Corrective action is not possible without such information.</p> <p>NSH has over 955 individuals with high BMI's (26 and over), and over 515 individuals in the morbid range (30 and over). These individuals are at high risk for obesity-related illness and need frequent and regular exercises in addition to a medically regulated nutritional plan.</p> <p>Enrichment activities/exercises should be individualized and appropriate to the individual's needs, preference, and interests. MG informed his WRPC that his enrichment group should take extra laps during bicycle rides. The response to him was that the group took a vote for the number of laps. It may be helpful to MG to provide him time for extra laps after the group has been dismissed, arrange additional time for him to exercise, or arrange for other enrichment activities that allow him to expend more energy to help him reduce his BMI.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Review the developed list for redundancy. 2. Continue to provide training to Mall facilitators to conduct the activities appropriately. 3. Develop the system to track and review participation of individuals in scheduled group exercise and recreational activities.
--	--	---

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>4. Implement corrective action, if participation is low.</p>
<p>C.2.k</p>	<p>Individuals who have an assessed need for family therapy services receive such services in their primary language, as feasible, consistent with generally accepted professional standards of care and that these services, and their effectiveness for addressing the indicated problem, are comprehensively documented in each individual's chart.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1-3, February 2007:</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. <p>Findings: NSH has yet to implement these recommendations.</p> <p>According to Ann Long, Chief of Social Work, the 30-Day Psychosocial Assessment and Annual Psychosocial Assessment have been revised and approved by the Chiefs of Social Work and are pending DMH approval . The revised instruments contain an item specific to addressing this recommendation (item #5: <i>Include assessment of need for family therapy and opportunities to engage family/support system in treatment</i>). The 30-Day Psychosocial Assessment and Instruction Manual have been approved by the Chiefs of Social Work and are pending DMH approval.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Conduct a needs assessment with individuals and/or their families. 2. 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.

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		3. Review pre-admission reports and services/treatments provided to identify the need for family therapy services.
C.2.l	Each individual's therapeutic and rehabilitation service plan identifies general medical diagnoses, the treatments to be employed, the related symptoms to be monitored by nursing staff (i.e., registered nurses ["RNs"], licensed vocational nurses ["LVNs"] and psychiatric technicians) and the means and frequency by which such staff shall monitor such symptoms, consistent with generally accepted professional standards of care.	<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Develop and implement a monitoring and tracking system to address the elements of this requirement.</p> <p>Findings: NSH has not yet addressed this recommendation.</p> <p>Compliance: Noncompliance.</p> <p>Current recommendations: Develop and implement a monitoring and tracking system to address the elements of this requirement.</p>
C.2.m	The children and adolescents it serves receive, consistent with generally accepted professional standards of care:	MSH only
C.2.m.i	Therapy relating to traumatic family and other traumatic experiences, as clinically indicated; and	
C.2.m.ii	reasonable, clinically appropriate opportunities to involve their families in treatment and treatment decisions.	

Section C: Integrated Therapeutic and Rehabilitation Services Planning

<p>C.2.n</p>	<p>Policies and procedures are developed and implemented consistent with generally accepted professional standards of care to ensure appropriate screening for substance abuse, as clinically indicated.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Revise the screening policy 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>Findings: A statewide workgroup is currently in the process of implementing this recommendation.</p> <p>Recommendation 2, February 2007: Finalize and implement the policy and procedure.</p> <p>Findings: NSH has yet to implement this recommendation.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Revise the screening policy 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. 2. Finalize and implement the policy and procedure.
<p>C.2.o</p>	<p>Individuals who require treatment for substance abuse are provided appropriate therapeutic and rehabilitation services consistent with generally accepted professional standards of care.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Ensure that the substance abuse program has a dedicated clinical leadership.</p>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>Findings: NSH has yet to implement this recommendation. An Acting Chief of Psychiatry, who has specialty certification in addictions, has been appointed effective August 1, 2007. This position will take a dedicated clinical leadership role in the substance recovery service.</p> <p>Recommendation 2, February 2007: The substance recovery program should develop and utilize clinical outcomes for individuals and process outcomes for the program.</p> <p>Findings: The facility has yet to implement this recommendation.</p> <p>Recommendation 3, February 2007: Revise the substance abuse check list to ensure that the stages of change are correctly identified and that monitoring accounts for the correct identification of these stages.</p> <p>Findings: NSH has implemented this recommendation. As mentioned in C.2.c, the facility used the revised Substance Abuse Checklist (in April 2007) to assess compliance (refer to C.2.c for a summary of the data).</p> <p>Recommendation 4, February 2007: Complete the training curriculum to address the maintenance phase of change.</p> <p>Findings: NSH has implemented this recommendation. The substance recovery service has completed a manual for the Maintenance Stage of Change curriculum, including facilitator training lesson plan. The material in this manual is aligned with the Trans-theoretical Model of the Stages of Change. The curriculum is also aligned with the in-service training guidelines that are contained in the publication by US</p>
--	--	---

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>Department of Health and Human Services SAMHSA regarding Enhancing Motivation for Change.</p> <p>Recommendation 5, February 2007: Ensure that substance abuse monitoring items are aligned with the principles outlined in the current training curriculum.</p> <p>Findings: Same as in C.2.c.</p> <p>Recommendation 6, February 2007: Ensure monitoring of a 20% sample of the target population.</p> <p>Findings: NSH's monitoring data are summarized in C.2.c. The facility has yet to implement this recommendation.</p> <p>Other findings: This monitor reviewed six charts of individuals with substance abuse disorders (TA, LTH, CAB, ERC, JA and BAS). The following are the main findings of compliance based on a review of the WRPs:</p> <ol style="list-style-type: none"> 1. All charts, except for one (JA) included documentation of substance use disorder as a diagnosis. 2. Three charts (LTH, JA and BAS) failed to include at least one corresponding objective and intervention. 3. Only one chart (CAB) included interventions that were linked to correct stage of change. <p>Compliance: Partial.</p>
--	--	---

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that the substance abuse program has a dedicated clinical leadership. 2. The substance recovery program should develop and utilize clinical outcomes for individuals and process outcomes for the program. The facility may share results of the work that has begun at NSH in this regard. 3. Utilize the in-service training manual developed by US Department of Health and Human Services, SAMHSA. 4. Ensure monitoring of substance use disorders using the Clinical Chart Audit and the Substance Abuse Checklist based on a sample size of at least 20% of individuals diagnosed with these disorders.
C.2.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>Current findings on previous recommendation:</p> <p>Recommendation, February 2007: Develop a system to monitor the competency of group facilitators and therapists in providing rehabilitation services.</p> <p>Findings: NSH has not developed a system to monitor competency of group facilitators and therapists in providing rehabilitation services. NSH has in file lists of providers it considers certified/qualified to lead the groups they are assigned to facilitate. However, no regular monitoring is carried out to evaluate if the groups are conducted according to the Mall manual, curriculum, and lesson plans.</p> <p>Compliance: Non-compliance.</p> <p>Current recommendations: Develop a system to monitor the competency of group facilitators and therapists in providing rehabilitation services.</p>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

<p>C.2.q</p>	<p>Group facilitators and therapists providing therapeutic and rehabilitation services in the field of substance abuse should be certified substance abuse counselors.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Identify trainers for the substance abuse training curriculum.</p> <p>Findings: NSH has a set of trainers for the substance abuse training curriculum who have been providing the training to facilitators.</p> <p>Recommendation 2, February 2007: Ensure that all providers complete the NSH substance abuse training curriculum at NSH.</p> <p>Findings: NSH has trained 65 providers at the Pre-Contemplative/Contemplative curriculum and 10 providers at the Preparation/Action curriculum.</p> <p>Recommendation 3, February 2007: Clarify and streamline staff competency criteria to ensure their alignment with the current training curriculum.</p> <p>Findings: NSH has yet to address this recommendation.</p> <p>Recommendation 4, February 2007: Ensure that training includes all of the five stages of change.</p> <p>Findings: NSH has not completed training of providers in all five stages of change. The training at the maintenance level is yet to be completed.</p>
--------------	--	--

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>Recommendation 5, February 2007: Provide data that training has occurred.</p> <p>Findings: Training rosters were provided to the Treatment Enhancement Office and copies are available for review.</p> <p>Recommendation 6, February 2007: Develop a review system to evaluate the quality of services provided by these trained facilitators.</p> <p>Findings: NSH has not developed a review system to evaluate the quality of services provided by trained facilitators.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Identify trainers for the substance abuse training curriculum. 2. Ensure that all providers complete the NSH substance abuse training curriculum at NSH. 3. Clarify and streamline staff competency criteria to ensure their alignment with the current training curriculum. 4. Ensure that training includes all of the five stages of change. 5. Provide data that training has occurred. 6. Develop a review system to evaluate the quality of services provided by these trained facilitators.
C.2.r	Transportation and staffing issues do not preclude individuals from attending appointments.	Current findings on previous recommendations:

Section C: Integrated Therapeutic and Rehabilitation Services Planning

Recommendations 1 and 2, February 2007:

1. Review reasons for cancellations and assess and correct factors contributing to such events.
2. Complete and implement the Medical Scheduler.

Findings:

NSH reviewed missed/cancelled appointments to address this recommendation. The table below showing the months, number of missed appointments (N) and the reasons for the missed appointments with their frequency percentage, is the summary of the facility's data.

	Jan	Feb	Mar	Apr	May	Jun	Mean
N	135	232	273	210	192	215	
% Refused	60	44	45	50	48	43	48
% Illness	1	4	1	1	0	0	1
% No Escort	4	6	3	3	3	1	3
% Other	24	38	39	37	38	47	37
% Out of Facility	10	8	11	8	11	8	9
% Pre-work Incomplete	1	0	1	1	0	1	1

NSH also reviewed reasons for missed outpatient referrals. The table below showing the months, number of missed appointments (N) each month, and the reasons for the missed appointments with their percentage, is the summary of the facility's data.

	Jan	Feb	Mar	Apr	May	Jun	Mean
N	34	24	29	16	17	14	
% Refused	50	50	34	37	47	64	47
% Illness	0	0	7	0	0	7	2
% No Escort	6	13	14	6	5	0	7

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<table border="1"> <tr> <td>% Other</td> <td>12</td> <td>29</td> <td>24</td> <td>43</td> <td>41</td> <td>22</td> <td>29</td> </tr> <tr> <td>% Out of Facility</td> <td>23</td> <td>4</td> <td>10</td> <td>12</td> <td>5</td> <td>7</td> <td>10</td> </tr> <tr> <td>% Pre-work Incomplete</td> <td>9</td> <td>4</td> <td>10</td> <td>0</td> <td>0</td> <td>0</td> <td>4</td> </tr> </table>	% Other	12	29	24	43	41	22	29	% Out of Facility	23	4	10	12	5	7	10	% Pre-work Incomplete	9	4	10	0	0	0	4	<p>In both cases, transportation was not a major reason for the cancellations. Refusals are very high. NSH has not identified or developed plans to correct the high refusals.</p> <p>NSH has yet to implement the Medical Scheduler. The total number of missed appointments cannot be verified without the Medical Scheduler in place.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Review reasons for cancellations and assess and correct factors contributing to such events. 2. Complete and implement the Medical Scheduler.
% Other	12	29	24	43	41	22	29																				
% Out of Facility	23	4	10	12	5	7	10																				
% Pre-work Incomplete	9	4	10	0	0	0	4																				
C.2.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>Current findings on previous recommendation:</p> <p>Recommendation, February 2007: Develop and implement monitoring systems that address the required elements.</p> <p>Findings: NSH audited this recommendation using item #10 of the DMH WRP Clinical Chart Auditing Form, reporting 1% compliance. The table below with its monitoring indicator showing the number of charts available for audit in the quarter (N), the number of charts audited (n), and the percent compliance (%C), is a summary of the facility's data.</p>																									

Section C: Integrated Therapeutic and Rehabilitation Services Planning

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.

	Jan	Feb	Mar	Apr	May	Jun	Mean
N	39	40	34	44	45	40	
n	19	17	21	24	33	13	
% S	48	42	61	54	73	32	
% C - 10	0	0	0	0	3	0	1

This monitor reviewed 15 charts (VH, MW, CC, EH, JB, EM, AL, AT, AS, AS, GB, MP, CH, LK, and SB). Only one (CH) had an acceptable plan of Psychosocial Rehabilitation Plan and Enrichment activities that matched her diagnosis, needs, and strengths. There was a match between the groups and the schedule, and the groups she actually attends. In all the other cases, there was a poor match among the diagnosis, the assigned groups, the individual's cognitive functioning, the schedules, and the groups attended by the individual's. Many of them (MP, LK, AL, EM, and JB) were not assigned to appropriate milieu interventions or any milieu interventions at all. Other examples of deficiencies include a lack of plans for assisting individuals who are not attending assigned groups (EH), and lack of alignment between the individual's objectives and intervention (MW).

Other findings:

VH's WRPC (June 7, 2007) was conducted while she was in five-point restraints. This appears to be a poor choice by the WRPT. Interviewing the individual under such conditions is harmful to the individual's self-esteem and self-worth in addition to being unhelpful to the individual and the team as it is not conceivable

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>that the individual would be in a frame of mind to fully participate and cooperate during the conference. In the Present Status section of VH's WRP, documentation shows she has made progress, and most of the documentation is positive of her functioning. For example, one sentence reads, "When PRNs are give [sic] without placing her in restraints or seclusion she has been easily redirected and receptive to staff teaching."</p> <p>Compliance: Partial.</p> <p>Current recommendation: Develop and implement monitoring systems that address the required elements.</p>
C.2.t	<p>Treatment, rehabilitation and enrichment services are monitored appropriately against rational, operationally-defined target variables and revised as appropriate in light of significant developments, and the individual's progress, or lack thereof;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, February 2007: Ensure that the newly developed process is fully implemented and addresses all of the elements of this requirement.</p> <p>Findings: NSH audited charts using item #11 (<i>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</i>) of the DMH WRP Clinical Chart Auditing Form, reporting 0% compliance. The table below with its monitoring indicator showing the number of charts available for audit (N), number audited (n), and the percent compliance (%C) is a summary of the facility's data.</p>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<table border="1" data-bbox="961 228 1663 402"> <thead> <tr> <th></th> <th>Jan</th> <th>Feb</th> <th>Mar</th> <th>Apr</th> <th>May</th> <th>Jun</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>1171</td> <td>1166</td> <td>1163</td> <td>1152</td> <td>1158</td> <td>1144</td> <td></td> </tr> <tr> <td>n</td> <td>19</td> <td>17</td> <td>21</td> <td>24</td> <td>33</td> <td>13</td> <td></td> </tr> <tr> <td>% S</td> <td>1</td> <td>1</td> <td>1</td> <td>2</td> <td>2</td> <td>1</td> <td></td> </tr> <tr> <td>% C - 11</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> </tr> </tbody> </table> <p data-bbox="884 444 1875 623">This monitor reviewed 14 charts (VH, MW, CC, EH, JB, EM, AL, AT, AS, GB, MP, CH, LK, and SB). None of them met all the elements needed to comply with this recommendation, for example failing to make appropriate and timely revision of objectives and/or interventions when an individual has made or not made timely progress for each active treatment in the WRP.</p> <p data-bbox="884 667 1083 732">Compliance: Non-compliance.</p> <p data-bbox="884 781 1902 878">Current recommendation: Ensure that the newly developed process is fully implemented and addresses all of the elements of this requirement.</p>		Jan	Feb	Mar	Apr	May	Jun	Mean	N	1171	1166	1163	1152	1158	1144		n	19	17	21	24	33	13		% S	1	1	1	2	2	1		% C - 11	0	0	0	0	0	0	0
	Jan	Feb	Mar	Apr	May	Jun	Mean																																			
N	1171	1166	1163	1152	1158	1144																																				
n	19	17	21	24	33	13																																				
% S	1	1	1	2	2	1																																				
% C - 11	0	0	0	0	0	0	0																																			
C.2.u	Individuals are educated regarding the purposes of their treatment, rehabilitation and enrichment services. They will be provided a copy of their WRP when appropriate based on clinical judgment.	<p data-bbox="884 932 1482 959">Current findings on previous recommendations:</p> <p data-bbox="884 1003 1772 1068">Recommendation 1, February 2007: Fully implement the Wellness and Recovery Orientation Mall curriculum.</p> <p data-bbox="884 1117 1902 1365">Findings: NSH has yet to implement this recommendation. The implementation of this curriculum has continued on the admissions unit (A-9) in Program IV. A new group started on Unit Q-9 in Program V (June, 2007). The facility plans to expand this group to include all Program V admissions. The curriculum was discontinued on Unit T-3 when it ceased to be an admissions unit, but will resume on that unit on August 1, 2007.</p>																																								

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>Recommendation 2 February 2007: Develop and implement a monitoring tool to address the requirement.</p> <p>Findings: The facility recently instituted an admission orientation flow sheet (Programs IV, Unit A-9 and V, Unit Q9) to improve tracking of newly admitted individuals. The tool was developed to track the admit date and whether the individual is in a group activity and has passed the recovery post-test. The anticipated implementation of WaRMSS is expected to track the provision of a copy of the WRP to the individuals, when clinically appropriate.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Fully implement the Wellness and Recovery Orientation Mall curriculum. 2. Develop and implement a tool to address both elements of this requirement. 3. Increase the number of Mall groups that are provided to educate individuals regarding the purposes of their treatment, rehabilitation and enrichment services.
C.2.v	<p>Staff educates individuals about their medications, the expected results, and the potential common and/or serious side effects of medications, and staff regularly asks individuals about common and/or serious side effects they may experience.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Develop and implement a curriculum with a lesson plan regarding medication education that is consistent with recovery philosophy.</p> <p>Findings: This curriculum was developed and shared with medical and other clinical staff. A review of a 12-week lesson plan regarding medication education showed that the curriculum is appropriate to the requirement. The curriculum has been</p>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>implemented in at least one group course.</p> <p>Recommendation 2, February 2007: Increase the number of Mall groups that address this requirement.</p> <p>Findings: NSH has increased the number of groups from three to 11. Currently there are 11 Medication Education courses in the hospital, including five at off-unit locations. The current providers consist of psychiatrists, psychologists and social workers. Nursing staff are expected to begin using the new curriculum as Mall providers.</p> <p>Recommendation 3, February 2007: Provide monitoring data regarding this requirement.</p> <p>Findings: NSH has yet to implement this recommendation. The Medical Director and Nurse Administrator are expected to develop a plan to address this recommendation.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure full implementation of the curriculum regarding medication education. 2. Increase the number of Mall groups that offer education regarding medication management. 3. Develop and implement a tool to monitor requirements regarding medication education. The facility may utilize the process developed at MSH.
C.2.w	Interdisciplinary teams review, assess, and develop positive clinical strategies to overcome individual's barriers to participation in therapeutic and	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Finalize process to provide Key Indicator data regarding individuals' non-</p>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

	<p>rehabilitation services.</p>	<p>adherence to interventions in the WRP.</p> <p>Findings: NSH has yet to implement this recommendation. The anticipated implementation of the WaRMSS WRP Module in the fall of 2007 should facilitate compliance.</p> <p>Recommendation 2, February 2007: Ensure that certified NRT therapists provide individual therapy to individuals who trigger non-adherence to WRP in the Key Indicator.</p> <p>Findings: NSH has yet to implement this recommendation. None of the first group of therapists who were trained in 2006 is currently providing NRT due to departure from the facility, staffing issues or other reasons. The NRT trainers (Drs. Robert Wahler and Judy Singh) were able to train another group of therapists (two nurses and one rehabilitation therapist) in May 2007, using the same training format that was used with the first group. With further supervision via the weekly conference calls, all three therapists appeared to have made progress in their ability to help their individuals improve their narratives and become more contemplative about events that occurred in their lives. This is evident in the narratives of two (RP and MN) of the three individuals (RP, MN and AG) who participated in this training. In the early NRT sessions, the narratives of both these individuals were sketchy and lacking in detail. Over time, through prompting from the therapists, the individuals became able to provide more meaningful accounts of their experiences. This appeared to have resulted in the individuals moving from precontemplation to the contemplation stage of change, with enhanced insight into their mental illness.</p> <p>NSH has set up a better system for utilizing NRT therapists that should enable them to accomplish the following:</p> <ol style="list-style-type: none"> 1. Incorporate the NRT as an intervention in the individuals' WRP;
--	---------------------------------	---

		<p>2. Attend each WRP review of these individuals; and</p> <p>3. Provide NRT during PSR Mall hours to those individuals who either reach the non-attendance at Mall groups trigger, or are at the precontemplation stage of change in their readiness to engage in treatment and rehabilitation.</p> <p>Recommendation 3, February 2007: Assess barriers to individuals' participation in their WRPs and provide strategies to individuals to facilitate participation.</p> <p>Findings: NSH has yet to implement this recommendation. The facility has plans to provide training to clinicians on Motivational Interviewing by December 31, 2007.</p> <p>Recommendation 4, February 2007: Develop and implement monitoring tools to assess compliance with this item.</p> <p>Findings: NSH has yet to implement this recommendation. Monitoring tools will be developed when the new MAPP Module is available.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Finalize process to provide Key Indicator data regarding individuals' non-adherence to interventions in the WRP. 2. Ensure that certified NRT therapists provide individual therapy to individuals who trigger non-adherence to WRP in the Key Indicator. 3. Assess barriers to individuals' participation in their WRPs and provide strategies to individuals to facilitate participation. 4. Develop and implement monitoring tools to assess compliance with this item.
--	--	--

Section D: Integrated Assessments

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. Despite significant physician shortages, the facility has, in general, maintained its practice of timely implementation of the admission medical and psychiatric assessments. 2. NSH has continued the process of internal monitoring of psychiatric assessments/reassessments and has reached or approached the required sample sizes in some of these instruments. 3. NSH provided an assessment of some areas of low compliance in sections D.1 (psychiatric assessments) and D.7 (court assessments). 4. NSH has revised its Medical Staff Manual to incorporate requirements of the EP.

Section D: Integrated Assessments

D.1	Psychiatric Assessments and Diagnoses	
	<p>Each State hospital shall provide all of the individuals it serves with routine and emergency psychiatric assessments and reassessments consistent with generally accepted professional standards of care; and,</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Jeffrey Zwerin, DO, Medical Director 2. David Thomas, MD Assistant Medical Director 3. Howard Eisenstark, MD, Assistant Medical Director 4. George Splane, MD, Staff Psychiatrist 5. Scott Sutherland, DO, Staff Psychiatrist <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Charts of 35 individuals (JAR, JB, RJH, PA, WQ, CDD, JMS, JY, KNZ, DR, NA, RAH, LTH, EER, ERC, TA, JTF, JP, JA, PH, WGS, CR, SVC, JMA, TE, LRJ, DKB, CTS, JR, MSB, LRJ, SAR, RDV, TAQ and BVP) 2. Initial Admission Assessment Monitoring Form 3. Initial Admission Monitoring summary data (January to May 2007) 4. Seven-Day Integrated Psychiatric Assessment Monitoring Form 5. Seven-Day Integrated Psychiatric Assessment summary data (January to June 2007) 6. Draft Medical Staff Manual 7. DSM-IV Diagnosis Monitoring Form 8. DSM-Diagnosis Monitoring summary data (January to June 2007) 9. Monthly Physician's Progress Notes Monitoring form 10. Monthly Physician's Progress Notes Monitoring summary data (January to June 2007) 11. Psychology Monitoring Form 12. Psychology Monitoring summary data (January to June 2007) 13. NSH Tracking Log regarding Refusals/Deferrals of Physical Examinations (within 24 hours of admission)
D.1.a	<p>Each State hospital shall use the diagnostic criteria in the most current Diagnostics and</p>	<p>Current findings on previous recommendations:</p>

Section D: Integrated Assessments

	<p>Statistical Manual of Mental Disorders ("DSM") for reaching the most accurate psychiatric diagnoses.</p>	<p>Recommendation 1, February 2007: Ensure that the Psychiatric Evaluation Monitoring Form clearly addresses the accuracy of diagnosis.</p> <p>Recommendation 2, February 2007: Ensure that Monthly Progress Notes Monitoring (Psychiatry) Form adequately addresses the finalization of deferred, rule- out and/or NOS diagnoses.</p> <p>Findings: NSH did not present data regarding this recommendation. However, reviews by this monitor showed that at this time, the facility addresses the accuracy of diagnoses in all three psychiatry assessment monitors in addition to a separate monitoring instrument titled DSH-IV Diagnosis. The following is an outline of relevant indicators in each tool. These indicators are appropriate to this requirement of the EP. However, the tool regarding DSM-IV Diagnosis duplicates items from other tools unnecessarily and these tools have yet to be accompanied by complete instructions and to be streamlined and standardized for statewide use.</p> <table border="1" data-bbox="884 894 1871 1343"> <thead> <tr> <th data-bbox="884 894 1377 935">Monitoring instrument</th> <th data-bbox="1377 894 1871 935">Indicators related to diagnosis</th> </tr> </thead> <tbody> <tr> <td data-bbox="884 935 1377 1081">Initial Admission Assessment Monitoring Form</td> <td data-bbox="1377 935 1871 1081"><i>Admission diagnosis-Axis I-V addressed/ DSM diagnosis consistent with history and presentation.</i></td> </tr> <tr> <td data-bbox="884 1081 1377 1343" rowspan="2">Seven-day Integrated Psychiatric Assessment Monitoring Form (Psychiatric Evaluation Monitoring Form)</td> <td data-bbox="1377 1081 1871 1162"><i>Are all five Axes addressed from DSM-IV (TR)?</i></td> </tr> <tr> <td data-bbox="1377 1162 1871 1343"><i>Are the diagnostic criteria included for the given diagnosis?</i> <i>Does diagnostic formulation address findings which may support other diagnosis?</i></td> </tr> </tbody> </table>	Monitoring instrument	Indicators related to diagnosis	Initial Admission Assessment Monitoring Form	<i>Admission diagnosis-Axis I-V addressed/ DSM diagnosis consistent with history and presentation.</i>	Seven-day Integrated Psychiatric Assessment Monitoring Form (Psychiatric Evaluation Monitoring Form)	<i>Are all five Axes addressed from DSM-IV (TR)?</i>	<i>Are the diagnostic criteria included for the given diagnosis?</i> <i>Does diagnostic formulation address findings which may support other diagnosis?</i>
Monitoring instrument	Indicators related to diagnosis								
Initial Admission Assessment Monitoring Form	<i>Admission diagnosis-Axis I-V addressed/ DSM diagnosis consistent with history and presentation.</i>								
Seven-day Integrated Psychiatric Assessment Monitoring Form (Psychiatric Evaluation Monitoring Form)	<i>Are all five Axes addressed from DSM-IV (TR)?</i>								
	<i>Are the diagnostic criteria included for the given diagnosis?</i> <i>Does diagnostic formulation address findings which may support other diagnosis?</i>								

Section D: Integrated Assessments

			<i>Is there a differential diagnosis?</i>
			<i>Is there a current psychiatric diagnosis?</i>
	Monthly Progress Notes Monitoring (Psychiatry)	<i>Is current diagnosis clinically justified?</i>	
		<i>If not clinically justifiable, is there indication it will be changed or eliminated in the monthly or PPN notes (section)?</i>	
		<i>Is the justification for the diagnosis based on DSM IV or DSM IV checklist?</i>	
		<i>Is there a deferred/rule out/ or NOS diagnosis present?</i>	
		<i>If answer to above question is yes, are they addressed in the monthly progress notes with plan for resolution or confirmation (i.e. get a consult/ order more psych testing etc?)</i>	
		<i>A diagnosis of "no diagnosis" is clinically justified and documented (review last two monthly progress notes and annual psychiatric evaluation and last 90 day conference).</i>	
	DSM-IV Diagnosis	<i>Are current diagnoses clinically justified?</i>	
		<i>Are all diagnoses that cannot be clinically justified for an individual discontinued no later than 60 days</i>	

Section D: Integrated Assessments

		<table border="1"> <tr> <td data-bbox="877 186 1381 228"></td> <td data-bbox="1381 186 1869 228"><i>after admission?</i></td> </tr> <tr> <td data-bbox="877 228 1381 380"></td> <td data-bbox="1381 228 1869 380"><i>The documented justification of the diagnosis is in accord with the criteria contained in the most current DSM-IV-TR?</i></td> </tr> <tr> <td data-bbox="877 380 1381 639"></td> <td data-bbox="1381 380 1869 639"><i>If there differential diagnoses such as "deferred", "rule out" or "NOS", they are timely addressed within 60 days after admission, through clinically appropriate assessments and resolved in a clinically justifiable manner</i></td> </tr> <tr> <td data-bbox="877 639 1381 716"></td> <td data-bbox="1381 639 1869 716"><i>If "no diagnosis" is present, is it clinically justified and documented?</i></td> </tr> </table>		<i>after admission?</i>		<i>The documented justification of the diagnosis is in accord with the criteria contained in the most current DSM-IV-TR?</i>		<i>If there differential diagnoses such as "deferred", "rule out" or "NOS", they are timely addressed within 60 days after admission, through clinically appropriate assessments and resolved in a clinically justifiable manner</i>		<i>If "no diagnosis" is present, is it clinically justified and documented?</i>	
	<i>after admission?</i>										
	<i>The documented justification of the diagnosis is in accord with the criteria contained in the most current DSM-IV-TR?</i>										
	<i>If there differential diagnoses such as "deferred", "rule out" or "NOS", they are timely addressed within 60 days after admission, through clinically appropriate assessments and resolved in a clinically justifiable manner</i>										
	<i>If "no diagnosis" is present, is it clinically justified and documented?</i>										
		<p>Recommendation 3, February 2007: Continue to monitor this requirement and ensure sample sizes of 20% of the target populations.</p> <p>Findings: NSH presented data based on Initial Admission Assessment Monitoring Form (January to May 2007, an average sample size of 18% of all monthly admission assessments) and the DSM-IV Diagnosis Monitoring Form (January to June 2007, average sample size of 2% of all individuals). Data from the latter tool were based on a review of the WRPs. The following is a summary of the data, including the monitoring instrument, indicators used and corresponding mean compliance rates. The facility did not provide an analysis of the discrepant findings between items #1 and 3 on the DSM-IV Diagnosis Monitoring Form.</p> <p>Initial Admission Assessment: <i>Admission diagnoses-Axis I-V are addressed/DSM diagnoses are consistent with history and diagnoses : 89%.</i></p>									

		<p>DSM-IV Diagnosis:</p> <ol style="list-style-type: none"> 1. <i>Are current diagnoses clinically justifiable?</i> : 92%. 2. <i>The documented justification of the diagnoses is in accord with the criteria contained in the most current DSM -IV-TR:</i> 87%. 3. <i>Are all diagnoses that cannot be justified for an individual discontinued no later than 60 days after admission?</i> : 0% (data completed for April to June 2007). 4. <i>If there are differential diagnoses such as "deferred", "rule-out" or "NOS" they are timely addressed within 60 days after admission, through clinically appropriate assessments, and resolved in a clinically justifiable manner:</i> 19%. 5. <i>If 'no diagnosis' is present, is it clinically justified and documented?</i> : 82%. <p>Recommendation 4, February 2007: Standardize the names of the monitoring instruments statewide and ensure that the facilities' progress reports use these names consistently.</p> <p>Findings: This recommendation has yet to be implemented.</p> <p>Recommendation 5, February 2007: Address and correct factors related to low compliance.</p> <p>Findings: The facility cites staffing shortage as the main barrier to implementation. As mentioned earlier, efforts are underway to recruit senior psychiatrists to participate in the monitoring and mentoring needed for improve compliance with the EP.</p> <p>Other findings: Chart reviews by this monitor indicate that by and large, psychiatric diagnoses are listed for Axes I-V and stated in terminology that is consistent with the</p>
--	--	--

Section D: Integrated Assessments

		<p>current version of DSM. However, the deficiencies in the admission and integrated psychiatric assessments (see D.1.c.i through D.1.c.iii) must be corrected to achieve substantial compliance.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Continue to monitor this requirement and ensure sample sizes of 20% of the target populations. 2. Ensure that all psychiatry monitoring instruments are accompanied by instructions and streamlined/standardized for statewide use. 3. Expedite efforts to recruit senior psychiatrists to address and correct all deficiencies outlined by this monitor and ensure compliance with all requirements of the EP.
D.1.b	Each State hospital shall ensure that all psychiatrists responsible for performing or reviewing psychiatric assessments:	Please see sub-cells for compliance findings.
D.1.b.i	are certified by the American Board of Psychiatry and Neurology ("ABPN") or have successfully completed at least three years of psychiatry residency training in an Accreditation Counsel for Graduate Medical Education accreditation program, and	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Address and correct factors regarding psychiatry staff shortage, including the pay differential versus other State institutions.</p> <p>Findings: Since January 1, 2007, eight psychiatrists have left employment at NSH. In recent months, the facility has gained eight psychiatrists (seven of whom were hired last week on contracts and are currently in the orientation phase). The Medical Director reports that the facility has recently received relatively large number of applications following the announcement regarding improved pay differential versus other state institutions. As a result, the facility anticipates</p>

Section D: Integrated Assessments

		<p>recruitment of eight or nine additional psychiatrists by August 31, 2007. At this time, the facility has 44.3 FTE staff psychiatrists, no senior psychiatrists, a Medical Director and two Assistant Medical Directors. This represents decreased staffing levels since the last report. At present, all psychiatrists at the facility have completed at least three years of residency training approved by the AGGME Residency Review Committee (or osteopathic equivalent). Due to increased psychiatry vacancies, the current psychiatrist to individual ratios fall sort of requirements of the EP in all admission and long-term units (see C.1.i).</p> <p>Recommendation 2, February 2007: Consider the hiring of mental health nurse practitioners to support current psychiatry staff.</p> <p>Findings: The facility has maintained current staffing of two NPs and has hired four additional nurse practitioners, who have yet to start employment.</p> <p>Compliance: Full.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue current practice. 2. Expedite recruitment of staff and senior psychiatrists to ensure compliance with other requirements of the EP regarding staffing levels.
D.1.b.ii	<p>Are verifiably competent (as defined by privileging at initial appointment and thereafter by repriviliging for continued appointment) in performing psychiatric assessments consistent with each State Hospital's standard diagnostic protocols.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Ensure that the repriviliging process incorporates a quality profile that includes competency in the diagnosis, assessment and reassessment of individuals.</p>

Section D: Integrated Assessments

		<p>Findings: NSH has yet to implement this recommendation.</p> <p>Recommendation 2, February 2007: Ensure that the medical staff manual includes the facility's expectations regarding competency in diagnosis, assessments and reassessments.</p> <p>Findings: The current revision of the Medical Staff Manual (II, D; page 4) incorporates this requirement (but see f. below).</p> <p>Other findings: The facility must correct deficiencies outlined in all sections of D.1. regarding psychiatric diagnosis and assessments in order to achieve substantial compliance with this requirement.</p> <p>Compliance: Partial.</p> <p>Current recommendations: Develop and implement a Quality Profile for staff psychiatrists to include competency in the diagnosis, assessment and reassessment of individuals, and ensure that the reprivileging process incorporates internal monitoring data derived from this process. The facility may share results of the work completed at MSH in this regard.</p>
D.1.c	Each State hospital shall ensure that:	<p>Compliance: Please see sub-cells for compliance findings.</p>
D.1.c.i	Within 24 hours of an individual's admission to each State hospital, the	<p>Current findings on previous recommendations:</p>

Section D: Integrated Assessments

	<p>individual receives an Admission Medical Assessment that includes:</p>	<p>Recommendation 1, February 2007: Continue to monitor completeness of the admission medical examination within the specified time frame.</p> <p>e</p> <p>Findings: NSH used the Initial Admission Assessment Monitoring Form to assess compliance with the requirements in this section (January to June 2007). Reviewing an average sample size of 36% (of all admissions per month), the facility reported a mean compliance rate of 80% with this requirement. The Medical Director has identified a systems flaw that accounted for majority of history and physician examinations that were not completed within the required 24 hours; corrective action is underway. The facility's data regarding the requirements in D.1.c.i.1 to D.1.c.i.5 are listed for each corresponding sub-cell. For requirements D.1.c.i.1 to D.1.c.4, monitoring was conducted between January and May 2007 based on an average sample size of 24%. For the requirement in D.1.c.i.4, monitoring was conducted in January, February and May 2007 and the average sample size was 15%. This audit was revised in March 2007 to ensure that the total target population (N) represents only those individuals admitted with acute medical conditions.</p> <p>Recommendation 2, February 2007: Monitor the rationale for deferral of items on the examination and follow up regarding the deferral/refusal of the examination.</p> <p>Findings: NSH has yet to implement this recommendation. The Medical Director has reportedly reviewed copies of admission history and examinations for all admissions in June 2007 to assess and track reasons for deferrals/refusals. However, the facility did not present data regarding outcome of this review.</p> <p>Recommendation 3, February 2007: Ensure monitoring of a 20% sample of the target population.</p>
--	---	--

Section D: Integrated Assessments

		<p>Findings: The facility has implemented this recommendation for this requirement of the EP.</p> <p>Other findings: This monitor reviewed the charts of 13 individuals (RAH, LTH, EER, ERC, TA, JTF, JP, JA, PH, WGS, CR, SVC, and MSB) who have been admitted during this review period. The review generally corroborates the facility's compliance data regarding requirements D.1.ci.1 thorough D.1.c.i.v. However, this monitor found lower compliance regarding the completeness of the examination. The following are examples:</p> <ol style="list-style-type: none"> 1. No documentation of follow-up regarding deferral of genital/rectal examinations (JA). 2. Inadequate documentation of follow-up regarding the individual's refusal of the examination, (TA, JTF and SVC). 3. Incomplete documentation of the neurological examination (JA, JTF and CR). <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to monitor completeness of the admission medical examination within the specified time frame, based on at least 20% sample. This monitoring must address follow-up regarding incomplete items on the examination. 2. Monitor the rationale for deferral of items on the examination and follow up regarding the deferral/refusal of the examination.
D.1.c.i.1	a review of systems;	90%
D.1.c.i.	medical history;	89%

Section D: Integrated Assessments

2		
D.1.c.i. 3	physical examination;	72%
D.1.c.i. 4	diagnostic impressions; and	81%
D.1.c.i. 5	management of acute medical conditions	79%
D.1.c.ii	within 24 hours of an individual's admission to each State hospital, the individual receives an Admission Psychiatric Assessment that includes:	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Ensure that the mental examinations are completed on all admission psychiatric assessments. An adequate narrative must be entered whenever indicated to complete the section titled "elaborate on positive mental status examination."</p> <p>Findings: NSH used the Initial Admission Assessment Monitoring Form to assess compliance with this requirement. The data regarding this recommendation are presented below. The mental status examination was considered complete if it addressed all of the following items: attitude and cooperation; general appearance; motor activity; speech; mood-affect; thought process-content; perceptual alterations; fund of general knowledge; abstraction ability; judgment; insight; mini-mental status exam; and individual's strengths/assets. The most common omissions were the sections regarding the mini-mental status exam and strengths/assets. The data in January and February were gathered by different reviewers, which may have compromised inter-rater reliabilities (this applies to all internal monitoring for D.1.c.ii).</p> <p>Recommendation 2, February 2007: Ensure documentation of a provisional plan of care upon the completion of the initial psychiatric examination.</p>

Section D: Integrated Assessments

		<p>Findings: The facility presented data based on the Initial Admission Assessment Monitoring Form based on a review of an average sample size of 24% (January to May 2007). The data showed a mean compliance rate of 64% based on a review of the admission WRPs. The facility recognized that the significant difference in compliance between monitoring done in January and February (mean compliance of 15%) and that performed in March to May (mean compliance of 96%) was unexplained. At any rate, this monitor reviewed 13 randomly selected charts and found no documentation of a provisional plan of care in the admission psychiatric assessments (see other findings below).</p> <p>Recommendation 3, February 2007: Update the medical staff manual to include the requirements regarding D.1.c.ii.1 through D.1.c.ii.6.</p> <p>Findings: NSH has implemented this recommendation. The updated Medical Staff Manual incorporates these requirements. (III. B2, Page 9)</p> <p>Recommendation 4, February 2007: Ensure that monitoring of the admission psychiatric examination addresses completeness of the examination and that overall compliance rate accounts for the completeness of each item.</p> <p>Findings: DMH efforts are underway to standardize the Initial Admission Monitoring Form across all facilities and ensure implementation of this recommendation.</p> <p>NSH used the current Initial Admission Assessment Monitoring Form to assess compliance with the requirements in D.1.c.ii.1 to D.1.c.ii.6. The facility reviewed an average sample size of 24% (January to May 2007) for the requirements in D.1.c.ii.1 through D.1.c.ii.5 and a sample size of 22% (January, February, April and</p>
--	--	--

Section D: Integrated Assessments

		<p>May 2007) for D.1.c.ii.6. The mean compliance rates are listed for each corresponding requirement below. The facility's data indicated that some of the initial evaluations are hand-written in a hurry, a reflection of the high caseloads psychiatrists are carrying. The facility's reviews also cited a frequent omission regarding information from the sending facility, usually a jail, for individuals admitted under PC 1370. The facility anticipates corrective actions upon recruitment of supervising psychiatrists.</p> <p>Recommendation 5, February 2007: Ensure that monitoring of the item regarding consultations accounts for the intent of monitoring, i.e. compliance rate in only those cases where the reviewer felt that consultations were indicated.</p> <p>Findings: NSH has implemented this recommendation. The monitoring instrument now includes a "N/A" response on this item.</p> <p>Recommendation 6, February 2007: Ensure monitoring of a 20% sample of the target population.</p> <p>Findings: NSH has monitoring data based on an average sample size of 24%, but the monthly data indicate that the sample size was occasionally less than 20%.</p> <p>Other findings: This monitor reviewed 13 charts of individuals (RAH, LTH, EER, ERC, TA, JTF, JP, JA, PH, WGS, CR, SVC, and MSB) who were admitted during this interval. These reviews demonstrated a much lower compliance rate regarding completeness of the mental status examination than that reported by the facility. The main deficiency continues to be lack of needed narrative to elaborate on positive mental status findings. This includes recent history of aggression/self-abuse (JA and TA), suicide attempts (TA) or thoughts of harm to others (JTF), and current</p>
--	--	--

Section D: Integrated Assessments

		<p>delusional thinking (JTF, CR, EER and JA). In addition, there was evidence of generic assessment of insight and judgment in almost all the charts reviewed. The reviews also demonstrated that the facility did not make any progress in addressing the lack of documentation regarding a plan of care in all the assessments reviewed.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that the mental examinations are completed on all admission psychiatric assessments. An adequate narrative must be entered whenever indicated to complete the section titled "elaborate on positive mental status examination." 2. Ensure documentation of a provisional plan of care as part of the initial psychiatric examination. 3. Ensure monitoring of at least a 20% sample of the target population. 4. Identify and implement corrective actions to address the deficiencies outlined by this monitor above.
D.1.c.ii. 1	psychiatric history, including a review of presenting symptoms;	48% (the item was considered complete if it addressed all of the following sub-items: <i>reason for admission/chief complaint; pertinent history leading to admission; pertinent past history; significant substance abuse, allergies-food and medications and physician orders written</i>).
D.1.c.ii. 2	complete mental status examination;	51% (the mental status examination was considered complete if it addressed all of the following sub-items: <i>attitude and cooperation; general appearance; motor activity; speech; mood-affect; thought process-content; perceptual alterations; fund of general knowledge; abstraction ability; judgment; insight; mini-mental status exam. and individual's strengths-assets</i>).
D.1.c.ii.	admission diagnoses;	86%

Section D: Integrated Assessments

3		
D.1.c.ii. 4	completed AIMS;	88%
D.1.c.ii. 5	laboratory tests ordered; and	92%
D.1.c.ii. 6	consultations ordered.	84% (depending on the rater's judgment as to when an immediate consultation was needed).
D.1.c.iii	within 7 days (60/72 hrs) of an individual's admission to each State hospital, the individual receives an Integrated Psychiatric Assessment that includes:	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: 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 seven days of admission.</p> <p>Findings: NSH has yet to implement this recommendation.</p> <p>Recommendation 2, February 2007: Update the medical staff manual to include the requirements regarding D.1.c.iii.1 through D.1.c.iii.10.</p> <p>Findings: The revised Medical Staff Manual (IV A., page 14) incorporates this recommendation.</p> <p>Recommendation 3, February 2007: Ensure that monitoring of the integrated psychiatric examination addresses completeness of the examination and that overall compliance rate accounts for the completeness of each item.</p>

Section D: Integrated Assessments

		<p>Findings: DMH efforts are underway to standardize the Seven-Day Integrated Assessment Monitoring Form across all facilities and ensure implementation of this recommendation.</p> <p>NSH used the current Seven-Day Integrated Assessment Form to assess compliance with the requirements in D.1.c.iii.1 through D.1.c.iii.10. The facility reviewed an average sample size of 22% (January to May 2007) and reported mean compliance rates that are listed for each corresponding requirement below.</p> <p>NSH provided analysis of the low compliance rates that were obtained in some of these requirements. The facility judged that the low compliance rate reported in D.1.c.iii.1 was influenced by the frequent lack of information from the referring facility, usually a jail, in the case of admissions under PC 1370. The data regarding completeness of the mental status examination (D.1.c.iii.2) showed that the most frequently missed item was the Mini-Mental Status Examination. The low compliance regarding completion of the risk assessment (D.1.c.iii.5) was thought to be a result of lack of instructions regarding assessment of relevant demographic factors. The lack of sufficient time due to staffing shortages combined with lack of supervision and feedback were thought to be responsible for the low compliance with the requirements regarding diagnostic formulation (D.1.c.iii.6) and psychopharmacology treatment plans (D.1.c.iii.9). The facility did not identify corrective actions other than recruitment of needed staff.</p> <p>Recommendation 4, February 2007: Ensure that monitoring of the integrated assessment addresses the practice of conducting the assessments so early that the purpose is defeated.</p> <p>Findings: Same as in recommendation #1 above.</p>
--	--	---

		<p>Recommendation 5, February 2007: Ensure monitoring of a 20% sample of the target population.</p> <p>Findings: NSH has monitoring data based on an average sample size of 22%, but the monthly data indicate that the sample size was occasionally less than 20%.</p> <p>Other findings: In reviewing 13 charts (RAH, LTH, EER, ERC, TA, JTF, JP, JA, PH, WGS, CR, SVC, and MSB), this monitor found low compliance due to a pattern of deficiencies as shown in the following examples:</p> <ol style="list-style-type: none"> 1. The integrated assessment was not completed (ERC, TA, JP, PH, WGS and JA). 2. The integrated assessment was not timely (JTF) 3. Important components were missing, including: <ol style="list-style-type: none"> a. Risk assessment (RAH); b. Diagnostic formulation (RAH, EER, LTH); c. Differential diagnosis (LTH and EER); and d. Strengths (RAH, EER,) 4. The mental status examinations were incomplete due to missing items, including: <ol style="list-style-type: none"> a. General appearance (LTH); b. Nature of auditory hallucinations (CR); c. Nature of delusional thinking (JTF) d. Specifics regarding cognitive examination (CR); and e. Specifics regarding impaired judgment and insight (LTH, EER and SVC). 5. The psychopharmacology plans were generic and inadequate (RAH, MSB and EER). <p>These deficiencies must be corrected to achieve substantial compliance.</p>
--	--	--

Section D: Integrated Assessments

		<p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure completeness of the integrated assessment within the specified timeframe. Ensure that monitoring of the integrated assessment addresses the practice of conducting the assessments so early that the purpose is defeated. The assessment must integrate information that cannot be obtained at the time of admission but becomes available during the first seven days of admission. 2. Ensure that monitoring of the integrated psychiatric examination addresses completeness of the examination and that overall compliance rate accounts for the completeness of each item. 3. Ensure monitoring of a 20% sample of the target population. 4. Identify and implement corrective actions to address low compliance.
D.1.c.iii .1	psychiatric history, including a review of present and past history;	21% (the item was considered complete if it addressed all of the following sub-items: <i>review of present and past history; review of present illness/reason for admission and chief complaints; included statements from the individual; included pertinent positive and negative findings (related to differential diagnosis); included the diagnosis and medications given at previous facilities and included the effectiveness of the medication given at previous facility).</i>
D.1.c.iii .2	psychosocial history;	89%
D.1.c.iii .3	mental status examination;	59% (the mental status examination was considered complete if it addressed all of the following sub-items: <i>Attitude and cooperation, General appearance, Motor activity, Speech, Mood - affect, Thought process - content, Perceptual alterations, Fund of general knowledge, Abstraction ability, Judgment, Insight and Mini-Mental Status Examination).</i>

Section D: Integrated Assessments

D.1.c.iii .4	strengths;	78%
D.1.c.iii .5	psychiatric risk factors;	26%
D.1.c.iii .6	diagnostic formulation;	60%
D.1.c.iii .7	differential diagnosis;	46%
D.1.c.iii .8	current psychiatric diagnoses;	92%
D.1.c.iii .9	psychopharmacology treatment plan; and	42%
D.1.c.iii .10	management of identified risks.	80%
D.1.d	Each State hospital shall ensure that:	Please see sub-cells for compliance findings.
D.1.d.i	Clinically justifiable diagnoses are provided for each individual, and all diagnoses that cannot be clinically justified for an individual are discontinued no later than the next review;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Provide continuing medical education to psychiatry staff to improve competency in the area of assessment of cognitive and other neuropsychiatric disorders.</p> <p>Findings: NSH has yet to implement this recommendation.</p> <p>Recommendation 2, February 2007: Same as in D.1.a.</p> <p>Findings: Same as in D.1.a.</p>

Section D: Integrated Assessments

		<p>Other findings: This monitor reviewed the charts of ten individuals with current diagnoses that were listed as rule out (R/O) or not otherwise specified (NOS) for more than three months. The reviews showed a pattern of inadequate documentation, evaluation and updates in the WRPs of these disorders. The following table outlines the charts reviewed and the current diagnoses:</p> <table border="1" data-bbox="884 485 1866 1019"> <thead> <tr> <th>Initials</th> <th>Diagnosis</th> </tr> </thead> <tbody> <tr> <td>JAR</td> <td>Psychosis, NOS</td> </tr> <tr> <td>CDD</td> <td>Psychotic Disorder, NOS</td> </tr> <tr> <td>CTS</td> <td>Psychotic Disorder, NOS and Mental Disorder, NOS due to unspecified Brain Damage</td> </tr> <tr> <td>DKB</td> <td>Mental Disorder, NOS due to Head Injury</td> </tr> <tr> <td>RJH</td> <td>Mood Disorder, NOS</td> </tr> <tr> <td>PA</td> <td>Depressive disorder, NOS, Anxiety disorder NOS, R/O Post-Traumatic Stress Disorder and R/O Psychotic disorder NOS.</td> </tr> <tr> <td>WQ</td> <td>Dementia NOS.</td> </tr> <tr> <td>TE</td> <td>Dementia NOS</td> </tr> <tr> <td>LRJ</td> <td>Dementia NOS (and Mild Mental Retardation).</td> </tr> <tr> <td>JMA</td> <td>Impulse Control Disorder, NOS</td> </tr> </tbody> </table> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Same as in D.1.a. 2. Provide continuing medical education to psychiatry staff to improve competency in the area of assessment of cognitive and other neuropsychiatric disorders. 	Initials	Diagnosis	JAR	Psychosis, NOS	CDD	Psychotic Disorder, NOS	CTS	Psychotic Disorder, NOS and Mental Disorder, NOS due to unspecified Brain Damage	DKB	Mental Disorder, NOS due to Head Injury	RJH	Mood Disorder, NOS	PA	Depressive disorder, NOS, Anxiety disorder NOS, R/O Post-Traumatic Stress Disorder and R/O Psychotic disorder NOS.	WQ	Dementia NOS.	TE	Dementia NOS	LRJ	Dementia NOS (and Mild Mental Retardation).	JMA	Impulse Control Disorder, NOS
Initials	Diagnosis																							
JAR	Psychosis, NOS																							
CDD	Psychotic Disorder, NOS																							
CTS	Psychotic Disorder, NOS and Mental Disorder, NOS due to unspecified Brain Damage																							
DKB	Mental Disorder, NOS due to Head Injury																							
RJH	Mood Disorder, NOS																							
PA	Depressive disorder, NOS, Anxiety disorder NOS, R/O Post-Traumatic Stress Disorder and R/O Psychotic disorder NOS.																							
WQ	Dementia NOS.																							
TE	Dementia NOS																							
LRJ	Dementia NOS (and Mild Mental Retardation).																							
JMA	Impulse Control Disorder, NOS																							

Section D: Integrated Assessments

D.1.d.ii	<p>The documented justification of the diagnoses is in accord with the criteria contained in the most current DSM (as per DSM-IV-TR Checklist);</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Same as in recommendations 1, 2 and 3 in D.1.a.</p> <p>Findings: Same as in D.1.a and D.1.d.i.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Same as in D.1.d.i.</p>
D.1.d.iii	<p>Differential diagnoses, "deferred," or "rule-out" diagnoses, and diagnoses listed as "NOS" ("Not Otherwise Specified") are timely addressed (i.e., within 60 days), through clinically appropriate assessments, and resolved in a clinically justifiable manner; and</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Same as above.</p> <p>Findings: Same as above.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Same as above.</p>
D.1.d.iv	<p>"no diagnosis" is clinically justified and documented.</p>	<p>Current findings on previous recommendations:</p>

Section D: Integrated Assessments

		<p>Recommendation, February 2007: Continue current practice.</p> <p>Findings: The facility has continued its current practice. The facility has monitoring data that are reviewed in D.1.a.</p> <p>Other findings: Chart reviews by this monitor did not show any Axis I diagnosis listed as "no diagnosis."</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
D.1.e	<p>Each State hospital shall ensure that psychiatric reassessments are conducted at a frequency that reflects the individual's clinical needs. At a minimum the reassessments are completed weekly for the first 60 days on the admissions units and monthly on other units.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Assess and correct factors related to non-compliance with the requirement for weekly progress notes on the admission teams.</p> <p>Findings: The facility used the Monthly Physicians Progress Notes Monitoring Form to assess its compliance with the requirement regarding weekly progress notes during the first 60 days and monthly thereafter. Reviewing a sample size of 2% of all individuals, the facility reported mean compliance rate of 41%. However, the data do not delineate the requirements regarding weekly and monthly documentation of psychiatric reassessments. The facility reported that the increased caseloads due to staffing shortages have resulted in sporadic compliance by the psychiatrists with the requirements for weekly and monthly</p>

Section D: Integrated Assessments

		<p>documentation. Current recruitment efforts are anticipated to resolve this issue.</p> <p>Other findings: This monitor reviewed the charts of five individuals (PH, WGS, CR, SVC and MSB) on the admissions unit to assess frequency of documentation during the first 60 days. The review showed non-compliance in three charts (PH, WGS and MSB); partial compliance in one (CR) and compliance in one (SVC).</p> <p>This monitor also reviewed the charts of six individuals (RDV, TAQ, BVP, LRJ, AT and SAR) to assess compliance with the required monthly progress documentation. The review showed compliance in three charts (RDV, TAQ and BVP) and non-compliance in the charts of SAR (no progress note since June 2006), AT (no progress note since December 2006) and LRJ (no progress note since March 15, 2007).</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Assess and correct factors related to non-compliance with this requirement of the EP. 2. Provide monitoring data that delineate the frequency of progress notes during the first 60 days and the frequency of documentation thereafter.
D.1.f	<p>Each State hospital shall ensure that psychiatric reassessments are documented in progress notes that address the following:</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Develop and implement a standardized format for psychiatric reassessments that addresses and corrects the deficiencies identified above.</p> <p>Findings: The facility has developed a template for documentation of psychiatric</p>

Section D: Integrated Assessments

		<p>reassessments that aligns with requirements of the EP. This template has yet to be implemented. Using the Monthly Physicians Progress Notes monitoring tool (January to June 2007), NSH reviewed an average sample size of 1% of all individuals and reported compliance rates for each of the requirements in this section (D.1.f.i through D.1.f.vii). The mean compliance rates are listed for each corresponding requirement below.</p> <p>NSH reported that the medical staff needs training and feedback regarding the requirement for documentation of an analysis of risks and benefits of chosen treatment interventions (D.1.f.iii). The facility found that most psychiatry progress notes did not review the number of medications used as PRN or their effects (D.1.f.vi). The data regarding integration of psychiatric and behavioral treatments (D.1.f.vii) were reportedly based on a misunderstanding of this requirement by the one or more raters. The facility did not identify corrective actions other than the anticipated recruitment of supervising psychiatrists.</p> <p>Recommendation 2, February 2007: When the individuals receive both pharmacological and behavioral interventions, the reassessments need to address the following specific items:</p> <ul style="list-style-type: none">• Review of behavioral plans prior to implementation as documented in progress notes and/or behavioral plan;• Review of individual's progress in behavioral treatment;• Differentiation, as clinically appropriate, of learned behaviors from behaviors that are targeted for pharmacological treatment; and• Modification, as clinically appropriate, of diagnosis and/or pharmacological treatment based on above reviews/assessments. <p>Findings: In addition to the process of Monthly Physician's Progress Notes Monitoring that was described above, NSH used the Psychology Monitoring Form to assess compliance with this requirement of the EP and the monitor's recommendation.</p>
--	--	---

Section D: Integrated Assessments

		<p>The data were based on a review of all individuals (average N=15) receiving positive behavior support plans (January to June 2007). The facility reported mean compliance rate of 55% with an indicator that specifies that <i>positive behavior support teams and team psychologist integrate their therapies with other treatment modalities, including drug therapy</i>. The data listed below for the corresponding requirement of the EP (D.1.f.vii) are derived from the Monthly Physician's Progress Notes Monitoring Form.</p> <p>Recommendation 3, February 2007: Update the medical staff manual to specify requirements regarding documentation of psychiatric reassessments.</p> <p>Findings: The facility recognized that the revised manual still includes some omissions that need to be addressed in order to improve alignment with requirements of the EP.</p> <p>Recommendation 4, February 2007: Ensure that monitoring instruments are aligned with the above expectations.</p> <p>Findings: NSH facility has developed a tool that aligns with requirements of the EP. However, the facility has yet to develop operational instructions to ensure that all current indicators address all of the requirements of the EP. Efforts are still underway to streamline and standardize all psychiatry monitoring tools for statewide use.</p> <p>Other findings: Chart reviews by this monitor showed that NSH has yet to implement the newly developed template regarding documentation of psychiatric reassessments. The psychiatric reassessments, by and large, still showed all of the deficiencies that were described by this monitor in the baseline assessment and in the last progress report. The monitor's findings corroborated the facility's compliance</p>
--	--	--

Section D: Integrated Assessments

		<p>rates in sections D.1.f.iii through D.1.f.vi and showed much lower compliance rates that those reported by the facility in other requirements in this section.</p> <p>In one chart (JR), a psychiatry monthly progress note included a section named "Medication Monitoring". This section was basically a rehash of the process of internal monitoring used at the facility, without any apparent relevance to the status of the individual. The section included review of the indicators regarding medications that the individual did not receive. This type of documentation does not belong in a clinical note and it represents major failure in understanding the intent of the requirements regarding clinical documentation that are embodied in the EP. In summary, the EP requires the practitioners to provide a clinically meaningful documentation to ensure a continuous review of important developments in the clinical status of the individual and the provision of appropriately tailored, safe and effective treatment that meets the individual's needs in the domains of symptom/risk reduction and psychosocial functioning. The operational requirements outlined in various provisions of the EP are intended to guide, not derail, the implementation of this main principle.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Implement a standardized format for psychiatric reassessments, including operational instructions that addresses and corrects the deficiencies identified by this monitor in the last progress report. 2. Ensure that requirements regarding the integration of pharmacologic and behavioral treatments are clearly incorporated in the current monitoring indicators and/or instructions. 3. Continue monitoring based on random sample sizes of at least 20%.
D.1.f.i	significant developments in the	65%

Section D: Integrated Assessments

	individual's clinical status and of appropriate psychiatric follow up;	
D.1.f.ii	Timely and justifiable updates of diagnosis and treatment, as clinically appropriate;	89%
D.1.f.iii	Analyses of risks and benefits of chosen treatment interventions;	17%
D.1.f.iv	Assessment of, and attention to, high-risk behaviors (e.g., assaults, self-harm, falls) including appropriate and timely monitoring of individuals and interventions to reduce risks;	85%
D.1.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;	38%
D.1.f.vi	Timely review of the use of "pro re nata" or "as-needed" ("PRN") and "Stat" (i.e., emergency psychoactive) medications and adjustment of regular treatment, as indicated, based on such use; and	19%
D.1.f.vii	Verification in a clinically justifiable manner, that psychiatric and behavioral treatments are properly integrated. The psychiatrist shall review the positive behavior support plan prior to implementation to ensure consistency	84%

Section D: Integrated Assessments

	<p>with psychiatric formulation, document evidence of regular exchange of data or information with psychologists regarding differentiation of learned behaviors and behaviors targeted for psychopharmacological treatments, and document evidence of integration of treatments.</p>	
<p>D.1.g</p>	<p>When individuals are transferred between treatment teams, a psychiatric transfer note shall be completed addressing: review of medical and psychiatric course of hospitalization, including medication trials; current target symptoms; psychiatric risk assessment; current barriers to discharge; and anticipated benefits of transfer.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Continue to monitor using current instrument.</p> <p>Findings: NSH used the Physician Inter-Unit Transfer Summary monitoring form to assess compliance. The data were based on a sample size that averaged 20% from January to June 2007. The form indicators are appropriate to this requirement. The facility found a mean compliance rate of 38%.</p> <p>Recommendation 2, February 2007: 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.</p> <p>Findings: NSH has yet to implement this recommendation.</p> <p>Other findings: This monitor reviewed the transfer assessments in the charts of five individuals who required inter-unit transfers during this review period. The following is an outline of the charts reviewed:</p>

Section D: Integrated Assessments

		Initials		Date of transfer
		JMS	In compliance	02/2/07
		JY	Partial	04/05/07
		KNZ	Partial	03/06/07
		DR	Non-compliance	04/23/07
		NA	Non-compliance	05/10/07
		<p>The reviews showed partial compliance in two charts (JY and KNZ), non-compliance in two (DR and NA) and partial compliance in one (JMS).</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to monitor using current instrument using at least 20% sample size. 2. 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. 		

Section D: Integrated Assessments

D.2	Psychological Assessments
	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Kathleen Patterson, PhD, Interim Senior Supervising Psychologist 2. Ann Hoff, PhD, Interim Senior Supervising Psychologist 3. Donna Robeson, LCSW, DCAT member 4. Saeed Elmi, PT, DCAT member 5. Cynthia Morgan, RN, DCAT member 6. Robin Rogers, OT, DCAT member 7. Barry Wagener, RN, PBS team member 8. Linda Monahan, PT, PBS team member 9. Kelley Jarrett, PT, PBS team member 10. Shirley Duran, Data Technician, PBS team member 11. Wendy Hatcher, PhD, Psychologist, PBS team member 12. Sue Silverman, PT, PBS team member 13. Coral Parrish, RB, PBS team member 14. Darrel Bailey, PT, PBS team member 15. Patricia White, PhD, Psychologist, PBS team member 16. Shoko Kokubun, Psychology Intern, PBS team member 17. Jeff Barnes, PT, PBS team member 18. Jessica Michaelson, PhD, Psychologist, PBS team member <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Charts of 74 individuals (AB, AG, AJ, AJG, AL, AM, AN, AP, AR, AS, BD, BN, CC, CG, CW, DD, DE, DK, DL, DM, DN, DP, DR, DS, DT, FP, GO, GP, GR, HW, JA, JB, JC, JD, JH, JJ, JK, JM, JP, JR, JS, JW, KP, KS, LH, LL, LM, LP, MB, MD, MH, MS, PB, PC, PF, PM, PS, RB, RC, RF, RM, RP, RR, RT, SS, TA, TL, TW, VK, VM, WA, WL, WP, and YL) 2. Psychologists' Credentials and Curriculum Vitae 3. List of Social Work Clinical Privileges

Section D: Integrated Assessments

		<ol style="list-style-type: none"> 4. Integrated Psychological Assessment Worksheet 5. DMH Psychology Monitoring Form Instructions 6. DMH Psychology Monitoring Form 7. DMH Mall Alignment Monitoring Form 8. DMH Mall Alignment Monitoring Form Instructions 9. WRP Chart Auditing Form 10. WRP Observation Monitoring Form 11. Functional Behavioral Assessments (BN, CH, AL, and MR) 12. Crisis Interventions (JB, DC, and CC) 13. Structural Assessments (CH, BN, DC, MP, AS, and RM) 14. List of Neuropsychological Assessment Referred and Completed 15. Behavior Guidelines (FC, SB, JP, JC, DG, RB, NF, ST, DR, PB, BN, LT, MW, MP, JB, JM, and DC) 16. Positive Behavior Support Plans (CC, BN, HS, AL, and CH) 17. Psychological Assessments (GP, MB, DL, RM, JB, JW, TD, GR, RP, CG, and DN) 18. List of Individuals Below 23 Years of Age 19. List of Individuals Whose Primary Language is Not English 20. List of Individuals with a 'Deferred' Diagnosis 21. List of Individuals with a 'NOS' Diagnosis 22. List of Individuals with a 'NO-Diagnosis' Diagnosis 23. List of Individuals with a 'Rule-Out' Diagnosis 24. List of Individuals Admitted Prior to January, 2006 25. Behavioral Consultation Committee Meeting Minutes (January 16, February 5, March 6, March 20, April 3, April 17, June 5, June 19, and July, 3, 2007) 26. Behavioral Consultation Committee Meeting Attendance Record 27. List of Completed DSM-IV-TR Checklists 28. ADs #850 and #853
D.2.a	Each State hospital shall develop and implement standard psychological assessment protocols, consistent with generally accepted professional standards	<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Continue current practice.</p>

Section D: Integrated Assessments

	<p>of care. These protocols shall address, at a minimum, diagnostic neuropsychological assessments, cognitive assessments, and I.Q./achievement assessments, to guide psychoeducational (e.g., instruction regarding the illness or disorder, and the purpose or objectives of treatments for the same, including medications), educational, rehabilitation, and habilitation interventions, and behavioral assessments (including functional assessment of behavior in schools and other settings), and personality assessments, to inform positive behavior support plans and psychiatric diagnoses.</p>	<p>Findings: NSH has developed standard psychological assessment protocols. NSH has also revised the DMH Psychology Manual (July 2007) which outlines the Assessment Procedures. AD #853 (effective January 18, 2007) established the criteria to be adhered to for cognitive screening.</p> <p>Compliance: Full compliance.</p> <p>Current recommendation: Continue current practice.</p>
D.2.b	<p>Each State hospital shall require the completion of cognitive and academic assessments within 30 days of admission of all school-age and other individuals, as required by law, unless comparable testing has been performed within one year of admission and is available to the interdisciplinary team.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Implement this requirement of the EP.</p> <p>Findings: NSH used item #1 (<i>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</i>) of the DMH Psychology Monitoring Form to address these recommendations. NSH audited individuals admitted prior to 1/1/07. Twenty individuals met criteria for the 30-day evaluations. Sixteen of the twenty individuals (75%) had their assessments conducted in a timely manner.</p> <p>NSH also audited all admissions since January 1, 2007, and identified 44 individuals who met criteria for the evaluations, reporting 83% timeliness.</p>

Section D: Integrated Assessments

		<p>Ninety-two percent of the remaining was untimely, and the remaining eight percent was not evaluated. [Note to reviewer: clarification of this point is pending.] In the last six months (January 1, 2006 - June 30, 2007) 20 individuals less than 23 years of age were admitted at NSH. Eighty-three percent (N=17) of them were tested in a timely manner.</p> <p>This monitor reviewed charts of eight individuals (NF, SB, AR, SD, AA, VS, JE, and VH) who met the age criteria and were eligible for the 30-day cognitive and academic assessments. Only one (SB) of the eight had the evaluation conducted within the required timeline. NF had the academic and cognitive evaluation conducted but was not within the required 30-day timeline. AR's evaluations started began within 30 days but were completed after 30 days. SD was stated as untestable due to her psychosis. For VH and JE, there is documentation in their IPAs that the evaluations were completed but the reports were not found in their charts. Evaluations for AA and VS were not conducted and no reasons or plans for completing the assessments were documented.</p> <p>Recommendation 2, February 2007: Develop and implement monitoring and tracking instruments to assess the key requirement of this step.</p> <p>Findings: NSH has yet to develop and implement tracking instruments to meet compliance with this recommendation.</p> <p>Compliance. Partial.</p> <p>Current recommendation:</p> <ol style="list-style-type: none">1. Implement this requirement of the EP.2. Develop and implement monitoring and tracking instruments to assess the key requirement of this step.
--	--	---

Section D: Integrated Assessments

D.2.c	Each State hospital shall ensure that all clinicians responsible for performing or reviewing psychological assessments and evaluations are verifiably competent in the methodology required to conduct the assessment.	<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Continue current practice.</p> <p>Findings: This monitor reviewed credentials and privileges of psychologists (N=56) at NAPA. All psychologists who are responsible for performing or reviewing psychological assessments and evaluations meet the hospital's credentialing and privileging requirements. Those who are pre-licensed (N=25) are under supervision by the senior licensed psychologists.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
D.2.d	Each State hospital shall ensure that all psychological assessments, consistent with generally accepted professional standards of care, shall:	<p>Compliance: Partial.</p>
D.2.d.i	expressly state the clinical question(s) for the assessment;	<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Continue to train psychologists on writing clearly stated referral/clinical questions.</p> <p>Findings: NSH has continued to provide training to the psychology staff on psychological assessment methods, and policies and procedures aligned with EP requirements.</p>

Section D: Integrated Assessments

		<p>The recent training dates included March 7, 14, 21, and 28, 2007; April 4, 11, 18, and 25, 2007; May 16, 23, and 30, 2007; and June 6 and 13, 2007. Matters pertaining to this recommendation were discussed during the April 2007 training sessions. A review of the list of psychologists attending the training sessions showed that only two (one each from Programs 1 and 5) of the 42 psychologists in Programs 1-5, failed to attend any of the training sessions, all others have attended one or more of the training sessions.</p> <p>NSH used item #3 (<i>All psychological assessments, consistent with generally accepted professional standards of care, shall expressly state the clinical question(s) for the assessment</i>) of the DMH Psychology Monitoring Form to address this recommendation. NSH audited 100% (N=33) of all Focused Psychological Assessments conducted between January and June, 2007, reporting 94% compliance.</p> <p>This monitor reviewed 11 psychological assessments (MB, JW, RP, GR, GP, DM, RM, CG, JB, DAT, DPN, and DL). Eight of them had the clinical questions clearly identified and the rationale for the referral specifically stated (MB, JW, RP, GR, GP, CG, DAT, and DPN). Three of them (JB, RM, and DL) did not meet this criterion.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Continue to train psychologists on writing clearly stated referral/clinical questions.</p>
D.2.d.ii	include findings specifically addressing the clinical question(s), but not limited to diagnoses and treatment recommendations;	<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Ensure that psychological assessments include all findings relevant to the clinical</p>

Section D: Integrated Assessments

		<p>question(s), but not limited to diagnoses and treatment recommendations.</p> <p>Findings: NSH used item #4 (<i>All psychological assessments, consistent with generally accepted professional standards of care, shall include findings specifically addressing the clinical questions, but not limited to diagnosis and treatment recommendations</i>), to address this recommendation, reporting 57% compliance.</p> <p>This monitor reviewed 11 charts (MB, JW, RP, GR, GP, DM, RM, CG, JB, DT, and DL). Eight of them (JW, GR, GP, DM, RM, CG, DT, and DL) met criterion by clearly addressing the clinical questions, inform the psychiatric diagnosis, identified treatment/rehabilitation needs, and suggested intervention priorities. Three of them (RP, MB, and JB) did not provide sufficient information or address individual/group rehabilitation service needs.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Ensure that psychological assessments include all findings relevant to the clinical question(s), but not limited to diagnoses and treatment recommendations.</p>
D.2.d.iii	Specify whether the individual would benefit from individual therapy or group therapy in addition to attendance at mall groups;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Continue to train psychologists on the requirement that all psychological assessments specify whether the individual would benefit from individual therapy or group therapy.</p> <p>Findings: NSH used item #5 (<i>All psychological assessments, consistent with generally accepted professional standards of care, shall specify whether the individual</i></p>

Section D: Integrated Assessments

		<p>would benefit from individual therapy or group therapy in addition to attendance at mall groups), to address this recommendation, reporting 48% compliance.</p> <p>This monitor reviewed eleven charts (MB, JW, RP, GR, GP, DM, RM, CG, JB, DT, and DL). Six of them (JW, GR, GP, DM, RP, and CG) met criterion by recommending individual/group therapy with a rationale for the recommendation and the benefit to be realized that can be specified in the objective of the individual's WRP. Five of them (MB, DL, RM, DT, and JB) did not provide sufficient information.</p> <p>Recommendation 2, February 2007: Provide data and lists of the number of psychologists trained and the number still needing to be trained.</p> <p>Findings: NSH has trained the psychology staff on assessments to align with the EP. Training was conducted on March 7, 14, 21, and 28, 2007; April 4, 11, 18, and 25, 2007; May 16, 23, and 30, 2007; and June 6 and 13, 2007. All but two of the psychologists from Program 1-5 have undergone training.</p> <p>Compliance: Partial.</p> <p>Current recommendation:</p> <ol style="list-style-type: none">1. Continue to train psychologists on the requirement that all psychological assessments specify whether the individual would benefit from individual therapy or group therapy.2. Provide data and lists of the number of psychologists trained and the number still needing to be trained.
--	--	---

Section D: Integrated Assessments

D.2.d.iv	<p>be based on current, accurate, and complete data;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation February 2007: Provide training to psychologists so that assessments include current, accurate, and complete data.</p> <p>Findings: NSH has conducted training to the psychology staff (March 7, 14, 21, and 28; April- 4, 11, 18, and 25; May-16, 23, 30; and June 6, 13). Each training session was 90 minutes in length.</p> <p>NSH reviewed 35 charts, using item #6 (<i>All psychological assessments, consistent with generally accepted professional standards of care, shall be based on current, accurate, and complete data</i>) of the DMH Psychology Monitoring Form), to address this recommendation, reporting 85% compliance.</p> <p>This monitor reviewed ten charts (CG, DT, PR, GP, DN, JB, JW, GR, RM, and DL). Five of them (CG, DT, DN, RM, and DL) had the necessary information, were accurate, and current, and five of them (PR, GP, JB, JW, and GR) were either missing sources of information, or contained inaccurate and/or incomplete information.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Provide training to psychologists so that assessments include current, accurate, and complete data.</p>
D.2.d.v	<p>determine whether behavioral supports or interventions (e.g., behavior guidelines or mini behavior</p>	<p>Current findings on previous recommendations:</p>

Section D: Integrated Assessments

	<p>plans) are warranted or whether a full positive behavior support plan is required;</p>	<p>Recommendation, February 2007: Continue to provide training and supervision to all psychologists to ensure that all psychological assessments of individuals with maladaptive behavior meet this requirement.</p> <p>Findings: NSH has provided training to the psychology staff on matters pertaining to this recommendation. Training was conducted during the months of April to June, 2007.</p> <p>NSH reviewed 35 charts, using item #7 (<i>All psychological assessments, consistent with generally accepted professional standards of care, shall determine whether behavioral supports or interventions (e.g. behavior guidelines or mini behavior plans) are warranted or whether a full positive behavior support plan is required</i>), to address this recommendation, reporting 22% compliance.</p> <p>This monitor reviewed eleven charts (DL, MB, RM, GR, JW, JB, DN, GP, DT, RP, and CG). None of them met full compliance with this recommendation. Most of them did not address this recommendation at all. A few mentioned that the individual does not need any behavioral interventions (DL and GR), but without any reasoning for the recommendation. For JB, the examiner stated, "Staff should learn and follow any positive behavioral support plan", rather than making the recommendations with reasons for the recommendations.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Continue to provide training and supervision to all psychologists to ensure that all psychological assessments of individuals with maladaptive behavior meet this requirement.</p>
--	---	--

Section D: Integrated Assessments

<p>D.2.d.vi</p>	<p>include the implications of the findings for interventions;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Continue to provide training to psychologists to ensure that all focused psychological assessments include the implications of the findings for interventions, especially psychosocial rehabilitation.</p> <p>Findings: NSH reviewed 35 charts, using item #8 (<i>All psychological assessments, consistent with generally accepted professional standards of care, shall include the implications of the findings for interventions</i>), to address this recommendation, reporting 66% compliance.</p> <p>This monitor reviewed seven charts (JB, JW, RM, DN, CG, GR, and RP). Six of the focused psychological assessments included the implications of the findings for intervention with explanations for the recommendations (JB, JW, RM, DN, CG, and RP), whereas one (GR) did not.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Continue to provide training to psychologists to ensure that all focused psychological assessments include the implications of the findings for interventions, especially psychosocial rehabilitation.</p>
<p>D.2.d.vii</p>	<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</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Ensure that all focused psychological assessments specify whether there is a need for further observations, record review, interviews, or re-evaluations.</p>

Section D: Integrated Assessments

	<p>to resolve such issues; and</p>	<p>Findings: NSH reviewed 35 charts, using item #9 (<i>All psychological assessments, consistent with generally accepted professional standards of care, shall identify any unresolved issues encompassed by the assessment and, where appropriate, specify further observations, records review, interviews, or re-evaluations that should be performed or considered to resolve such issues</i>), to address this recommendation, reporting 22% compliance.</p> <p>This monitor reviewed nine charts (RM, DL, JB, DN, MB, RP, GR, JW, and CG). Five of them (RM, DL, JB, DN, and CG) identified unresolved issues, stated there were no unresolved issues, or recommended further assessments/test. Four of them did not meet this criterion (MB, RP, GR, and JW).</p> <p>Compliance: Partial.</p> <p>Current recommendation: Ensure that all focused psychological assessments specify whether there is a need for further observations, record review, interviews, or re-evaluations.</p>
<p>D.2.d. viii</p>	<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>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Ensure that psychologists use tools and techniques appropriate for individuals and in accordance with the American Psychological Association Ethical Standards and Guidelines for testing.</p> <p>Findings: NSH reviewed 35 charts, using item #10 (<i>All psychological assessments, consistent with generally accepted professional standards of care, shall use assessment tools and techniques appropriate for the individuals assessed and in accordance with the American Psychological Association Ethical Standards and</i></p>

Section D: Integrated Assessments

		<p><i>Guidelines for testing</i>), to address this recommendation, reporting 90% compliance.</p> <p>This monitor reviewed ten psychological assessments (RP, CG, DPN, GR, JW, JB, RM, DL, GP, and DT). All ten used assessment tools appropriate to address the referral/clinical question. All of them included a clear statement of confidentiality in the written assessment. Three of them (RP, JW, and GP) failed to address previous assessments conducted and or provided minimal information on findings from the previous assessments. The actual administration of the assessments and the techniques used were not observable by this monitor.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Ensure that psychologists use tools and techniques appropriate for individuals and in accordance with the American Psychological Association Ethical Standards and <i>Guidelines for testing</i>.</p>
D.2.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 S [IV.B.1 and IV.B.2], above.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Ensure that psychological tests are completed as required.</p> <p>Findings: The EP requires that psychological assessments of all individuals who were admitted before June 1, 2006, be reviewed by clinicians qualified in psychological testing and, where indicated, revised. This recommendation can be evaluated using item #11 of the DMH Psychology Monitoring Form.</p> <p>NSH obtained list of individuals admitted to the facility before June 1, 2006 from Standards and Compliance. There are currently 854 individuals in the</p>

Section D: Integrated Assessments

		<p>facility who were admitted before June 1, 2006; the Integrated Psychological Assessments of 233 (27%) were reviewed and revised or a new one completed when there was no assessment found.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Ensure that psychological tests are completed as required.</p>
D.2.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>
D.2.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>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Ensure that integrated psychological assessments are conducted in a timely manner as required.</p> <p>Findings: NSH did not audit this recommendation.</p>

Section D: Integrated Assessments

		<p>This monitor reviewed nineteen charts (WA, JA, VK, JK, CC, PB, AM, WP, JJ, TL, JR, LP, AL, DP, TW, KS, AJ, DK, and TA). Fifteen (TA, DK, AJ, KS, TW, DP, AL, LP, JR, TL, JJ, WP, AM, PB, and CC) of the Integrated Psychological Assessments were conducted in a timely manner. Two of them (VK and JK) did not have their Integrated Psychological Assessments in their charts. Two of them (WA and JA) were untimely.</p> <p>Current recommendation: Ensure that integrated psychological assessments are conducted in a timely manner as required.</p>
D.2.f.i.1	<p>address the nature of the individual's impairments to inform the psychiatric diagnosis; and</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1-2, February 2007:</p> <ol style="list-style-type: none"> 1. Continue to provide training to ensure that integrated psychology assessments address the nature of the individual's impairments to inform the psychiatric diagnosis. 2. Use the DSM-IV-TR Checklist to inform psychiatric diagnoses. <p>Findings: NSH audited 239 Integrated Psychological Assessments, using item #12 (<i>Address the nature of the individual's impairments to inform the psychiatric diagnosis</i>) of the DMH Psychology Monitoring Form, reporting 55% compliance.</p> <p>This monitor reviewed sixteen charts (TA, DK, AJ, JS, DP, AL, LP, JR, TL, JJ, WP, AM, PB, WA, JA, and CC). Only three of the Integrated Psychological Assessments (JR, AL, and TA) met criterion by providing adequate information with regards to the individual's nature and extent of signs and symptoms including excesses and deficits, to inform the psychiatric diagnosis. The remaining thirteen of them (DK, AJ, JS, DP, LP, TL, JJ, WP, AM, PB, WA, JA, and CC) did not provide sufficient information to meet criterion.</p>

Section D: Integrated Assessments

		<p>Review of the list on DSM-IV-TR checklists showed that examiners are not routinely using the DSM-IV-TR checklist. The following 12 individuals (JP, DP, JB, VM, PF, DE, RT, PS, JH, SS, AR, and AG) did not have a DSM-IV-TR checklist completed or was not found in the chart.</p> <p>Current recommendation:</p> <ol style="list-style-type: none"> 1. Continue to provide training to ensure that integrated psychology assessments address the nature of the individual's impairments to inform the psychiatric diagnosis. 2. Use the DSM-IV-TR Checklist to inform psychiatric diagnoses.
D.2.f.i.2	<p>provide an accurate evaluation of the individual's psychological functioning to inform the therapeutic and rehabilitation service planning process;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, July, 2006: Ensure accurate evaluation of psychological functioning that informs the WRPT of the individual's rehabilitation service needs.</p> <p>Findings: NSH audited 239 Integrated Psychological Assessments, using item #13 (<i>Provides an accurate evaluation of the individual's psychological functioning to inform the therapeutic and rehabilitation service planning process</i>) of the DMH Psychology Monitoring Form, reporting 58% compliance.</p> <p>This monitor reviewed 19 charts (PB, AM, WA, WP, JJ, LP, DP, TW, KS, DK, TA, JK, VK, CC, JA, TL, JR, AL, and AJ). Ten of them (PB, AM, WA, WP, JJ, LP, DP, KS, DK, and TA) did not provide accurate or sufficient information on the individual's psychological functioning. Seven of them (CC, JA, TL, JR, TW, AL, and AJ) provided accurate and valid evaluation of the individual's functioning to be meaningful for the individual's WRPT to develop an appropriate rehabilitation service plan . Two of them (JK and VK) did not have an IPA.</p>

Section D: Integrated Assessments

		<p>Current recommendation: Ensure accurate evaluation of psychological functioning that informs the WRPT of the individual's rehabilitation service needs.</p>
D.2.f.ii	<p>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>	<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Ensure appropriate structural and functional assessments are undertaken by a qualified psychologist when an individual has learned maladaptive behavior that has not responded to a behavior guideline.</p> <p>Findings: NSH used item #14 (<i>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 behavioral supports</i>) of the DMH Psychology Monitoring Form, reporting 46% compliance.</p> <p>This monitor reviewed 17 charts (PB, AM, WA, WP, JJ, LP, KS, DP, TW, DK, TA, CC, JA, TL, JR, AL, and AJ). Three of them (JR, DP, and TW) met criteria and fourteen of them did not meet criteria (PB, AM, WA, WP, JJ, LP, KS, DK, TA, CC, JA, TL, AL, and AJ).</p> <p>Current recommendation: Ensure appropriate structural and functional assessments are undertaken by a qualified psychologist when an individual has learned maladaptive behavior that has not responded to a behavior guideline.</p>
D.2.f.iii	<p>additional psychological assessments shall be performed, as appropriate, where clinical information is otherwise insufficient, and to</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Ensure that additional psychological assessments are performed, as appropriate,</p>

Section D: Integrated Assessments

	<p>address unresolved clinical or diagnostic questions, including differential diagnosis, "rule-out," "deferred," "no-diagnosis" and "NOS" diagnoses.</p>	<p>where clinical information is otherwise insufficient, and address unresolved clinical or diagnostic questions.</p> <p>Findings: NSH audited a total of 324 charts, representing different diagnostic categories, using items #'s 16-20, of the DMH Psychology Monitoring Form, reporting 22% compliance. The table below with its monitoring indicators shows the various diagnostic categories (Dx), the number charts audited under each category (n), and the percent compliance within each category (%C).</p> <p><i>#16: Additional psychological assessments are performed, as appropriate for diagnostic questions, specifically "differential diagnosis".</i></p> <p><i>#17: Additional psychological assessments are performed, as appropriate for diagnostic questions, specifically "rule-out".</i></p> <p><i>#18: Additional psychological assessments are performed, as appropriate for diagnostic questions, specifically "deferred".</i></p> <p><i>#19: Additional psychological assessments are performed, as appropriate for diagnostic questions, specifically "no-diagnosis".</i></p> <p><i>#20: Additional psychological assessments are performed, as appropriate for diagnostic questions, specifically "NOS diagnosis".</i></p> <table border="1" data-bbox="884 1117 1801 1307"> <thead> <tr> <th>Dx</th> <th>Differ- ential Dx</th> <th>Rule out</th> <th>Defer- red</th> <th>No Dx</th> <th>NOS</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>6</td> <td>15</td> <td>22</td> <td>135</td> <td>36</td> </tr> <tr> <td>Monitor</td> <td>#16</td> <td>#17</td> <td>#18</td> <td>#19</td> <td>#20</td> </tr> <tr> <td>%C</td> <td>50</td> <td>31</td> <td>0</td> <td>21</td> <td>14</td> </tr> </tbody> </table> <p>This monitor reviewed 35 charts (RC, LP, LL, TA, DK, AL, AJ, DP, AL, LP, TW,</p>	Dx	Differ- ential Dx	Rule out	Defer- red	No Dx	NOS	N	6	15	22	135	36	Monitor	#16	#17	#18	#19	#20	%C	50	31	0	21	14
Dx	Differ- ential Dx	Rule out	Defer- red	No Dx	NOS																					
N	6	15	22	135	36																					
Monitor	#16	#17	#18	#19	#20																					
%C	50	31	0	21	14																					

Section D: Integrated Assessments

		<p>JR, TL, JJ, WP, WA, AM, PB, JA, CC, KS, TW, AJG, CW, AS, DS, AG, PC, DL, RF, JC, FP, BD, YL, and RR) of individuals with various categories of diagnostic uncertainties (rule out, no diagnosis, not otherwise specified, deferred) to evaluate if the examiner recommended follow up assessments to address unresolved clinical or diagnostic questions. Two of them (AJG and RC) identified the need for follow-up evaluations and the follow up evaluations were conducted in a timely manner. The remaining 33 did not address the diagnostic uncertainties properly. For example, AG had a request for DCAT to conduct cognitive assessment without giving a reason or showing a need for it, DL was given a 'NO DIAGNOSIS' strictly based on review of history, RF has a 'deferred' since 1999 with no follow-up, FP has a 'NO DIAGNOSIS' with no testing or documentation.</p> <p>Current recommendation: Ensure that additional psychological assessments are performed, as appropriate, where clinical information is otherwise insufficient, and address unresolved clinical or diagnostic questions.</p>
D.2.g	<p>For individuals whose primary language is not English, each State hospital shall endeavor to assess them in their own language; if this is not possible, each State hospital will develop and implement a plan to meet the individuals' assessment needs, including, but not limited to the use of interpreters in the individual's primary language and dialect, if feasible.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1-3, February 2007:</p> <ol style="list-style-type: none"> 1. Continue to train psychologists on the procedure for obtaining interpreters. 2. Monitor the use of the procedure for those individuals whose preferred language is not English. 3. Implement the referral system for individuals requiring interpreters. <p>Findings: According to Kathleen Patterson and Ann Hoff, Interim Senior Supervising Psychologists, all psychology staff in NSH are aware of the process and procedures for obtaining interpreters for those individuals whose primary/preferred language is not English. One system in place is for the psychologists to contact the 'Lan Do' Transcription Services for interpreters</p>

Section D: Integrated Assessments

		<p>when one is needed.</p> <p>NSH audited 36 charts of individuals whose primary/preferred language is not English, reporting 86% compliance.</p> <p>This monitor reviewed seven charts (AB, GO, LM, MD, AP, KP, and WL) of individuals whose primary/preferred language is not English. In all cases, the evaluations were conducted in the individuals' preferred language/mode of communication. In certain cases (MD) the examiner was competent in the language of testing (Spanish), or interpreters were used (LM and WL), and in other cases (AP) the individual was bilingual (Spanish and English) and the examiner affirmed that the individual's English was sufficiently functional to make the evaluation in English valid.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Monitor the use of the procedure for those individuals whose preferred language is not English.</p>
--	--	--

Section D: Integrated Assessments

D.3	Nursing Assessments	
		<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Linda Goodwin, RN, Assistant Coordinator of Nursing Services 2. Suezette Zielinski, RN, Health Care Specialist 3. Steve Weule, Assistant Coordinator of Nursing Services 4. Dean Percy, Acting Nurse Administrator 5. Eve Arcala, RN, Nursing Quality Improvement Coordinator <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. DMH WRPC CET Attendance and Nursing Participation Monitoring Form 2. Statewide Nursing Admission Nursing Assessment Monitoring Form and instructions (August 2006) 3. Admission Nursing Assessment draft (7/8/07) 4. Nursing Policies # 115, Pain Management; #010, Emergency Suctioning; #101.3, Nursing Assessment; #101.5, WRP-Wellness and Recovery Plan of Care (Nursing); #111, Dysphagia (Draft); #113, Care of the Individuals in Bed Bound Status (Draft); #119.1, Hospice Care; #130, Nutritional Assessment Referral for High Risk Individuals; #702, Bowel & Bladder Assessment; #709, Nasogastric Tube Insertion and Removal; #907, Standard Precautions; #1001, Intravenous Procedures: General Information; #1102.1, Medication Variance: Reporting & Analysis; #1500, Falls, Prevention and Management; #1506.1, Safety Restraint (Draft); #1501, Assaultive Individuals: Guidelines for Interventions (Draft); #1506, Behavioral Seclusion or Restraint (Draft); #101, Nursing Process; 5. Administrative Directive 650, Nursing Services (Draft) 6. WRP CET Nursing Participation Reviews data for January -June 2007 7. Nursing Admission Assessments and Integrated Assessments for 33 individuals (BS, CP, JR, JN, WF, AG, JS, VV, CR, FC, MG, MP, BT, JR, AC, SW, DW, SB, RC, SB, DK, GB, JB, CH, LK, EL, EH, CC, MW, VH, AS, DC, HV)

Section D: Integrated Assessments

D.3.a	Each State hospital shall develop standard nursing assessment protocols, consistent with generally accepted professional standards of care. These protocols shall address, at a minimum:	Compliance: Partial.
D.3.a.i	a description of presenting conditions;	<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Continue to monitor this requirement.</p> <p>Findings: NSH has continued to use the 2005 version of the Nursing Admission Assessment. The statewide Nursing Committee is in the process of developing admission and integrated nursing assessments using the Wellness and Recover Model as its framework. In addition, I noted that there was a significance difference in compliance rates between the Health Services Specialist's (HSS) and NSH Standards Compliance Department data related to some of the areas in nursing. I found that compliance rates were questionably high from the HSS's data. My review findings were more in alignment with Standards Compliance data. From the monitoring criteria described by Eve Arcala, RN, Nursing Quality Improvement Coordinator, for the two groups, the HSS monitoring does not accurately reflect the subject matter being reviewed. NSH need to address this issue.</p> <p>The tables below summarizes NSH's data regarding descriptions of presenting conditions, current prescribed medications, vital signs, allergies, assistive devices, activities of daily living, immediate alerts, and conditions needing immediate nursing interventions contained in the nursing admission assessments each month (N).</p> <p>Item: Is there a description of the presenting conditions?</p> <p>N= Number of monthly admissions</p>

Section D: Integrated Assessments

		<table border="1"> <thead> <tr> <th></th> <th>Jan</th> <th>Feb</th> <th>Mar</th> <th>Apr</th> <th>May</th> <th>Jun</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td colspan="8" style="text-align: center;">Admission Nursing Assessment Monitor</td> </tr> <tr> <td>N</td> <td>44</td> <td>50</td> <td>37</td> <td>36</td> <td>44</td> <td>40</td> <td>42</td> </tr> <tr> <td>n</td> <td>44</td> <td>48</td> <td>37</td> <td>36</td> <td>37</td> <td>31</td> <td>39</td> </tr> <tr> <td>% S</td> <td>100</td> <td>96</td> <td>100</td> <td>100</td> <td>84</td> <td>77</td> <td>93</td> </tr> <tr> <td>% C</td> <td>6</td> <td>18</td> <td>10</td> <td>8</td> <td>5</td> <td>3</td> <td>8</td> </tr> </tbody> </table> <p>From my review of 33 individuals' nursing admission assessments, (BS, CP, JR, JN, WF, AG, JS, VV, CR, FC, MG, MP, BT, JR, AC, SW, DW, SB, RC, SB, DK, GB, JB, CH, LK, EL, EH, CC, MW, VH, AS, DC, HV), I found that most were very superficial and vague regarding information regarding the presenting condition. Basic nursing information was missing or incomplete on most of the assessments I reviewed. In all but three admission assessments, the currently prescribed medication section was not completed or just left blank. Most of the nursing admission assessments included the vital signs, a pain assessment, activities of daily living and assistive devices. Only 10 of the admissions included complete documentation regarding allergies. In addition, four admission assessments adequately addressed immediate alerts and nursing interventions. Also, most of the admission assessments I reviewed had only one- to two-word answers describing the individual's goals.</p> <p>Although the statewide committee is working on developing a new nursing admission form, NSH needs to retrain nursing on completing the existing one.</p> <p>Current recommendation:</p> <ol style="list-style-type: none"> 1. Evaluate and correct issues regarding HSS auditing data. 2. Retrain nursing regarding appropriate completion of Nursing Admission Assessments. 3. Continue to monitor this requirement. 		Jan	Feb	Mar	Apr	May	Jun	Mean	Admission Nursing Assessment Monitor								N	44	50	37	36	44	40	42	n	44	48	37	36	37	31	39	% S	100	96	100	100	84	77	93	% C	6	18	10	8	5	3	8
	Jan	Feb	Mar	Apr	May	Jun	Mean																																											
Admission Nursing Assessment Monitor																																																		
N	44	50	37	36	44	40	42																																											
n	44	48	37	36	37	31	39																																											
% S	100	96	100	100	84	77	93																																											
% C	6	18	10	8	5	3	8																																											
D.3.a.ii	current prescribed medications;	Item: <i>Current prescribed medications are documented</i>																																																

Section D: Integrated Assessments

		<p>N = Number of monthly admissions</p> <table border="1"> <thead> <tr> <th></th> <th>Jan</th> <th>Feb</th> <th>Mar</th> <th>Apr</th> <th>May</th> <th>Jun</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td colspan="8" style="text-align: center;">Admission Nursing Assessment Monitor</td> </tr> <tr> <td>N</td> <td>44</td> <td>50</td> <td>37</td> <td>36</td> <td>44</td> <td>40</td> <td>42</td> </tr> <tr> <td>n</td> <td>44</td> <td>47</td> <td>37</td> <td>36</td> <td>37</td> <td>31</td> <td>39</td> </tr> <tr> <td>% S</td> <td>100</td> <td>94</td> <td>100</td> <td>100</td> <td>84</td> <td>77</td> <td>93</td> </tr> <tr> <td>% C</td> <td>13</td> <td>14</td> <td>21</td> <td>11</td> <td>24</td> <td>32</td> <td>19</td> </tr> </tbody> </table>		Jan	Feb	Mar	Apr	May	Jun	Mean	Admission Nursing Assessment Monitor								N	44	50	37	36	44	40	42	n	44	47	37	36	37	31	39	% S	100	94	100	100	84	77	93	% C	13	14	21	11	24	32	19
	Jan	Feb	Mar	Apr	May	Jun	Mean																																											
Admission Nursing Assessment Monitor																																																		
N	44	50	37	36	44	40	42																																											
n	44	47	37	36	37	31	39																																											
% S	100	94	100	100	84	77	93																																											
% C	13	14	21	11	24	32	19																																											
D.3.a.iii	vital signs;	<p>Item: <i>Vital signs are documented</i></p> <p>N = Number of monthly admissions</p> <table border="1"> <thead> <tr> <th></th> <th>Jan</th> <th>Feb</th> <th>Mar</th> <th>Apr</th> <th>May</th> <th>Jun</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td colspan="8" style="text-align: center;">Admission Nursing Assessment Monitor</td> </tr> <tr> <td>N</td> <td>44</td> <td>50</td> <td>37</td> <td>36</td> <td>44</td> <td>40</td> <td>42</td> </tr> <tr> <td>n</td> <td>44</td> <td>48</td> <td>37</td> <td>36</td> <td>37</td> <td>31</td> <td>39</td> </tr> <tr> <td>% S</td> <td>100</td> <td>96</td> <td>100</td> <td>100</td> <td>84</td> <td>77</td> <td>93</td> </tr> <tr> <td>% C</td> <td>97</td> <td>97</td> <td>97</td> <td>94</td> <td>86</td> <td>96</td> <td>95</td> </tr> </tbody> </table>		Jan	Feb	Mar	Apr	May	Jun	Mean	Admission Nursing Assessment Monitor								N	44	50	37	36	44	40	42	n	44	48	37	36	37	31	39	% S	100	96	100	100	84	77	93	% C	97	97	97	94	86	96	95
	Jan	Feb	Mar	Apr	May	Jun	Mean																																											
Admission Nursing Assessment Monitor																																																		
N	44	50	37	36	44	40	42																																											
n	44	48	37	36	37	31	39																																											
% S	100	96	100	100	84	77	93																																											
% C	97	97	97	94	86	96	95																																											
D.3.a.iv	allergies;	<p>Item: <i>Are allergies identified?</i></p> <p>N = Number of monthly admissions</p> <table border="1"> <thead> <tr> <th></th> <th>Jan</th> <th>Feb</th> <th>Mar</th> <th>Apr</th> <th>May</th> <th>Jun</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td colspan="8" style="text-align: center;">Admission Nursing Assessment Monitor</td> </tr> <tr> <td>N</td> <td>44</td> <td>50</td> <td>37</td> <td>36</td> <td>44</td> <td>40</td> <td>42</td> </tr> <tr> <td>n</td> <td>44</td> <td>48</td> <td>37</td> <td>36</td> <td>37</td> <td>31</td> <td>39</td> </tr> <tr> <td>% S</td> <td>100</td> <td>96</td> <td>100</td> <td>100</td> <td>84</td> <td>77</td> <td>93</td> </tr> <tr> <td>% C</td> <td>75</td> <td>77</td> <td>78</td> <td>69</td> <td>70</td> <td>58</td> <td>71</td> </tr> </tbody> </table>		Jan	Feb	Mar	Apr	May	Jun	Mean	Admission Nursing Assessment Monitor								N	44	50	37	36	44	40	42	n	44	48	37	36	37	31	39	% S	100	96	100	100	84	77	93	% C	75	77	78	69	70	58	71
	Jan	Feb	Mar	Apr	May	Jun	Mean																																											
Admission Nursing Assessment Monitor																																																		
N	44	50	37	36	44	40	42																																											
n	44	48	37	36	37	31	39																																											
% S	100	96	100	100	84	77	93																																											
% C	75	77	78	69	70	58	71																																											

Section D: Integrated Assessments

D.3.a.v	pain;	<p>Item: <i>Is the pain assessment completed per hospital policy?</i></p> <p>N = Number of monthly admissions</p> <table border="1" data-bbox="884 302 1923 532"> <thead> <tr> <th></th> <th>Jan</th> <th>Feb</th> <th>Mar</th> <th>Apr</th> <th>May</th> <th>Jun</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td colspan="8" style="text-align: center;">Admission Nursing Assessment Monitor</td> </tr> <tr> <td>N</td> <td>44</td> <td>50</td> <td>37</td> <td>36</td> <td>44</td> <td>40</td> <td>42</td> </tr> <tr> <td>n</td> <td>44</td> <td>48</td> <td>37</td> <td>36</td> <td>37</td> <td>31</td> <td>39</td> </tr> <tr> <td>% S</td> <td>100</td> <td>96</td> <td>100</td> <td>100</td> <td>84</td> <td>77</td> <td>93</td> </tr> <tr> <td>% C</td> <td>93</td> <td>89</td> <td>91</td> <td>91</td> <td>83</td> <td>83</td> <td>88</td> </tr> </tbody> </table>		Jan	Feb	Mar	Apr	May	Jun	Mean	Admission Nursing Assessment Monitor								N	44	50	37	36	44	40	42	n	44	48	37	36	37	31	39	% S	100	96	100	100	84	77	93	% C	93	89	91	91	83	83	88
	Jan	Feb	Mar	Apr	May	Jun	Mean																																											
Admission Nursing Assessment Monitor																																																		
N	44	50	37	36	44	40	42																																											
n	44	48	37	36	37	31	39																																											
% S	100	96	100	100	84	77	93																																											
% C	93	89	91	91	83	83	88																																											
D.3.a.vi	use of assistive devices;	<p>Item: <i>Is the use of assistive devices addressed?</i></p> <p>N = Number of monthly admissions</p> <table border="1" data-bbox="884 717 1923 948"> <thead> <tr> <th></th> <th>Jan</th> <th>Feb</th> <th>Mar</th> <th>Apr</th> <th>May</th> <th>Jun</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td colspan="8" style="text-align: center;">Admission Nursing Assessment Monitor</td> </tr> <tr> <td>N</td> <td>44</td> <td>50</td> <td>37</td> <td>36</td> <td>44</td> <td>40</td> <td>42</td> </tr> <tr> <td>N</td> <td>44</td> <td>48</td> <td>37</td> <td>36</td> <td>37</td> <td>31</td> <td>39</td> </tr> <tr> <td>% S</td> <td>100</td> <td>96</td> <td>100</td> <td>100</td> <td>84</td> <td>77</td> <td>93</td> </tr> <tr> <td>% C</td> <td>95</td> <td>97</td> <td>94</td> <td>91</td> <td>97</td> <td>93</td> <td>95</td> </tr> </tbody> </table>		Jan	Feb	Mar	Apr	May	Jun	Mean	Admission Nursing Assessment Monitor								N	44	50	37	36	44	40	42	N	44	48	37	36	37	31	39	% S	100	96	100	100	84	77	93	% C	95	97	94	91	97	93	95
	Jan	Feb	Mar	Apr	May	Jun	Mean																																											
Admission Nursing Assessment Monitor																																																		
N	44	50	37	36	44	40	42																																											
N	44	48	37	36	37	31	39																																											
% S	100	96	100	100	84	77	93																																											
% C	95	97	94	91	97	93	95																																											
D.3.a.vii	activities of daily living;	<p>Item: <i>Are activities of daily living addressed?</i></p> <p>N = Number of monthly admissions</p> <table border="1" data-bbox="884 1138 1923 1369"> <thead> <tr> <th></th> <th>Jan</th> <th>Feb</th> <th>Mar</th> <th>Apr</th> <th>May</th> <th>Jun</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td colspan="8" style="text-align: center;">Admission Nursing Assessment Monitor</td> </tr> <tr> <td>N</td> <td>44</td> <td>50</td> <td>37</td> <td>36</td> <td>44</td> <td>40</td> <td>42</td> </tr> <tr> <td>n</td> <td>44</td> <td>48</td> <td>37</td> <td>36</td> <td>37</td> <td>31</td> <td>39</td> </tr> <tr> <td>% S</td> <td>100</td> <td>96</td> <td>100</td> <td>100</td> <td>84</td> <td>77</td> <td>93</td> </tr> <tr> <td>% C</td> <td>95</td> <td>100</td> <td>100</td> <td>97</td> <td>100</td> <td>96</td> <td>98</td> </tr> </tbody> </table>		Jan	Feb	Mar	Apr	May	Jun	Mean	Admission Nursing Assessment Monitor								N	44	50	37	36	44	40	42	n	44	48	37	36	37	31	39	% S	100	96	100	100	84	77	93	% C	95	100	100	97	100	96	98
	Jan	Feb	Mar	Apr	May	Jun	Mean																																											
Admission Nursing Assessment Monitor																																																		
N	44	50	37	36	44	40	42																																											
n	44	48	37	36	37	31	39																																											
% S	100	96	100	100	84	77	93																																											
% C	95	100	100	97	100	96	98																																											

Section D: Integrated Assessments

<p>D.3. a.viii</p>	<p>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</p>	<p>Item: <i>Is the identified immediate alert(s) defined within the body of the nursing assessment?</i> (e.g., escape risk, physical assault, choking risk, suicidal risk, homicidal risk, fall risk, sexual assault, self-injurious behavior, arson or fire setting).</p> <p>N = Number of monthly admissions</p> <table border="1" data-bbox="884 526 1927 756"> <thead> <tr> <th></th> <th>Jan</th> <th>Feb</th> <th>Mar</th> <th>Apr</th> <th>May</th> <th>Jun</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td colspan="8" style="text-align: center;">Admission Nursing Assessment Monitor</td> </tr> <tr> <td>N</td> <td>44</td> <td>50</td> <td>37</td> <td>36</td> <td>44</td> <td>40</td> <td>42</td> </tr> <tr> <td>n</td> <td>42</td> <td>47</td> <td>37</td> <td>36</td> <td>36</td> <td>31</td> <td>38</td> </tr> <tr> <td>% S</td> <td>95</td> <td>94</td> <td>100</td> <td>100</td> <td>81</td> <td>77</td> <td>91</td> </tr> <tr> <td>% C</td> <td>73</td> <td>59</td> <td>70</td> <td>55</td> <td>50</td> <td>51</td> <td>60</td> </tr> </tbody> </table>		Jan	Feb	Mar	Apr	May	Jun	Mean	Admission Nursing Assessment Monitor								N	44	50	37	36	44	40	42	n	42	47	37	36	36	31	38	% S	95	94	100	100	81	77	91	% C	73	59	70	55	50	51	60
	Jan	Feb	Mar	Apr	May	Jun	Mean																																											
Admission Nursing Assessment Monitor																																																		
N	44	50	37	36	44	40	42																																											
n	42	47	37	36	36	31	38																																											
% S	95	94	100	100	81	77	91																																											
% C	73	59	70	55	50	51	60																																											
<p>D.3.a.ix</p>	<p>conditions needing immediate nursing interventions.</p>	<p>Item: <i>Documentation describes conditions needing immediate nursing interventions?</i></p> <p>N = Number of monthly admissions</p> <table border="1" data-bbox="884 980 1927 1211"> <thead> <tr> <th></th> <th>Jan</th> <th>Feb</th> <th>Mar</th> <th>Apr</th> <th>May</th> <th>Jun</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td colspan="8" style="text-align: center;">Admission Nursing Assessment Monitor</td> </tr> <tr> <td>N</td> <td>44</td> <td>50</td> <td>37</td> <td>36</td> <td>44</td> <td>40</td> <td>42</td> </tr> <tr> <td>n</td> <td>37</td> <td>41</td> <td>29</td> <td>31</td> <td>36</td> <td>28</td> <td>34</td> </tr> <tr> <td>% S</td> <td>84</td> <td>82</td> <td>78</td> <td>86</td> <td>81</td> <td>70</td> <td>80</td> </tr> <tr> <td>% C</td> <td>59</td> <td>51</td> <td>51</td> <td>45</td> <td>30</td> <td>60</td> <td>49</td> </tr> </tbody> </table>		Jan	Feb	Mar	Apr	May	Jun	Mean	Admission Nursing Assessment Monitor								N	44	50	37	36	44	40	42	n	37	41	29	31	36	28	34	% S	84	82	78	86	81	70	80	% C	59	51	51	45	30	60	49
	Jan	Feb	Mar	Apr	May	Jun	Mean																																											
Admission Nursing Assessment Monitor																																																		
N	44	50	37	36	44	40	42																																											
n	37	41	29	31	36	28	34																																											
% S	84	82	78	86	81	70	80																																											
% C	59	51	51	45	30	60	49																																											

Section D: Integrated Assessments

<p>D.3.b</p>	<p>Nursing may use a systems model (e.g., Johnson Behavioral System Model) for the nursing evaluation.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Continue to revise policies and procedures to include WRP language.</p> <p>Findings: Since January 2007, NSH has adequately revised the following policies and procedures to include WRP language:</p> <p>EMERGENCY: 010 Emergency Suctioning BASIC: 101 Nursing Process BASIC: 101.3 Nursing Assessment BASIC: 101.5 WRP - Wellness and Recovery Plan of Care (Nursing) BASIC:111 Dysphagia BASIC: 113 Care of the Individual in Bed-Bound Status BASIC: 119.1 Hospice Care Services BASIC: 130 Nutrition Assessment Referral for High Risk Individuals GI: 702 Bowel and Bladder Assessment GI: 709 NG Tube Insertion and Removal INFECTION: 907 Standard Precautions IV: 1001 Intravenous Procedures: General Information MEDICATION: 1102.1 Medication Variance Reporting and Analysis SAFE: 1500 Falls Prevention and Management SAFE: 1506.1 Safety Restraint SAFE: 1501 Assaultive Individuals; Guidelines for Interventions SAFE: 1506 Behavioral Seclusion or Restraint</p> <p>Recommendation 2, February 2007: Continue to implement WaRMSS Nursing Assessments and Integrated Nursing Assessments.</p>
--------------	--	--

Section D: Integrated Assessments

		<p>Findings: The statewide Nursing Committee continues to develop the Nursing Admission and Integrated Assessments using the Wellness and Recovery framework. The Nursing Department has adopted the Wellness and Recovery Model in place of the Johnson Behavioral System Model. NSH will continue to use the current Nursing Admission and Integrated Assessments until the statewide assessments are finalized. Once the new forms are developed and approved, training will be scheduled for the nurses. In addition, revisions of the monitoring instruments and instructions will need to be implemented regarding nursing assessments (admission and integrated). These actions are projected to be completed within the next six months.</p> <p>Compliance: Partial.</p> <p>Current recommendation:</p> <ol style="list-style-type: none"> 1. Continue to revise policies and procedures to include WRP language. 2. Continue to develop and implement the statewide Admission and Integrated Nursing Assessments. 3. Provide nursing training on new statewide assessment tools. 4. Revise monitoring instrument and instructions in alignment with the new assessments and the EP.
D.3.c	<p>Each State hospital shall ensure that all nurses responsible for performing or reviewing nursing assessments are verifiably competent in performing the assessments for which they are responsible. All nurses who are employed at Metropolitan State Hospital shall have graduated from an approved nursing program, shall have passed the NCLEX-RN and shall have a license to practice in the</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Continue current system to ensure that all nurses who are employed at Napa 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>Findings: The following table summarizes NSH data regarding Registered Nurses hired each month (N) and verification of licenses using the State Board of Registered Nurses</p>

Section D: Integrated Assessments

	<p>State of California.</p>	<p>license verification website. No data was submitted regarding LVN's license verification. This requirement is ongoing with each new nurse applicant that is hired by NSH.</p> <p>Item: <i>Verification of licenses for all new Registered Nurses has been completed.</i></p> <p>N = Number of RNs Hired</p> <table border="1" data-bbox="884 451 1927 683"> <thead> <tr> <th></th> <th>Jan</th> <th>Feb</th> <th>Mar</th> <th>Apr</th> <th>May</th> <th>Jun</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td colspan="8" style="text-align: center;">Competency Validation Form- pending</td> </tr> <tr> <td>N</td> <td>10</td> <td>X</td> <td>6</td> <td>5</td> <td>19</td> <td>3</td> <td>43</td> </tr> <tr> <td>n</td> <td>10</td> <td>X</td> <td>6</td> <td>5</td> <td>19</td> <td>3</td> <td>43</td> </tr> <tr> <td>% S</td> <td>100</td> <td>X</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> </tr> <tr> <td>% C</td> <td>100</td> <td>X</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> </tr> </tbody> </table> <p>Other findings: NSH did not provide data regarding steps taken to ensure that all nurses responsible for performing or reviewing nursing assessments are verifiably competent in performing the assessments for which they are responsible.</p> <p>Compliance: Partial.</p> <p>Current recommendation:</p> <ol style="list-style-type: none"> 1. Include data regarding LVN license verification. 2. Develop and implement a system to monitor that all nurses responsible for performing or reviewing nursing assessments are verifiably competent in performing the assessments for which they are responsible. 3. Continue to monitor this requirement. 		Jan	Feb	Mar	Apr	May	Jun	Mean	Competency Validation Form- pending								N	10	X	6	5	19	3	43	n	10	X	6	5	19	3	43	% S	100	X	100	100	100	100	100	% C	100	X	100	100	100	100	100
	Jan	Feb	Mar	Apr	May	Jun	Mean																																											
Competency Validation Form- pending																																																		
N	10	X	6	5	19	3	43																																											
n	10	X	6	5	19	3	43																																											
% S	100	X	100	100	100	100	100																																											
% C	100	X	100	100	100	100	100																																											
D.3.d	Each State hospital shall ensure that nursing assessments are undertaken on a	Please see sub-cells for compliance findings.																																																

Section D: Integrated Assessments

	timely basis, and in particular, that:																																																	
D.3.d.i	Initial nursing assessments are completed within 24 hours of the individual's admission;	<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Continue to monitor this requirement.</p> <p>Findings: From my review of 33 nursing assessments (see list in a.i), I found all 33 had been completed within eight hours. Unfortunately all are considered to be out of compliance because doing these assessments soon after the individual is admitted does not lead to obtaining comprehensive information. Information that the individual is not comfortable disclosing or refuses to answer is not pursued after the individual has become more comfortable on the unit. Consequently, this has resulted in blank sections, incomplete information, vague statements and superficial admission assessments.</p> <p>The table below summarizes NSH's data regarding the timeliness of the initial Nursing Admission Assessment. NSH's data also indicated that nursing staff are completing the assessment within eight hours, which is too soon for a comprehensive assessment to be completed in most cases.</p> <p><i>Item: Initial Nursing Admission Assessment is completed within 24 hours of the individual's admission.</i></p> <p>N = Number of monthly admissions</p> <table border="1" data-bbox="884 1117 1923 1344"> <thead> <tr> <th></th> <th>Jan</th> <th>Feb</th> <th>Mar</th> <th>Apr</th> <th>May</th> <th>Jun</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td colspan="8" style="text-align: center;">Admission Nursing Assessment Monitor</td> </tr> <tr> <td>N</td> <td>44</td> <td>50</td> <td>37</td> <td>36</td> <td>44</td> <td>40</td> <td>42</td> </tr> <tr> <td>n</td> <td>44</td> <td>48</td> <td>37</td> <td>35</td> <td>37</td> <td>31</td> <td>39</td> </tr> <tr> <td>% S</td> <td>100</td> <td>96</td> <td>100</td> <td>79</td> <td>84</td> <td>77</td> <td>89</td> </tr> <tr> <td>% C</td> <td>100</td> <td>72</td> <td>5</td> <td>0</td> <td>5</td> <td>6</td> <td>31</td> </tr> </tbody> </table>		Jan	Feb	Mar	Apr	May	Jun	Mean	Admission Nursing Assessment Monitor								N	44	50	37	36	44	40	42	n	44	48	37	35	37	31	39	% S	100	96	100	79	84	77	89	% C	100	72	5	0	5	6	31
	Jan	Feb	Mar	Apr	May	Jun	Mean																																											
Admission Nursing Assessment Monitor																																																		
N	44	50	37	36	44	40	42																																											
n	44	48	37	35	37	31	39																																											
% S	100	96	100	79	84	77	89																																											
% C	100	72	5	0	5	6	31																																											

Section D: Integrated Assessments

		<p>Compliance: Partial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
D.3.d.ii	<p>Further nursing assessments are completed and integrated into the individual's therapeutic and rehabilitation service plan within seven days of admission; and</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Continue implementation of WRP.</p> <p>Findings: WRP training is ongoing to include all assessments be completed and integrated into the individual's therapeutic and rehabilitation plan within seven days of admission.</p> <p>Recommendation 2, February 2007: Continue to provide ongoing Wellness and Recovery training to all staff.</p> <p>Findings: WRP training at NSH is ongoing.</p> <p>Recommendation 3, February 2007: Identify and implement appropriate timeframes for the elements of this requirement.</p> <p>Findings: NSH reported that the statewide Nursing assessment and Integrated Assessment would be implemented within the next six months.</p>

Section D: Integrated Assessments

	<p>Recommendation 4, February 2007: Continue to monitor this requirement.</p> <p>Findings:</p> <p>The table below summarizes NSH's data regarding completion of the Nursing Integrated Assessment within five days of an individual's admission.</p> <p><i>Item: Is the Nursing Integrated Assessment completed within 5 days of the Individual's admission?</i></p> <p>N = Number of monthly admissions</p> <table border="1"> <thead> <tr> <th></th> <th>Jan</th> <th>Feb</th> <th>Mar</th> <th>Apr</th> <th>May</th> <th>Jun</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td colspan="8" style="text-align: center;">Admission Nursing Assessment Monitor</td> </tr> <tr> <td>N</td> <td>44</td> <td>50</td> <td>37</td> <td>36</td> <td>44</td> <td>40</td> <td>42</td> </tr> <tr> <td>n</td> <td>44</td> <td>47</td> <td>35</td> <td>35</td> <td>37</td> <td>29</td> <td>37</td> </tr> <tr> <td>% S</td> <td>100</td> <td>94</td> <td>94</td> <td>97</td> <td>84</td> <td>72</td> <td>90</td> </tr> <tr> <td>% C</td> <td>50</td> <td>51</td> <td>65</td> <td>28</td> <td>45</td> <td>17</td> <td>43</td> </tr> </tbody> </table> <p>From my review of 33 Nursing Integrated Assessments (see list in D.3.a.i), I found that six were completed within five days of the individual's admission. This finding is below NSH's mean compliance rate for this requirement.</p> <p>Other findings:</p> <p>From my review of 33 Nursing Integrated Assessments, I found that generally, there was no additional information provided on the Integrated Assessments. In fact, most of the 33 that I reviewed had the exact information and quotes from the individuals that were documented on the Admission Assessments. There is no indication that nurses are actually going back to the individuals to clarify or obtain additional information. It appears that information is merely transferred from the Admission Assessment to the Integrated Assessment.</p>		Jan	Feb	Mar	Apr	May	Jun	Mean	Admission Nursing Assessment Monitor								N	44	50	37	36	44	40	42	n	44	47	35	35	37	29	37	% S	100	94	94	97	84	72	90	% C	50	51	65	28	45	17	43
	Jan	Feb	Mar	Apr	May	Jun	Mean																																										
Admission Nursing Assessment Monitor																																																	
N	44	50	37	36	44	40	42																																										
n	44	47	35	35	37	29	37																																										
% S	100	94	94	97	84	72	90																																										
% C	50	51	65	28	45	17	43																																										

Section D: Integrated Assessments

		<p>Compliance: Partial.</p> <p>Current recommendation:</p> <ol style="list-style-type: none"> 1. Continue to provide ongoing Wellness and Recovery training to all staff. 2. Continue to develop and implement the statewide Nursing Admission and Integrated Assessments. 3. Retrain nursing on appropriate and timely completion of the Nursing Integrated Assessments. 4. Continue to monitor this requirement.
D.3.d.iii	<p>Nursing assessments are reviewed every 14 days during the first 60 days of admission and every 30 days thereafter and updated as appropriate. The third monthly review shall be a quarterly review and the 12th monthly review shall be the annual review.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Monitor this requirement.</p> <p>Findings: Data provided by NSH did not address the elements of this requirement. From my interviews, there is no system in place addressing this requirement.</p> <p>Compliance: Noncompliance.</p> <p>Current recommendation: Develop and implement a system to monitor the elements of this requirement.</p>

Section D: Integrated Assessments

D.4	Rehabilitation Therapy Assessments
	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Karen Zanetell, Chief of Rehabilitation Therapy 2. Ron Lay, Art Therapist, Chair of Rehabilitation Therapy Professional Practice Group 3. John Dickinson, Assistant Chief, Central Program Services 4. Karen Breckenridge, Physical Therapist 5. Nancy Rooney, Speech Language Pathologist (Dysphagia) 6. Ellen Bachman, Program 5 Director 7. Leslie Cobb, Speech Language Pathologist, Central Program Specialist 8. Carmina Bensen, RN 9. Katie Cooper, Program Director Q11 10. Emilio Velazquez, Supervising RN 11. Eve Arcala, Nursing Quality Improvement Coordinator 12. Aaron Frazier, Physical Therapist 13. Maelinda Holliman, Occupational Therapist 14. Candy Asuncion, Supervising Registered Nurse <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Rehabilitation Therapy Operations Manual 2. Physical Rehabilitation Services Statement of Purpose 3. Integrated Rehabilitation Therapy Assessment Training Roster 4. Integrated Rehabilitation Therapy Assessment Template 5. Integrated Rehabilitation Therapy Assessment Instructions 6. Integrated Rehabilitation Therapy Assessment Audit 7. Integrated Rehabilitation Therapy Assessment Audit Instructions 8. Nursing Policy and Procedure 111 9. Nursing Policy and Procedure for Enteral Tube Feeding and Care 10. Physical Therapy Initial Evaluation/Discharge Summary template

Section D: Integrated Assessments

	<ol style="list-style-type: none"> 11. Speech/Language Hearing Evaluation Report 12. Comprehensive Team Assessment for Physical and Nutritional Management 13. Dysphagia/Choking Screening 14. Job Training/Monthly Training Report 15. Magnolia Enterprise Vocational Entry Level form 16. Magnolia Enterprise Vocational Services Training and Employment form 17. Napa State Hospital Vocational Screening Checklist 18. Vocational Services Sharps/Chemical Clearance form 19. Vocational Services Safety Test 20. List of individuals at risk for choking/aspiration 21. List of individuals receiving enteral nutrition 22. Dysphagia Risk Level definitions 23. Aspiration Risk Scale 24. Central Program Services Procedures for Speech Language Pathology, Hearing, and Education Services 25. Records and Integrated Rehabilitation Therapy Admission Assessments for the following individuals: RP, RM, PC, BP, IM, BS, JR, CM, JT, JL, JR, DB, DW 26. Records of new admissions for the following individuals admitted in June and July 2007: SC, MB, WS, AD, JM, CR, PH 27. Physical Therapy Initial Evaluations for the following individuals: TF, KJ, HV, SL, AF, JM, CD, EB, DP, AT, TW, AC 28. Physical Therapy Evaluations and Wellness Recovery Plans for the following individuals in conjunction with in vivo observation: LK, JJ, OM, DB 29. Speech Language/Hearing Evaluation Report for the following individuals: MW, JW, WF, WB, RR, JP, NH, DA, TC 30. Occupational Therapy Assessments/consultations for the following individuals: JD, PW, DB, EB, HR, JT, TP, WM, JB, SS 31. Vocational Assessments for the following individuals: NF, FR, DM, PS, GS, AD, DT, MR, EB, MR 32. Comprehensive Team Assessment for Physical and Nutritional Management and corresponding Dining Plans for the following individuals: SG, LH, GL, JM, CR, TR, BC, JC, QE, JF
--	---

Section D: Integrated Assessments

		<p>33. NSH Physical Therapy Documentation Audit 34. Rehabilitation Therapy IRTA Audit data for June 2007</p>
<p>D.4.a</p>	<p>Each State hospital shall develop standard rehabilitation therapy assessment protocols, consistent with generally accepted professional standards of care, for satisfying the necessary components of a comprehensive rehabilitation therapy assessment.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Finalize and implement the Integrated Rehabilitation Therapy Assessment to ensure that individuals are receiving a comprehensive rehabilitative assessment to meet their needs.</p> <p>Findings: The current Integrated Rehabilitation Therapy Assessment was implemented on 6/1/07. According to the report of the Chief of Rehabilitation Services, this assessment has been finalized and is pending statewide forms approval. Upon review of the Integrated Rehabilitation Therapy Assessment tool, instructions and procedure, it appears that the assessment serves as a screening, with referrals made for focused assessments based on findings. While the general guidelines of the IRTA instructions mention using a combination of methods to obtain findings, instructions for Physical Functioning and Life Skills sections do not contain information on how to assess these areas. The ITRA instructions should emphasize the importance of using multiple methodologies, including clinical observations, structured or standardized assessment activities, interview, and chart review when appropriate.</p> <p>Disciplines currently performing the Integrated Rehabilitation Therapy Assessment include Recreational, Music, Dance, Art, and Occupational Therapists. However, the integration aspect of a team assessment is not present with the current system, as it requires that only one team member (assigned therapist) complete the entire assessment. While the Integrated Rehabilitation Assessment contains a section for referrals for Occupational Therapy, Physical Therapy, Speech Therapy, Audiologist, Dietitian, Vocational Rehabilitation, and Optometrist evaluations, there is no instruction for</p>

Section D: Integrated Assessments

		<p>collaboration between the referring professionals and the disciplines within this group that are part of the Rehabilitation Services department (OT, PT, SLP, Vocational Services). Creating and implementing a protocol delineating this means of interdisciplinary assessment by appropriate disciplines based on individual need would lead to a truly integrated rehabilitation therapy assessment.</p> <p>The current protocol for Integrated Rehabilitation Therapy Assessments states that annual assessments are to be completed on the anniversary month of admission. However, the Wellness and Recovery system and the Enhancement Plan (EP) do not require annual assessments by Rehabilitation Therapy; assessment data is updated as needed during WRPCs and upon WRPT referral secondary to change in status, etc. The protocol should be revised to reflect this practice.</p> <p>Recommendation 2, February 2007: Continue to revise, update, and implement policies, procedures, operations manuals and ADs to address this requirement as systems evolve.</p> <p>Findings: Upon review of the Rehabilitation Therapy Operations Manual, it was noted that there was no policy/procedure outlining the department's vision and organizational structure as an integrated unit, with all disciplines represented. There are protocols detailing individual disciplines' responsibilities/duties; a protocol for the department dated 10/06 that defines Rehabilitation Services as being comprised of Recreational, Music, Dance/Movement, Art, and Occupational Therapists; a procedure that provides for a facility-wide committee with Specialized Rehabilitation Services membership (OT/PT/SLP representation); a Physical Rehabilitation Services Statement of Purpose; and a procedure that dictates the responsibility of the Physical and Nutritional Management Team as related to dysphagia. These documents, procedures and protocols serve to collectively provide some scope of Rehabilitation Therapy services. However,</p>
--	--	---

Section D: Integrated Assessments

	<p>they, like the department itself, are fragmented and do not provide a global and integrated depiction of the structure and function of the Rehabilitation Services department as a whole. In addition, Vocational Services are not currently incorporated into the Rehabilitation Therapy department. The department has undergone many changes in the last year, and would benefit immensely from redefining itself as a unified group, and refocusing its structure and vision in order to provide comprehensive and integrated Rehabilitation Therapy services.</p> <p>Currently, there are no protocols written or implemented for instructions/documentation requirements for provision of Comprehensive Team Assessment for Physical and Nutritional Management, Vocational Rehabilitation assessment, Occupational, Physical, or Speech Therapy assessments done in response to referral/consultation.</p> <p>While the Documentation, Assessments and Progress Notes section (4.0) of the Rehabilitation Therapy Operations Manual addresses documentation of Interdisciplinary Notes and quarterly notes, the section regarding assessment and documentation of progress of Specialized Rehabilitation (1:1 treatment), and clinically indicated assessments is brief and does not provide for standardized tools/instructions regarding documentation and assessment.</p> <p>Other findings:</p> <p>The Comprehensive Team Assessment for Physical and Nutritional Management is currently administered upon referral for individuals with dysphagia (with priority for Level 1 dysphagia). The assessment is interdisciplinary but is suited to meet the needs of a developmental disability target population, rather than to address acute and chronic rehabilitation therapy needs of individuals within an inpatient psychiatric facility. Upon chart review of Comprehensive Assessments, it was noted that one portion of each assessment (wheelchair tool) was titled with the name of a developmental center from another state. The Comprehensive Team Assessment for Physical and Nutritional Management does not address acute rehabilitation needs of individuals who are, for example, status post CVA, TBI, cumulative trauma conditions, etc., have a high incidence of falls (which may be</p>
--	---

Section D: Integrated Assessments

	<p>secondary to multiple factors such as physical limitations, visual/perceptual issues, vestibular dysfunction, and cognitive/communication difficulties), nor does it serve individuals who may have chronic needs related to degenerative conditions such as Parkinson's, Tardive Dyskinesia, Huntington's disease, etc. Upon review of the specialty assessments from Physical Therapy, it was noted that 70% of individuals reviewed would have benefited from a comprehensive interdisciplinary assessment in order to address related functional and quality-of-life issues associated with physical dysfunction.</p> <p>The current Comprehensive Team Assessment for Physical and Nutritional Management is a good initial effort, but should be expanded to serve individuals in need of specialized rehabilitation therapy services related to any functional domain(s), and not be limited to the realm of dysphagia-related health issues. A protocol for Comprehensive Team Assessment should include instructions to document reason for referral, pertinent diagnostic test findings, individual report/interview, and rationale for clinical recommendations.</p> <p>According to interview, review of the Central Program Services (CPS) procedures for Speech-Language Pathology, Hearing, and Education Services and assessment review, the protocol for Speech Therapy Assessments includes a screening upon consultation, followed by standardized evaluation tools based on screening findings and selected on an individualized basis as appropriate.</p> <p>Occupational Therapy assessments reviewed did not follow a consistent structure, but were written as a narrative in response to consultation. No standardized format for Occupational Therapy assessments has been developed or implemented.</p> <p>Upon review of the Rehabilitation Therapy Operations Manual, there were specifications for timelines for the completion of IRTA admission assessments, but no specifications for timeliness of response to consultation assessments/interventions for specialty disciplines. Record review of OT referrals and responses revealed an average of six days from the date of</p>
--	--

Section D: Integrated Assessments

		<p>consultation to the date of response. Review of the PT Referrals and Evaluation Monitoring database indicated an average of 16 days between date of referral and date evaluation was completed. There was no database available to assess similar averages for Speech Therapy response, but upon record review of Speech Therapy Assessments, it was noted that a referral for MW had been made by the WRP team, and the evaluation was not completed until six months following referral.</p> <p>The assessment process for Vocational Rehabilitation currently includes the following components: Vocational Screening Checklist, Sharps/Chemical Clearance, Magnolia Enterprise Vocational Services Training and Employment form, Learning Styles and Interest Survey, Vocational Services Safety Test, and the Extended Evaluation (this is done by the Vocational Services Specialist). However, there is not a protocol in place that describes the documentation requirements and time frames for this process.</p> <p>Compliance: Partial.</p> <p>Current recommendation:</p> <ol style="list-style-type: none"> 1. Revise and implement Rehabilitation Therapy protocol for Service Provision to include a description of all Rehabilitation Therapy disciplines, the disciplines' unified role in the WRP team process, and discipline-specific responsibilities in the team process. 2. Revise and implement Rehabilitation Therapy protocol for Documentation, Assessments, and Progress Notes to include descriptions of time frames, format, and content for all Rehabilitation Therapy Assessments, including Vocational Rehabilitation, Comprehensive Team Assessment for Physical and Nutritional Management, Physical Therapy, Speech Therapy, and Occupational Therapy assessments. 3. Revise and implement Comprehensive Team Assessment for Physical and Nutritional Management to address individual needs and supports that
--	--	--

Section D: Integrated Assessments

		<p>extend beyond the scope of dysphagia management, and ensure that this assessment is appropriate for use in assessing individuals within the inpatient Psychiatric Rehabilitation population.</p> <ol style="list-style-type: none"> 4. Develop and implement a plan to ensure that individuals who would benefit from a Comprehensive Team assessment are referred for this service by the WRPT. 5. Develop and implement Comprehensive Team Assessment for Physical and Nutritional Management instructions. 6. Revise and implement Integrated Rehabilitation Therapy Assessment procedure to ensure interdisciplinary assessment and/or collaboration, rather than assessment by one assigned therapist.
D.4.b	Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:	<p>Compliance: Partial.</p>
D.4.b.i	Is accurate and comprehensive as to the individual's functional abilities;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Continue to revise appropriate policies, procedures, and manuals regarding this requirement.</p> <p>Findings: Review of the Comprehensive Team Assessment for Physical and Nutritional Management revealed that the assessment is focused more on risk and disability/dysfunction than on determination of functional level and abilities and needs/supports. The assessment addresses mealtime function as far as adaptive equipment needs and mealtime risk factors, but does not assess specific functional level for eating, pleasure snacks, dining, or other activities of daily living. The section entitled "Sensory Perception/Integration and Aversions" does not allow for the assessment or documentation of sensory processing function, nor any assessment of modulation or self-regulation as it related to functional</p>

	<p>attention and arousal.</p> <p>Upon review of the Physical Therapy assessment, it is noted that the assessment is brief and based primarily on quantitative findings (e.g., range of motion measurements), and does not seem to allow for the documentation of narrative findings related to qualitative clinical observations (e.g., quality of movement, level of function).</p> <p>Recommendation 2, February 2007: Provide ongoing training to RT staff regarding changes implemented.</p> <p>Findings: Training entitled "Automation of Trigger System and Integrated Rehabilitation Therapy Assessment" was provided to rehabilitation therapists on 4/18/07, as evidenced by review of training rosters. However, no training materials or details of what information was presented was provided to this reviewer; according to email response from the trainer, it appears that training material was verbal, with no competency-based requirement.</p> <p>Recommendation 3, February 2007: Continue to develop and implement a system for monitoring and tracking the elements of this requirement.</p> <p>Findings: The Integrated Rehabilitation Therapy Assessment audit tool and instructions were developed and implemented in June 2007, and are pending statewide approval. However, the current Integrated Rehabilitation Therapy audit tool, instructions and assessment do not follow the same flow, order, and content. The audit tool currently seems to capture documentation compliance, and does not monitor for quality and accuracy of assessment findings. Interview with Rehabilitation Chief indicated that IRTA audits will be completed by five lead therapists. These therapists were trained with verbal instructions, as no written</p>
--	--

Section D: Integrated Assessments

		<p>training materials have been created, and there was no means to determine the competency of auditing therapists following training. Inter-rater reliability among the auditing therapists was not established prior to implementation of the auditing tool.</p> <p>There are no protocols written or in place for OT, SLP, Comprehensive Team Assessment for Physical Nutritional Management, or Vocational Services Assessment audits. There is an audit tool being used for Physical Therapy assessment and documentation, and upon review it appears to assess for documentation compliance rather than quality of content; no instructions for this audit were provided to this reviewer. Physical Therapy also tracks evaluation/consultation timeliness and completion in response to referral in a NSH Referrals and Evaluation Monitoring database. However, there was no protocol describing this process provided to this reviewer.</p> <p>Recommendation 4, February 2007: Provide ongoing training to all team members regarding dysphagia.</p> <p>Findings: Facility-wide trainings were provided in February and March 2007. This was verified by review of training rosters. Review of the flyer for the training indicated that training was presented by speakers from Speech Therapy and Nursing, and would address issues related to dysphagia, but no training curriculum material was made available to this reviewer. Nursing Education will provide dysphagia training in annual review, and all new employees will receive Dysphagia Basic Training as part of new employee orientation/training beginning in July 2007.</p> <p>Recommendation 5, February 2007: Obtain a wheelchair specialist to assist the teams in assessing the mobility needs and fabricating individual wheelchairs that promote appropriate body alignment for individuals who depend on the use of wheelchairs for the majority of their</p>
--	--	---

Section D: Integrated Assessments

		<p>mobility.</p> <p>Findings: The Physical Nutritional Management Planning (PNMP) Team has relationships with vendors who consult. A formal contract with a wheelchair specialist is pending and has not been established due to facility budget restrictions and protocol.</p> <p>Recommendation 6, February 2007: Streamline the process of obtaining adaptive equipment.</p> <p>Findings: The purchase of adaptive equipment follows state purchasing regulations and procedures; this is verified by review of purchase orders for adaptive equipment. However, it may be helpful to track dates upon which equipment is ordered, versus date of receipt and implementation/training.</p> <p>Recommendation 7, February 2007: Provide and document training to individuals and staff regarding the appropriate use of adaptive equipment.</p> <p>Findings: The PNMP team teaches and trains individuals and staff as adaptive equipment is implemented. However, this training is not currently competency-based. According to the monitoring of Dysphagia and Physical Nutrition Management program, training was provided by at least one member of the PNMP team for 28% of individuals with Physical and Nutritional support needs; however, this data does not specify whether it is related to training regarding adaptive equipment use or training regarding other supports such as positioning, techniques, and/or compensatory strategies.</p>
--	--	---

	<p>Recommendation 8, February 2007: Develop a monitoring system to ensure that individuals have access to their adaptive equipment and that it is in proper working condition, and that it is being used appropriately.</p> <p>Findings: There is a monitoring system in place to track whether an individual has a Dining Plan that has been completed, but there is no system in place to monitor in vivo to assess whether adaptive equipment used during meals, mobility (e.g., walker), activities of daily living (e.g., shower chair), or communication (e.g., pocket talker) are in use, in good repair, and appropriate to meet the individual's functional and safety-related needs.</p> <p>Recommendation 9, February 2007: Re-evaluate the adaptive equipment at least annually or in response to individuals' status changes to ensure that it is meeting the individuals' needs.</p> <p>Findings: The facility reports that this is being done by the PNMP team annually; however, this should be addressed throughout the year during monitoring of support implementation and upon reassessment secondary to change in status.</p> <p>Recommendation 10, February 2007: Develop a plan outlining how training, implementation of interventions, and monitoring will be executed for the units that have Level 1 risk individuals.</p> <p>Findings: The Rehabilitation Therapy Operations Manual procedure for the Physical and Nutritional Management Team states that individuals with Dining Plans and Level 1 risk will be monitored but does not specify frequency of monitoring. There is no form/means in place to document and report monitoring findings, or document incidence of incidental training or need for corrective action. Nursing Procedure</p>
--	---

Section D: Integrated Assessments

	<p>111 states that individuals at Level 1 risk will be monitored daily using the Dysphagia Risk Daily Flow record.</p> <p>Recommendation 11, February 2007: Implement the trigger flow sheets to actively collect clinical objective data in order to identify which individuals warrant priority standing for the completion of comprehensive assessments.</p> <p>Findings: This system has been implemented and continues to develop. According to the PNMP Team procedure, individuals referred for a comprehensive assessment are seen within two weeks and individuals referred for emergency consultations are seen for comprehensive assessment by the PNMP team within 24 hours.</p> <p>Other findings: According to record review of seven new admissions in June and July 2007, it was noted that 57% contained Integrated Rehabilitation Therapy Assessments according to protocol.</p> <p>According to NSH audit data for the month of June 2007 (combined data for initial and annual IRTA assessments with a total N of 39), 31% of assessments were completed within mandated time frames.</p> <p>Upon record review of assessments done within the last six months, it was noted that 77% contained an Integrated Rehabilitation Therapy Assessment, 46% of assessments were completed within five days according to procedure, 54% were complete, with all sections addressed, and 25% had findings that were accurate and consistent with those of other disciplines.</p> <p>Review of 10 comprehensive Team Assessments for Physical and Nutritional Management indicated that none were complete, with all objective findings sections and assessment summary documented, 30% adequately addressed functional status, none had documentation of rationale/justification for clinical</p>
--	---

Section D: Integrated Assessments

		<p>recommendations (e.g., adaptive equipment, liquid consistency) and 60% had Dining Plans that accurately addressed assessment findings/WRP recommendations.</p> <p>Review of Monitoring of Dysphagia/Physical Nutritional Management Program database indicated that 35% of individuals referred for Comprehensive Team Assessment (68 individuals) had all sections (PT, OT, ST, RD) completed.</p> <p>Review of Physical Therapy database of assessments completed between the months of March-July 2007 showed that 62% of referrals for Physical Therapy assessments were completed (with refusals excluded). Record review of Physical Therapy Assessments revealed that 100% of assessments addressed all sections regarding objective findings, and 32% contained functional and measurable objectives and findings. Record review for four individuals with mobility needs revealed that none of the four records contained adequate Physical Therapy follow-up/assessment in response to WRP referral, individual needs, and Falls Assessment triggers. In addition, upon later review of the state consultant's report dated 12/06, it was noted that one of these four individuals (DB) was identified by the consultants as in need of Physical Therapy assessment and mobility supports, and this individual's needs have not currently been met.</p> <p>Review of Speech Therapy Assessments showed that while 100% had recommendations regarding communication techniques and recommendations for direct/indirect treatment, only 11% contained functional and measurable objectives and findings.</p> <p>Upon record review of Vocational Assessments, it was noted that 100% contained Vocational Screening Checklist, 90% had Sharps Chemical clearance forms completed, 70% contained Magnolia Enterprise Vocational Services Training and Employment forms, and none had evidence of an Extended Evaluation or Vocational Safety Services Test.</p> <p>Compliance with Recommendations 7, 8, and 9 will be addressed in Rehabilitation</p>
--	--	--

Section D: Integrated Assessments

		<p>Services Treatment Enhancement section (F4) during next review, as these systems develop.</p> <p>Current recommendation:</p> <ol style="list-style-type: none"> 1. Ensure that all assessments provide a thorough assessment of functional ability, as opposed to a focus on dysfunction and disability. 2. Ensure that all individualized objectives are functional, meaningful, and measurable. 3. Provide competency-based training to Rehabilitation Therapy staff regarding all protocol revisions. 4. Develop and implement audit tools for all specialized Rehabilitation Therapy assessments, including Comprehensive Team Assessment for Physical and Nutritional Management, Vocational Rehabilitation, and Occupational and Speech Therapy assessments. 5. Revise and implement Physical Therapy audit tool to be consistent in format with newly developed audit tools and WRP Manual and EP requirements.
D.4.b.ii	<p>Identifies the individual's current functional status and the skills and supports needed to facilitate transfer to the next level of care; and</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Same as above.</p> <p>Findings: According to NSH audit data for the month of June 2007 (combined data for initial and annual IRTA assessments with a total N of 39), 33% of assessments identified skills and supports needed to transfer to the next level of care.</p> <p>Review of Physical Therapy, Speech Therapy, and Comprehensive Team assessments for Physical Nutritional Management revealed that 9% of Physical Therapy assessments, 11% of Speech Language assessments, and 30% of Comprehensive Team assessments had documentation of the individual's current</p>

Section D: Integrated Assessments

		<p>functional status and supports needed to facilitate transfer to the next level of care.</p> <p>Current recommendation: Ensure that all assessments identify the individual's current functional status and the skills and supports needed to facilitate transfer to the next level of care.</p>
D.4.b.iii	Identifies the individual's life goals, strengths, and motivation for engaging in wellness activities.	<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Same as above.</p> <p>Findings: According to NSH audit data for the month of June 2007 (combined data for initial and annual IRTA assessments with a total N of 39), 62% of assessments identified the individual's life goals, 53% identified strengths, and 56% identified motivation for engaging in wellness activities.</p> <p>Review of Physical Therapy, Speech Therapy, and Comprehensive Team assessments for Physical Nutritional Management revealed that 64% of Physical Therapy assessments, 50% of Speech Language assessments, and none of the Comprehensive Team assessments had documentation of identified individual's life goals.</p> <p>Current recommendation: Ensure that all assessments identify the individual's life goals, strengths, and motivation for engaging in wellness activities.</p>
D.4.c	Each State hospital shall ensure that all clinicians responsible for performing or reviewing rehabilitation therapy	<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007:</p>

Section D: Integrated Assessments

	<p>assessments are verifiably competent in performing the assessments for which they are responsible</p>	<p>Develop and implement a system for monitoring and tracking the elements of this requirement.</p> <p>Findings: Rehabilitation Therapy Operations Manual Credentials Verification and Privilege Delineation procedure states that therapists must meet criteria regarding appropriate entry-level practice degree (upon hiring), and continuing education, teaching, practice, publication/research, peer recommendation, supervision, consultation, and health status (reviewed every two years). New hires receive conditional privileges and proctorship during the first year of employment, although it is unclear per procedure what this entails as far as the performing or reviewing of assessments.</p> <p>Training regarding Integrated Rehabilitation Therapy Assessments and audits is not currently competency-based, no training/instructions exists for Comprehensive Team Assessments for Nutritional Physical Management, PT, OT, SLP, or Vocational Therapy Assessments, and thus no data is available regarding this requirement.</p> <p>Other findings: Inter-rater reliability was not established among the lead therapists and Chief of Rehabilitation Services prior to implementation of Integrated Rehabilitation Therapy audit tool.</p> <p>Compliance: Partial.</p> <p>Current recommendation:</p> <ol style="list-style-type: none"> 1. Establish inter-rater reliability prior to the implementation of Rehabilitation Therapy audit tools. 2. Ensure that individuals who are performing assessments have received competency-based training regarding these assessments, and have achieved
--	--	---

Section D: Integrated Assessments

		competency per protocol.
D.4.d	Each State hospital shall ensure that all rehabilitation therapy assessments of all individuals who were admitted to each State hospital before the Effective Date hereof shall be reviewed by qualified clinicians and, as indicated, revised to meet the criteria in § [IV.D.2], above.	<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Initiate process of reassessing and developing integrated rehabilitation therapy assessments for individuals who were admitted before June 1, 2006 upon approval of newly developed comprehensive Rehabilitation Therapy Assessment.</p> <p>Findings: According to interview with the Rehabilitation Therapy Chief, the plan for meeting this requirement is to schedule individuals according to the dates of annual assessments. However, therapists are no longer required to complete annual assessments, and a new plan will need to be made to ensure that individuals admitted to NSH prior to the June 2007 IRTA implementation date receive an Integrated Rehabilitation Therapy Assessment according to procedure within the next six months.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Ensure that all individuals admitted to NSH prior to 6/1/07 receive an Integrated Rehabilitation Therapy Assessment within the next six months.</p>

Section D: Integrated Assessments

D.5	Nutrition Assessments
	<p>Each State hospital shall provide nutrition assessments, reassessments, and interventions consistent with generally accepted professional standards of care. A comprehensive nutrition assessment will include the following:</p> <p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Wen Pao, Director of Dietetics 2. Kameo Campisi, Assistant Director of Dietetics <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Admission Nutrition Assessments from June and July 2007 for the following individuals: SC, MB, WS, AD, JM, CR, PH 2. Nursing Coordinator Meeting Minutes for 5/3/07 3. Dietetics Department Training Roster (1/07-6/07) 4. Dietetics Department Meeting Minutes and Plans of Correction (1/07-6/07) 5. RD Unit Lists (Tracking) 6. Nutrition Care Monitoring Tool (NCMT) (Monitoring) 7. Nutrition Care Monitoring Tool Instructions 8. Nutrition Assessment Initial/Annual 9. Nutrition Assessment Update 10. Nutrition Assessment form instructions 11. Nutrition Assessment Update form instructions 12. Records of new admissions for the following individuals admitted in June and July 2007: SC, MB, WS, AD, JM, CR, PH 13. Records of the following individuals with Nutrition Assessments Type B (direct admission to medical-surgical unit): RM, DG, DP, TF 14. Records of the following individuals with Nutrition Assessments Type D (new admission with identified nutrition triggers): EP, KJ 15. Records of the following individuals with Nutrition Assessments Type E (new admission with therapeutic diet order): DF, JW, RT, AR, JC, RT 16. Records of the following individuals with Nutrition Assessments Type F (therapeutic diet order after admission): EC, HW, CS, MH 17. Records of the following individuals with Nutrition Assessments Type G

Section D: Integrated Assessments

		<p>(standard admission assessment): VQ, MK, CL, AC, BS, JW, PV, PM</p> <p>18. List of individuals with Nutrition Assessment Type I</p> <p>19. Records of the following individuals with Nutrition Assessments Type I: RP, DG, JC, JC(2), DB, DC</p> <p>20. Records of the following individuals with Nutrition Assessments Type J (reassessment upon significant change in condition): RP, DG, JC, DB, DC, PR, TX, JN</p> <p>21. Records of the following individuals with Nutrition Assessments Type K (annual nutrition assessment): FM, IJ, JR, EL, JF, GB, BD, SB, AM</p> <p>22. Nursing Policy Basic 130</p> <p>23. High Risk Nutrition Referral Form</p>
D.5.a	<p>For new admissions with high risk referral (e.g., type I diabetes mellitus, enteral/parenteral feeding, dysphagia/recent choking episode), or upon request by physician, a comprehensive Admission Nutrition Assessment will be completed within 24 hours of notification to the dietitian.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Implement the high-risk referral monitoring and tracking system to identify individuals who meet this criterion to ensure that they receive adequate nutrition assessments.</p> <p>Findings: The High Risk Nutrition Referral Form was implemented 5/1/07. The Nursing Policy Basic 130 was revised to include these changes on 6/14/07, which is confirmed by review of the policy. Central Nursing Services Training was completed 5/3/07; this is verified by review of training record and meeting minutes.</p> <p>Other findings: No individuals admitted to NSH in the last six months met the criteria for high-risk referral, and so no records were available for audit or review.</p> <p>Compliance: Partial.</p>

Section D: Integrated Assessments

		<p>Current recommendation: Continue current practice.</p>
D.5.b	<p>For new admissions directly into the medical-surgical unit, a comprehensive Admission Nutrition Assessment will be completed within three days of admission.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Continue to monitor this requirement to ensure compliance with the EP.</p> <p>Findings: Record review of four individuals receiving Type B assessments from January-June 2007 (out of six total) indicated that 100% of assessments were completed on time, 75% had complete subjective findings, 100% had complete objective findings, 75% had functional and measurable goals, 75% had appropriate recommendations, and 50% had accurate acuity level assigned according to procedure.</p> <p>According to Nutrition Assessment audit data for January-June 2007, 100% of assessments were completed on time, 83% had complete subjective findings, 67% had complete objective findings, 67% had functional and measurable goals, 33% had appropriate recommendations, and 83% had accurate acuity level assigned according to procedure.</p> <p>Compliance: Partial.</p> <p>Current recommendations: Continue current practice.</p>
D.5.c	<p>For new admissions directly into the skilled nursing facility unit, a comprehensive Admission Nutrition</p>	<p>Current findings on previous recommendations:</p>

Section D: Integrated Assessments

	<p>Assessment will be completed within seven days of admission.</p>	<p>Recommendation 1, February 2007: Implement the high-risk referral monitoring and tracking system to identify individuals who meet this criterion to ensure that they receive adequate nutrition assessments.</p> <p>Findings: The High Risk Nutrition Referral Form was implemented 5/1/07. The Nursing Policy Basic 130 was revised to include these changes on 6/14/07, which is confirmed by review of the policy. Central Nursing Services Training was completed 5/3/07; this is verified by review of training record and meeting minutes.</p> <p>Recommendation 2, February 2007: Continue to monitor this requirement to ensure compliance with the EP.</p> <p>Findings: No individuals admitted to NSH in the last six months met the criteria for high-risk referral, and so no records were available for audit or review.</p> <p>Compliance: Partial.</p> <p>Current recommendations: Continue current practice.</p>
D.5.d	<p>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</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Identify issues/barriers that prevent Admission Nutrition Assessments for Assessment Type Ds from being completed in a timely manner.</p>

Section D: Integrated Assessments

	<p>diarrhea/vomiting more than 24hrs, and MAOI, as clinically indicated), a comprehensive Admission Nutrition Assessment will be completed within seven days of admission.</p>	<p>Findings: 100% of nutrition assessments have been completed in a timely manner past five months.</p> <p>Recommendation 2, February 2007: Implement the 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> <p>Findings: The High Risk Nutrition Referral Form was implemented 5/1/07. The Nursing Policy Basic 130 was revised to include these changes on 6/14/07, which is confirmed by review of the policy. Central Nursing Services Training was completed 5/3/07; this is verified by review of training record and meeting minutes.</p> <p>Recommendations 3 and 4, February 2007:</p> <ol style="list-style-type: none"> 3. Continue to retrain appropriate staff regarding deficiencies and appropriate procedures for Admission Nutrition Assessments. 4. Document the corrective actions taken. <p>Findings: Review of Dietetics Department Training Rosters from January-June 2007, corresponding meeting minutes emphasizing retraining in Nutrition Care Monitoring Tool areas under 90% compliance, and documentation of corrective actions/individual feedback for each dietitian/assessment audited reveal an excellent system in place for monitoring and retraining. The current system serves to identify departmental trends as well as areas in need of improvement on an individualized basis.</p> <p>Other findings: Record review of two individuals who received Type D assessments from</p>
--	--	--

Section D: Integrated Assessments

		<p>January-June 2007 (out of four total) indicated that 100% of assessments were completed on time, 100% had complete subjective findings, 100% had complete objective findings, 100% had functional and measurable goals, 100% had appropriate recommendations, and 100% had accurate acuity level assigned according to procedure.</p> <p>According to Nutrition Assessment audit data for January-June 2007, 75% of assessments were completed on time, 75% had complete subjective findings, 50% had complete objective findings, 50% had functional and measurable goals, 50% had appropriate recommendations, and 100% had accurate acuity level assigned according to procedure.</p> <p>Discrepancies in findings between NCMT audit data and the findings of this reviewer are due to small sample size (N of 4 for January-June 2007; N of 1 of records made available to this reviewer upon record request).</p> <p>Compliance: Partial.</p> <p>Current recommendation: Continue current practice.</p>
D.5.e	For new admissions with therapeutic diet orders for medical reasons, a comprehensive Admission Nutrition Assessment will be completed within seven days of admission.	<p>Recommendation 1 Identify issues/barriers that prevent Admission Nutrition Assessments for Assessment Type Es from being completed in a timely manner.</p> <p>Findings: According to NSH progress report data gleaned from trend analysis of staff attendance and monitoring data, staff shortage prevented >90% compliance for January, March, and June. The average compliance for Nutrition Care Assessment timeliness for January-June 2007 is 91% as indicated by corresponding audit data.</p>

Section D: Integrated Assessments

	<p>Recommendations 2 and 3, February 2007: Continue to retrain appropriate staff regarding deficiencies and appropriate procedures for Admission Nutrition Assessments. Document the corrective actions taken.</p> <p>Findings: Review of Dietetics Department Training Rosters from January-June 2007, corresponding meeting minutes emphasizing retraining in Nutrition Care Monitoring Tool areas under 90% compliance, and documentation of corrective actions/individual feedback for each dietitian/assessment audited reveal an excellent system in place for monitoring and retraining. The current system serves to identify departmental trends as well as areas in need of improvement on an individualized basis.</p> <p>Recommendation 4 Implement a system within the current monitoring system to track and follow up on nutritional assessments that were incomplete.</p> <p>Findings: All new admissions are audited each month. When an assessment is found incomplete, the Registered Dietician (RD) is notified, assessment is completed, audited, and included in the data source.</p> <p>Other findings: Record review of six individuals receiving Type E assessments from January-June 2007 (out of 35 total) indicated that 100% of assessments were completed on time, 100% had complete subjective findings, 100% had complete objective findings, 100% had functional and measurable goals, 100% had appropriate recommendations, and 100% had accurate acuity level assigned according to procedure.</p> <p>According to Nutrition Assessment audit data for January-June 2007, 91% of</p>
--	--

Section D: Integrated Assessments

		<p>assessments were completed on time, 98% had complete subjective findings, 87% had complete objective findings, 80% had functional and measurable goals, 68% had appropriate recommendations, and 89% had accurate acuity level assigned according to procedure.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Continue current practice.</p>
D.5.f	<p>For individuals with therapeutic diet orders for medical reason after admission, a comprehensive Admission Nutrition Assessment will be completed within seven days of the therapeutic diet order but no later than 30 days of admission.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Identify issues/barriers that prevent Admission Nutrition Assessments for Assessment Type Fs from being completed in a timely manner.</p> <p>Findings: The average compliance for Nutrition Care Assessment type F timeliness for January-June 2007 is 94% as indicated by corresponding audit data.</p> <p>Recommendations 2 and 3, February 2007:</p> <ol style="list-style-type: none"> 2. Continue to retrain appropriate staff regarding deficiencies and appropriate procedures for Admission Nutrition Assessments. 3. Document the corrective actions taken. <p>Findings: Review of Dietetics Department Training Rosters from January-June 2007, corresponding meeting minutes emphasizing retraining in Nutrition Care Monitoring Tool areas under 90% compliance, and documentation of corrective actions/individual feedback for each dietitian/assessment audited reveal an excellent system in place for monitoring and retraining. The current system</p>

Section D: Integrated Assessments

		<p>serves to identify departmental trends as well as areas in need of improvement on an individualized basis.</p> <p>Recommendation 4, February 2007: Implement a system within the current monitoring system to track and follow up on nutritional assessments that were incomplete.</p> <p>Findings: All new admissions are audited each month. When an assessment is found incomplete, the RD is notified, assessment is completed, audited and included in the data source.</p> <p>Other findings: Records review of four individuals receiving Type F assessments from January-June 2007 (out of 16 total) indicated that 100% of assessments were completed on time, 100% had complete subjective findings, 100% had complete objective findings, 100% had functional and measurable goals, 100% had appropriate recommendations, and 100% had accurate acuity level assigned according to procedure.</p> <p>According to Nutrition Assessment audit data for January-June 2007, 94% of assessments were completed on time, 94% had complete subjective findings, 81% had complete objective findings, 88% had functional and measurable goals, 75% had appropriate recommendations, and 94% had accurate acuity level assigned according to procedure.</p> <p>Compliance: Partial.</p> <p>Current recommendations: Continue current practice.</p>
--	--	---

Section D: Integrated Assessments

<p>D.5.g</p>	<p>For all other individuals, a comprehensive Admission Nutrition Assessment will be completed within 30 days of admission.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Continue to monitor Admission Nutrition Assessments for Assessment Type Gs to ensure that they are completed in a timely manner.</p> <p>Findings: The average compliance for Nutrition Care Assessment type g timeliness for January-June 2007 is 98% as indicated by corresponding audit data.</p> <p>Recommendations 2 and 3, February 2007:</p> <ol style="list-style-type: none"> 2. Continue to retrain appropriate staff regarding deficiencies and appropriate procedures for Admission Nutrition Assessments. 3. Document the corrective actions taken. <p>Findings: Review of Dietetics Department Training Rosters from January-June 2007, corresponding meeting minutes emphasizing retraining in Nutrition Care Monitoring Tool areas under 90% compliance, and documentation of corrective actions/individual feedback for each dietitian/assessment audited reveal an excellent system in place for monitoring and retraining. The current system serves to identify departmental trends as well as areas in need of improvement on an individualized basis.</p> <p>Recommendation 4, February 2007: Implement a system within the current monitoring system to track and follow up on nutritional assessments that were incomplete.</p> <p>Findings: All new admissions are audited each month. When an assessment is found incomplete, the RD is notified, assessment is completed, audited, and included in the data source.</p>
--------------	---	---

Section D: Integrated Assessments

		<p>Other findings: Records review of eight individuals receiving Type G assessments from January-June 2007 (out of 143 total) indicated that 100% of assessments were completed on time, 100% had complete subjective findings, 100% had complete objective findings, 100% had functional and measurable goals, 100% had appropriate recommendations, and 88% had accurate acuity level assigned according to procedure.</p> <p>According to Nutrition Assessment audit data for January-June 2007, 98% of assessments were completed on time, 96% had complete subjective findings, 79% had complete objective findings, 79% had functional and measurable goals, 74% had appropriate recommendations, and 94% had accurate acuity level assigned according to procedure.</p> <p>Compliance: Partial.</p> <p>Current recommendations: Continue current practice.</p>
D.5.h	Acuity level of an individual at nutritional risk will be determined by Nutritional Status Type ("NST") which defines minimum services provided by a registered dietitian.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Continue to monitor this requirement.</p> <p>Findings: According to Nutrition Care Monitoring Tool audit data for January-June 2007, 98% of assessments had documentation of correctly assigned acuity level.</p> <p>Other findings: Record review indicated the 95% of all Nutrition Care Assessments reviewed</p>

Section D: Integrated Assessments

		<p>contained correctly assigned acuity levels.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
D.5.i	<p>The frequency of a comprehensive Nutrition Assessment Update will be determined by the NST. Updates should include, but not be limited to: subjective data, weight, body-mass index ("BMI"), waist circumference, appropriate weight range, diet order, changes in pertinent medication, changes in pertinent medical/psychiatric problems, changes in nutritional problem(s), progress toward goals/objectives, effectiveness of interventions, changes in goals/plan, recommendations, and follow-up as needed.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Implement documents for tracking and monitoring system related to the elements of Nutrition Assessment Updates.</p> <p>Findings: The RD Unit Lists for tracking and Nutrition Care Monitoring tool have been implemented.</p> <p>Recommendation 2, February 2007: Continue to monitor this requirement for compliance.</p> <p>Findings: According to NSH progress report data gleaned from trend analysis of staff attendance and monitoring data, staff shortage prevented >90% compliance for January, April, and May. The average compliance for Nutrition Care Assessment timeliness for January-June 2007 is 89% as indicated by corresponding audit data.</p> <p>Other findings: Records review of individuals receiving Type I assessments from January-June 2007 indicated that 100% of assessments were completed on time, 100% had complete subjective findings, 100% had complete objective findings, 100% had</p>

Section D: Integrated Assessments

		<p>functional and measurable goals, 100% had appropriate recommendations, and 80% had accurate acuity level assigned according to procedure.</p> <p>According to Nutrition Assessment audit data for January-June 2007, 89% of assessments were completed on time, 88% had complete subjective findings, 78% had complete objective findings, 81% had functional and measurable goals, 87% had appropriate recommendations, and 96% had accurate acuity level assigned according to procedure.</p> <p>Compliance: Partial.</p> <p>Current recommendations: Continue current practice.</p>
D.5.j.i	Individuals will be reassessed when there is a significant change in condition.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Develop and implement a system to ensure that individuals who have a significant change in condition will be reassessed in a timely manner.</p> <p>Findings: The High Risk Nutrition Referral Form was implemented 5/1/07. The Nursing Policy Basic 130 was revised to include all updates to system on 6/14/07, which is confirmed by review of the policy. Central Nursing Services Training was completed 5/3/07; this is verified by review of training record and meeting minutes.</p> <p>Recommendation 2, February 2007: Develop and implement monitoring system to ensure that these individuals are adequately reassessed in a timely manner.</p>

Section D: Integrated Assessments

	<p>Findings: The average compliance for Nutrition Care Assessment Type J timeliness for January-June 2007 is 100% as indicated by corresponding audit data and by review of eight records by this reviewer.</p> <p>Recommendation 3, February 2007: Develop and implement a protocol addressing the criteria to be included in a nutrition assessment addressing a change in condition.</p> <p>Findings: Revisions regarding documentation of information related to change in condition have been made to Nutrition Care Assessment update form, NCMT instructions, and Nutrition Care Process.</p> <p>Recommendation 4, February 2007: Provide training regarding #3.</p> <p>Findings: This is verified by review of training roster for 03/20/07.</p> <p>Other findings: Record review of sample of eight individuals receiving Type J assessments from January-June 2007 indicated that 100% of assessments were completed on time, 100% had complete subjective findings, 100% had complete objective findings, 100% had functional and measurable goals, 66% had appropriate recommendations, and 100% had accurate acuity level assigned according to procedure.</p> <p>Nutrition Assessment auditing data of assessments that meet the criteria for D.5.j.i. are separated for the purposes of data analysis into j.i.(a) (reassessment with Significant Change in Condition/High Risk Referral) and j.i.(b) (reassessment with non-administrative transfer to med-surgical unit). According to audit data</p>
--	--

Section D: Integrated Assessments

		<p>for j.i.(a), 100% of assessments were completed on time, 100% had complete subjective findings, 90% had complete objective findings, 86% had functional and measurable goals, 83% had appropriate recommendations, and 100% had accurate acuity level assigned according to procedure. Audit data for j.i.(b) indicated 100% of assessments were completed on time, 86% had complete subjective findings, 14% had complete objective findings, 60% had functional and measurable goals, 94% had appropriate recommendations, and 93% had accurate acuity level assigned according to procedure.</p> <p>Compliance: Partial.</p> <p>Current recommendations: Continue current practice.</p>
D.5.j.ii	Every individual will be assessed annually.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Continue to ensure that each individual is nutritionally assessed annually.</p> <p>Findings: According to Nutrition Care audit data from February-July 2007, and sample of records reviewed by this reviewer, 100% of nutrition assessments were completed in a timely manner.</p> <p>Recommendations 2 and 3, February 2007: Continue to retrain appropriate staff regarding deficiencies and appropriate procedures for Admission Nutrition Assessments. Document the corrective actions taken.</p> <p>Findings: Review of Dietetics Department Training Rosters from January-June 2007,</p>

Section D: Integrated Assessments

		<p>corresponding meeting minutes emphasizing retraining in Nutrition Care Monitoring Tool areas under 90% compliance, and documentation of corrective actions/individual feedback for each dietitian/assessment audited reveal an excellent system in place for monitoring and retraining. The current system serves to identify departmental trends as well as areas in need of improvement on an individualized basis.</p> <p>Other findings: Record review of sample of individuals receiving Type K assessments from January-June 2007 indicated that 100% of assessments were completed on time, 100% had complete subjective findings, 100% had complete objective findings, 88% had functional and measurable goals, 77% had appropriate recommendations, and 100% had accurate acuity level assigned according to procedure.</p> <p>According to Nutrition Assessment audit data for January-June 2007, 100% of assessments were completed on time, 97% had complete subjective findings, 79% had complete objective findings, 79% had functional and measurable goals, 59% had appropriate recommendations, and 95% had accurate acuity level assigned according to procedure.</p> <p>Compliance: Partial.</p> <p>Recommendations: Continue current practice.</p>
--	--	--

Section D: Integrated Assessments

D.6	Social History Assessments	
	<p>Each State hospital shall ensure that each individual has a social history evaluation that, consistent with generally accepted professional standards of care:</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Ann Long, LCSW, Chief of Social Work Services <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Charts of 13 individuals (DF, JJ, JL, SD, GC, LM, MV, LG, DR, TG, JT, DP, and TF) 2. DMH Integrated Assessment Social Work Section 3. DMH 30-Day Psychosocial Assessment 4. DMH 30-Day Psychosocial Assessment Instructions 5. DMH Social History Assessments Audit Form 6. NSH Progress Report
D.6.a	<p>Is, to the extent reasonably possible, accurate, current and comprehensive:</p>	<p>NSH reviewed 41 5-day Integrated Social Work Assessments to address this recommendation, reporting 75% accuracy, 95% timely, and 28% comprehensive. A further review of 18 30-day Psychosocial Assessments showed 93% accuracy, 93% timely, and 57% comprehensive.</p> <p>This monitor reviewed 11 charts (TF, JT, DR, MV, LM, GC, SD, LG, JL, JJ, and DF). Three of them (TF, GC, and JL) did not have the assessments. Two of them (JT and SD) had no dates on the assessments to verify timeliness. Five of them (DF, JJ, DR, LG, and MV) were timely but not comprehensive, lacking information on social factors and educational status. LM was untimely and also was not comprehensive.</p> <p>Current findings on previous recommendations:</p> <p>Recommendations 1-4, February 2007:</p> <ol style="list-style-type: none"> 1. Develop quality indicators in the Social Work monitoring instruments.

Section D: Integrated Assessments

	<ol style="list-style-type: none">2. Implement the 30-day social history reviews.3. Develop and implement monitoring of the 30-day social history evaluations.4. Develop, finalize and implement statewide annual social history evaluations. <p>Findings: The facility adapted item #11 (<i>The assessment contributes to clinical decision making, discharge planning and aftercare services</i>) of the DMH Assessments Audit Form, as a quality indicator. According to Ann Long, Chief of Social Work, item #11 was approved as a quality indicator by the Chiefs of Social Work on June 14, 2007, and the documents and Manual were finalized on July 6, 2007. NSH now is waiting for DMH approval of these instruments.</p> <p>The 30-day social history evaluation monitoring tool and criteria were approved by the Chiefs of Social Work, and is awaiting DMH approval. Meanwhile, NSH has conducted staff training on the monitoring tool on June 20, 2007. The facility indicated that six social workers conducted inter-rater reliability assessment on items #4 (<i>Expressly identifies factual inconsistencies among sources</i>), #5 (<i>Resolves or attempts to resolve inconsistencies</i>), and #6 (<i>Explain the rationale for the resolution offered</i>) of the 5-day and 30-day assessment monitoring tools. A review of the facility's inter-rater reliability data showed lack of total agreement on many items. Staff is in need of further training.</p> <p>Recommendation 5, February 2007: Align monitoring tools with the Evaluation Plan.</p> <p>Findings: NSH has aligned the 5-Day social history assessment and the 30-Day psychosocial assessment monitoring tools, along with appropriate instructions for the assessment monitoring tools, with the EP. Staff has been trained on the new version of the monitoring instruments.</p>
--	---

Section D: Integrated Assessments

		<p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Implement the 30-day social history reviews. 2. Develop and implement monitoring of the 30-day social history evaluations. 3. Develop, finalize and implement statewide annual social history evaluations.
D.6.b	Expressly identifies factual inconsistencies among sources, resolves or attempts to resolve inconsistencies, and explains the rationale for the resolution offered;	<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Ensure that social workers identify and address the inconsistencies in current assessments.</p> <p>Findings:</p> <p>NSH reviewed 18 30-Day Psychosocial Assessments completed in March through May, 2007, using items #4 (<i>Expressly identifies factual inconsistencies among sources</i>), #5 (<i>Resolves or attempts to resolve the inconsistencies</i>), and #6 (<i>Explains the rationale for the resolution offered</i>), reporting 56%, 67% and 57% compliance respectively. The data showed that inconsistencies are not always identified or resolved.</p> <p>Factual inconsistencies are addressed through the 30-day Psychosocial Assessment. This monitor reviewed ten charts (TF, JT, DR, LM, GC, SD, LG, JL, JJ, and DF). Three of the charts (TF, GC, and JL) did not have the individuals' 30-day assessments. Two of them (JT and DR) addressed inconsistencies. Five of them (SD, LG, JJ, DF, and LM) did not address inconsistencies.</p> <p>Compliance: Partial.</p>

Section D: Integrated Assessments

		<p>Current recommendation: Ensure that social workers identify and address the inconsistencies in current assessments.</p>
D.6.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>Current findings on previous recommendations:</p> <p>Recommendation 1-3, February 2007:</p> <ol style="list-style-type: none"> 1. Ensure all SW integrated assessments are completed and available to the WRPT before the seven-day WRPC. 2. Ensure that assessments are not completed too early. 3. Continue to implement the 5-day and 30-day SW assessments. <p>Findings: NSH used item #7 (<i>Is included in the 5-day integrated assessment</i>) of the 5-day Integrated Social Work Assessment, to evaluate timeliness of the assessments. Thirty-one of the 41 (75%) assessments were timely. However, ten of them (25%) were completed by the first day of admission, such early completion of the assessments potentially exclude additional information that may be available if the assessments were conducted later in the week.</p> <p>This monitor reviewed twelve 5-day assessments (DF, JJ, JL, SD, GC, LM, MV, LG, DR, TF, JT, and DP). Nine of them (DF, JL, SD, GC, LM, MV, LG, TF, and JT) were timely, and three of them were untimely (JJ, DR, and DP).</p> <p>This monitor also reviewed eleven 30-day psychosocial assessments (TF, JT, DR, MV, LM, GC, SD, LG, JL, JJ, and DF). Five of them (MV, DR, LG, JJ, and DF) were conducted in a timely manner, one was untimely (LM), two (JT and SD) were undated and their timeliness not verifiable, and three of them (TF, GC, and JL) did not have their 30-day assessments.</p>

Section D: Integrated Assessments

		<p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure all SW integrated assessments are completed and available to the WRPT before the 7-day WRPC. 2. Ensure that assessments are not completed too early.
D.6.d	Reliably informs the individual's interdisciplinary team about the individual's relevant social factors and educational status.	<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Ensure that social histories reliably inform the individual's WRPT about the individual's relevant social factors and educational status.</p> <p>Findings: NSH reviewed a sample of 18 of 91 (20% sample) individuals' charts meeting the 30-day length of stay (March through June 2007), to address this recommendation. Eighty-six percent of the charts reviewed identified both educational status and social factors.</p> <p>This monitor reviewed eleven (MV, JT, DF, LG, JJ, LM, DR, TF, GC, JL, and SD) 30-Day Psychosocial Assessments to determine if the assessments contained relevant social factors and educational status. Only three (MV, JT, and DF) of the eleven were complete. One of them (LG) identified the individual's educational status and one of them (JJ) identified the individual's social factors. Three of them (LM, DR, and SD) did not have either the social factors or the educational status. Three of them (TF, GC, and JL) did not have the 30-Day assessments.</p> <p>Compliance: Partial.</p>

Section D: Integrated Assessments

		<p>Current recommendation: Ensure that social histories reliably inform the individual's WRPT about the individual's relevant social factors and educational status.</p>
--	--	---

Section D: Integrated Assessments

D.7	Court Assessments	
		<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. George Splane, MD, Staff Psychiatrist and member of the Forensic Review Panel (FRP) 2. Jeffrey Zwerin, DO, Medical Director 3. David Thomas, MD, Assistant Medical Director <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Charts of six individuals who were admitted under PC 1026 (JM, EH, MHJ, LD, GT and QV)) 2. Charts of six individuals who were admitted under PC 1370 (CS, BJ, FM, JJ, MAH and JN) 3. A sample of e mail communications from FRP to members of the WRPTs 4. Court reports Monitoring Form for PC 1026 5. Court reports Monitoring for PC 1026 summary data (January to June 2007) 6. Court reports Monitoring Form for PC 1370 7. Court reports Monitoring for PC 1370 summary data (January to June 2007) 8. Minutes of the FRP meetings January to June 2007
D.7.a	<p>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>	<p>Compliance: Partial.</p>

Section D: Integrated Assessments

<p>D.7.a.i</p>	<p>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>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Continue FRP reviews and corrective feedback regarding all PC 1026 and PC 1370 court submissions.</p> <p>Findings: FRP continues to review 100% of reports and gives feedback and/or requests for correction via email.</p> <p>Recommendation 2, February 2007: Address the reason(s) for any significant discrepancy between findings of the monitor and the facility's data.</p> <p>Findings: FRP has worked on inter-rater reliability by discussing reports as a group during the weekly meetings. The facility expects that this process will diminish the discrepancy between the monitor's and NSH data. The responsibility for report writing is now shared between unit psychiatrists and other disciplines (psychology, social work and rehabilitation therapy). The facility anticipates that this will improve the quality of the reports in view of the excessive case loads that the psychiatrists currently have as a result of increased vacancy rate. Reviews by this monitor indicate that the facility has made some progress in providing an assessment of areas of low compliance. However, significant discrepancy between findings of the monitor and the facility's data still exists.</p> <p>Recommendation 3, February 2007: Continue to monitor this requirement.</p> <p>Findings: Using the Court Reports PC 1026 Monitoring Form, the FRP has reviewed a 100% of the reports between January and June 2007. The facility reported mean</p>
----------------	---	---

Section D: Integrated Assessments

		<p>compliance rate of 91% for this requirement. The mean compliance rate for each of the other requirements (D.76.a.ii through D.7.a.ix) is entered for each corresponding cell below.</p> <p>Other findings: This monitor reviewed the charts of six individuals (JM, EH, MHJ, LD, GT and QV) who were admitted under PC 1026. The FRP representative participated in these reviews. This monitor found compliance in four cases (JM, EH, LD and QV) and partial compliance in two (MHJ and GT).</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. The FRP should continue to review all PC 1026 reports, provide feedback to the teams, with follow-up, to ensure compliance with plan requirements prior to court submission. 2. Address the reason(s) for any significant discrepancy between findings of the monitor and the facility's data. 3. Continue to monitor this requirement.
D.7.a.ii	acts of both verbal and physical aggression and property destruction during the past year of hospitalization and, if relevant, past acts of aggression and dangerous criminal behavior;	<p>Using the above-mentioned process, NSH reported a mean compliance rate of 79% with this requirement. The FRP has found that some report writers omit mention of this requirement when individuals are doing well (e.g. having Level III grounds access) or when they reside on an open unit and that further feedback from the panel is needed to improve compliance.</p> <p>Reviews by this monitor of six charts showed compliance in three cases (JM, EH and MHG), non-compliance in two (LOD and QV) and partial compliance in one (GT).</p>
D.7.a.ii i	understanding of potential for danger and precursors of dangerous/criminal behavior, including instant offense;	<p>The facility reported a mean compliance rate of 75% with this requirement. The FRP found that the report writers tend to omit the requirements in D.7.a.iv to D.7.a.v when the individual is doing poorly and focus instead on severe maladaptive behavior. The FRP is aware of the need for further feedback to</p>

Section D: Integrated Assessments

		<p>improve compliance.</p> <p>This monitor found non-compliance in five charts (JM, EH, LD, GT and QV) and partial compliance in one (MHJ)</p>
D.7.a.iv	<p>acceptance of mental illness and understanding of the need for treatment, both psychosocial and biological, and the need to adhere to treatment;</p>	<p>NSH reported a mean compliance rate of 83%.</p> <p>This monitor found compliance in two charts (EH and QV), partial compliance in two (JM and MHJ) and non-compliance in two (LD and GT).</p>
D.7.a.v	<p>development of relapse prevention plan (i.e., Personal Wellness Recovery Plan or Wellness Recovery Action Plan) for mental illness symptoms, including the individual's recognition of precursors and warning signs and symptoms and precursors for dangerous acts;</p>	<p>The facility's mean compliance rate was 77%.</p> <p>This monitor found non-compliance in three charts (LD, GT and QV), partial compliance in two (JM and EH) and compliance in one (MHJ).</p>
D.7.a.vi	<p>willingness to achieve understanding of substance abuse issues and to develop an effective relapse prevention plan (as defined above);</p>	<p>NSH reported a mean compliance rate of 66% (for applicable cases). The FRP acknowledged the need for frequent feedback due the omission of this requirement by some teams, generally when the individual is not engaged in treatment.</p> <p>This monitor found compliance in one chart (QV) and non-compliance in one (LD). This item was not applicable in other four charts reviewed.</p>
D.7.a.vii	<p>previous community releases, if the individual has had previous CONREP revocations;</p>	<p>The facility's mean compliance rate was 92% (for applicable cases). The FRP found that in some reports, there is little or no further discussion either in the background history or current progress sections when the identifying information indicates previous revocations. The facility acknowledged that its high compliance rate is limited by the small number of applicable cases.</p>

Section D: Integrated Assessments

		This item was applicable in three out of six charts reviewed by this monitor. There was compliance in two charts (LD and GT) and non-compliance in one (QV).
D.7.a. viii	social support, financial resources, family conflicts, cultural marginalization, and history of sexual and emotional abuse, if applicable; and	The facility reported mean compliance rate of 51%. This monitor's reviews showed non-compliance in all charts (JM, EH, MHJ, LD, GT and QV).
D.7.a. ix	relevant medical issues, all self-harm behaviors, risks for self harm and risk of harm to others, to inform the courts and the facility where the individual will be housed after discharge.	The facility reported mean compliance rate of 91%. This monitor found non-compliance in four charts (MHJ, LD, GT and QV) and partial compliance in two (JM and EH).
D.7.b	Each State hospital shall develop and implement policies and procedures to ensure an interdisciplinary approach to the development of court submissions for individuals admitted to the hospital pursuant to Penal Code Section 1370, "incompetent to stand trial" ("IST"), based on accurate information and individualized risk assessments. Consistent with the right of an individual accused of a crime to a speedy trial, the focus of the IST hospitalization shall be the stabilization of the symptoms of mental illness so as to enable the individual to understand the legal proceedings and to assist his or her attorney in the preparation of the defense. The forensic reports should include the following:	Compliance: Partial.

Section D: Integrated Assessments

D.7.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>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Same as above.</p> <p>Findings: Using the Court Reports PC 1370 Monitoring Form, the facility reported a mean compliance rate of 92% for this requirement. The mean compliance rates for requirements in D.7.b.ii to D.7.b.iv are listed for each corresponding requirement below.</p> <p>Other findings: This monitor reviewed the charts of six individuals who were admitted under PC 1370 (CS, BJ, FM, JJ, MAH and JN). The FRP representative participated in these reviews. This monitor found partial compliance in three cases (CS, JJ and JN), non-compliance in two (BJ and MAH) and compliance in one (FM). The FRP representative agreed with this monitor that some reports addressed this requirement by using generic language that reiterated legal criteria of incompetence rather than providing an individualized and meaningful clinical description.</p> <p>Current recommendation: Same as D.7.a.i (as applicable to PC 1370).</p>
D.7.b.ii	<p>clinical description of the individual at the time of admission to the hospital;</p>	<p>The facility reported a mean compliance rate of 98% for this requirement.</p> <p>Reviewing six charts, this monitor found compliance in three cases (CS, FM, JJ and JN), partial compliance in one (BJ) and non-compliance in one (MAH).</p>
D.7.b.iii	<p>course of hospital stay, describing any progress or lack of progress, response to treatment, current relevant mental</p>	<p>The facility reported the following mean compliance rates for each sub-item of this requirement:</p>

Section D: Integrated Assessments

	<p>status, and reasoning to support the recommendation; and</p>	<ol style="list-style-type: none"> 1. Describing any progress or lack of progress: 95%. 2. Individual's response to treatment: 92%. 3. Current relevant mental status: 89%. 4. Reasoning to support the recommendation: 90%. <p>This monitor found partial compliance in three charts (BJ, FM and MAH), non-compliance in two (CS and JN) and compliance in one (JJ).</p>
<p>D.7.b. iv</p>	<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>The facility reported a mean compliance rate of 76%. The facility acknowledged that its compliance rating is limited by the small number of applicable cases.</p> <p>This monitor found non-compliance rate in all charts (CS, JJ and JN) where the requirement was applicable</p>
<p>D.7.c</p>	<p>Each State hospital shall establish a Forensic Review Panel (FRP) to serve as the internal body that reviews and provides oversight of facility practices and procedures regarding the forensic status of all individuals admitted pursuant to Penal Code 1026 and 1370. The FRP shall review and approve all forensic court submissions by the Wellness and Recovery Teams and ensure that individuals receive timely and adequate assessments by the teams to evaluate changes in their psychiatric condition, behavior and/or risk factors that may warrant modifications in their forensic status and/or level of restriction</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Continue current practice.</p> <p>Findings: FRP continues to meet weekly, reviews all reports and has a full complement of members.</p> <p>Compliance: Substantial.</p> <p>Current recommendation:</p> <ol style="list-style-type: none"> 1. The FRP should continue to review all PC 1026 reports, provide feedback to the teams, with follow-up, to ensure compliance with plan requirements prior to court submission. 2. The Chair of the FRP should have supervisory responsibilities and administrative support to ensure coordination of the FRP process, tracking of

Section D: Integrated Assessments

		<p>the status of all PC 1370 and 1026 reports, prioritization of reports for review by the FRP, keeping minutes of the FRP meetings and provision of feedback to psychiatrists (and other clinicians) and follow-up corrective actions. These essential enhancements would ensure that a full array of forensic services that meet generally accepted professional standards are provided in the California DMH State Hospitals.</p>
<p>D.7.c.i</p>	<p>The membership of the FRP shall include Director of Forensic Psychiatry, Facility Director or designee, Medical Director or designee, Chief of Psychology or designee, Chief of Social Services or designee, Chief of Nursing Services or designee, and Chief of Rehabilitation Services or designee. The Director of Forensic Psychiatry shall serve as the chair and shall be a board certified forensic psychiatrist. A quorum shall consist of a minimum of four FRP members or their designee.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Continue current practice.</p> <p>Findings: The prior FRP chair left the hospital and the panel is currently chaired by a consultant from the Forensic Psychiatry Program at the University of California at Davis. NSH expects to hire more board-certified forensic psychiatrists in the upcoming months and one of them may assume this position.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Expedite recruitment of needed psychiatrists, including a permanent Chair of the FRP who has specialty certification in forensic psychiatry.</p>

Section E: Discharge Planning and Community Integration

E	Discharge Planning and Community Integration	
		<p>Summary of Progress:</p> <ol style="list-style-type: none"> 1. NSH has put into place a number of structural pieces to effect change in the system and to provide support to mid-manager and unit staff. 2. NSH has developed and implemented a number of monitoring and auditing tools to help track and monitor EP requirements. 3. NSH has continued to provide teaching/training/education using resources within the system (staff, CRIPA consultants), as well as encouraging and supporting staff attendance at conferences and workshops outside the system. 4. NSH has collaborated with the other facilities to coordinate development of tools and resources.
E	<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><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Ann Long, LCSW, Chief of Social Work <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Charts of 32 individuals (AL, AR, AS, AT, BH, CH, CLC, CS, DC, DCC, EA, EH, EM, FK, GB, GS, JB, JL, JS, KW, LK, LT, MC, MP, MW, NF, RAE, SB, TM, TQ, VH, and VV) 2. DMH WRP Manual 3. WRP Observation Monitoring Tool 4. DMH WRP observation Monitoring Form Instructions 5. WRP Clinical Chart Audit Form 6. DMH WRP Discharge Planning and Community Integration Audit Form 7. DMH WRP Discharge Planning and Community Integration Audit Form Manual 8. NSH progress report on Discharge Planning and Community Integration section

Section E: Discharge Planning and Community Integration

		<p>9. List of Individuals Referred for Discharge but Still Hospitalized 10. WRP 7-day Observation Form 11. WRP Monthly Observation Form 12. WRP Quarterly/Annual Observation Form</p> <p><u>Observed:</u> 1. Individuals AL, WR, MG, and WB</p>
E.1	<p>Each State hospital shall identify at the 7-day therapeutic and rehabilitation service planning conference, and address at all subsequent planning conferences, the particular considerations for each individual bearing on discharge, including:</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Develop a plan to achieve continuity of the discharge process from admission to discharge through the WRP and WRPT process.</p> <p>Findings: NSH has yet to develop any plans to evaluate the continuity of the discharge process from admission to discharge through the WRP and WRPT process.</p> <p>Recommendation 2, February 2007: Develop a tool to monitor the involvement of the individual in the discussion of progress on meeting discharge criteria.</p> <p>Findings: NSH chose to use the DMH WRP Observation Monitoring Form as the tool to address this recommendation.</p> <p>NSH observed 70 WRPCs using item #40 of the WRP Observation Monitoring Form to address this recommendation, reporting a mean compliance of 10%. The table below with its monitoring indicator is a summary of the facility's data.</p> <p><i>The WRPC asks the individual for his or her input into the evaluation of progress on each objective related to discharge.</i></p>

Section E: Discharge Planning and Community Integration

	Jan	Feb	Mar	Apr	May	Jun	Mean
# WRPC Observed	2	5	10	16	24	20	
#meeting Criteria	0	0	3	2	3	1	
% C #40	0	0	30	12.5	12.5	5	10

This monitor observed two WRP conferences (WB and MG). The individual's input and discussion into each discharge criterion was not elicited during the conference proceedings.

Recommendation 3, February 2007:
Ensure that social workers review discharge status on each discharge criterion with the WRPT and the individual at all scheduled WRP conferences involving the individual.

Findings:
NSH used item #35 of the WRP Observation Monitoring Form (*The team reviews the PSR Mall Facilitator's Monthly Progress Notes for all objectives related to discharge*) to monitor this item. However, NSH's review of the Mall progress notes to address this recommendation is incorrect. The recommendation calls for social workers to review discharge status at WRPCs and this data can be obtained only through observation of WRPCs and chart audits.

This monitor observed two WRPCs (WB and MG). The individual's discharge status on each discharge criterion was not reviewed in either conference.

This monitor also reviewed ten charts (LT, CH, SB, DCC, NF, EH, DC, CLC, VH, and AT). None of them showed documented evidence that the social worker in

Section E: Discharge Planning and Community Integration

		<p>the WRPT reviewed the individual's discharge status on each discharge criterion with the WRPT and or the individual.</p> <p>Recommendation 4, February 2007: Ensure that the Present Status section of the Quarterly WRP is updated to reflect the status of each discharge criteria.</p> <p>Findings: NSH reviewed 57 charts using item #58 (<i>Present Status includes progress toward discharge and potential placement</i>) of the WRP Clinical Chart Audit Monitoring Form, reporting 0% compliance.</p> <p>This monitor reviewed ten charts (LT, CH, SB, DCC, NF, EH, DC, CLC, VH, and AT). One WRP (LT) did not have any boxes checked to indicate the time period of the conference. A review of the remaining nine Quarterly WRPs (CH, SB, DCC, NF, EH, DC, CLC, VH, and AT) showed that none of them documented the status of each discharge criterion of the individual in the Present Status sections of their WRPs. Documentation in SB's Present Status section read, "There are no specific discharge plans at this time", and the Discharge Criteria for Anticipated Placement section of his WRP was left blank.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Develop a plan to achieve continuity of the discharge process from admission to discharge through the WRP and WRPT process. 2. Ensure that social workers review discharge status on each discharge criterion with the WRPT and the individual at all scheduled WRP conferences involving the individual. 3. Ensure that the Present Status section of the Quarterly WRP is updated to reflect the status of each discharge criterion.
--	--	--

Section E: Discharge Planning and Community Integration

<p>E.1.a</p>	<p>those factors that likely would foster successful discharge, including the individual's strengths, preferences, and personal life goals;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Develop a Discharge Planning Audit tool.</p> <p>Findings: NSH has adopted the WRP Discharge Planning & Community Integration Audit Form as the facility's tool to audit Discharge Planning. NSH has also developed the DMH WRP Discharge Planning and Community Integration Audit Form Manual to standardize the administration of the tool, and assist staff in utilizing the audit tool. According to Ann Long, Chief of Social Work, the audit tool and its instructions were agreed to by the Chiefs of Social Work from the other facilities on June 13, 2007. The facilities are awaiting DMH approval for these instruments.</p> <p>Recommendation 2, February 2007: Link the individual's life goals to one or more focus/foci of hospitalization, with associated objectives and interventions.</p> <p>Findings: NSH audited charts using item #5 of the WRP Chart Auditing Form (<i>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)</i>) to address this recommendation, reporting 0% compliance. The table below with its monitoring indicator is a summary of the facility's data. Item #5 is not specific to this recommendation.</p>
--------------	---	--

Section E: Discharge Planning and Community Integration

		<table border="1" data-bbox="894 228 1892 418"> <thead> <tr> <th></th> <th>Jan</th> <th>Feb</th> <th>Mar</th> <th>Apr</th> <th>May</th> <th>Jun</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td># WRPs Reviewed</td> <td>671</td> <td>555</td> <td>467</td> <td>345</td> <td>204</td> <td>233</td> <td></td> </tr> <tr> <td># Meeting Criteria</td> <td>8</td> <td>4</td> <td>2</td> <td>1</td> <td>0</td> <td>0</td> <td></td> </tr> <tr> <td>% C #5</td> <td>1</td> <td>1</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> </tr> </tbody> </table> <p data-bbox="894 461 1839 565">This monitor reviewed five charts (CLC, EH, LK, AS, and CH). None of them linked the individuals' life goals to a focus/foci of hospitalization with associated objectives and interventions.</p> <p data-bbox="894 610 1094 675">Compliance: Non-compliance.</p> <p data-bbox="894 721 1877 824">Current recommendations: Link the individual's life goals to one or more focus/foci of hospitalization, with associated objectives and interventions.</p>		Jan	Feb	Mar	Apr	May	Jun	Mean	# WRPs Reviewed	671	555	467	345	204	233		# Meeting Criteria	8	4	2	1	0	0		% C #5	1	1	0	0	0	0	0
	Jan	Feb	Mar	Apr	May	Jun	Mean																											
# WRPs Reviewed	671	555	467	345	204	233																												
# Meeting Criteria	8	4	2	1	0	0																												
% C #5	1	1	0	0	0	0	0																											
E.1.b	the individual's level of psychosocial functioning;	<p data-bbox="894 870 1495 899">Current findings on previous recommendations:</p> <p data-bbox="894 945 1881 1081">Recommendation 1, February 2007: Ensure that the level of psychosocial functioning (functional status) is included in the individual's Present Status section of the case formulation section of the WRP.</p> <p data-bbox="894 1127 1871 1268">Findings: NSH reviewed five charts using item #3 (<i>The individual's level of psychosocial functioning</i>) of the DMH WRP Discharge Planning and Community Integration Auditing tool to address this recommendation, reporting 100% compliance.</p> <p data-bbox="894 1313 1887 1380">This monitor reviewed ten charts (LK, GB, MP, AL, AS, EM, AT, VH, MW, and CLC). In all cases, the individual's "general functioning" was mentioned, however,</p>																																

Section E: Discharge Planning and Community Integration

		<p>none of them specifically documented the individual's "level of psychosocial functioning" in the individual's Present Status section of the WRP. For example, for MW, "Mr. W has attended and showed pleasure in Art class in the past," or for CLC, "C was encouraged to attend groups regularly for skills building, and to participate in unit activities to improve social skills and peer interactions" are insufficient.</p> <p>Documentation of the individual's level of psychosocial functioning requires statements on how much progress/lack of progress the individual has made with regards to his/her assigned groups and therapies.</p> <p>The individual's DMH Monthly PSR Progress Notes become indispensable for the WRP teams to fully document the individual's "level of psychosocial functioning" and to meet compliance with this recommendation. NSH should take immediate steps to fully implement the Mall Monthly Progress Notes.</p> <p>Recommendation 2, February 2007: Implement the DMH WRP Manual in developing and updating the case formulation.</p> <p>Findings: According to Ann Long, Chief of Social Work, NSH is continuing to train, monitor, and implement this recommendation.</p> <p>This monitor reviewed five charts (EM, AS, AT, MW, and VH). The WRPs in these charts lacked specificity and depth in their case formulation. For example, entry in the Predisposing Factors section of MW reads, "His parents were both hospitalized at Napa State Hospital at the time he was conceived. He was raised in a variety of foster homes and group homes." This entry left out the individual's biological considerations, psychosocial considerations, emotional and physical and or sexual abuse, and medical illnesses and risks that directly or indirectly contributed to the individual's current status of</p>
--	--	--

Section E: Discharge Planning and Community Integration

		<p>functioning. The weakest section among the WRPs reviewed was the Present Status section. None of the WRPs discussed barriers to discharge and how the team was helping individuals overcome the barriers. Review of the individual's self-assessment of recovery, and BY CHOICE entries were non-existent (VH, MW, and AS). When the individual was asked about his/her own self-assessment, there was no follow-up to make the response meaningful. For example, in the case of AT, the entry simply states, "Mr. T was asked about his own assessment of the progress in recovery," without noting what was said by AT, and if any follow-up to the response was necessary.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that the level of psychosocial functioning (functional status) is included in the individual's Present Status section of the case formulation section of the WRP. 2. Implement the DMH WRP Manual in developing and updating the case formulation.
E.1.c	<p>any barriers preventing the individual from transitioning to a more integrated environment, especially difficulties raised in previously unsuccessful placements; and</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007:</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 WRPCs. 2. Include skill training and supports in the WRP so that the individual can overcome the stated barriers. 3. Report to the WRPT, on a monthly basis, the individual's progress made in overcoming the barriers to discharge.

Section E: Discharge Planning and Community Integration

		<p>Findings:</p> <p>NSH audited 57 charts using item #41 (<i>Psychosocial Interventions: summary of and response over course of illness including positive responses</i>) of the WRP Clinical Chart Audit to address this recommendation, reporting 0% compliance.</p> <p>NSH also audited 71 WRPCs (between January and June 2007) using item #35 of the WRP observation Monitoring Form, reporting 2% compliance. The table below with its monitoring indicator is a summary of the facility's data:</p> <p><i>The team reviews the PSR Mall Facilitator's Monthly Progress Notes for all objectives related to discharge.</i></p> <table border="1" style="margin-left: auto; margin-right: auto;"> <thead> <tr> <th></th> <th>Jan</th> <th>Feb</th> <th>Mar</th> <th>Apr</th> <th>May</th> <th>Jun</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td># WRPC Observed</td> <td>1</td> <td>5</td> <td>8</td> <td>16</td> <td>23</td> <td>18</td> <td></td> </tr> <tr> <td>#meeting Criteria</td> <td>0</td> <td>0</td> <td>1</td> <td>0</td> <td>0</td> <td>0</td> <td></td> </tr> <tr> <td>% C #35</td> <td>0</td> <td>0</td> <td>12.5</td> <td>0</td> <td>0</td> <td>0</td> <td>2.1</td> </tr> </tbody> </table> <p>The PSR Mall Facilitator's Monthly Progress notes have just recently been introduced at NSH in three units (A9, T16, and T3). Most WRPTs would not have received the progress notes for review.</p> <p>This monitor reviewed six charts (EM, AS, AT, NF, CH, and JB). Discharge barriers were identified in two of them (JB and CH), though in the case of CH the discussion was not entered in the Present Status section but was entered as a post note under the Discharge Criteria for Anticipated Placement section. Progress made in overcoming the barriers was indicated (as in this case no progress was made) in CH. The skills support and training the individual needs to overcoming the barriers were not discussed in any of the Present Status sections of these individuals. The Present Status section of NF's WRP clearly</p>		Jan	Feb	Mar	Apr	May	Jun	Mean	# WRPC Observed	1	5	8	16	23	18		#meeting Criteria	0	0	1	0	0	0		% C #35	0	0	12.5	0	0	0	2.1
	Jan	Feb	Mar	Apr	May	Jun	Mean																											
# WRPC Observed	1	5	8	16	23	18																												
#meeting Criteria	0	0	1	0	0	0																												
% C #35	0	0	12.5	0	0	0	2.1																											

Section E: Discharge Planning and Community Integration

		<p>documents the difficulty NF has had in previous placements (“Many failed placements in many different settings. Mr. F has reportedly been “kicked out of hospitals, residential facilities, and jails all over California”). Yet, there is no indication as to what the difficulties/ barriers were or what plans NSH had for NF to overcome/manage the barriers.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that discharge barriers, especially difficulties in previously unsuccessful placements, are discussed with the individual at scheduled WRPCs. 2. Include skill training and supports in the WRP so that the individual can overcome the stated barriers. 3. Report to the WRPT, on a monthly basis, the individual's progress made in overcoming the barriers to discharge.
E.1.d	the skills and supports necessary to live in the setting in which the individual will be placed.	<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Develop a tool to track and monitor this requirement.</p> <p>Findings: NSH has adapted item #6 (<i>The skills and supports necessary to live in the setting in which the individual will be placed</i>) of the DMH WRP Discharge Planning & Community Integration Auditing Form as a tool to track and monitor this recommendation. NSH has also developed an instructional Manual in the usage of the auditing tool.</p> <p>Compliance: Partial.</p>

Section E: Discharge Planning and Community Integration

		<p>Current recommendation: Ensure that the skills and supports necessary for the individual to live in the setting in which he/she will be placed are documented in the Present Status section of the individual's WRP.</p>																																
E.2	<p>Each State hospital shall ensure that, beginning at the time of admission and continuously throughout the individual's stay, the individual is an active participant in the discharge planning process, to the fullest extent possible, given the individual's level of functioning and legal status.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1-2, February 2007:</p> <ol style="list-style-type: none"> 1. Continue to train the Social Work Department on engaging the individual as an active participant in the discharge planning process. 2. Implement the requirements outlined in the DMH WRP Manual on discharge process. <p>Findings: NSH audited 77 WRPCs using item #39 of the WRP Observation Audit Form to evaluate if the individual was an active participant throughout his/her admission, reporting 8% compliance. The table below with its monitoring indicator is a summary of the facility's data:</p> <p><i>Each state hospital shall ensure that, beginning at the time of admission and continually throughout the individual's stay, the individual is an active participant in the discharge planning process, to the fullest extent, given the individual's level of functioning and legal status.</i></p> <table border="1" data-bbox="894 1117 1890 1380"> <thead> <tr> <th></th> <th>Jan</th> <th>Feb</th> <th>Mar</th> <th>Apr</th> <th>May</th> <th>Jun</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td># WRPC Observed</td> <td>2</td> <td>5</td> <td>10</td> <td>16</td> <td>24</td> <td>20</td> <td></td> </tr> <tr> <td>#meeting Criteria</td> <td>0</td> <td>0</td> <td>3</td> <td>1</td> <td>2</td> <td>1</td> <td></td> </tr> <tr> <td>% C #39</td> <td>0</td> <td>0</td> <td>30</td> <td>6</td> <td>8</td> <td>5</td> <td>8</td> </tr> </tbody> </table>		Jan	Feb	Mar	Apr	May	Jun	Mean	# WRPC Observed	2	5	10	16	24	20		#meeting Criteria	0	0	3	1	2	1		% C #39	0	0	30	6	8	5	8
	Jan	Feb	Mar	Apr	May	Jun	Mean																											
# WRPC Observed	2	5	10	16	24	20																												
#meeting Criteria	0	0	3	1	2	1																												
% C #39	0	0	30	6	8	5	8																											

Section E: Discharge Planning and Community Integration

		<p>According to Ann Long, Chief of Social Work, she had distributed the DMH WRP Manual to all the SW staff. Training of the staff on using the Manual to meet EP guidelines has not been completed.</p> <p>This monitor reviewed nine charts (NF, SB, CH, AS, EM, MW, VH, AT, and AL). None of them met all elements of the recommendations in this cell. None of them included documented evidence that the SW staff updated the individual's barriers to discharge and progress made towards eliminating the barriers or engaged the individual on his/her discharge status. Especially missing from the reviewed WRPs were the skills and supports the individual needs to overcome his/her barriers to discharge, and the transition supports and services the individual needs for proper adjustment upon placement in his/her next setting.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to train the Social Work Department on engaging the individual as an active participant in the discharge planning process. 2. Implement the requirement outlined in the DMH WRP Manual on discharge process.
E.3	<p>Each State hospital shall ensure that, consistent with generally accepted professional standards of care, each individual has a professionally developed discharge plan that is integrated within the individual's therapeutic and rehabilitation service plan, that addresses his or her particular discharge considerations, and that includes:</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation February 2007: Develop a tool to track and monitor this requirement.</p> <p>Findings: NSH has adapted items #8 (<i>measurable interventions regarding these discharge considerations</i>), #9 (<i>the staff responsible for implement the interventions</i>) and #10 (<i>the time frames for completion of the interventions</i>) of</p>

Section E: Discharge Planning and Community Integration

		<p>the DMH WRP Discharge Planning and Community Integration Auditing Form as a tool to track and monitor this requirement. NSH also has developed a Manual (DMH WRP Discharge Planning and Community Integration Audit Form Manual) to assist staff on scoring the audit form. According to Ann Long, Chief of Social Work staff received training on the audit tool.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Implement the newly developed monitoring tool to ensure that the individual has a professionally developed discharge plan that is integrated within the individual's therapeutic and rehabilitation service plan and addresses his/her discharge considerations.</p>
E.3.a	measurable interventions regarding these discharge considerations;	<p>Current findings on previous recommendations:</p> <p>Recommendation February 2007: Ensure that all discharge criteria and their related intervention(s) are measurable.</p> <p>Findings: NSH used item #19 of the WRP Chart Audit Form (<i>The WRP includes behavioral, observable, and/or measurable objectives written in terms of what the individual will do</i>) to address this recommendation, reporting 6.5% compliance. The table below with its monitoring indicator is a summary of the facility's data.</p>

Section E: Discharge Planning and Community Integration

		<table border="1" data-bbox="894 228 1892 493"> <thead> <tr> <th></th> <th>Jan</th> <th>Feb</th> <th>Mar</th> <th>Apr</th> <th>May</th> <th>Jun</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td># charts reviewed</td> <td>668</td> <td>553</td> <td>465</td> <td>343</td> <td>202</td> <td>231</td> <td></td> </tr> <tr> <td># meeting criteria</td> <td>58</td> <td>40</td> <td>25</td> <td>15</td> <td>15</td> <td>14</td> <td></td> </tr> <tr> <td>% C #19</td> <td>8.7</td> <td>7.2</td> <td>5.4</td> <td>4.4</td> <td>7.4</td> <td>6.0</td> <td>6.5</td> </tr> </tbody> </table> <p data-bbox="894 534 1892 751">This monitor reviewed six charts (KW, JB, SB, CH, AS, and EM). None of them met criteria on this recommendation. One of EM's recommendation was written as, "The WRT will offer groups as outlined in her attached ITI. Ms. M responds to a promise of a primary reinforce." KW's intervention was written as, "ID team will provide appropriate treatment groups." AS's discharge criteria was written as, "A will show a willingness to participate..."</p> <p data-bbox="894 797 1045 857">Compliance: Partial.</p> <p data-bbox="894 906 1770 1008">Current recommendation: Ensure that all discharge criteria and their related intervention(s) are measurable.</p>		Jan	Feb	Mar	Apr	May	Jun	Mean	# charts reviewed	668	553	465	343	202	231		# meeting criteria	58	40	25	15	15	14		% C #19	8.7	7.2	5.4	4.4	7.4	6.0	6.5
	Jan	Feb	Mar	Apr	May	Jun	Mean																											
# charts reviewed	668	553	465	343	202	231																												
# meeting criteria	58	40	25	15	15	14																												
% C #19	8.7	7.2	5.4	4.4	7.4	6.0	6.5																											
E.3.b	the staff responsible for implement the interventions; and	<p data-bbox="894 1057 1495 1084">Current findings on previous recommendations:</p> <p data-bbox="894 1130 1892 1268">Recommendation, February 2007: For those active treatment interventions where a discipline is specified rather than the staff members name and discipline, clearly state the name of the staff member responsible.</p> <p data-bbox="894 1317 1705 1377">Findings: NSH used item #9 of the WRP Chart Audit Form to address this</p>																																

Section E: Discharge Planning and Community Integration

		<p>recommendation, reporting 5.6% compliance. The table below with its monitoring indicator is a summary of the facility's data.</p> <p><i>Each intervention includes the name of the staff responsible for implementation, the group name, and the group time/day.</i></p> <table border="1" data-bbox="898 415 1892 678"> <thead> <tr> <th></th> <th>Jan</th> <th>Feb</th> <th>Mar</th> <th>Apr</th> <th>May</th> <th>Jun</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td># Charts reviewed</td> <td>670</td> <td>555</td> <td>467</td> <td>345</td> <td>204</td> <td>233</td> <td></td> </tr> <tr> <td>#meeting Criteria</td> <td>49</td> <td>36</td> <td>28</td> <td>18</td> <td>9</td> <td>10</td> <td></td> </tr> <tr> <td>% C #9</td> <td>7.3</td> <td>6.5</td> <td>6.0</td> <td>5.2</td> <td>4.4</td> <td>4.3</td> <td>5.6</td> </tr> </tbody> </table> <p>This monitor reviewed five charts (JB, SB, CH, AS, and EM). All of them contained numerous interventions with general labels such as "staff", "all staff", "nursing staff", "the psychiatrist", etc., except for CH's chart, which identified staff by name in most of its interventions.</p> <p>Compliance: Partial.</p> <p>Current recommendation: For those active treatment interventions where a discipline is specified rather than the staff members name and discipline, clearly state the name of the staff member responsible.</p>		Jan	Feb	Mar	Apr	May	Jun	Mean	# Charts reviewed	670	555	467	345	204	233		#meeting Criteria	49	36	28	18	9	10		% C #9	7.3	6.5	6.0	5.2	4.4	4.3	5.6
	Jan	Feb	Mar	Apr	May	Jun	Mean																											
# Charts reviewed	670	555	467	345	204	233																												
#meeting Criteria	49	36	28	18	9	10																												
% C #9	7.3	6.5	6.0	5.2	4.4	4.3	5.6																											
E.3.c	the time frames for completion of the interventions.	<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Ensure that interventions are reviewed at least monthly.</p>																																

Section E: Discharge Planning and Community Integration

		<p>Findings: NSH audited 71 WRPCs (between January and June 2007) using item #35 of the WRP observation Monitoring Form to address this recommendation, reporting 2% compliance. The table below with its monitoring indicator is a summary of the facility's data.</p> <p><i>The team reviews the PSR Mall Facilitator's Monthly Progress Notes for all objectives related to discharge.</i></p> <table border="1" data-bbox="896 524 1892 789"> <thead> <tr> <th></th> <th>Jan</th> <th>Feb</th> <th>Mar</th> <th>Apr</th> <th>May</th> <th>Jun</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td># WRPC Observed</td> <td>1</td> <td>5</td> <td>8</td> <td>16</td> <td>23</td> <td>18</td> <td></td> </tr> <tr> <td>#meeting Criteria</td> <td>0</td> <td>0</td> <td>1</td> <td>0</td> <td>0</td> <td>0</td> <td></td> </tr> <tr> <td>% C #35</td> <td>0</td> <td>0</td> <td>12.5</td> <td>0</td> <td>0</td> <td>0</td> <td>2.1</td> </tr> </tbody> </table> <p>NSH introduced the PSR Mall Facilitator's Monthly Progress Notes recently to a few units. Most WRPTs do not receive the progress notes for review.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Ensure that interventions are reviewed at least monthly.</p>		Jan	Feb	Mar	Apr	May	Jun	Mean	# WRPC Observed	1	5	8	16	23	18		#meeting Criteria	0	0	1	0	0	0		% C #35	0	0	12.5	0	0	0	2.1
	Jan	Feb	Mar	Apr	May	Jun	Mean																											
# WRPC Observed	1	5	8	16	23	18																												
#meeting Criteria	0	0	1	0	0	0																												
% C #35	0	0	12.5	0	0	0	2.1																											
E.4	Each State hospital shall provide transition supports and services consistent with generally accepted professional standards of care. In particular, each State hospital shall ensure that:	Please see sub-cells for compliance findings.																																

Section E: Discharge Planning and Community Integration

<p>E.4.a</p>	<p>individuals who have met discharge criteria are discharged expeditiously, subject to the availability of suitable placements; and</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1, 2 and 3, February 2007:</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. <p>Findings:</p> <p>NSH's documentation showed a total of 27 individuals on the 'Referred for discharge but still hospitalized' list.</p> <p>This monitor reviewed the reasons for the delay from discharge. Most of the reasons identified were due to external system factors. For example, waiting on court order to COT (MP), delay in receiving report back from the court (CS), CONREP working on getting a community placement (BH), waiting on a court date (MC), and victim's attorney contesting release (JL). NSH did not identify any internal system factors that affected timely discharge of individuals'.</p> <p>NSH has automated the WRP in the WaRMSS system. The system has a checkbox to indicate if an individual has met his/her discharge criteria. NSH can use the data from the WaRMSS system to keep track and monitor individuals who have met discharge criteria but are still hospitalized. NSH has chosen to use this as the tracking and monitoring tool for obtaining data on individuals delayed from their discharge.</p> <p>Compliance: Partial.</p>
--------------	--	---

Section E: Discharge Planning and Community Integration

		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to reduce the overall number of individuals still hospitalized after referral for discharge has been made. 2. Identify and resolve system factors that act as barriers to timely discharge.
E.4.b	individuals receive adequate assistance in transitioning to the new setting.	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, February 2007:</p> <ol style="list-style-type: none"> 1. Develop and implement a monitoring and tracking system to address this requirement. 2. Develop and implement documentation guidelines to ensure that individuals receive adequate assistance when they transition to the new setting. <p>Findings: NSH has yet to develop and/or implement these recommendations.</p> <p>This monitor observed MG's WRP Conference. MG complained that he would rather stay at NSH as he had no support during his previous placements from other facilities. He complained that he was not getting his medications for a long time after discharge. The WRPT did not address his feedback or discuss a plan to address this as a transitional issue needing preparation prior to discharge.</p> <p>This monitor reviewed ten charts (FK, GS, RAE, JS, AR, EA, KW, TM, VV, and TQ). None of them had documentation to show that transitional support and resources were being considered or obtained for the next placement. In one case (EA), for example, recommendation was made for discharge but EA seems concerned and discouraged as evidenced by this notation in her Present Status section, "What do I have to do to get discharged. Every time I come to this conference you say to me that I can be discharged but you don't tell me what else I need to do. I go to stepping stones every day.</p>

Section E: Discharge Planning and Community Integration

		<p>I have work three days a week from stepping stones. I have a D card. I have been here seven years and I am doing everything you have asked." There is no documentation as to the response from the WRPT to EA's concerns.</p> <p>Compliance: Non-compliance.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a monitoring and tracking system to address this requirement. 2. Develop and implement documentation guidelines to ensure that individuals receive adequate assistance when they transition to the new setting.
E.5	For all children and adolescents it serves, each State hospital shall:	MSH only
E.5.a	develop and implement policies and protocols that identify individuals with lengths of stay exceeding six months; and	
E.5.b	establish a regular review forum, which includes senior administration staff, to assess the children and adolescents identified in § V.E.1 above, to review their treatment plans, and to create an individualized action plan for each such child or adolescent that addresses the obstacles to successful discharge to the most integrated, appropriate placement as clinically and legally indicated.	

Section F: Specific Therapeutic and Rehabilitation Services

F	Specific Therapeutic and Rehabilitation Services	<p>Summary of Progress:</p> <ol style="list-style-type: none"> 1. NSH has adopted individualized medication guidelines that were developed by a statewide committee and that comport with current generally accepted professional standards of care. 2. There is evidence of significant increase in the reporting of Adverse Drug Reactions (ADRs) at NSH since January 1, 2007. 3. NSH has made some progress in the identification of practitioner trends/patters regarding ADRs. 4. NSH has maintained its practice of monitoring medication uses, including benzodiazepines, anticholinergics, polypharmacy, new generation antipsychotics, PRNs and Stats, using instruments that reflect requirements of the EP. 5. NSH has maintained a level of staffing of Physicians and Surgeons, specialty consultation services and after-hours medical coverage that can meet the needs of its individuals.
F.1	Psychiatric Services	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Jeffrey Zwerin, DO, Medical Director 2. David Thomas, Assistant Medical Director 3. John Banducci, Pharmacy Director 4. Javed Iqbal, MD, Chair, Pharmacy and Therapeutics (P & T) Committee 5. George Splane, MD, Staff Psychiatrist 6. Pam Moe, PharmD, Assistant Pharmacy Director 7. Steve Weule, RN, Assistant Coordinator, Nursing Services 8. Suezette Zielinski, Health Services Specialist 9. Jim Shaw, Pharmacy Technician

Section F: Specific Therapeutic and Rehabilitation Services

		<p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Charts of 42 individuals (RLH, JCI, PMA, LRJ, EMS, DR, MT, DKB, RAV, JE, NA, RBC, AT, WFO, PA, MDM, RMP, JY, SAR, RCW, JHC, RBR, JY, SAR, RCW, JHC, RBR, SLS, RL, RJ, RM, BLD, BVP, RLA, MW, WFO, JS, RDV, TAQ, FMM, CW and RLG) 2. List of all individuals with their psychotropic medications, diagnoses and attending physicians 3. Minutes of the P & T Committee meetings since January 1, 2007 (March 14 and May 9, 2007) 4. California Department of Mental Health (DMH) Psychotropic Medication Policies and Guidelines (June 13, 2007) 5. DMH Drug utilization Evaluation (DUE) instruments (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, lamotrigine, divalproex and SSRI antidepressants) 6. Monthly Psychotropic Medication Use Monitoring Form 7. Monthly Psychotropic Medication Use Monitoring summary data (January to June 2007) 8. PRN & Stat Monitoring Form 9. PRN & Stat Monitoring summary data (January to March 2007) 10. Monthly PRN Data Monitoring Form 11. Monthly PRN Data Monitoring summary data (April to June 2007) 12. STAT Psychiatric Medication Monitoring Form 13. STAT Psychiatric Medication Monitoring summary data (April to June 2007) 14. Benzodiazepine Data Collection Sheet 15. Anticholinergic Data Collection Sheet 16. Polypharmacy Data Collection Sheet 17. Benzodiazepines, anticholinergics and polypharmacy summary data (January to June 2007) 18. New generation antipsychotics data collection sheet 19. New generation antipsychotics summary data (January to June 2007) 20. List of individuals currently diagnosed with Tardive Dyskinesia (TD)
--	--	--

Section F: Specific Therapeutic and Rehabilitation Services

		<p>21. Tardive Dyskinesia Monitoring Form 22. Tardive Dyskinesia Monitoring summary data (January to February and April to June 2007) 23. Adverse Drug Reaction (ADR) reports January to June 2007 24. Last ten completed NSH Suspected ADR Report Forms 25. Medication Variance Data Reports (January to June 2007) 26. Last ten completed NSH Medication Variance Report Forms 27. NSH Nursing Policy and procedure (MED: 1102.1), Medication Variance: Reporting and Analysis (January 5, 2007) 28. DUE regarding use of aripiprazole (completed in June 2007) 29. List of all individuals diagnosed with Tardive Dyskinesia (TD)</p>
F.1.a	<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>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Develop and implement individualized medication guidelines that include specific information regarding indications, contraindications, clinical and laboratory monitoring and adverse effects for all psychotropic and anticonvulsant medications in the formulary. The guidelines must be derived from current literature, relevant clinical experience and current generally accepted professional practice guidelines.</p> <p>Findings: A Statewide Psychopharmacology Advisory Committee (PAC) has developed individualized medication guidelines regarding the use of clozapine and new-generation antipsychotic medications (aripiprazole, olanzapine, quetiapine, risperidone and ziprasidone), some mood stabilizers (e.g. lamotrigine and divalproex) and some antidepressants (e.g. serotonin-specific reuptake inhibitors). The guidelines contain indications and contraindications and clinical and laboratory screening and monitoring requirements. These guidelines accord with current generally accepted professional standards.</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<p>The guidelines were completed in April 2007 and subsequently implemented in late April 2007. The PAC has completed an update of the guidelines, which has yet to be approved and implemented. The most recent version of the guidelines was communicated to the facilities on June 13, 2007. The guidelines are accompanied by Drug utilization Evaluation (DUE) monitoring instruments that are aligned with the information in the guidelines. NSH has implemented the DUE instrument regarding the use of aripiprazole.</p> <p>Recommendation 2, February 2007: Implement recommendations listed in D.1.c, D.1.d and D.1.e.</p> <p>Findings: Same as in D.1.c, D.1.d and D.1.e.</p> <p>Other findings: NSH used the Monthly Psychotropic Medication Use Form to assess compliance with requirements F.1.a.i through F.1.a.viii. The data were based on peer reviews of randomly selected samples each month from January to June 2007. However, the facility presented data that were complete only for the month of June 2007 and were based on a sample size of 4%. The indicators used are aligned with the corresponding requirement of the EP. The compliance rates are outlined for each corresponding sub-cell below. The facility assessed the reported low compliance rates regarding the requirements in F.1.1.a.iv, F.1.1.a.v., F.1.1.a.vi and F.1.1.a.vii. and identified, as contributing factors, excessive case loads and the lack of specific instructions to psychiatrists who write the notes. As a corrective action, NSH recently implemented a new template (available online) for the monthly progress note documentation. The facility anticipates improved compliance upon completion of current recruitment efforts and development of a feedback system to psychiatrist through the Acting Chief of Psychiatry and Senior Psychiatrists. The item regarding proper documentation of medication use (F.1.1.a.viii) was measured by determining if all of the previous requirements were met. It was</p>
--	--	---

Section F: Specific Therapeutic and Rehabilitation Services

		<p>added to the monitor beginning with the May 2007 reviews.</p> <p>This process has yet to incorporate the newly developed individualized Medication guidelines.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Implement the new statewide individualized medication guidelines and DUE instruments across state facilities. 2. Ensure that the Medical Staff manual includes the same individualized DUE instruments that accompany the guidelines. 3. Same as in D.1.c, D.1.d and D.1.e. 4. Standardize the monitoring forms and other mechanisms of review across state facilities and ensure that all forms are accompanied by operational instructions (applies to all relevant requirements in F.1). 5. Ensure that compliance rates derived from internal monitoring are based on a monthly review of a stratified 20% sample (applies to all relevant requirements in F.1).
F.1.a.i	specifically matched to current, clinically justified diagnoses or clinical symptoms;	96%
F.1.a.ii	prescribed in therapeutic amounts, as dictated by the needs of the individual served;	96%
F.1.a.iii	tailored to each individual's symptoms;	98%
F.1.a.iv	monitored for effectiveness against clearly identified target variables and time frames;	63%

Section F: Specific Therapeutic and Rehabilitation Services

F.1.a.v	monitored appropriately for side effects;	35%
F.1.a.vi	modified based on clinical rationales;	63%
F.1.a.vii	are not inhibiting individuals from meaningfully participating in treatment, rehabilitation, or enrichment and educational services as a result of excessive sedation; and	63%
F.1.a.vii i	properly documented.	32%
F.1.b	Each State hospital shall monitor the use of PRN and Stat medications to ensure that these medications are administered in a manner that is clinically justified and are not used as a substitute for appropriate long-term treatment of the individual's condition.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Continue to monitor the use of PRN and Stat medications to ensure correction of the deficiencies noted by this monitor.</p> <p>Recommendation 2, February 2007: Consolidate the monitoring processes for PRN and/or Stat medications and for psychiatric reassessments (progress notes).</p> <p>Findings: NSH used the PRN and Stat Monitoring Form (January to February/March 2007) to assess compliance. During March/April to June 2007, this form was discontinued in favor of two separate instruments: the Stat Psychiatric Medication (March to June 2007) and Monthly PRN Data (April to June 2007). The data for January to June 2007 were based on a review of average sample sizes of 4% and 2% of the total target populations (N) of individuals receiving PRN and Stat medications, respectively. The facility's process of aggregating data from January to June 2007 has made it unclear as to the link between</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<p>the presented compliance data and the relevant indicator. For example, some of the data presented for the Stat Psychiatric Medication Monitor described an indicator (<i>psychiatrist's progress notes include a strategy to modify regular treatment based upon review of use</i>) that appeared only on the Monthly PRN Data Monitoring Form. The interpretation of the facility's data is also complicated by the fact that the facility presented two sets of compliance data in different sections of the EP based on the same indicators; one set was based on a total target population (N) of the number of individuals receiving PRN and Stat medications (presented in this section) and the other was based on the number of PRN and Stat medications used (presented in Section H, Restraints, Seclusion and PRN and Stat medications).</p> <p>The facility's data based on a target population (N) of the number of the PRNs and Stat medications appear to be more relevant and more clearly linked to the requirement. However, the data regarding PRN medication use are not summarized here because it utilized a sample size of less than 1%. The data from the Stat Psychiatric Medication Monitoring Form were complete for only for the months of March, May and June, 2007 (average sample size of approximately 3%). Based on this monitoring, the facility reported mean compliance rates of 11% and 7% for the following two indicators:</p> <ol style="list-style-type: none"> 1. <i>As appropriate, adjustment of current treatment and/or</i> 2. <i>Diagnosis (as a result of review of the usIs there evidence of a strategy to modify regular treatment based upon the review of patterns of PRN usage? 10%.</i> <p>NSH did not present aggregated monitoring data regarding other indicators that are essential to this requirement of the EP.</p> <p>Recommendation 3, February 2007: Ensure monitoring of a sample of 20% of the target population.</p>
--	--	--

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Findings: NSH has yet to implement this recommendation.</p> <p>Other findings: Most of the charts reviewed by this monitor demonstrated the same pattern of deficiencies that was outlined in the baseline report. The areas that require special attention by the facility involve the documentation by psychiatrists and nurses of the following:</p> <ol style="list-style-type: none"> 1. Review of the circumstances that required the use of the medication and the individual's response; 2. Specific indications for the use of PRN medications; 3. Delineating the indications for each drug when more than one drug is used; 4. Ordering of PRN medications when the individual's condition no longer requires their use; 5. The psychiatrist's face-to-face assessment within one hour of Stat medication use; and 6. Appropriate modifications of regular treatment based on a critical review of the PRN and/or Stat use. <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Develop feedback and oversight system to ensure correction of the deficiencies outlined above. 2. Streamline/standardize the monitoring instruments regarding PRN and Stat medications across all facilities. 3. Monitor this requirement based on at least 20% sample and aggregate data for all relevant indicators regarding the use of PRN and/or Stat medications.
--	--	--

Section F: Specific Therapeutic and Rehabilitation Services

<p>F.1.c</p>	<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>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Develop medication guidelines for benzodiazepines and anticholinergics. The guidelines must specify risks of use and clinical monitoring requirements to minimize these risks.</p> <p>Findings: The statewide guidelines and the current monitoring instruments comply with this recommendation.</p> <p>Recommendation 2, February 2007: Continue to use current monitoring instruments regarding the use of benzodiazepines, anticholinergics and polypharmacy. Ensure that the justification of use is consistent with current generally accepted standards.</p> <p>Findings: The facility used its data collection sheets regarding the use of benzodiazepines, anticholinergics and polypharmacy to assess compliance with this requirement. From January to June 2007, the facility reviewed a number of charts that varied for each category of use. The variation is explained by whether the review was applicable to the chart. However, the facility did not identify the sample size and the appropriate target population (e.g. total number of individuals receiving benzodiazepines). The following is a summary of the data, including average number of charts reviewed per month, monitoring indicators and corresponding mean compliance rates. The facility recognized that the compliance rates for some indicators (e.g. <i>Treatment modified in an appropriate and timely manner to ensure proper indications and minimize risk</i>) were influenced by differing interpretations among the raters and that the inter-rater reliability should improve if operational instructions have been developed.</p>
--------------	---	--

		<p>Benzodiazepines (average number of charts: 26):</p> <ol style="list-style-type: none"> 1. <i>Documentation justifies regular use of benzodiazepine for anxiety or other diagnosis?</i> : 37%. 2. <i>Benzodiazepines used regularly include documentation, in psychiatric progress notes (PPN), of risk of: Sedation, Drug dependence, Cognitive decline:</i> 5%. 3. <i>Treatment modified in an appropriate and timely manner to ensure proper indications and minimize risk:</i> 61%. <p>Anticholinergics (average number of charts: 24):</p> <ol style="list-style-type: none"> 1. <i>Documentation in physician's progress note (PPN) justifies regular use of anticholinergic?</i> : 43%. 2. <i>Documentation includes extrapyramidal indications:</i> 26%. 3. <i>Treatment modified in an appropriate and timely manner to ensure proper indications and minimize risk:</i> 27%. <p>Polypharmacy (average number of charts: 47):</p> <ol style="list-style-type: none"> 1. <i>Documentation in Psychiatric Progress Notes (PPN) which justifies the use of 2 or more psychotropic medications in the same class (intra-class). (Example: two or more antidepressants, two or more antipsychotics, two or more anti-anxiety medications, etc.).</i> 25%. 2. <i>Documentation in Psychiatric Progress Notes (PPN) which justifies using two medications from different classes (inter-class). (Example: one antidepressant and one antipsychotic medication, one antidepressant and one anti-anxiety medication or one antipsychotic medication and one anti-anxiety medication).</i> 43%. 3. <i>Documentation in Psychiatric Progress Notes (PPN) which justifies using 4 or more psychotropic medications from any class:</i> 14%. 4. <i>If the use of polypharmacy is modified, documentation in psychiatric progress notes indicates that changes are made in a timely manner to ensure proper indications and minimize risks:</i> 64%. 5. <i>Use of intra- or inter-class polypharmacy accompanied by documentation</i>
--	--	--

Section F: Specific Therapeutic and Rehabilitation Services

		<p><i>(PPN) of drug-drug interactions and their risks: 5%.</i></p> <p>Recommendation 3, February 2007: Consolidate the process of monitoring of all individual medications within the Drug Utilization Evaluation (DUE) Process.</p> <p>Findings: NSH has yet to implement this recommendation. The current barriers include significant shortages in psychiatrists and pharmacists.</p> <p>Recommendation 4, February 2007: Ensure monitoring of a sample of 20% of the target population.</p> <p>Findings: NSH has yet to implement this recommendation</p> <p>Other findings: Chart reviews by this monitor revealed persistent deficiencies regarding the long-term use of benzodiazepines, anticholinergic medications and polypharmacy. The deficiencies are focused on the lack of adequate justification based on documentation of the risks and benefits of treatment, modification of treatment to utilize safer alternatives and/or a critical review of the use of these medications on a PRN basis.</p> <p>The following tables outline the categories of use, the charts reviewed and the medications used.</p> <p>Benzodiazepines for individuals diagnosed with substance use and/or cognitive disorders:</p>
--	--	--

Section F: Specific Therapeutic and Rehabilitation Services

Initials	Medication (s)	Diagnosis
RDV	Lorazepam	Polysubstance Dependence
TAQ	Lorazepam	Polysubstance Dependence
RLG	Lorazepam	Polysubstance Dependence
JS	Lorazepam	Polysubstance Dependence
RLH	Lorazepam (and Benztropine)	Mild Mental Retardation
RAV	Lorazepam	Alcohol Abuse and Dementia Due to Head Injury
JE	Lorazepam	Vascular Dementia with Behavioral Disturbance
BVP	Lorazepam	Alcohol Abuse
MW	Lorazepam	Dementia Due to head Injury, with Behavioral Disturbance.
DR	Clonazepam	Polysubstance Dependence
MT	Clonazepam	Mild Mental Retardation
DKB	Clonazepam	Mental Disorder, NOS, Due to Head Injury

Anticholinergics for individuals with cognitive disorders:

Initials	Medication (s)	Diagnosis
RLH	Benztropine (and Lorazepam)	Mild Mental Retardation
JCI	Benztropine	Cognitive Disorder, NOS
PMA	Benztropine	Borderline Intellectual Functioning
LRJ	Benztropine	Dementia NOS and Mild Mental retardation
EMS	Benztropine	Mild Mental Retardation.

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Polypharmacy:*</p> <table border="1" data-bbox="913 264 1837 495"> <thead> <tr> <th data-bbox="913 264 1123 305">Initials</th> <th data-bbox="1123 264 1837 305">Medications</th> </tr> </thead> <tbody> <tr> <td data-bbox="913 305 1123 378">LRJ</td> <td data-bbox="1123 305 1837 378">Fluphenazine decanoate, Fluphenazine, olanzapine and quetiapine</td> </tr> <tr> <td data-bbox="913 378 1123 418">FMM</td> <td data-bbox="1123 378 1837 418">Clozapine, olanzapine and risperidone</td> </tr> <tr> <td data-bbox="913 418 1123 459">PMA</td> <td data-bbox="1123 418 1837 459">Clozapine and haloperidol</td> </tr> <tr> <td data-bbox="913 459 1123 495">WFO</td> <td data-bbox="1123 459 1837 495">Risperidone and quetiapine</td> </tr> </tbody> </table> <p>*Review of the charts of RLH and JCI showed evidence of appropriate documentation of the long-term use of polypharmacy.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to monitor the use of benzodiazepines, anticholinergics and polypharmacy, based on at least 20% sample size. 2. Incorporate the standards in the new medication guidelines and associated DUE instruments in the process of monitoring. 3. Identify patterns and trends regarding high-risk medication uses and implement corrective and educational actions. 	Initials	Medications	LRJ	Fluphenazine decanoate, Fluphenazine, olanzapine and quetiapine	FMM	Clozapine, olanzapine and risperidone	PMA	Clozapine and haloperidol	WFO	Risperidone and quetiapine
Initials	Medications											
LRJ	Fluphenazine decanoate, Fluphenazine, olanzapine and quetiapine											
FMM	Clozapine, olanzapine and risperidone											
PMA	Clozapine and haloperidol											
WFO	Risperidone and quetiapine											
F.1.d	Each State hospital shall ensure the monitoring of the metabolic and endocrine risks associated with the use of new generation antipsychotic medications.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Same as in F.1.a.</p> <p>Findings: Same as in F.1.a.</p>										

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Recommendation 2, February 2007: Same as in F.1.g.</p> <p>Findings: Same as in F.1.g.</p> <p>Other findings: NSH used the New Generation Antipsychotic Medication Data Collection Sheet to assess its compliance with this requirement. The facility reviewed a monthly average of 56 charts (January to June 2007), but did not identify the total target population and sample sizes. The mean compliance rates and corresponding indicators are as follows. The facility reported that a change of reviewers starting with the April data may explain some of the monthly changes in ratings of compliance (April to June as compared to January to March). As mentioned earlier, the indicators have yet to align with the new individualized medication guidelines.</p> <ol style="list-style-type: none"> 1. <i>Use of medications based on documentation of benefits and tolerability.</i> 55%. 2. <i>Justification for use documented in PPN for individuals with diagnosis of: a) dyslipidemia, b) diabetes, or c) obesity:</i> 21%. 3. <i>Risperidone use in individual with hyperprolactinemia justification documented in PPN:</i> 22%. 4. <i>Appropriate baseline and periodic monitoring of: a) family/personal risk factors, b) Body Mass Index (BMI), c) waist circumference, d) triglycerides, e) cholesterol, f) fasting blood glucose, g) glucosylated HgbA1c levels, h) menstrual cycle, i) breast signs:</i> 31%. 5. <i>Appropriate baseline and periodic monitoring EKG for: a) individuals receiving ziprasidone, b) other new generation antipsychotics as indicated:</i> 50%. 6. <i>Appropriate baseline and periodic monitoring for postural hypotension for individuals receiving: a)quetiapine, b)ziprasidone, c)olanzapine, and/or</i>
--	--	---

Section F: Specific Therapeutic and Rehabilitation Services

		<p><i>d)risperidone: 10%.</i></p> <p>7. <i>Appropriate baseline and periodic monitoring of individuals receiving clozapine for: a) blood counts (WBC/ANC), b) vital signs: 90%.</i></p> <p>8. <i>PPN documentation of potential and actual risks for each medication used: 13%.</i></p> <p>9. <i>Treatment modified in an appropriate and timely manner to address identified risks: 62%.</i></p> <p>This monitor reviewed the charts of 13 individuals who are receiving new-generation antipsychotic agents, all of whom are diagnosed with a variety of metabolic disorders. The following table outlines the initials of the individuals, the medication used and the metabolic disorder, if applicable:</p> <table border="1" data-bbox="913 673 1885 1323"> <thead> <tr> <th>Individual's initials</th> <th>Medication</th> <th>Associated Metabolic Condition</th> </tr> </thead> <tbody> <tr> <td>RBC</td> <td>Olanzapine</td> <td>Diabetes Mellitus</td> </tr> <tr> <td>AT</td> <td>Olanzapine</td> <td>Diabetes Mellitus</td> </tr> <tr> <td>PA</td> <td>Olanzapine</td> <td>Obesity</td> </tr> <tr> <td>MDM</td> <td>Olanzapine</td> <td>Obesity</td> </tr> <tr> <td>WFO</td> <td>Risperidone</td> <td>Diabetes Mellitus</td> </tr> <tr> <td>PMP</td> <td>Risperidone</td> <td>Hyperlipidemia and Hypercholesterolemia</td> </tr> <tr> <td>JY</td> <td>Risperidone</td> <td>None documented</td> </tr> <tr> <td>SAR</td> <td>Risperidone</td> <td>Diabetes Mellitus and Obesity</td> </tr> <tr> <td>RCW</td> <td>Clozapine</td> <td>Hyperlipidemia</td> </tr> <tr> <td>JHC</td> <td>Clozapine</td> <td>Diabetes Mellitus and Hypercholesterolemia</td> </tr> <tr> <td>PMA</td> <td>Clozapine</td> <td>Diabetes Mellitus, Obesity and Hyperprolactinemia</td> </tr> <tr> <td>RBR</td> <td>Quetiapine</td> <td>Hyperlipidemia and Diabetes Mellitus</td> </tr> <tr> <td>RLA</td> <td>Ziprasidone</td> <td>None documented</td> </tr> </tbody> </table>	Individual's initials	Medication	Associated Metabolic Condition	RBC	Olanzapine	Diabetes Mellitus	AT	Olanzapine	Diabetes Mellitus	PA	Olanzapine	Obesity	MDM	Olanzapine	Obesity	WFO	Risperidone	Diabetes Mellitus	PMP	Risperidone	Hyperlipidemia and Hypercholesterolemia	JY	Risperidone	None documented	SAR	Risperidone	Diabetes Mellitus and Obesity	RCW	Clozapine	Hyperlipidemia	JHC	Clozapine	Diabetes Mellitus and Hypercholesterolemia	PMA	Clozapine	Diabetes Mellitus, Obesity and Hyperprolactinemia	RBR	Quetiapine	Hyperlipidemia and Diabetes Mellitus	RLA	Ziprasidone	None documented
Individual's initials	Medication	Associated Metabolic Condition																																										
RBC	Olanzapine	Diabetes Mellitus																																										
AT	Olanzapine	Diabetes Mellitus																																										
PA	Olanzapine	Obesity																																										
MDM	Olanzapine	Obesity																																										
WFO	Risperidone	Diabetes Mellitus																																										
PMP	Risperidone	Hyperlipidemia and Hypercholesterolemia																																										
JY	Risperidone	None documented																																										
SAR	Risperidone	Diabetes Mellitus and Obesity																																										
RCW	Clozapine	Hyperlipidemia																																										
JHC	Clozapine	Diabetes Mellitus and Hypercholesterolemia																																										
PMA	Clozapine	Diabetes Mellitus, Obesity and Hyperprolactinemia																																										
RBR	Quetiapine	Hyperlipidemia and Diabetes Mellitus																																										
RLA	Ziprasidone	None documented																																										

Section F: Specific Therapeutic and Rehabilitation Services

		<p>The above reviews showed that, in general, the facility provided adequate laboratory monitoring of the metabolic indicators, blood counts and vital signs for individuals at risk. However, deficiencies existed in the following areas:</p> <ol style="list-style-type: none"> 1. Psychiatric documentation of the risks and benefits of use (SAR and AT) and of recent significant change in the individual's weight status (AT); 2. Addressing significant laboratory abnormalities in the endocrine status of the individual (PMA); 3. The required frequency of laboratory testing of triglyceride levels (PA); and 4. The required laboratory and clinical monitoring of the risk of endocrine disorders in female individuals (RMP and SAR). <p>This pattern of deficiencies must be corrected in order to achieve substantial compliance with this requirement.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Same as in F.1.a. 2. Same as in F.1.g. 3. Ensure that all monitoring indicators are aligned with the new individualized medication guidelines.
F.1.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</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Ensure monitoring of a 20% sample of the target population (i.e. individuals with diagnosis or history of TD).</p>

Section F: Specific Therapeutic and Rehabilitation Services

	<p>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>Recommendation 2, February 2007: Address (and correct) factors related to low compliance.</p> <p>Findings: NSH used the Tardive Dyskinesia Monitoring Form (January to February and April to June 2007) to assess compliance. The facility's data are based on a review of a number of charts that averaged 10 per month (%S and N were not identified). The facility reported having current difficulty in the accurate identification of all individuals diagnosed with TD and in locating the quarterly AIMS for individuals with known TD, all of whom are referred to the Movement Disorders clinic. Corrective actions are underway. The following is an outline of the monitoring indicators and the mean compliance rates:</p> <ol style="list-style-type: none"> 1. <i>Was an AIMS exam done on admission? (67%).</i> 2. <i>Was an annual AIMS exam done at time of last annual physical exam? (71%).</i> 3. <i>If this individual has a history of TD was an AIMS done every 3 months? (19%).</i> 4. <i>Do monthly progress notes for past 3 months indicate that antipsychotic treatment has been modified for individuals with TD, a history of TD or a positive AIMS test? (4%).</i> 5. <i>If a conventional antipsychotic is used, is there evidence in PPN or monthly progress note of justification of using the older generation medication? (10%).</i> 6. <i>If this patient has TD was a new AIMS exam done every 3 months? (44%).</i> <p>Recommendation 3, February 2007: Ensure that the diagnoses listed on the WRP are aligned with those listed in psychiatric documentation.</p> <p>Recommendation 4, February 2007: Ensure that TD is recognized as one of the foci of hospitalization and that</p>
--	--	--

Section F: Specific Therapeutic and Rehabilitation Services

		<p>appropriate objectives and interventions are identified for treatment and/or rehabilitation.</p> <p>Findings: NSH did not present data to address these recommendations. The facility anticipates that the introduction of the automated WaRMSS (in August 2007) should facilitate the development of a trigger item that prompts the WRPTs to address TD in the WRPs.</p> <p>Recommendation 5, February 2007: Ensure that the TD statement addresses management strategies.</p> <p>Findings: NSH did not present data regarding this recommendation.</p> <p>Other findings: This monitor reviewed the charts of seven individuals (SLS, RL, RJ, RM, BLD, CW and RBC) who were identified on the facility's TD list. The reviews show the following deficiencies:</p> <ol style="list-style-type: none"> 1. TD is identified as a diagnosis on the most recent psychiatric evaluation but the WRP does not list the diagnosis or include TD as one of the foci (RM). 2. The WRP lists the diagnosis of TD, but do not include it as a focus or provide corresponding objectives/interventions (SLS, RL and RBC). 3. The WRP includes interventions that are not linked to the focus that is written in the chart (BLD). 4. The stated interventions do not include treatment/management and/or rehabilitation strategy (RJ and CW). 5. The required schedule of quarterly AIMS was implemented in only one chart (RBC).
--	--	---

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement systems to ensure accurate identification of all individuals with current diagnosis or history of TD. 2. Monitor all individuals with current diagnosis or history of TD. 3. Ensure that the diagnoses listed on the WRP are aligned with those listed in psychiatric documentation. 4. Ensure that TD is recognized as one of the foci of hospitalization and that appropriate objectives and interventions are identified for treatment and/or rehabilitation. 5. Ensure that the TD statement/policy/procedure addresses management strategies. 6. Continue current practice of referring all individuals diagnosed with TD for management and follow up at a specialized movement disorders clinic. Ensure that the clinic is run by a neurologist with specialized training/expertise in movement disorders.
F.1.f	Each State hospital shall ensure timely identification, reporting, data analyses, and follow up remedial action regarding all adverse drug reactions ("ADR").	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Revise current policy and procedure and develop guidelines to staff to improve attention to the monitor's findings described above.</p> <p>Findings: NSH has yet to implement this recommendation.</p> <p>Recommendation 2, February 2007: Develop and implement data analysis systems.</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Findings: NSH has partially implemented this recommendation. A data base utilizing Access has been developed by the pharmacy.</p> <p>Data were presented in July 2007 to the P & T committee covering the period of January-June 2007. The database tracked the following variables: hospital number, allergies, age, weight, height, gender, ethnicity, type of drug, type of reaction, whether medication was discontinued, manifestations, severity, duration, probability and severity scales, the reporting person (by code number) and physician involved. Since the last progress report, the P & T Committee has developed practitioner-specific trends regarding the occurrence of clozapine, but has yet to analyze the data and institute appropriate follow-up actions.</p> <p>In the past six months, a total of 401 ADRs were reported at NSH. During the previous six months (July to December 2006), the facility reported 294 ADRs. This represents a significant increase in reporting since January 1, 2007.</p> <p>Recommendation 3, February 2007: Provide educational programs to address trends in the occurrence of ADRs.</p> <p>Findings: NSH has yet to implement this recommendation.</p> <p>Recommendation 4, February 2007: Develop and implement an intensive case analysis procedure based on established severity/ outcome thresholds. The analysis must include proper discussion of history/circumstances, preventability, contributing factors and recommendations.</p>
--	--	---

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Findings: NSH has yet to implement this recommendation. During this review period, the facility reported one ADR that met severity threshold for performing an ICA, but the analysis has yet to be completed.</p> <p>Other findings: Reviews by this monitor showed that NSH has yet to revise its current processes to address and correct all the deficiencies that were outlined in this section of the last progress report.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Revise current policy and procedure and develop guidelines to staff to improve attention to the monitor's findings described in this monitor's report of February 2007. 2. Develop written instructions to all clinicians regarding significance and proper methods in reporting, investigating and analyzing ADRs. 3. Analyze data regarding practitioner/group trends/patterns and provide follow up corrective actions, including educational programs. 4. Develop and implement an intensive case analysis procedure based on established severity/outcome thresholds. The analysis must include: <ol style="list-style-type: none"> a. Proper discussion of history/circumstances; b. Preventability; c. Contributing factors; and d. Recommendations.
F.1.g	Each State hospital shall ensure drug utilization evaluation ("DUE") occurs in accord with established, up-to-date medication guidelines that shall specify indications,	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Same as Recommendation 1 in F.1.a.</p>

Section F: Specific Therapeutic and Rehabilitation Services

	<p>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: Same as in F.1.a.</p> <p>Recommendation 2 February 2007: Develop and implement a DUE system based on established individualized medication guidelines.</p> <p>Findings: NSH has completed a DUE regarding the use of aripiprazole based on the new monitoring instrument. The instrument is aligned with the guideline and with current literature. The facility has yet to provide conclusions and, as appropriate, recommendations regarding this DUE. A DUE regarding the use of ziprasidone is reportedly in process.</p> <p>Recommendation 3, February 2007: Ensure systematic review of all medications, with priority give to high-risk, high-volume uses.</p> <p>Findings: NSH has yet to implement this recommendation.</p> <p>Recommendation 4, February 2007: Determine the criteria by which the medications are evaluated, the frequency of evaluation, the indicators to be measured, the DUE data collection form, the sample size, and acceptable thresholds of compliance.</p> <p>Findings: The facility has adopted the DMH individualized medications guidelines which provide the basis for compliance with this recommendation.</p>
--	--	--

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Recommendation 5 February 2007: Ensure that the individualized medication guidelines are continually updated to reflect current literature, relevant clinical experience and current professional practice guidelines.</p> <p>Findings: NSH has yet to implement this recommendation.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a DUE policy/procedure to codify the requirement that all medications are reviewed based on the individualized guidelines with priority given to high risk/high volume uses, and to determine the frequency of reviews. 2. Ensure that all DUEs include conclusions and recommendations for corrective actions regarding findings of deficiency, with follow-up by the medical staff and the P & T Committee, as appropriate. 3. Ensure proper aggregation and analysis of DUE data to determine practitioner and group patterns and trends. 4. Ensure that the individualized medication guidelines are continually updated to reflect current literature, relevant clinical experience and current professional practice guidelines.
F.1.h	<p>Each State hospital shall ensure documentation, reporting, data analyses, and follow up remedial action regarding actual and potential medication variances ("MVR") consistent with generally accepted professional standards of care.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Provide instruction to all clinicians regarding significance of and proper methods in MVR.</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Findings: NSH has yet to implement this recommendation.</p> <p>Recommendation 2, February 2007: Develop and implement a policy and procedure regarding MVR that includes a revised data collection tool. The procedure and the revised tool must address the deficiencies identified above.</p> <p>Findings: NSH has yet to implement this recommendation. The facility has revised its data collection tool and made some improvements, but the most recent revision still falls short of correcting all the deficiencies outlined by this monitor in the last progress report.</p> <p>Recommendation 3, February 2007: Develop and implement tracking log and data analysis systems.</p> <p>Findings: NSH has a tracking system that captures the information on the current data collection tool. The facility has yet to implement this recommendation based on a data collection tool and a procedure that adequately addresses all the specific deficiencies outlined by this monitor in the past progress report.</p> <p>Recommendation 4, February 2007: Provide educational programs to address trends in the occurrence of MVRs.</p> <p>Recommendation 5, February 2007: Develop and implement an intensive case analysis procedure based on established severity/outcome thresholds. The analysis must include proper discussion of history/circumstances, preventability, contributing factors and recommendations.</p>
--	--	---

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Findings: The facility has yet to implement these recommendations.</p> <p>Other findings: Reviews by this monitor showed that NSH has yet to revise its current processes to address and correct all the deficiencies that were outlined in this section of the last progress report.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Provide instruction to all clinicians regarding significance of and proper methods in MVR. 2. Develop and implement a policy and procedure regarding MVR that includes a revised data collection tool. The procedure and the revised tool must address all the deficiencies identified in the in this monitor's report of February 2007. 3. Develop and implement a tracking log and data analysis systems based on a revised data collection tool. 4. Provide educational programs to address trends in the occurrence of MVRs.
F.1.i	<p>Each State hospital shall ensure tracking of individual and group practitioner trends, including data derived from monitoring of the use of PRNs, Stat medications, benzodiazepines, anticholinergics, and polypharmacy, and of ADRs, DUE, and MVR consistent with generally accepted professional standards of care.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Same as in F.1.a. through F.1.h.</p> <p>Findings: Same as in F.1.a. through F.1.h.</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Recommendation 2, February 2007: Improve IT resources to the pharmacy to facilitate the development of databases regarding medication use.</p> <p>Findings: NSH has yet to implement this recommendation.</p> <p>Compliance: Partial</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Same as in F.1.a. through F.1.h. 2. Improve IT resources to the pharmacy department to facilitate the development of databases regarding medication use.
F.1.j	<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>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Same as above.</p> <p>Findings: Same as above.</p> <p>Compliance: Partial.</p> <p>Current recommendations: Same as above.</p>
F.1.k	<p>Each State hospital shall ensure integration of information derived from ADRs, DUE, MVR, and the Pharmacy & Therapeutics,</p>	<p>Current findings on previous recommendations:</p>

Section F: Specific Therapeutic and Rehabilitation Services

	<p>Therapeutics Review, and Mortality and Morbidity Committees consistent with generally accepted professional standards of care.</p>	<p>Recommendation, February 2007: Same as above.</p> <p>Findings: Same as above.</p> <p>Compliance: Partial.</p> <p>Current recommendations: Same as above.</p>
<p>F.1.l</p>	<p>Each State hospital shall ensure that all physicians and clinicians are verifiably competent, consistent with generally accepted professional standards of care, in appropriate medication management, interdisciplinary team functioning, and the integration of behavioral and pharmacological treatments.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Same as in D.1.b., D.1.c., D.1.f.viii. and F.1.a. through F.1.h.</p> <p>Findings: Same as in D.1.b., D.1.c., D.1.f.viii. and F.1.a. through F.1.h.</p> <p>Recommendation 2, February 2007: Develop and implement a formalized supervisory system for the psychiatry department to ensure clinical and administrative support to staff, proper oversight and development, implementation and coordination of monitoring, educational and peer review systems. Specifically, the facility should consider creating a dedicated position for Chief of Psychiatry and positions for a lead psychiatrist for each of the programs.</p> <p>Findings: NSH has yet to implement this recommendation.</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Same as in D.1.b., D.1.c., D.1.f.viii. and F.1.a. through F.1.h. 2. Develop and implement a formalized supervisory system for the psychiatry department to ensure clinical and administrative support to staff, proper oversight and development, implementation and coordination of monitoring, educational and peer review systems. 3. The facility should expedite the appointments of Chief of Psychiatry and senior psychiatrists. The Chief must have both authority and responsibility regarding the clinical assignment of psychiatrists as well as compliance with EP requirements in the areas of WRPT leadership and psychiatric assessments and services
F.1.m	Each State hospital shall review and ensure the appropriateness and safety of the medication treatment, consistent with generally accepted professional standards of care, for:	<p>Compliance: Partial.</p>
F.1.m.i	all individuals prescribed continuous anticholinergic treatment for more than two months;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Same as in F.1.c.</p> <p>Findings: Same as in F.1.c.</p> <p>Recommendation 2, February 2007: Ensure that this practice is triggered for TRC review and follow-through.</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Findings: The facility has yet to implement this recommendation.</p> <p>Current 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 appropriate clinical oversight mechanism, with corrective follow- up actions by the psychiatry department.
F.1.m.ii	all elderly individuals and individuals with cognitive disorders who are prescribed continuous anticholinergic treatment regardless of duration of treatment;	Same as above.
F.1.m.ii i	all individuals prescribed benzodiazepines as a scheduled modality for more than two months;	Same as above.
F.1.m.iv	all individuals prescribed benzodiazepines with diagnoses of substance abuse or cognitive impairments, regardless of duration of treatment; and	Same as above.
F.1.m.v	all individuals with a diagnosis or evidencing symptoms of tardive dyskinesia.	<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Same as in F.1.e.</p> <p>Findings: Same as in F.1.e.</p> <p>Other findings: NSH has maintained its practice of referral of individuals with known TD for management and follow-up at a specialized movement disorders clinic.</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Current recommendations: Same as in F.1.e.</p>
F.1.m.vi	<p>all individuals diagnosed with dyslipidemia, and/or obesity, and/or diabetes mellitus who are prescribed new generation antipsychotic medications</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Same as in F.1.g.</p> <p>Recommendation 2, February 2007: Develop and implement a DUE monitoring system based on individualized medication guidelines.</p> <p>Findings: Same as in F.1.g.</p> <p>Current recommendations: Same as in F.1.d. and F.1.g.</p>
F.1.n	<p>Each State hospital shall ensure that the medication management of individuals with substance abuse disorders is provided consistent with generally accepted professional standards of care.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Same as in C.2.o, F.1.c and F.1.m.iii.</p> <p>Findings: Same as in C.2.o, F.1.c and F.1.m.iii.</p> <p>Compliance: Partial.</p> <p>Current recommendations: Same as in C.2.o and F.1.c.</p>

Section F: Specific Therapeutic and Rehabilitation Services

F.1.o	Metropolitan State Hospital shall provide a minimum of 16 hours per year of instruction, through conferences, seminars, lectures and /or videotapes concerning psychopharmacology. Such instruction may be provided either onsite or through attendance at conferences elsewhere.	MSH only
-------	---	-----------------

Section F: Specific Therapeutic and Rehabilitation Services

F.2	Psychological Services	
	<p>Each State hospital shall provide adequate and appropriate psychological supports and services that are derived from evidence-based practice or practice-based evidence and are consistent with generally accepted professional standards of care, to individuals who require such services; and:</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Individuals AL (through interpreter) and DT 2. Tony Rabin, PhD, Mall Director 3. Kathleen Patterson, PhD, Interim Senior Supervising Psychologist 4. Ann Hoff, PhD, Interim Senior Supervising Psychologist 5. Nicole Aviles-Galberth, PhD, BY CHOICE Coordinator 6. Donna Robeson, LCSW, DCAT member 7. Saeed Elmi, PT, DCAT member 8. Cynthia Morgan, RN, DCAT member 9. Robin Rogers, OT, DCAT member 10. Barry Wagener, RN, PBS team member 11. Linda Monahan, PT, PBS team member 12. Kelley Jarrett, PT, PBS team member 13. Shirley Duran, Data Technician, PBS team member 14. Wendy Hatcher, PsyD, Psychologist, PBS team member 15. Sue Silverman, PT, PBS team member 16. Coral Parrish, RN, PBS team member 17. Darrel Bailey, PT, PBS team member 18. Patricia White, PhD, Psychologist, PBS team member 19. Shoko Kokubun, Psychology Intern, PBS team member 20. Jeff Barnes, PT, PBS team member 21. Jessica Michaelson, PsyD, Psychologist, PBS team member 22. Herman Mercado, RN 23. Jason Bermack, MD, PhD 24. Kathrin Capeto, ACSW 25. Kristin Menne, ATK-BC 26. Carmen Caruso, Clinical Administrator 27. Sophie Tramel, PT, BY CHOICE Store

Section F: Specific Therapeutic and Rehabilitation Services

		<p>28. Jeffrey Salcedo, PTA 29. Karen Zanetell, Chief of Rehabilitation Services 30. Odie Ashford, Interpreter 31. Imelda Catacuten, PT 32. Julie Winn, PsyD, Psychologist 33. Bruce Bugbee, Unit Supervisor 34. Luesilvia Smith, PTA 35. Sharon Sanguinetti, RN</p> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Charts of 35 individuals (AC, AL, AS, AT, BN, CC, CCF, CD, CH, CLC, DB, DC, DG, DR, EH, EM, FC, HS, JB, JP, LT, MK, MP, MR, MW, NF, PB, PM, RB, RM, RP, SB, SH, TX, and VH) 2. Behavior Guidelines (FC, SB, JP, JC, DG, RB, NF, ST, DR, PB, BN, LT, MW, MP, JB, JM, and DC) 3. Crisis Intervention Plans (JB, DC, and CC) 4. Positive Behavior Support Plans (CC, BN, HS, AL, and CH) 5. Functional Behavior Assessments (BN, MR, and CH) 6. Psychological Assessments (GP, MB, DL, RM, JB, JW, TD, GR, RP, CG, and DN) 7. BCC Meetings Attendance Record 8. BCC Meeting Minutes 9. Procedural Steps for Behavioral Consultation Committee Form 10. Behavior Guideline Worksheet 11. Positive Behavior Support Manual, Draft, 2007 12. PBS Training Roster 13. Psychologists Training Roster 14. BY CHOICE Individual Satisfaction Survey Form 15. BY CHOICE Red List (choking, allergy, diabetes) 16. BY CHOICE Inventory List 17. BY CHOICE Inventory Check Sheet 18. Structural Assessments (CH, BN, DC, MP, AS, and RM)
--	--	---

Section F: Specific Therapeutic and Rehabilitation Services

		<p>19. List of Neuropsychological Assessments referred and completed 20. Psychology Monitoring Form 21. Psychology Training Roster 22. Missed Appointment List 23. List of Individuals in Need of PBS Plan Update 24. List of Individuals with PBS Plans Being Consistently Implemented 25. List of Individuals Referred to BCC, January to July 3, 2007) 26. BCC Attendance Record 27. List of Individuals Not Making Timely Progress on PBS Plans 28. List of Current PBS Plans 29. Special Orders #129.01. and #130.01 30. Administrative Directives #851, #850 and #798</p> <p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. Individuals AL, WR, MG, and WB) 2. WRP Conference (WB, Program 5, Unit 6; and MG, Program 5, Unit 9) 3. Mall groups (Coping Skills/Money Management, Coping Skills/Karaoke (bed-bound unit), Wellness and Recovery Action Plan
F.2.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>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Finalize Special Order #129.01.</p> <p>Findings: NSH has finalized SO #129.01 and implemented the order effective January 26, 2007.</p> <p>Recommendation 2, February 2007: Finalize the statewide PBS Manual.</p> <p>Findings:</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<p>NSH has completed and revised the Psychology Manual. The manual is now being reviewed by their CRIPA Chief Consultant.</p> <p>Recommendation 3, February 2007: Continue to use Behavior Guidelines and PBS plans as the terms for identifying Behavior Supports.</p> <p>Findings: NSH has revised AD #851 (Positive Behavior Support) to align with SO #129.01, effective April 26, 2007. According to Kathleen Patterson, Interim Senior Supervising Psychologist, NSH now uses behavior guidelines and PBS plans as the pathway to providing Behavioral Support to individuals in NSH.</p> <p>Recommendation 4, February 2007: Continue to recruit additional PBS team members.</p> <p>Findings: NSH has four PBS teams. The four teams meet the EP requirement of one team for each 300 individuals. However, at this time, only two teams are fully staffed. One team is missing a Psychologist and the other team is missing a Psychiatric Technician. NSH is actively recruiting to fill these vacant positions.</p> <p>Recommendation 5 Ensure that all PBS psychologists use the PBS model as currently identified in the literature.</p> <p>Findings: PBS team members at NSH have been trained (February 21 and 22, 2007, April 4, 2007 and May 10, 2007) and continually monitored by Angela Adkins, the facility's consultant. PBS team members are applying the PBS model as currently conceptualized in the literature. A review of PBS plans shows that PBS team members have improved (20% full compliance and 50% partial</p>
--	--	---

Section F: Specific Therapeutic and Rehabilitation Services

		<p>compliance in March 2007, and 33% full compliance and 70% partial compliance in May 2007) in their practice after receiving training.</p> <p>Recommendation 6, February 2007: Ensure that the PBS Psychologists provide training to the RNs, PTs and data analysts in data collection methods and on the reliable use of evidence-based tools.</p> <p>Findings: PBS psychologists in NSH have been providing training to the nurses, psychiatric technicians, and data analysts in their teams. Training will continue until all staff is fully trained to competency.</p> <p>Recommendation 7 Develop a standardized referral system across all facilities.</p> <p>Findings: A standardized referral system is outlined in the PBS Manual. The Manual currently is under revision.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none">1. Finalize and implement the statewide PBS Manual.2. Continue to recruit additional PBS team members until all PBS teams are fully staffed.3. Ensure that PBS psychologists continue to provide training to the RNs, PTs and data analysts in data collection methods and on the reliable use of evidence-based tools until they achieve competency.4. Ensure that the PBS referral system is implemented.
--	--	---

Section F: Specific Therapeutic and Rehabilitation Services

<p>F.2.a.i</p>	<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>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Continue with training of all PBS team staff.</p> <p>Findings: The PBS teams at NSH continue to receive training from Angela Adkins, the facility's consultant. The recent training sessions were held on February 21 and 22, 2007, April 11, 2007, and May 10, 2007. The consultant also monitors and evaluates the PBS plans and behavior guidelines and provides corrective feedback to the PBS teams.</p> <p>Recommendation 2, February 2007: Ensure that Fidelity Implementation checks delineate the specific steps of the PBS plan.</p> <p>Findings: NSH has introduced a new template for PBS plans. The new template includes fidelity-check boxes beside each step of the PBS plan. This new template will automatically show the steps of the PBS Plans that can be checked off during observation of the implementation of PBS plans.</p> <p>Recommendation 3 and 4, February 2007:</p> <ol style="list-style-type: none"> 3. Conduct the fidelity checks prior to implementation of the plan. 4. Ensure that staff responsible for implementing the PBS plans is certified. <p>Findings: PBS teams at NSH used item #36 (<i>All staff has received competency-based training on implementing the specific behavioral interventions for which they are responsible, and performance improvement measures are in place for monitoring the implementation of such interventions</i>) of the Psychology Monitoring Form. NSH used this item to show that staff was trained and</p>
----------------	---	---

Section F: Specific Therapeutic and Rehabilitation Services

		<p>fidelity checks were conducted prior to implementation of the five PBS plans developed and implemented since January 2007, reporting 100% compliance. This monitor's review of the same plans reviewed by NSH showed agreement with the facility's findings. However, implementation of the plans was limited to the unit. The plans should be implemented across settings and the staff across the relevant settings should be trained.</p> <p>Recommendation 5, February 2007: Ensure that Senior Psychologists review all Guidelines, PBS plans and Crisis Intervention plans.</p> <p>Findings: NSH has assigned one Interim Senior Supervising Psychologist who is reviewing all behavior guidelines, PBS plans, and crisis intervention plans submitted by PBS and from the WRPT Psychologists.</p> <p>Recommendation 6 and 7, February 2007:</p> <ol style="list-style-type: none"> 6. PBS team leaders need to develop a systematic way of evaluating treatment outcomes and reporting those outcomes to the WRP. 7. Ensure that outcome data is updated in the Present Status Section of the case formulation and the PBS plan is identified in the intervention section of the WRP. <p>Findings: NSH audited 76 charts using item #34 (<i>All positive behavior support plans are specified in the objectives and interventions sections of the individual's Wellness and Recovery Plan</i>), of the DMH Psychology Monitoring Forum, reporting 40% compliance.</p> <p>This monitor reviewed seven (CH, JP, AL, PB, HS, RP, and AS) charts. Two of them (JP and HS) had the individual's PBS plan documented in the Present Status section and identified in the interventions section of the WRP. Four of</p>
--	--	--

Section F: Specific Therapeutic and Rehabilitation Services

		<p>them (CH, AL, AS, and PB) had the plans documented in the Present Status section but not identified in the interventions section. One of them (RP) did not mention the individual's plan in the WRP.</p> <p>According to Kathleen Patterson, Interim Senior Supervising Psychologist, PBS team members now attend WRPC meetings to present outcome data and update PBS plans.</p> <p>Recommendation 8, February 2007: Ensure that revisions of WRPs with PBS plans as an intervention are based on the outcome data of the PBS plan.</p> <p>Findings: NSH audited 76 charts using item #35 (<i>All positive behavior support plans are updated as indicated by outcome data and reported at least quarterly in the Present Status section of the case formulation in the individual's Wellness and Recovery Plan</i>) of the DMH Psychology Monitoring Form, reporting 36% compliance.</p> <p>NSH has trained PBS team members and WRPT psychologists using the DMH WRP Manual. Kathleen Patterson, Interim Senior Supervising Psychologist who conducted the training of the PBST and WRPT team members, indicated PBS team members attend WRPCs to update on PBS data, however, she noted that WRPCs do not always update WRPs with reported PBS data.</p> <p>This monitor reviewed five charts (AL, JB, AS, HS, and DC). None of them had quantitative data or updates indicating changes as a result of the interventions. In general, information in the Present Status section of WRPs related to milieu interventions, individual therapies, and PBS/Behavior Guidelines was recorded using qualitative terms (JB's present status section, for example, reads, "Mr. B...appears to respond very well [sic] to these treatment sessions"; or in AS's Present Status section, "PBST has reported that her current behaviors appear</p>
--	--	---

Section F: Specific Therapeutic and Rehabilitation Services

		<p>to be baseline..."; and in DC, "He continues to be on behavior guidelines"). WRP teams should use quantitative data (raw scores/transformed scores) indicating changes from the previous conference to the current conference.</p> <p>Recommendation 9, February 2007: The PBS teams, WRPTs and the BCC require further training to fully understand their roles, agenda at the BCC and tracking of referrals made to the BCC.</p> <p>Findings: NSH had a meeting and training session (February 5, 2007) between the BCC and PBS teams. WRPT psychologists have been trained on the use of the PBS/BCC. A standardized referral process has been instituted and included in the DMH PBS Manual. The manual currently is being reviewed by the facility's CRIPA consultant.</p> <p>Recommendation 10, February 2007: Ensure that all PBS team leaders receive training in the development of structural assessment, functional assessment and functional analysis, and the development and implementation of PBS plans.</p> <p>Findings: NSH conducted training sessions for PBS teams led by the facility's consultant, Angela Adkins (February 21 and 22, 2007, April 11, 2007, and May 10, 2007). The consultant continues to monitor the assessments and intervention plans following training. Review of the assessments and intervention plans between March and May 2007 showed an improvement in the quality, accuracy, and comprehensiveness of these assessments. For example, the March score on the PBS plans and assessments stood at 20% full compliance whereas the May scores increased to 33% compliance.</p> <p>Recommendation 11, February 2007: Ensure that all RNs, PTs and data analysts on the PBS teams receive guidelines</p>
--	--	--

Section F: Specific Therapeutic and Rehabilitation Services

		<p>for using evidence-based tools for referrals, training on evidence-based tools for data collection and that a team leader performs reliability checks in this area.</p> <p>Findings: NSH's PBS non-psychology team members have received training from many fronts including peer teaching and training by their consultants. NSH also held formal training sessions, by way of retreats. Training rosters and meeting agenda were reviewed by this monitor. A review of the training agendas showed that the training focused on elements contained in this recommendation. An email dated June 19, 2007 (6:35:55PM), titled <i>Retreat Agenda</i>, showed the following topics:</p> <ul style="list-style-type: none"> • DBT training using Linehan module for adolescents. • Formal training on PBS approved tools/clinical interviewing/ motivational interviewing. • How to facilitate group psychotherapy. • How to support staff more effectively in situations. • Roles of the teams. <p>Recommendation 12, February 2007: Integrate a response to triggers in the referral process to PBS.</p> <p>Findings: NSH has provided training to PBS teams and WRPT psychologists on triggers and the use of triggers in the referral process to PBS. According to Kathleen Patterson, Interim Senior Supervising Psychologist, NSH has yet to have the automated trigger system hospital-wide, instead the non-automated trigger system is being used, but is being used inconsistently.</p> <p>NSH audited all individuals (n) with three or more episodes of Seclusions or Seclusions and Restraints between January through June, 2007, using item #32</p>
--	--	---

Section F: Specific Therapeutic and Rehabilitation Services

of the DMH Psychology Monitoring Form to address this recommendation, reporting 49% compliance. The table below with its monitoring indicator is a summary of the facility's data.

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.

	Jan	Feb	Mar	Apr	May	Jun	Mean
N	11	13	16	18	16	19	
N	11	13	16	18	16	19	
% S	100	100	100	100	100	100	
% C-32	55	23	50	61	63	47	49

Recommendation 13, February 2007:

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.

Findings:

This monitor reviewed NSH's Training and Development Roster (July 5 and 12, 2007), attendance, and post-test of training conducted with PBS team members. All but three team members were trained in the DMH WRP Manual on the WRP process. All participants had scored at the 100% level on the post-test. On July 5, eight members of PBS scored 100% on the WRP post-test. According to Kathleen Patterson, Interim Senior Supervising Psychologist, the remaining three PBS team members will be trained as soon as their schedule permits.

Compliance:

Partial.

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Complete training of all PBS team members on PBS plans and WRP procedures. 2. Ensure that staff who will be responsible for implementing the PBS plans are certified. 3. Conduct the fidelity checks prior to implementation of the plan. 4. Ensure that outcome data is updated in the Present Status section of the case formulation and the PBS plan is identified in the intervention section of the WRP. 5. Integrate a response to triggers in the referral process to PBS. 6. Complete training of team psychologists and PBS psychologists 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.
F.2.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>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, February 2007:</p> <ol style="list-style-type: none"> 1. Fully implement the BY CHOICE program. 2. Train all staff in correctly implementing the BY CHOICE program. <p>Findings: NSH has fully implemented the BY CHOICE program facility wide.</p> <p>According to Nicole Aviles-Galberth, BY CHOICE Coordinator, staff has been trained to competency on correctly implementing the BY CHOICE program, but she also noticed inconsistencies in the implementation of the program. This monitor reviewed the training rosters showing dates of training (June 6, 7, 8, 11, 12, 13, 14, 25, and 29, 2007). Unit and management staff had received training in implementing the program.</p>

Section F: Specific Therapeutic and Rehabilitation Services

	<p>Recommendation 3, February 2007: Implement the program as per the manual.</p> <p>Findings: NSH has implemented the BY CHOICE program as per the Manual, except for establishing the Committee and an inventory tracking program. According to Nicole Aviles-Galberth, BY CHOICE coordinator, the BY CHOICE Individual Satisfaction Surveys are conducted monthly. The Satisfaction Survey contains items on recommendations for store items/events. NSH has developed and printed satisfaction surveys in English, Chinese, Spanish, and Vietnamese.</p> <p>NSH used item #7 (<i>Is there an item or activity that you would like offered in the activity stores?</i>), of the BY CHOICE Satisfaction Survey, reporting 61% satisfaction of those surveyed on the activities and items currently offered by the BY CHOICE program.</p> <p>This monitor reviewed the BY CHOICE Satisfaction Survey results. Almost all the individuals were happy with the BY CHOICE program. Across the programs, the general complaint was that the point costs of items were high. In addition, the individuals have given additional comments, many thoughtful and some interesting. A few examples of the individuals' feedback include:</p> <ul style="list-style-type: none"> • "Give us the right points that belong to us." • "I worked on this committee and most of what we spoke on was never applied. A complete waste of time." • "I don't participate in B.C. because I don't want to bother the staff to fill out my card." • "Sometimes weekend points are defaulted because of no computer to save." • "Staff is too lazy to escort to store." (repeated across individuals and programs) • "If you are sick you lose points for not going to meals/groups." • "Some staff don't have red pens so they don't sign the cards." (repeated
--	--

Section F: Specific Therapeutic and Rehabilitation Services

		<p>across individuals and programs)</p> <ul style="list-style-type: none">• "Open the store on time. Extend store time." <p>NSH also developed and implemented lists of individuals with risk for allergies, choking, and diabetes, so as to ensure that the individuals do not purchase/exchange items unsafe for them.</p> <p>Recommendation 4, February 2007: Ensure that the program has additional resources, including computers and software that will assist in running the system smoothly.</p> <p>Findings: According to the BY CHOICE Coordinator, the program still lacks resources, some as basic as lack of space and furniture and some as critical as card errors/problems with printers, frequent database failures with the consequence that data entry, audits, and store openings were delayed. Apparently, the database failures originate from the servers in Sacramento using Microsoft 97 that is yet to be upgraded to Microsoft 03. Currently only one user gets to access the database at any onetime to run off BY CHOICE graphs. The graphs are essential for the WRPTs to update the individuals' WRPs.</p> <p>Recommendation 5, February 2007: BY CHOICE point allocation should be determined by the individual at the individual's WRPC, with facilitation by the staff.</p> <p>Findings: NSH did not audit this recommendation.</p> <p>This monitor reviewed ten charts (CD, EH, MP, CLC, AS, MW, EM, CH, VH, and AT). Other than CD, the Present Status section of whose WRP had some information on point allocation and participation, none of them had documented evidence that the point allocation was discussed with the individual and/ or that</p>
--	--	---

Section F: Specific Therapeutic and Rehabilitation Services

		<p>the point allocation was determined by the individual with facilitation by the staff.</p> <p>Recommendation 6, February 2007: Document BY CHOICE point allocation in the Present Status section of the individual's case formation and update at every scheduled WRPC as per the DMH WRP manual. (Same as in C.2.xii, recommendation 1).</p> <p>Findings: NSH used item #38 of the DMH WRP Observation Monitoring Form to address this recommendation, reporting 13% compliance. The table below with its monitoring indicator is a summary of the facility's data, showing the number of WRPCs observed (n) and the percent compliance observed (% C), from January through June 2007.</p> <table border="1" data-bbox="894 743 1890 922"> <thead> <tr> <th></th> <th>Jan</th> <th>Feb</th> <th>Mar</th> <th>Apr</th> <th>May</th> <th>Jun</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>1082</td> <td>1096</td> <td>1125</td> <td>1117</td> <td>1136</td> <td>1144</td> <td></td> </tr> <tr> <td>n</td> <td>1</td> <td>5</td> <td>8</td> <td>14</td> <td>24</td> <td>18</td> <td></td> </tr> <tr> <td>% S</td> <td>0</td> <td>0</td> <td>0</td> <td>1</td> <td>2</td> <td>1</td> <td></td> </tr> <tr> <td>% C-38</td> <td>0</td> <td>20</td> <td>12</td> <td>28</td> <td>16</td> <td>0</td> <td>13</td> </tr> </tbody> </table> <p>This monitor reviewed ten charts (PB, AC, PM, MK, DB, DR, RM, AS, RP, and TX). None of them met criteria on documentation of the the individuals' BY CHOICE point allocation as required by the DMH WRP Manual.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Monitor the implementation of the BY CHOICE program to ensure that the program is being implemented as required by the DMH WRP Manual. 		Jan	Feb	Mar	Apr	May	Jun	Mean	N	1082	1096	1125	1117	1136	1144		n	1	5	8	14	24	18		% S	0	0	0	1	2	1		% C-38	0	20	12	28	16	0	13
	Jan	Feb	Mar	Apr	May	Jun	Mean																																			
N	1082	1096	1125	1117	1136	1144																																				
n	1	5	8	14	24	18																																				
% S	0	0	0	1	2	1																																				
% C-38	0	20	12	28	16	0	13																																			

Section F: Specific Therapeutic and Rehabilitation Services

		<ol style="list-style-type: none"> 2. Ensure that the program has additional resources, including computers and software necessary for the program to function efficiently. 3. BY CHOICE point allocation should be determined by the individual at the individual's WRPC, with facilitation by the staff, and documented in the Present Status section of the individual's WRP.
F.2.b	Each State Hospital shall ensure that the Chief of Psychology has the clinical and administrative responsibility for the Positive Behavior Supports Team and the By CHOICE incentive program.	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, February 2007:</p> <ol style="list-style-type: none"> 1. Use the Special Order as the NSH AD. 2. Implement the AD. <p>Findings: NSH has established that the Chief of Psychology will have the clinical and administrative responsibility for the Positive Behavior Supports Team and the BY CHOICE incentive program. AD #851 (Positive Behavioral Support) now is aligned with SO #129.01; and AD #798 (BY CHOICE Incentive Program) is aligned with SO #130.1.</p> <p>Compliance: Full compliance.</p>
F.2.c	Each State Hospital shall ensure that:	<p>Compliance: Partial.</p>
F.2.c.i	behavioral assessments include structural and functional assessments and, as necessary, functional analysis;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Train all PBS team members in structural and functional assessment, functional analysis, data collection, data analysis, graphing, plan implementation and data interpretation.</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Findings:</p> <p>NSH provided training to its PBS team members on the elements required in this recommendation. Training has been conducted by Angela Adkins, the facility's consultant. Training dates included February 21 and 22, April 11, and May 10, 2007.</p> <p>NSH used items #5-#9 of the DMH PBS Monitoring Form. The items are as follows:</p> <p><i>#5: Pertinent records were reviewed.</i></p> <p><i>#6: Structural assessments (e.g. ecological, sleep, medication effects, mall attendance, etc.) were conducted, as needed, to determine broader variables affecting the individual's behavior.</i></p> <p><i>#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.</i></p> <p><i>#8: Direct observations were conducted across relevant circumstances (e.g. multiple settings, over time) and by more than one observer, as appropriate.</i></p> <p><i>#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.</i></p> <p>Using the items #5-#9, NSH audited one set of plans on CH, BN, and RM, with the results showing 37% full compliance, 51% partial compliance, and 11% non-compliance; and audited another set of plans on SH, AL, TK, CC, and DC, with the results showing 13% full compliance, 80% partial compliance, and 7% non-compliance.</p>
--	--	---

Section F: Specific Therapeutic and Rehabilitation Services

		<p>This monitor reviewed the assessments audited by NSH and is in agreement with the facility's findings.</p> <p>Recommendation 2, February 2007: Develop a system for identifying and tracking individuals in the hospital who are in need of behavioral interventions.</p> <p>Findings: NSH has chosen to use the Automated WaRMSS and Trigger Tracking systems to track individuals who are in need of behavioral interventions. NSH has designed the Automated WaRMSS system but has yet to implement the system due to hardware problems. NSH has trained the PBS Team members on the Automated PRN tracking portion of the system. Kathleen Patterson, Interim Senior Supervising Psychologist, has been working with the PBS teams and the unit psychologists on matters pertaining to the identification of individuals' maladaptive behaviors and appropriate referrals following the approved referral pathway.</p> <p>Recommendation 3, February 2007: Utilize Senior Psychologists to monitor the appropriateness of Behavior Guidelines, Crisis Intervention Plans and the need for a referral to PBS teams when an assessment or analysis is indicated.</p> <p>Findings: NSH has assigned a Senior Supervising Psychologist to this task. The Senior Supervising Psychologist has been monitoring the Behavior Guidelines and Crisis Intervention Plans of all programs in the facility.</p> <p>Compliance: Substantial.</p>
--	--	---

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Current recommendation: Implement the Automated WaRMSS and Trigger Tracking systems to track individuals in need of behavioral interventions.</p>																				
F.2.c.ii	<p>hypotheses of the maladaptive behavior are based on structural and functional assessments;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation February 2007: Ensure that hypotheses of the maladaptive behavior are based on reliable data.</p> <p>Findings: NSH used item #28 of the DMH Psychology Monitoring Form to address this recommendation, reporting 0% compliance, indicating that none of the four PBS plans based their hypothesis on structural and functional assessments. The table below, with its monitoring indicator, showing the number of PBS plans developed in the months of March and May (N), the number of PBS plans reviewed (n), and their percent compliance (%C), is a summary of the facility's data.</p> <p><i>The hypotheses of the maladaptive behavior are based on structural and functional assessments.</i></p> <table border="1" data-bbox="894 971 1394 1143"> <thead> <tr> <th></th> <th>Mar</th> <th>May</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>2</td> <td>2</td> <td></td> </tr> <tr> <td>n</td> <td>2</td> <td>2</td> <td></td> </tr> <tr> <td>% S</td> <td>100</td> <td>100</td> <td></td> </tr> <tr> <td>% C-28</td> <td>0</td> <td>0</td> <td>0</td> </tr> </tbody> </table> <p>This monitor reviewed three PBS plans (CH, CC, and BN). This monitor's findings are in agreement with NSH's findings.</p> <p>Compliance: Partial.</p>		Mar	May	Mean	N	2	2		n	2	2		% S	100	100		% C-28	0	0	0
	Mar	May	Mean																			
N	2	2																				
n	2	2																				
% S	100	100																				
% C-28	0	0	0																			

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Current Recommendation: Ensure that hypotheses of maladaptive behavior are based on reliable data.</p>																																								
F.2.c.iii	<p>There is documentation of previous behavioral interventions and their effects;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation February 2007: Document previous behavioral interventions.</p> <p>Findings: NSH has provided training to its WRPT psychologists on documenting previous behavioral interventions and their effects when conducting assessments.</p> <p>NSH audited all of the Focused Assessments conducted from January through June 2007, using item #29 of the DMH Psychology Monitoring Form, to address this recommendation, reporting 4% compliance. The table below with its monitoring indicator, showing the number of focused assessments conducted (N), the number of focused assessments audited (n), and the percent compliance (%C), is a summary of the facility's data.</p> <p><i>There is documentation of previous behavioral interventions and their effects.</i></p> <table border="1" data-bbox="894 1003 1890 1179"> <thead> <tr> <th></th> <th>Jan</th> <th>Feb</th> <th>Mar</th> <th>Apr</th> <th>May</th> <th>Jun</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>3</td> <td>5</td> <td>4</td> <td>5</td> <td>11</td> <td>7</td> <td></td> </tr> <tr> <td>n</td> <td>3</td> <td>5</td> <td>4</td> <td>5</td> <td>11</td> <td>7</td> <td></td> </tr> <tr> <td>% S</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td></td> </tr> <tr> <td>% C-29</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>27</td> <td>0</td> <td>4</td> </tr> </tbody> </table> <p>This monitor reviewed seven structural assessments (BN, DC, MR, AS, CH, AL, and DR). Two of them (DC and CH) had mention of the previous behavioral interventions and their effects, and the remaining five (BN, MR, AS, AL, and DR) did not.</p>		Jan	Feb	Mar	Apr	May	Jun	Mean	N	3	5	4	5	11	7		n	3	5	4	5	11	7		% S	100	100	100	100	100	100		% C-29	0	0	0	0	27	0	4
	Jan	Feb	Mar	Apr	May	Jun	Mean																																			
N	3	5	4	5	11	7																																				
n	3	5	4	5	11	7																																				
% S	100	100	100	100	100	100																																				
% C-29	0	0	0	0	27	0	4																																			

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Compliance: Partial.</p> <p>Current recommendation: Document previous behavioral interventions.</p>																																			
F.2.c.iv	<p>behavioral interventions, which shall include positive behavior support plans, are based on a positive behavior supports model and do not include the use of aversive or punishment contingencies;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Ensure that all behavioral interventions are based on a positive behavior supports model and do not include the use of aversive or punishment contingencies.</p> <p>Findings: NSH used item #30 of the DMH Psychology Monitoring Form to address this recommendation, reporting 90% compliance. The table below showing the number of PBS plans completed each month (N), the number of PBS plans audited (n), and the percent compliance (%C), with its monitoring indicator is a summary of the facility's data.</p> <p><i>Behavioral interventions, which include positive behavior support plans, are based on a positive behavior supports model and do not include the use of aversive or punishment contingencies.</i></p> <table border="1" data-bbox="894 1117 1770 1312"> <thead> <tr> <th></th> <th>Jan</th> <th>Mar</th> <th>Apr</th> <th>May</th> <th>Jun</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>1</td> <td>2</td> <td>1</td> <td>2</td> <td>1</td> <td></td> </tr> <tr> <td>n</td> <td>1</td> <td>2</td> <td>1</td> <td>2</td> <td>1</td> <td></td> </tr> <tr> <td>% S</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td></td> </tr> <tr> <td>% C-30</td> <td>100</td> <td>50</td> <td>100</td> <td>100</td> <td>100</td> <td>90</td> </tr> </tbody> </table>		Jan	Mar	Apr	May	Jun	Mean	N	1	2	1	2	1		n	1	2	1	2	1		% S	100	100	100	100	100		% C-30	100	50	100	100	100	90
	Jan	Mar	Apr	May	Jun	Mean																															
N	1	2	1	2	1																																
n	1	2	1	2	1																																
% S	100	100	100	100	100																																
% C-30	100	50	100	100	100	90																															

Section F: Specific Therapeutic and Rehabilitation Services

NSH also audited all behavioral guidelines developed and implemented from February through June 2007, again using item #30 of the DMH Psychology Monitoring Form to address this recommendation and found 57% compliance. The table below showing the number of behavioral guidelines completed each month (N), the number of behavioral guidelines audited (n), and the percent compliance (%C) is a summary of the facility's data.

	Feb	Mar	Apr	May	Jun	Mean
N	16	10	9	14	18	
n	16	10	9	14	18	
% S	100	100	100	100	100	
% C	25	40	67	79	72	57

This monitor reviewed four PBS plans (CH, CC, SH, and BN), and 14 behavioral guidelines (DC, PB, FC, SB, JP, MP, JB, LT, MW, DG, RB, DR, BN, and NF). None of the interventions in these plans themselves included any negative/punishing steps/procedures. However, one PBS plan (CC), and seven behavioral guidelines (DC, FC, SB, JP, JB, MW, and NF) contained emergency/crisis plans that involved negative/punishing steps/procedures. Crisis/emergency plans when necessary should be separated from the PBS and behavioral guidelines and placed under the hospital policy and procedures and not be part of the behavioral intervention procedure.

Compliance:

Partial.

Current recommendation:

Ensure that all behavioral interventions are based on a positive behavior supports model and do not include the use of aversive or punishment contingencies.

Section F: Specific Therapeutic and Rehabilitation Services

<p>F.2.c.v</p>	<p>behavioral interventions are consistently implemented across all settings, including school settings;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Ensure that all behavioral interventions are consistently implemented across all settings, including mall, vocational and education settings.</p> <p>Findings: NSH audited all PBS plans from January through June 2007, using item #31 of the DMH Psychology Monitoring Form to address this recommendation, reporting 16% compliance. The table below with its monitoring indicator, showing the number of active PBS plans (N) and the number of PBS plans audited, with its compliance (%C) is a summary of the facility's data.</p> <p><i>Behavioral interventions are consistently implemented across all settings, including school settings.</i></p> <table border="1" data-bbox="892 779 1890 974"> <thead> <tr> <th></th> <th>Jan</th> <th>Feb</th> <th>Mar</th> <th>Apr</th> <th>May</th> <th>Jun</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>3</td> <td>3</td> <td>3</td> <td>3</td> <td>2</td> <td>2</td> <td></td> </tr> <tr> <td>n</td> <td>3</td> <td>3</td> <td>3</td> <td>3</td> <td>2</td> <td>2</td> <td></td> </tr> <tr> <td>% S</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td></td> </tr> <tr> <td>% C-31</td> <td>33</td> <td>33</td> <td>33</td> <td>0</td> <td>0</td> <td>0</td> <td>16</td> </tr> </tbody> </table> <p>According to the Interim Senior Supervising Psychologists, the staff in the facility consulted with outside providers for individuals (BN sent to the Queen of the Valley Hospital, and CCF at Napa County jail) sent to settings outside the facility.</p> <p>This monitor's review of CC's PBS plan showed that the plan was not consistently implemented across settings. Fidelity check and staff training data was not documented.</p>		Jan	Feb	Mar	Apr	May	Jun	Mean	N	3	3	3	3	2	2		n	3	3	3	3	2	2		% S	100	100	100	100	100	100		% C-31	33	33	33	0	0	0	16
	Jan	Feb	Mar	Apr	May	Jun	Mean																																			
N	3	3	3	3	2	2																																				
n	3	3	3	3	2	2																																				
% S	100	100	100	100	100	100																																				
% C-31	33	33	33	0	0	0	16																																			

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Compliance: Partial.</p> <p>Current recommendation: Ensure that all behavioral interventions are consistently implemented across all settings, including mall, vocational and education settings.</p>																
F.2.c.vi	<p>triggers for instituting individualized behavioral interventions are specified and utilized, and that these triggers include excessive use of seclusion, restraint, or psychiatric PRN and Stat medication for behavior control;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation February 2007: The hospital should have a system for using their trigger data to initiate a Behavior Guideline or obtain PBS consultation.</p> <p>Findings: NSH has yet to automate the trigger system. According to the Interim Senior Psychologists, the trigger system is not consistently implemented on the units. According to them, only the PRN automated system has been implemented, and the PBS team members have been trained on the system.</p> <p>NSH audited individuals who experienced three or more seclusions and restraints per month, for January to June 2007, using item #32 of the DMH Psychology Monitoring Form, reporting 49% compliance. The table below with its monitoring indicator shows the number of individuals with 3 or more episodes of seclusion and seclusion and restraint (N), the number of individuals audited (n), and the resulting compliance (%C).</p> <p><i>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</i></p> <table border="1" data-bbox="894 1300 1896 1377"> <thead> <tr> <th></th> <th>Jan</th> <th>Feb</th> <th>Mar</th> <th>Apr</th> <th>May</th> <th>Jun</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>11</td> <td>13</td> <td>16</td> <td>18</td> <td>16</td> <td>19</td> <td></td> </tr> </tbody> </table>		Jan	Feb	Mar	Apr	May	Jun	Mean	N	11	13	16	18	16	19	
	Jan	Feb	Mar	Apr	May	Jun	Mean											
N	11	13	16	18	16	19												

Section F: Specific Therapeutic and Rehabilitation Services

		<table border="1"> <tr> <td>n</td> <td>11</td> <td>13</td> <td>16</td> <td>18</td> <td>16</td> <td>19</td> <td></td> </tr> <tr> <td>% S</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td></td> </tr> <tr> <td>% C-32</td> <td>55</td> <td>23</td> <td>50</td> <td>61</td> <td>63</td> <td>47</td> <td>49</td> </tr> </table> <p>Compliance: Partial.</p> <p>Current recommendation: The hospital should have a system for using their trigger data to initiate a Behavior Guideline or obtain PBS consultation.</p>	n	11	13	16	18	16	19		% S	100	100	100	100	100	100		% C-32	55	23	50	61	63	47	49
n	11	13	16	18	16	19																				
% S	100	100	100	100	100	100																				
% C-32	55	23	50	61	63	47	49																			
F.2.c.vii	positive behavior support teams and team psychologists integrate their therapies with other treatment modalities, including drug therapy;	<p>Current findings on previous recommendations:</p> <p>Recommendations February 2007: Integrate all behavioral interventions with other treatment modalities, including drug therapy.</p> <p>Findings: NSH psychology staff has been trained by the Interim Senior Supervising Psychologists on integrating behavioral interventions with other treatment modalities including drug therapy.</p> <p>NSH audited 88 current PBS plans and behavior guidelines using item #33 of the DMH Psychology Monitoring Form, reporting 55% compliance. The table below with its monitoring indicator is a summary of the facility's data showing the number of available PBS plans and behavior guidelines (N), the number of PBS plans and behavior guidelines audited (n), and the resulting compliance (%C)</p> <p><i>Positive behavior support teams and team psychologists integrate their therapies with other treatment modalities, including drug therapy</i></p>																								

Section F: Specific Therapeutic and Rehabilitation Services

		<table border="1"> <thead> <tr> <th></th> <th>Jan</th> <th>Feb</th> <th>Mar</th> <th>Apr</th> <th>May</th> <th>Jun</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>16</td> <td>16</td> <td>12</td> <td>10</td> <td>15</td> <td>19</td> <td></td> </tr> <tr> <td>n</td> <td>16</td> <td>16</td> <td>12</td> <td>10</td> <td>15</td> <td>19</td> <td></td> </tr> <tr> <td>% S</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td></td> </tr> <tr> <td>% C-33</td> <td>75</td> <td>31</td> <td>75</td> <td>50</td> <td>40</td> <td>52</td> <td>55</td> </tr> </tbody> </table> <p>This monitor reviewed 18 (FC, SB, JP, MP, AL, JM, DC, JC, JB, LT, MW, CC, DG, RB, DR, PB, BN, and HS) behavioral intervention plans. Four of these plans (LT, BN, HS, and AL) had considered and or included other treatment modalities in their active intervention plans. For example, treadmill exercise for LT, milieu intervention for DR, medication for BN, and sensory integration through occupational therapy for AL. The others failed to integrate other treatment modalities into the individual's treatment plan.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Integrate all behavioral interventions with other treatment modalities, including drug therapy.</p>		Jan	Feb	Mar	Apr	May	Jun	Mean	N	16	16	12	10	15	19		n	16	16	12	10	15	19		% S	100	100	100	100	100	100		% C-33	75	31	75	50	40	52	55
	Jan	Feb	Mar	Apr	May	Jun	Mean																																			
N	16	16	12	10	15	19																																				
n	16	16	12	10	15	19																																				
% S	100	100	100	100	100	100																																				
% C-33	75	31	75	50	40	52	55																																			
F.2.c.viii	all positive behavior support plans are specified in the objectives and interventions sections of the individual's Wellness and Recovery Plan;	<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Specify PBS plans in the objectives and interventions sections of the individual's WRP Plan as outlined in the DMH PBS Manual.</p> <p>Findings: NSH audited intervention plans from January through June 2007, using item #34 of the DMH Psychology Monitoring Form, reporting 40% compliance. The table below with this monitoring indicator shows the number of available plans (N), the number of plans audited (n), and the obtained percent compliance (%C).</p>																																								

Section F: Specific Therapeutic and Rehabilitation Services

		<p><i>All positive behavior support plans are specified in the objectives and interventions sections of the individual's Wellness and Recovery Plan.</i></p> <table border="1" data-bbox="894 337 1890 513"> <thead> <tr> <th></th> <th>Jan</th> <th>Feb</th> <th>Mar</th> <th>Apr</th> <th>May</th> <th>Jun</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>3</td> <td>16</td> <td>12</td> <td>10</td> <td>16</td> <td>19</td> <td></td> </tr> <tr> <td>n</td> <td>3</td> <td>16</td> <td>12</td> <td>10</td> <td>16</td> <td>19</td> <td></td> </tr> <tr> <td>% S</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td></td> </tr> <tr> <td>% C</td> <td>33</td> <td>25</td> <td>58</td> <td>60</td> <td>25</td> <td>42</td> <td>40</td> </tr> </tbody> </table> <p>This monitor reviewed seven intervention plans (SH, AL, CLC, AT, JB, MP, and EH). Four of them (SH, AL, CLC, and AT) had their plans specified in their objectives and interventions sections of the individual's WRP. The remaining three (JB, MP, and EH) did not.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Specify PBS plans in the objectives and interventions sections of the individual's WRP Plan as outlined in the DMH PBS Manual.</p>		Jan	Feb	Mar	Apr	May	Jun	Mean	N	3	16	12	10	16	19		n	3	16	12	10	16	19		% S	100	100	100	100	100	100		% C	33	25	58	60	25	42	40
	Jan	Feb	Mar	Apr	May	Jun	Mean																																			
N	3	16	12	10	16	19																																				
n	3	16	12	10	16	19																																				
% S	100	100	100	100	100	100																																				
% C	33	25	58	60	25	42	40																																			
F.2.c.ix	all positive behavior support plans are updated as indicated by outcome data and reported at least quarterly in the Present Status section of the case formulation in the individual's Wellness and Recovery Plan	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Update all PBS plans as indicated by outcome data and document at every scheduled WRPC in the Present Status section of the individual's case formulation.</p> <p>Findings: NSH audited 76 intervention plans using item #35 of the DMH Psychology Monitoring Form to address this recommendation, reporting 36% compliance.</p>																																								

Section F: Specific Therapeutic and Rehabilitation Services

The table below with its monitoring indicator shows the number of available plans (N), the number of plans audited (n) and the compliance rate obtained (%C).

All positive behavior support plans are updated as indicated by outcome data and reported at least quarterly in the Present Status section of the case formulation in the individual's Wellness and Recovery Plan

	Jan	Feb	Mar	Apr	May	Jun	Mean
N	3	16	12	10	16	19	
n	3*	16	12	10	16	19	
% S	100	100	100	100	100	100	
% C-35	33	18	41	50	37	42	36

This monitor reviewed five charts (AL, NB, SH, CH, and MW). CH has a comprehensive PBS plan with the necessary assessment and treatment components and documentation, and acceptable documentation in the Present Status section of his WRP. The others did not include any quantitative data or meaningful discussion/update of the individual's PBS plan and progress thereof. In the case of AL, for example, the psychologist has collected good quantitative data (frequency data); however, the PBS plan does not specify the type of data to be collected, the methods and procedures to be used, or the person(s) to collect the data. In the case of SH, the plan was written on May 21, 2007, and according to the documentation in the Present Status section (WRPC, July 18, 2007) the plan was implemented in June 29, 2007, and was referred to the BCC on July 17, 2007. No discussion on the outcome and/or data was documented in the Present Status section of SH's WRP.

Recommendation 2, February 2007:

Ensure that PBS teams are a part of the regularly scheduled monthly and quarterly WRPCs for the individuals and that they are not a separate weekly meeting.

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Findings: According to the Interim Senior Supervising Psychologists, PBS team members attend daily change shift and trigger meetings on units, and attend WRP conference meetings when they have active cases.</p> <p>Other findings: Documentation in the Present Status Section of AL's WRP states, "Attachments were unable to be reviewed as the court monitors currently have the charts off the unit for review". WRP teams should request the charts from the court monitor team when a chart is needed for patient care. It has been the practice of the court monitors to return the charts to the appropriate personnel when requested and have them to be returned to the court monitor team when the chart can be freed up.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Update all PBS plans as indicated by outcome data and document it at every scheduled WRPC in the Present Status section of the individual's case formulation.</p>
F.2.c.x	all staff has received competency-based training on implementing the specific behavioral interventions for which they are responsible, and performance improvement measures are in place for monitoring the implementation of such interventions.	<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: 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>

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Findings:</p> <p>According to the Interim Senior Supervising Psychologists and the PBS team members, all staff responsible for implementing the intervention plan are trained to competency and certified before implementing the plan.</p> <p>NSH audited active PBS plans using item #36 of the DMH Psychology Monitoring Form, reporting 100% compliance. The table below with its monitoring indicator showing the number of active plans (N), the number of plans audited (n), and the percent compliance (%C), is a summary of the facility's data.</p> <p><i>All staff has received competency-based training on implementing the specific behavioral interventions for which they are responsible, and performance improvement measures are in place for monitoring the implementation of such interventions.</i></p> <table border="1" style="margin-left: auto; margin-right: auto;"> <thead> <tr> <th></th> <th>Jan</th> <th>Apr</th> <th>Jun</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>3</td> <td>1</td> <td>1</td> <td></td> </tr> <tr> <td>n</td> <td>3</td> <td>1</td> <td>1</td> <td></td> </tr> <tr> <td>% S</td> <td>100</td> <td>100</td> <td>100</td> <td></td> </tr> <tr> <td>% C-36</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> </tr> </tbody> </table> <p>This monitor's review of two active PBS plans (BN and CH) showed that the plans were implemented following training of the staff responsible for implementing the plan. Staff training data, fidelity check data, and staff certification on competency were documented for the plan. However, staff should collect fidelity data more frequently, at least once a month, and ensure implementation of the plan across settings and training of staff responsible for implementation of the plan in those settings.</p> <p>Compliance: Substantial.</p>		Jan	Apr	Jun	Mean	N	3	1	1		n	3	1	1		% S	100	100	100		% C-36	100	100	100	100
	Jan	Apr	Jun	Mean																							
N	3	1	1																								
n	3	1	1																								
% S	100	100	100																								
% C-36	100	100	100	100																							

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Current recommendation: Continue to provide competency-based training to appropriate staff across settings 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>
F.2.c.xi	<p>all positive behavior support team members shall have as their primary responsibility the provision of behavioral interventions;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Maintain current service provision.</p> <p>Findings: NSH chose to use item #37 (<i>All positive behavior support team members shall have as their primary responsibility the provision of behavioral interventions</i>) of the DMH Psychology Monitoring Form, reporting 100% compliance.</p> <p>This monitor met with the PBS team members and all of them reported to have as their primary responsibility the provision of PBS services. PBS team members are also providing one hour of Mall services.</p> <p>Compliance: Full compliance.</p> <p>Current recommendation: Maintain current service provision.</p>
F.2.c.xii	<p>the By CHOICE point allocation is updated monthly in the individual's Wellness and Recovery Plan.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Ensure that BY CHOICE point allocation is updated monthly in the individual's WRP.</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Findings: NSH chose to use item #37 (<i>The By CHOICE point allocation is updated monthly in the individual's Wellness and Recovery Plan</i>) of the audited DMH Psychology Monitoring Form, reporting 13% compliance.</p> <p>This monitor reviewed ten charts (AL, JB, MP, EH, JY, DC, LS, CH, EM, and AS). None of them had updated the individual's BY CHOICE point allocation following the DMH WRP Manual guidelines. Most of them did not have any mention of the individual's BY CHOICE participation and points. In DC's case, the documentation notes that the team was unable to conduct point allocation because, "over the last 3 months was requested by the unit psychologist prior to this conference but it was not received." There was no documentation as to who was to provide the unit psychologists with the data/information. For EM, the documentation in the Present Status section was that EM, "has expressed that she want nothing to do with the BY CHOICE Program." The staff was said to work with EM by explaining to her the benefits of participation in the BY CHOICE program.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Ensure that BY CHOICE point allocation is updated monthly in the individual's WRP.</p>
<p>F.2.d</p>	<p>Each State hospital shall ensure that it has at least one developmental and cognitive abilities team (DCAT; consisting of 1 clinical psychologist, 1 registered nurse, 1 social worker, 1 psychiatric technician, and 1 data analyst (who may be a behavior specialist)</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Ensure that the DCAT has a full team as required by EP.</p>

Section F: Specific Therapeutic and Rehabilitation Services

	<p>who have a demonstrated competence, consistent with generally accepted professional standards of care, in assessing individuals with cognitive disorders/challenges; developing therapeutic interventions (including positive behavior supports); advising therapy and rehabilitation providers on the implementation of interventions at the cognitive level of the individuals; and managing discharge processes for individuals with developmental disabilities and cognitive disorders/challenges,. This team shall assume some of the functions of the positive behavior support teams if the individuals they serve also need positive behavioral supports.</p>	<p>Findings: NSH does not have a full DCAT. The team is short a psychologist. The psychology position has been vacant since April 2007. The team does have all the other required team members for the team (registered nurse, social worker, psychiatric technician, and data analyst). NSH is actively recruiting to fill this position.</p> <p>Recommendation 2, February 2007: Ensure that the DCAT team is available for consultation to other staff to assist with planning individuals' therapeutic activities at the individuals' cognitive functioning levels.</p> <p>Findings: This monitor's meeting with the DCAT members revealed that the team continues to work with the WRPT's and Mall groups, assisting with levels of placement and planning of therapeutic activities according to the individual's cognitive functioning.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that the DCAT has a full team as required by EP. 2. Ensure that the DCAT team is available for consultation to other staff to assist with planning individuals' therapeutic activities at the individuals' cognitive functioning levels.
F.2.e	<p>Each State Hospital shall develop and implement a Behavioral Consultation Committee (BCC), chaired by the Chief of Psychology, and co-chaired by the Chief of Psychiatry, to review the Wellness and</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: The Chief of Psychology must chair this committee as required by the EP.</p>

Section F: Specific Therapeutic and Rehabilitation Services

	<p>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: NSH has established the Chief of Psychology as its Chair of the Behavioral Consulting Committee (BCC). A review of the BCC meeting minutes revealed that the Chief of Psychology is listed as the chairman (BCC meeting minutes attendance register, March 20, 2007). The Chief of Psychology, Jim Jones, was on medical leave at the time of this tour and was not available for interview. In his absence, the Interim Senior Supervising Psychologists are assisting with functions of the Chief of Psychology.</p> <p>Recommendation 2, February 2007: Use the PBS-BCC checklist to define the sequence of steps for referrals to the BCC.</p> <p>Findings: NSH is using the PBS-BCC checklist as the pathway to referral to the BCC. Individuals referred to the BCC have completed PBS-BCC checklists.</p> <p>Recommendation 3, February 2007: Ensure that all standing members of the BCC attend every meeting.</p> <p>Findings: NSH has a BCC team. The team meets regularly. However, attendance at these meetings was not always complete. According to Kathleen Patterson, Interim Senior Supervising Psychologist, BCC team members are always informed of meeting dates and times, but the meetings are not always fully attended.</p> <p>This monitor reviewed the BCC meeting attendance record for 2007. The BCC has met nine times since January 2007. Attendance at these meetings ranged from 14% to 28%.</p> <p>Compliance: Partial.</p>
--	---	---

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Use the PBS-BCC checklist to define the sequence of steps for referrals to the BCC. 2. Ensure that all standing members of the BCC attend every meeting.
<p>F.2.f</p>	<p>Each State Hospital shall ensure that it has sufficient neuropsychological services for the provision of adequate neuropsychological assessment of individuals with persistent mental illness.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Ensure that WRPTs, especially psychologists, make referrals that are appropriate for neuropsychological assessments.</p> <p>Findings: In January 2007 through July 2007, thirteen referrals have been made for neuropsychological assessments. There are individuals on the DCAT list who would be candidates for neuropsychological assessments. It takes one to four months to complete the individuals' neuropsychological assessments. Two individuals (LM and DT) have been waiting for over two years for their neuropsychological assessments. These individuals have to be tested in Spanish. NSH should contract outside examiners for such cases when in-house examiners are not available. NSH should hire additional neuropsychologists so that neuropsychological assessments can be conducted in a timely manner.</p> <p>Recommendation 2, February 2007: Ensure that neuropsychologists provide cognitive remediation and cognitive retraining groups in the PSR Mall.</p> <p>Findings: NSH does not have sufficient numbers of neuropsychologists to provide cognitive remediation and cognitive retraining groups in the PSR Mall. The one neuropsychologist in the facility needs all the time just to conduct assessments.</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Recommendation 3, February 2007: Increase the number of neuropsychologists to meet the anticipated demand for neuropsychological services.</p> <p>Findings: NSH has one neuropsychologist on staff. One neuropsychologist for a facility with over one thousand individuals is insufficient to conduct all the neuropsychological activities required.</p> <p>NSH is actively recruiting to fill the open neuropsychologist positions.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that WRPTs, 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.
F.2.g	All clinical psychologists with privileges at any State Hospital shall have the authority to write orders for the implementation of positive behavior support plans, consultation for educational or other testing, and positive behavior support plan updates.	<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Continue current practice.</p> <p>Findings: Clinical psychologists at NSH have the privileges to write orders for implementation of positive behavior support plans, consultation for educational or other testing, and positive behavior support plan updates.</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Compliance: Full compliance.</p> <p>Current recommendation: Continue current practice.</p>
--	--	---

Section F: Specific Therapeutic and Rehabilitation Services

F.3	Nursing Services	
	<p>Each State hospital shall provide adequate and appropriate nursing care and services consistent with generally accepted professional standards of care to individuals who require such services.</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Linda Goodwin, RN, Assistant Coordinator of Nursing Services 2. Suzette Zielinski, RN, Health Care Specialist 3. Steve Weule, Assistant Coordinator of Nursing Services 4. Dean Percy, Acting Nurse Administrator 5. Eve Arcala, RN, Nursing Quality Improvement Coordinator 6. Lovecil Veloso, Supervising RN, Unit A9 7. Candy Asuncion, Supervising RN, Unit A4 8. Daniel Garcia, Program Director, Unit A4 <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. NSH Medication Administration Monitoring Form and instructions 2. DMH Statewide 24-Hour Noc Audit Monitoring Form and instructions 3. Nursing policies 1102.1, Medication Variance: Reporting & Analysis; #108.5, Documentation: Nightly Audits; #101, Nursing Process; #101.5, WRP-Wellness and Recovery Plan of Care (Nursing); #111, Dysphagia; #130, Nutritional Assessment Referral for High Risk Individuals; #1510, Mealtime and Snacks: Nursing Supervision; #1101, Medication Administration: General Information; #113, Care of the Individuals in Bed Bound Status; #1501, Assaultive Clients: Guidelines for Interventions 4. NSH Performance Improvement Quality Assessment and Improvement Summary Report for Analysis of Variance Problems dated 7/18/07 5. Nursing Performance Improvement Monthly Variance Report form 6. NSH Medication Variance Report form (Draft) 7. NSH Medication Variance Report for June 2007 8. Monthly NOC Audit Reporting Tracking form 9. NSH Duty Statements for Coordinator of Nursing Services, Psychiatric Nursing Education Director, Assistant Coordinator of Nursing Services, Supervising Registered Nurse, Unit Supervisor, Registered Nurse-A and B,

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Pre-Registered Nurse, Psychiatric Technician, and Licensed Vocational Nurse.</p> <ol style="list-style-type: none"> 10. Clinical Competency Review for Registered Nurse-B and Psychiatric Technician (Drafts). 11. DMH Nursing Services: Nursing Monitoring Nursing Interventions form 12. DMH Nursing Services: Nursing Staff Working with an Individual Shall be Familiar With Goals, Objectives, and Interventions For That Individual Monitoring Form 13. DMH Nursing Services: Shift Change Monitoring Form and instructions 14. Dysphagia/Choking Screening form 15. Dysphagia Risk Daily Flow Record form 16. DMH Medication Administration Monitoring form and instructions 17. Direct Observation Checklist of Competencies at NSH: Registered Nurses form 18. Course outline from Dr. Colleen Love regarding Violence Prevention in Recovery: Building Staff Competency in Mental Status Assessment, Helping Relationships and Milieu Interventions 19. The following 41 individuals' charts: BS, CP, JR, JN, WF, AG, JS, VV, CR, FC, MG, MP, BT, JR, AC, SW, DW, SB, RC, SB, DK, GB, JB, CH, LK, EL, EH, CC, MW, VH, AS, DC, HV, SS, SP, GL, SG, QE, JM, RM, AND JW <p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. Shift report on unit A9 2. Individuals on unit A4
F.3.a	Each State hospital shall develop and implement policies and protocols regarding the administration of medication, including pro re nata ("PRN") and "Stat" medication (i.e., emergency use of psychoactive medication), consistent with generally accepted professional standards of care, to	Please see sub-cells for compliance findings.

Section F: Specific Therapeutic and Rehabilitation Services

	ensure:	
F.3.a.i	safe administration of PRN medications and Stat medications;	<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Continue to develop, revise, implement, and provide training regarding policies and procedures that ensure the safe administration of PRN medications and Stat medications.</p> <p>Findings:</p> <p>NSH revised the following nursing policies and procedures addressing this recommendation:</p> <p>Medication: 1101 Medication Administration: General Information</p> <p>Medication: 1102.1 Medication Variance Reporting and Analysis</p> <p>Medication: 1102 Medication Administration Documentation</p> <p>Medication: 1131 PRN/Stat Medication Use for Physical and Psychiatric Symptom Management</p> <p>The above policies and procedures with the exception of 1102.1, Medication Variance Reporting and Analysis were adequately revised. However, the policy for Medication Variance Reporting and Analysis is not comprehensive and does not address potential medication errors.</p> <p>Since November 2006, NSH through Nursing Education has implemented training during initial New Employee Orientation and annually on policies and procedures regarding safe administration of PRN and Stat medications. The facility projected that by December 2007, all nursing staff will have completed</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<p>annual PRN and Stat medication administration competency training. In addition, each month the HSSs monitor 20% of nurses who administer medications. However, from my review, there is no policy/procedure in place that outlines the steps to be taken if a nurse does not appropriately administer medications.</p> <p>Compliance: Partial.</p> <p>Current recommendation:</p> <ol style="list-style-type: none"> 1. Revise policy 1102.1: Medication Variance Reporting and Analysis to ensure that it is comprehensive. 2. Develop and implement a policy/procedure addressing the protocol for inadequate medication administration by nurses. 3. Continue to monitor this requirement.
F.3.a.ii	documentation of the circumstances requiring PRN and Stat administration of medications;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007s: Continue to provide training to staff regarding the use of alternative therapeutic strategies to assist individuals to deal with emotions.</p> <p>Findings:</p> <p>The progress report from NSH indicated that Nursing Education provides an "Axis II" training that includes therapeutic strategies to deal with the emotions of the individuals. Although this is a relevant topic for training, it does not adequately address this requirement. Addition training beginning in August 2007, regarding "Therapeutic Communication and Improving the Therapeutic Milieu" should include the elements of this requirement. Also, in May 2007, Dr. Colleen Love from ASH trained 254 of approximately 900 nursing staff regarding "Violence Prevention in Recovery: Building Self Competency in Mental</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Status Assessment, Helping Relationships and Milieu Interventions." From my review of the course outline, this training included the use of PRN and Stat medications, addressing this requirement. Ongoing training addressing adequate documentation of circumstances requiring PRN and/or Stat medications is needed.</p> <p>Recommendation 2, February 2007: Ensure staff documents the attempts to use these strategies prior to PRN and/or Stat medication administration.</p> <p>Findings: The data submitted by NSH could not be interpreted. However, from my interviews with nursing, it was reported that nursing staff are not consistently documenting circumstances and/or alternative interventions prior to giving PRN/Stat medications. NSH indicated that the Medication Administration Monitoring Form will be modified by August 2007 to include monitoring of documentation of alternative therapeutic strategies prior to PRN/STAT administration.</p> <p>Although the facility had implemented training during New Employee Orientation and has annual mandatory trainings addressing this requirement, there has been little progress noted. From my review of 50 incidents of PRNs administered to 18 individuals (SB, DK, GB, JB, CH, LK, EL, EH, CC, MW, VH, AS, DC, HV, SL, JR, KS, and CR), I found that seven had adequate documentation indicating the circumstances for the PRN. Most of the documentation only indicted that the PRN was given for a generic reason such as agitation, or that the individual asked for the PRN without the rationale documented in the progress notes.</p> <p>From my review of 20 incidents of Stat medications administered to the 18 individuals listed above, I found that 19 had adequate documentation.</p>
--	--	---

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Other findings: In a number of incidents, I found PRN medications that were actually given in emergency situations. However, they were logged as PRN medications.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to provide training to staff regarding the use of alternative therapeutic strategies to assist individuals to deal with emotions. 2. Ensure that staff documents the attempts to use these strategies prior to PRN and/or Stat medication administration. 3. Revise and implement the Medication Administration Monitoring Form to include monitoring of documentation of alternative therapeutic strategies prior to PRN/STAT administration. 4. Determine definitions of PRN and Stat medications to ensure accurate and reliable data. 5. Monitor and provide data regarding this requirement.
F.3.a.iii	documentation of the individual's response to PRN and Stat medication.	<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Continue to monitor this requirement.</p> <p>Findings: The data submitted by NSH could not be interpreted. However, in my discussions with nursing, they reported that their review of a number of PRN/STAT incidents indicated that nursing staff generally document only "effective"/"non-effective" as the description of individual's response to the medication. The facility noted in its progress report that the HSSs review and train nurses regularly on this requirement. However, the HSSs may require additional training regarding the documentation criteria for PRN and Stat</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<p>medications.</p> <p>From my review of 50 incidents of PRNs administered to 18 individuals (see list in a.ii), I found 12 that had adequate documentation regarding the effectiveness of the PRN medication. Of the 20 incidents I reviewed of administration of Stat medications, I found that 17 had adequate documentation of effectiveness of the Stat Medication. The documentation regarding Stat medications was clearly more descriptive and individualized than the PRN documentation.</p> <p>Compliance: Partial.</p> <p>Current recommendation:</p> <ol style="list-style-type: none"> 1. Provide ongoing training to nurses regarding this requirement. 2. Ensure that HSSs understand the criteria for adequate documentation regarding PRN and Stat medications. 3. Monitor and provide data regarding this requirement.
F.3.b	<p>Each State hospital shall ensure that all failures to properly sign the Medication Treatment Record (MTR) or the controlled medication log are treated as medication variances, and that appropriate follow-up occurs to prevent recurrence of such variances.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Ensure data regarding this requirement is reliable and complete.</p> <p>Findings: The data submitted by NSH could not be interpreted. However, during my interview with nursing, they reported that their current data regarding medication variances were not reliable and reported that at times they receive late and/or incomplete data from the units. A monitoring tool has been developed to ensure that data is received timely. From my discussion with NSH, there is no system in place in which the MTRs and controlled drug logs are spot-checked regularly. NSH had updated Nursing Policy 1102.1, Medication Variance: Reporting & Analysis, to clearly state that</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<p>the absence of the required signatures and/or initials on the MTR and controlled drug log constitutes a medication variance and thus a Medication Variance Report (MVR) must be completed.</p> <p>Recommendation 2, February 2007: Continue to monitor this requirement.</p> <p>Findings:</p> <p>Although the data for this requirement could not be interpreted, NSH indicated during the interview that from January 2007 to June 2007, approximately half of all MVR reports received were related to omission errors. The facility agreed to implement HSS random spot checks for failure to sign or initial MTR/controlled medication logs and to compare these findings to the completed MVRs that are received by Nursing Services to ensure reliability.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Implement a monitoring tool to ensure data regarding this requirement is timely. 2. Implement HSS random checks for MTR and controlled medication logs to ensure reliability of medication variance data. 3. Monitor this requirement and provide data.
F.3.c	Each State hospital shall ensure that all nursing interventions are fully integrated into the therapeutic and rehabilitation service plan and that nursing interventions are written in a manner aligned with the rest of the interventions in the therapeutic	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Continue to provide ongoing training regarding the WRP and the Wellness and Recovery Model.</p>

Section F: Specific Therapeutic and Rehabilitation Services

	<p>and rehabilitation service plan, in particular, in observable, behavioral, and/or measurable terms. No nursing care plans other than the nursing interventions integrated in the therapeutic and rehabilitation service plan are required. No nursing diagnoses other than as specified in the therapeutic and rehabilitation service plan, in terms of the current DSM criteria, are required.</p>	<p>Findings: NSH's progress report indicated that Nursing Coordinators are required to attend the weekly WRP Consultation Group to discuss related issues. In addition, a training plan was developed by the Treatment Enhancement Coordinator targeting the nursing staff. This training was started March 26, 2007 and continued into May. The training included nursing objectives; revised Nursing Policy BASIC #101, Nursing Process; the WRP with examples in all 11 foci; and a review of the Wellness and Recovery Plan Manual. During my site visit, it was noted that this intensive training resulted from a citation from a survey indicating that there was a significant lack of nursing interventions in the WRPs in all foci except for 6.</p> <p>Recommendation 2, February 2007: Ensure nursing staff are provided training regarding therapeutic communication and interventions.</p> <p>Findings: The current training that NSH is providing (listed in F.3.a.ii) is a start but will need to be expanded and conducted on an ongoing basis. Curriculum similar to basic psychiatric nursing would be most helpful in assisting the nurses to regarding therapeutic communications and interventions. NSH has a significant number of medically trained nurses with little to no psychiatric background or experience. To facilitate development and integration of nursing interventions into the WRP in areas other than medical, additional training will be necessary.</p> <p>Recommendation 3, February 2007: Initiate a system to ensure that therapeutic interactions are expected as part of staffs' duties and performance.</p> <p>Findings: NSH is revising the duty statements of licensed nursing staff to include this component. However, unless this recommendation is formalized into a system</p>
--	--	--

Section F: Specific Therapeutic and Rehabilitation Services

		<p>that includes being part of the annual performance reviews, it will be difficult if not impossible to monitor its implementation and effectiveness for the individuals.</p> <p>Recommendation 4, February 2007: Continue to monitor that interventions are written in observable, behavioral, and/or measurable terms.</p> <p>Findings: The data submitted by NSH could not be interpreted. The progress report indicated that Central Nursing Services questioned the data and in May 2007 implemented an inter-rater reliability program. However, no data was provided by NSH regarding the results of this program. In addition, the Nursing Monitoring: Nursing Interventions Form will need to be revised in alignment with this requirement. Also, nursing interventions will need to be monitored to ensure that frequency, duration, and responsible person is included.</p> <p>From my review of the nursing objectives and interventions contained in 33 individuals' WRPs (BS, CP, JR, JN, WF, AG, JS, VV, CR, FC, MG, MP, BT, JR, AC, SW, DW, SB, RC, SB, DK, GB, JB, CH, LK, EL, EH, CC, MW, VH, AS, DC, HV), I found documentation in four that was observable, behavioral, and/or measurable.</p> <p>Recommendation 5, February 2007: Develop and implement proactive interventions related to the individuals needs.</p> <p>Findings: As in the above recommendation, the NSH progress report indicated there were issues with the reliability of data for this recommendation. The data provided by the facility could not be accurately interpreted. During my interview with nursing, they reported that there was a lack of proactive nursing interventions. A plan has been developed that will include the</p>
--	--	--

Section F: Specific Therapeutic and Rehabilitation Services

		<p>collaboration of Central Nursing Services, the Nursing Education Department, and the Treatment Enhancement Coordinator to develop/implement a training program addressing this recommendation. NSH has agreed to initiate hospital-wide training to educate nursing staff on proactive interventions.</p> <p>From my review of 33 individuals' WRPs, I found 15 that had some type of proactive intervention listed in the WRP, mainly related to education. However, I found no documentation that these interventions were ever initiated.</p> <p>Recommendation 6, February 2007: Continue to revise policies and procedures to reflect the elements in this requirement.</p> <p>Findings: NSH's Nursing Policies BASIC 101: Nursing Process and BASIC 101.5: WRP Wellness and Recovery Plan of Care have been adequately revised addressing this recommendation.</p> <p>Other findings: From my review, I found no indication that there were nursing care plans other than the nursing interventions integrated in the WRPs. Also, I found no nursing diagnoses other than as specified in the therapeutic and rehabilitation service plan.</p> <p>From my review of nursing interventions contained in 33 WRPs, I found no documentation that any of the interventions listed were ever implemented. In addition, none of the monitoring instruments that I reviewed included this issue. A system needs to be developed and implemented to ensure that nursing interventions are being executed and documented.</p> <p>Compliance: Partial.</p>
--	--	---

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to provide ongoing training regarding the WRP and the Wellness and Recovery Model. 2. Continue to develop and implement nursing training regarding therapeutic communication and interventions. 3. Initiate a system to ensure that therapeutic interactions are expected as part of nursing staff duties and performance. 4. Provide data regarding the inter-rater reliability program. 5. Revise the Nursing Interventions Monitoring Form to be in alignment with this requirement. 6. Develop and implement a monitoring system for nursing interventions to ensure that frequency, duration, responsible person, and implementation/documentation are included. 7. Continue to develop and implement proactive interventions related to the individual's needs.
F.3.d	All nursing staff working with an individual shall be familiar with the goals, objectives and interventions for that individual.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Continue to provide ongoing training regarding recovery-focused interactions with individuals.</p> <p>Findings: See F.3.c.</p> <p>Recommendation 2, February 2007: Ensure nursing staff are provided training regarding therapeutic communication and interventions.</p> <p>Findings: See F.3.c.</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Recommendation 3, February 2007: Initiate a system to ensure that therapeutic interactions are expected as part of staffs' duties and performance.</p> <p>Findings: See F.3.c.</p> <p>Recommendation 4, February 2007: Develop strategies that provide positive reinforcement to staff familiar with the goals, objectives, and interactions of individuals.</p> <p>Findings: The facility is developing plans to set up a work group to discuss possible options that would be effective in promoting adherence and to provide incentives for staff to become familiar with the goals, objectives, and interactions of individuals. Thus far, this recommendation has not been implemented.</p> <p>Other findings: NSH did not provide data addressing this requirement.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to develop strategies that provide positive reinforcement to staff familiar with the goals, objectives, and interactions of individuals. 2. Monitor and provide data for this requirement.
F.3.e	Each State hospital shall ensure that nursing staff timely monitor, document and report the status of symptoms, target	Current findings on previous recommendations:

Section F: Specific Therapeutic and Rehabilitation Services

	<p>variables, health, and mental health status, of individuals in a manner that enables interdisciplinary teams to assess each individual's status, and response to interventions, and to modify, as appropriate, individuals' therapeutic and rehabilitation service plans. Each State Hospital shall ensure that all nursing shift changes include a review of changes in status of individuals on the unit.</p>	<p>Recommendation 1, February 2007: Develop and implement systems to generate individualized, clinical, objective data.</p> <p>Findings: This recommendation has not yet been addressed.</p> <p>Recommendation 2, February 2007: Implement specific criteria for reporting for shift reports.</p> <p>Findings: The Statewide Nursing Committee is developing a statewide shift report form. While on site, I observed a shift report on admission unit A9. The staff members involved in the report provided significant information to assist the oncoming. This shift report was the best I have observed at NSH. Implementing a structure for shift report will assist staff in consistently providing meaningful information.</p> <p>Recommendation 3, February 2007: Implement monitoring and tracking instruments to measure this requirement.</p> <p>Findings: An automated WRP within the WaRMSS system is scheduled for implementation in September 2007 and will assist in addressing this recommendation. However, the first requirement of this cell (stating that nursing staff timely monitor, document and report the status of symptoms, target variables, health, and mental health status of individuals in a manner that enables interdisciplinary teams to assess each individual's status, and response to interventions, and to modify, as appropriate, individuals' therapeutic and rehabilitation service plans) does not refer to shift report; it refers to chart reviews. Thus far, NSH has not addressed this section of the requirement.</p>
--	--	---

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Recommendation 4, February 2007: Continue to develop and implement individualized interventions for patients who are at risk for choking and/or aspiration.</p> <p>Findings: The PNMT (Physical Nutrition and Management Team - dysphagia committee) at NSH is in the process of developing and implementing policies, procedures, and staff training to monitor individuals at risk for choking and/or aspiration. NSH has identified the Level I, high-risk individuals. Nursing policy BASIC: 111 - Dysphasia, has been revised to include proactive pre- and post-meal assessment Nursing interventions. Once this policy is approved, training of nursing staff will need to be implemented.</p> <p>Recommendation 5, February 2007: Develop and implement a monitoring and tracking system to ensure that the above interventions are consistently initiated.</p> <p>Findings: This recommendation has not yet been addressed.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none">1. Develop and implement systems to generate individualized, clinical, objective data.2. Implement specific criteria for reporting for shift reports.3. Implement monitoring and tracking instruments to measure that nursing staff timely monitor, document and report the status of symptoms, target variables, health, and mental health status, of individuals in a manner that enables interdisciplinary teams to assess each individual's status and response to interventions, and to modify, as appropriate, individuals'
--	--	---

Section F: Specific Therapeutic and Rehabilitation Services

		<p>therapeutic and rehabilitation service plans.</p> <p>4. Continue to develop and implement individualized interventions for patients who are at risk for choking and/or aspiration.</p> <p>5. Develop and implement a monitoring and tracking system to ensure that the above interventions are consistently initiated.</p>																																								
F.3.f	Each State hospital shall develop and implement a system to monitor nursing staff while administering medication to ensure that:	<p>Compliance: Partial.</p>																																								
F.3.f.i	nursing staff are knowledgeable regarding each individual's prescribed medications;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Continue to increase the number of Medication Pass and Treatment Administration Reviews to at least 20% per program per quarter.</p> <p>Findings: The following table summarizes NSH's data regarding observed medication administration. The facility has achieved 20% per quarter.</p> <p>N=Average number of nursing staff licensed to administer medications n=number of nursing staff observed during medication administration</p> <table border="1"> <thead> <tr> <th></th> <th>Jan</th> <th>Feb</th> <th>Mar</th> <th>Apr</th> <th>May</th> <th>Jun</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td colspan="8" style="text-align: center;">Medication Administration Observation Monitor Form</td> </tr> <tr> <td>N</td> <td>X</td> <td>507</td> <td>507</td> <td>507</td> <td>507</td> <td>507</td> <td>507</td> </tr> <tr> <td>n</td> <td>X</td> <td>47</td> <td>46</td> <td>47</td> <td>49</td> <td>44</td> <td>47</td> </tr> <tr> <td>% S</td> <td>X</td> <td>9%</td> <td>9%</td> <td>9%</td> <td>10%</td> <td>9%</td> <td>9%</td> </tr> </tbody> </table> <p>Recommendation 2, February 2007: Provide ongoing training for staff regarding medications.</p>		Jan	Feb	Mar	Apr	May	Jun	Mean	Medication Administration Observation Monitor Form								N	X	507	507	507	507	507	507	n	X	47	46	47	49	44	47	% S	X	9%	9%	9%	10%	9%	9%
	Jan	Feb	Mar	Apr	May	Jun	Mean																																			
Medication Administration Observation Monitor Form																																										
N	X	507	507	507	507	507	507																																			
n	X	47	46	47	49	44	47																																			
% S	X	9%	9%	9%	10%	9%	9%																																			

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Findings: Nursing staff at NSH attend an initial Medication Administration class upon hire and thereafter annually. The Nursing Education Department conducts competency-based testing to ensure safe and competent medication administration by nursing staff.</p> <p>Recommendation 3, February 2007: Continue to monitor this requirement.</p> <p>Findings: The following table summarizes the items listed below from the Medication Administration Observation Monitoring form regarding the nurses' knowledge about individuals' medications.</p> <p>Item 1: <i>Verbalize general and trade names of medications administered</i></p> <p>Item 2: <i>Describes therapeutic effects, usual dose, and routes of medication administration</i></p> <p>Item 3: <i>Differentiates expected side effects from adverse reactions</i></p> <p>Item 4: <i>Explains "sliding scale" for regular insulin</i></p> <p>Item 5: <i>Verbalizes symptoms and appropriate interventions of hypo/hyperglycemia</i></p> <p>N=Ave. number of nursing staff licensed to administer medications n=number of nursing staff observed administering medication</p> <table border="1" data-bbox="894 1187 1892 1382"> <thead> <tr> <th></th> <th>Jan</th> <th>Feb</th> <th>Mar</th> <th>Apr</th> <th>May</th> <th>Jun</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td colspan="8" style="text-align: center;">Medication Administration Observation Monitor Form</td> </tr> <tr> <td>N</td> <td>X</td> <td>507</td> <td>507</td> <td>507</td> <td>507</td> <td>507</td> <td>507</td> </tr> <tr> <td>n</td> <td>X</td> <td>47</td> <td>46</td> <td>47</td> <td>49</td> <td>44</td> <td>47</td> </tr> <tr> <td>% S</td> <td>X</td> <td>9%</td> <td>9%</td> <td>9%</td> <td>10%</td> <td>9%</td> <td>9%</td> </tr> </tbody> </table>		Jan	Feb	Mar	Apr	May	Jun	Mean	Medication Administration Observation Monitor Form								N	X	507	507	507	507	507	507	n	X	47	46	47	49	44	47	% S	X	9%	9%	9%	10%	9%	9%
	Jan	Feb	Mar	Apr	May	Jun	Mean																																			
Medication Administration Observation Monitor Form																																										
N	X	507	507	507	507	507	507																																			
n	X	47	46	47	49	44	47																																			
% S	X	9%	9%	9%	10%	9%	9%																																			

Section F: Specific Therapeutic and Rehabilitation Services

		<table border="1" data-bbox="894 190 1890 386"> <tr> <td>%C 1</td> <td>X</td> <td>81%</td> <td>91%</td> <td>83%</td> <td>69%</td> <td>70%</td> <td>79%</td> </tr> <tr> <td>%C 2</td> <td>X</td> <td>72%</td> <td>67%</td> <td>62%</td> <td>69%</td> <td>61%</td> <td>66%</td> </tr> <tr> <td>%C 3</td> <td>X</td> <td>83%</td> <td>93%</td> <td>83%</td> <td>78%</td> <td>84%</td> <td>84%</td> </tr> <tr> <td>%C 4</td> <td>X</td> <td>93%</td> <td>98%</td> <td>91%</td> <td>88%</td> <td>95%</td> <td>93%</td> </tr> <tr> <td>%C 5</td> <td>X</td> <td>70%</td> <td>93%</td> <td>80%</td> <td>86%</td> <td>80%</td> <td>82%</td> </tr> </table> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that 20% of nurses per program per quarter are observed during Medication Pass and Treatment Administration. 2. Continue to monitor this requirement. 	%C 1	X	81%	91%	83%	69%	70%	79%	%C 2	X	72%	67%	62%	69%	61%	66%	%C 3	X	83%	93%	83%	78%	84%	84%	%C 4	X	93%	98%	91%	88%	95%	93%	%C 5	X	70%	93%	80%	86%	80%	82%
%C 1	X	81%	91%	83%	69%	70%	79%																																			
%C 2	X	72%	67%	62%	69%	61%	66%																																			
%C 3	X	83%	93%	83%	78%	84%	84%																																			
%C 4	X	93%	98%	91%	88%	95%	93%																																			
%C 5	X	70%	93%	80%	86%	80%	82%																																			
F.3.f.ii	education is provided to individuals during medication administration;	<p>Current findings on previous recommendations:</p> <p>Recommendations 1, 2 and 3, February 2007:</p> <ol style="list-style-type: none"> 1. Continue to increase the number of Medication Pass and Treatment Administration Reviews to at least 20% per program per quarter. 2. Provide ongoing training for staff regarding medications. 3. Continue to monitor this requirement. <p>Findings: Same as above in F.3.f.i</p> <p>Other findings: The table below summarizes NSH's data regarding the provision of medication education to individuals during medication administration.</p> <p>Item 8: <i>Educates the individual regarding medications</i></p>																																								

Section F: Specific Therapeutic and Rehabilitation Services

		<p>N=Average number of nursing staff licensed to administer medications n=number of nursing staff observed administering medication</p> <table border="1" data-bbox="894 326 1894 557"> <thead> <tr> <th></th> <th>Jan</th> <th>Feb</th> <th>Mar</th> <th>Apr</th> <th>May</th> <th>Jun</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td colspan="8" style="text-align: center;">Medication Administration Observation Monitor Form</td> </tr> <tr> <td>N</td> <td>X</td> <td>507</td> <td>507</td> <td>507</td> <td>507</td> <td>507</td> <td>507</td> </tr> <tr> <td>n</td> <td>X</td> <td>47</td> <td>46</td> <td>47</td> <td>49</td> <td>44</td> <td>47</td> </tr> <tr> <td>% S</td> <td>X</td> <td>9%</td> <td>9%</td> <td>9%</td> <td>10%</td> <td>9%</td> <td>9%</td> </tr> <tr> <td>%C 8</td> <td>X</td> <td>83%</td> <td>76%</td> <td>72%</td> <td>67%</td> <td>64%</td> <td>68%</td> </tr> </tbody> </table> <p>Compliance: Partial.</p> <p>Current recommendations: Continue to monitor this requirement.</p>		Jan	Feb	Mar	Apr	May	Jun	Mean	Medication Administration Observation Monitor Form								N	X	507	507	507	507	507	507	n	X	47	46	47	49	44	47	% S	X	9%	9%	9%	10%	9%	9%	%C 8	X	83%	76%	72%	67%	64%	68%
	Jan	Feb	Mar	Apr	May	Jun	Mean																																											
Medication Administration Observation Monitor Form																																																		
N	X	507	507	507	507	507	507																																											
n	X	47	46	47	49	44	47																																											
% S	X	9%	9%	9%	10%	9%	9%																																											
%C 8	X	83%	76%	72%	67%	64%	68%																																											
F.3.f.iii	nursing staff are following the appropriate medication administration protocol; and	<p>Current findings on previous recommendations:</p> <p>Recommendations 1, 2 and 3, February 2007:</p> <ol style="list-style-type: none"> 1. Continue to increase the number of Medication Pass and Treatment Administration Reviews to at least 20% per program per quarter. 2. Provide ongoing training for staff regarding medications. 3. Continue to monitor this requirement. <p>Findings: Same as above in F.3.f.i</p> <p>Other findings: The following table summarizes NSH's data regarding the nurses following appropriate medication administration protocol while administering medications. The items below identify the items listed in the table.</p>																																																

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Item 9: <i>Applies principles of asepsis to medication administration</i></p> <p>Item 10: <i>Prepares/organizes medications no more than one hour before administration</i></p> <p>Item 11: <i>Identifies individual by name and photograph to ensure correct identification</i></p> <p>Item 12: <i>Checks for allergies</i></p> <p>Item 13: <i>Measures, interprets & records BP & pulse before administering cardiac & antihypertensive medication. Withholds medication as indicated</i></p> <p>Item 14: <i>Opens/pours medication in front of individual</i></p> <p>Item 15: <i>Correctly administers crushed and liquid medication</i></p> <p>Item 16: <i>Checks medication with MTR three times</i></p> <p>Item 17: <i>Ensures individual swallowed all medications</i></p> <p>Item 18: <i>Applies proper technique with use of safety syringes</i></p> <p>Item 19: <i>Ensures individual's privacy and confidentiality</i></p> <p>Item 20: <i>Properly administers eye/ear drops, inhalers/spray</i></p> <p>N=Averages number of nursing staff licensed to administer medications n=number of nursing staff observed during medication administration</p> <table border="1"> <thead> <tr> <th></th> <th>Jan</th> <th>Feb</th> <th>Mar</th> <th>Apr</th> <th>May</th> <th>Jun</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td colspan="8" style="text-align: center;">Medication Administration Observation Monitor Form</td> </tr> <tr> <td>N</td> <td>X</td> <td>507</td> <td>507</td> <td>507</td> <td>507</td> <td>507</td> <td>507</td> </tr> <tr> <td>n</td> <td>X</td> <td>47</td> <td>46</td> <td>47</td> <td>49</td> <td>44</td> <td>47</td> </tr> <tr> <td>% S</td> <td>X</td> <td>9%</td> <td>9%</td> <td>9%</td> <td>10%</td> <td>9%</td> <td>9%</td> </tr> <tr> <td>9</td> <td>X</td> <td>83%</td> <td>80%</td> <td>91%</td> <td>90%</td> <td>86%</td> <td>86%</td> </tr> <tr> <td>10</td> <td>X</td> <td>98%</td> <td>98%</td> <td>100%</td> <td>96%</td> <td>100%</td> <td>98%</td> </tr> <tr> <td>11</td> <td>X</td> <td>96%</td> <td>100%</td> <td>98%</td> <td>96%</td> <td>98%</td> <td>98%</td> </tr> <tr> <td>12</td> <td>X</td> <td>79%</td> <td>81%</td> <td>83%</td> <td>63%</td> <td>82%</td> <td>78%</td> </tr> <tr> <td>13</td> <td>X</td> <td>94%</td> <td>97%</td> <td>91%</td> <td>98%</td> <td>95%</td> <td>95%</td> </tr> </tbody> </table>		Jan	Feb	Mar	Apr	May	Jun	Mean	Medication Administration Observation Monitor Form								N	X	507	507	507	507	507	507	n	X	47	46	47	49	44	47	% S	X	9%	9%	9%	10%	9%	9%	9	X	83%	80%	91%	90%	86%	86%	10	X	98%	98%	100%	96%	100%	98%	11	X	96%	100%	98%	96%	98%	98%	12	X	79%	81%	83%	63%	82%	78%	13	X	94%	97%	91%	98%	95%	95%
	Jan	Feb	Mar	Apr	May	Jun	Mean																																																																											
Medication Administration Observation Monitor Form																																																																																		
N	X	507	507	507	507	507	507																																																																											
n	X	47	46	47	49	44	47																																																																											
% S	X	9%	9%	9%	10%	9%	9%																																																																											
9	X	83%	80%	91%	90%	86%	86%																																																																											
10	X	98%	98%	100%	96%	100%	98%																																																																											
11	X	96%	100%	98%	96%	98%	98%																																																																											
12	X	79%	81%	83%	63%	82%	78%																																																																											
13	X	94%	97%	91%	98%	95%	95%																																																																											

Section F: Specific Therapeutic and Rehabilitation Services

		<table border="1" data-bbox="892 188 1879 462"> <tr><td>14</td><td>X</td><td>94%</td><td>96%</td><td>94%</td><td>96%</td><td>98%</td><td>96%</td></tr> <tr><td>15</td><td>X</td><td>98%</td><td>92%</td><td>88%</td><td>92%</td><td>95%</td><td>93%</td></tr> <tr><td>16</td><td>X</td><td>94%</td><td>98%</td><td>96%</td><td>90%</td><td>86%</td><td>93%</td></tr> <tr><td>17</td><td>X</td><td>81%</td><td>93%</td><td>85%</td><td>69%</td><td>77%</td><td>81%</td></tr> <tr><td>18</td><td>X</td><td>97%</td><td>95%</td><td>98%</td><td>96%</td><td>95%</td><td>96%</td></tr> <tr><td>19</td><td>X</td><td>91%</td><td>100%</td><td>100%</td><td>92%</td><td>91%</td><td>95%</td></tr> <tr><td>20</td><td>X</td><td>83%</td><td>83%</td><td>88%</td><td>69%</td><td>80%</td><td>81%</td></tr> </table> <p data-bbox="892 500 1045 570">Compliance: Partial.</p> <p data-bbox="892 613 1365 678">Current recommendations: Continue to monitor this requirement.</p>	14	X	94%	96%	94%	96%	98%	96%	15	X	98%	92%	88%	92%	95%	93%	16	X	94%	98%	96%	90%	86%	93%	17	X	81%	93%	85%	69%	77%	81%	18	X	97%	95%	98%	96%	95%	96%	19	X	91%	100%	100%	92%	91%	95%	20	X	83%	83%	88%	69%	80%	81%
14	X	94%	96%	94%	96%	98%	96%																																																			
15	X	98%	92%	88%	92%	95%	93%																																																			
16	X	94%	98%	96%	90%	86%	93%																																																			
17	X	81%	93%	85%	69%	77%	81%																																																			
18	X	97%	95%	98%	96%	95%	96%																																																			
19	X	91%	100%	100%	92%	91%	95%																																																			
20	X	83%	83%	88%	69%	80%	81%																																																			
F.3.f.iv	medication administration is documented in accordance with the appropriate medication administration protocol.	<p data-bbox="892 724 1495 756">Current findings on previous recommendations:</p> <p data-bbox="892 797 1495 829">Recommendations 1, 2 and 3, February 2007:</p> <ol data-bbox="892 837 1780 976" style="list-style-type: none"> 1. Continue to increase the number of Medication Pass and Treatment Administration Reviews to at least 20% per program per quarter. 2. Provide ongoing training for staff regarding medications. 3. Continue to monitor this requirement. <p data-bbox="892 1019 1188 1084">Findings: Same as above in F.3.f.i</p> <p data-bbox="892 1130 1866 1235">Other findings: The table below summarizes NSH's compliance data regarding the items listed regarding medication administration.</p> <p data-bbox="905 1279 1654 1344">Item 24: <i>Documents and signs out controlled medications correctly</i></p>																																																								

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Item 25: <i>Documents medication that is given on MTR immediately after administering</i></p> <p>Item 26: <i>Documents on the MTR when medication is not taken and notifies physician</i></p> <p>Item 27: <i>Documents telephone order, "read back" noting and transcribing orders</i></p> <p>N=Average number of nursing staff licensed to administer medications n=number of nursing staff observed during medication administration</p> <table border="1" data-bbox="894 524 1892 870"> <thead> <tr> <th></th> <th>Jan</th> <th>Feb</th> <th>Mar</th> <th>Apr</th> <th>May</th> <th>Jun</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td colspan="8" style="text-align: center;">Medication Administration Observation Monitor Form</td> </tr> <tr> <td>N</td> <td>X</td> <td>507</td> <td>507</td> <td>507</td> <td>507</td> <td>507</td> <td>507</td> </tr> <tr> <td>n</td> <td>X</td> <td>47</td> <td>46</td> <td>47</td> <td>49</td> <td>44</td> <td>47</td> </tr> <tr> <td>% S</td> <td>X</td> <td>9%</td> <td>9%</td> <td>9%</td> <td>10%</td> <td>9%</td> <td>9%</td> </tr> <tr> <td>24</td> <td>X</td> <td>95%</td> <td>93%</td> <td>95%</td> <td>92%</td> <td>93%</td> <td>94%</td> </tr> <tr> <td>25</td> <td>X</td> <td>98%</td> <td>98%</td> <td>93%</td> <td>92%</td> <td>95%</td> <td>95%</td> </tr> <tr> <td>26</td> <td>X</td> <td>92%</td> <td>85%</td> <td>98%</td> <td>96%</td> <td>95%</td> <td>93%</td> </tr> <tr> <td>27</td> <td>X</td> <td>86%</td> <td>93%</td> <td>90%</td> <td>84%</td> <td>84%</td> <td>87%</td> </tr> </tbody> </table> <p>Compliance: Partial.</p> <p>Current recommendations: Continue to monitor this requirement.</p>		Jan	Feb	Mar	Apr	May	Jun	Mean	Medication Administration Observation Monitor Form								N	X	507	507	507	507	507	507	n	X	47	46	47	49	44	47	% S	X	9%	9%	9%	10%	9%	9%	24	X	95%	93%	95%	92%	93%	94%	25	X	98%	98%	93%	92%	95%	95%	26	X	92%	85%	98%	96%	95%	93%	27	X	86%	93%	90%	84%	84%	87%
	Jan	Feb	Mar	Apr	May	Jun	Mean																																																																			
Medication Administration Observation Monitor Form																																																																										
N	X	507	507	507	507	507	507																																																																			
n	X	47	46	47	49	44	47																																																																			
% S	X	9%	9%	9%	10%	9%	9%																																																																			
24	X	95%	93%	95%	92%	93%	94%																																																																			
25	X	98%	98%	93%	92%	95%	95%																																																																			
26	X	92%	85%	98%	96%	95%	93%																																																																			
27	X	86%	93%	90%	84%	84%	87%																																																																			
F.3.g	Each State hospital shall ensure that individuals remain in a "bed-bound" status only for clinically justified reasons.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Implement a system to ensure that clinical justification is documented in the medical records for individuals who are in a "bed-bound" status.</p>																																																																								

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Findings: NSH has developed Nursing Policy: Basic 113 - Care of Individual in a Bed Bound Status. However, there has not been any monitoring thus far of this recommendation.</p> <p>Recommendation 2, February 2007: Initiate interventions in the WRP to integrate bed-bound individuals into milieu activities both in and out of their rooms.</p> <p>Findings: This recommendation has not yet been addressed.</p> <p>Recommendation 3, February 2007: Develop and implement a system to ensure that no individual is rendered bed-bound due to the lack of needed adaptive equipment.</p> <p>Findings: The Physical Nutrition Management Team at NSH has been assessing individuals for needed adaptive equipment and assistive devices. The facility's progress report noted that during the Fiscal Year 06/07, approximately \$50,000 has been spent for specialized adaptive equipment. However, there is no system in place to ensure that no individual is rendered bed-bound due to the lack of adaptive equipment.</p> <p>Other findings: From my observations and interviews on unit A4, there are a number of individuals who are rendered bed-bound due to staff shortages. I reviewed the Medications and Treatments documentation for 10 individuals (VH, SS, CR, SP, GL, SG, QE, JM, RM, and JW) for June 2007 and found that each of these individuals did not get out of bed for several days. None of these individuals had a clinical reason documented for being bed-bound. The supervising RN for the unit cited staffing shortages as to the reason why individuals were not</p>
--	--	--

Section F: Specific Therapeutic and Rehabilitation Services

		<p>assisted out of bed. When I asked the Program Director if he was aware of this issue, he stated he was not. In addition, the staffing schedules for this unit did not accurately reflect how many staff were actually working on the unit. Clearly, there has been no oversight or monitoring being conducted on this unit.</p> <p>Compliance: Noncompliance.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Implement a system to ensure that clinical justification is documented in the medical records for individuals who are in a "bed-bound" status. 2. Develop and implement a system to ensure that interventions in the WRP integrate bed-bound individuals into milieu activities both in and out of their rooms. 3. Develop and implement a system to ensure that no individual is rendered bed-bound due to the lack of needed adaptive equipment 4. Develop and implement a system to ensure that no individual is rendered bed-bound due to lack of staff. 5. Revise staffing schedules to accurately reflect how many staff actually work on the unit.
F.3.h	Each State hospital shall ensure that, before they work directly with individuals, all nursing and psychiatric technicians have successfully completed competency-based training regarding:	Please see sub-cells for compliance findings.
F.3.h.i	mental health diagnoses, related symptoms, psychotropic medications and their side effects, monitoring of symptoms and target variables, and documenting and reporting of the individual's status;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Develop and implement a permanent system to monitor and track staff who have not completed orientation classes and annual mandatory training.</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Findings: NSH has developed and recently implemented (July 2007) a permanent system that monitors and tracks staff attendance for initial orientation and annual mandatory trainings in the Nursing Education Department. This system includes the tracking of competency-based training for administration of medications. Currently, the Nursing Education Department staff are being trained on data entry. At this time, data are not yet available regarding this requirement.</p> <p>Recommendation 2, February 2007: Continue to monitor this requirement.</p> <p>Findings: Data provided by NSH could not be interpreted.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue training and implementation of orientation and annual mandatory staff training. 2. Monitor and provide data regarding this requirement.
F.3.h.ii	the provision of a therapeutic milieu on the units and proactive, positive interventions to prevent and de-escalate crises; and	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Continue to implement additional training as recommended.</p> <p>Findings: See F.3.a.ii.</p> <p>Recommendation 2, February 2007: Develop and implement a reliable system to monitor and track staff attendance at training classes.</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Findings: See F.3.h.i</p> <p>Compliance: Partial.</p> <p>Current recommendations: Monitor and provide data regarding this requirement.</p>
F.3.h.iii	positive behavior support principles.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Continue to monitor this requirement.</p> <p>Findings: The Prevention and Management of Assaultive Behavior (PMAB) training has incorporated positive behavior support principles into the course. This course is required for all new nursing staff at initial orientation. In addition, a hospital-wide training of PBS principles was implemented in January of 2006 and was replaced by the Aggression Reduction Training class in August 2006.</p> <p>Recommendation 2, February 2007: Develop and implement a reliable system to monitor and track staff attendance at training classes.</p> <p>Findings: See F.3.h.i</p> <p>Other findings: No data was submitted by NSH regarding this requirement.</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Compliance: Partial.</p> <p>Current recommendations: Monitor and provide data regarding this requirement.</p>
F.3.i	<p>Each State hospital shall ensure that, prior to assuming their duties and on a regular basis thereafter, all staff responsible for the administration of medication has successfully completed competency-based training on the completion of the MTR and the controlled medication log.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Implement monitoring tools that address this requirement.</p> <p>Findings: See F.3.h.i</p> <p>Recommendation 2, February 2007: Monitor the elements of this requirement.</p> <p>Findings: The data provided by NSH did not address this requirement.</p> <p>Compliance: Partial.</p> <p>Current recommendations: Monitor and provide data regarding this requirement.</p>

Section F: Specific Therapeutic and Rehabilitation Services

F.4	Rehabilitation Therapy Services	
	<p>Each State hospital shall provide adequate, appropriate, and timely rehabilitation therapy services to each individual in need of such services, consistent with generally accepted professional standards of care.</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Karen Zanetell, Chief of Rehabilitation Services 2. Maelinda Holliman, Occupational Therapist 3. Candy Asuncion, Supervising Registered Nurse 4. Karen Breckenridge, Physical Therapist 5. Nancy Rooney, Speech Language Pathologist (Dysphagia) 6. Aaron Frazier, Physical Therapist 7. Marilyn Munroe, Psychology Intern 8. Ronald Lay, Art Therapist 9. David Schmitz, Registered Nurse 10. Nadine Richardson, Supervising Registered Nurse 11. The following individuals receiving active treatment from Rehabilitation Services: CD, DR, DH, TZ, RK, TM 12. Kristen Menine, Art Therapist 13. Nancy Caron, Occupational Therapist 14. Todd Thatcher, Occupational Therapist 15. Dolly Matteucci, Hospital Administrator and Co-Facilitator for Music/Movement group 16. Cheryl Wilkins, Recreational Therapist 17. Sam Kohn, Speech Language Pathology intern 18. Leslie Cobb, Speech Language Pathologist 19. Linda Howard, Music Therapist <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Physical Therapy Documentation Audit 2. Physical Therapy Services/Outcomes Monitoring data 3. Physical Rehabilitation Services Statement of Purpose 4. Central Program Services Procedures for Speech Language, Hearing, and Education Services

Section F: Specific Therapeutic and Rehabilitation Services

		<ol style="list-style-type: none"> 5. NSH Referrals and Evaluation Monitoring for Physical, Occupational, and Speech Therapy 6. Dysphagia Foundations Training and Post test 7. WRPs for the following individuals following in vivo observation in classes/groups: DS, RG, MA, BB, WJ, WP 8. Class/group rosters for all observed 9. Psychosocial Rehabilitation Mall Manual 10. PSR Mall Facilitator Monthly Progress Note 11. PSR Mall Facilitator Monthly Progress Note Instructions 12. Required PSR Mall Hours as Facilitators and Co-Facilitators 13. DMH Mall Alignment Form 14. DMH Mall Alignment Form Instructions 15. Music/Movement group curriculum and roster 16. Pet Therapy curriculum and roster 17. Walking/canteen group lesson plan and roster 18. OT Clinic Class curriculum guidelines, philosophy, and roster 19. New S.T.A.R.T. curriculum 20. Choices curriculum and workbook 21. Art Banner group roster 22. Creative Expression group roster 23. Coping Skills group roster 24. Summary of Facilitator hours by Rehabilitation Therapist for the week of 6/4/07-6/8/07 25. List of Active treatment groups scheduled/completed for each Rehabilitation Therapist for the week of 6/4/07-6/8/07 26. WRPs and corresponding Physical Therapy assessments for the following individuals requiring physical/mobility supports from in vivo observations and random sample: TF, JM, AT, HV, SL, OM, DB, LK 27. WRPs for the following individuals with Comprehensive Physical Nutritional Management Assessments: SG, LH, GL, JM, CR, TR, BC, JC, QE, JF 28. WRPs and corresponding Rehabilitation Services assessments for the following individuals observed in active treatment: CD, DR, DH, TZ, RK, TM,
--	--	--

Section F: Specific Therapeutic and Rehabilitation Services

		<p>MA, RG, DS, LK, DB, OM, WP, BB, WJ</p> <p>29. Referrals to the Mobility Enhancement Team for the following individuals: JW, LH, RE, DP, JC, SL, DS, QE, TR, SG</p> <p>30. Wheelchair screening and Wellness Recovery Plan for WQ</p> <p>31. Wellness and Recovery Attachments for the following individuals assessed by Physical Therapy for mobility/positioning needs: JD, DB, JS, CH</p> <p>32. Mealtime Competency Based Training Checklists completed July 2007</p> <p>33. Durable Medical Equipment database for Program 1, 2, 3, 4, and 5</p> <p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. Coping Skills group in Q11 2. Creative Expression class in Q11 3. In vivo observations of the following individuals with wheelchairs or mobility devices/needs in Q11, A3, A4: LK, JJ, OM, DB, JM, TM, HV, BC, DS, JY 4. In vivo observations of the following individuals at mealtimes in A3 and A4 with review of the corresponding Dining Plans: JM, TM, LS (enteral), JB, JY, BC, HV, DS, JM, JM, JF 5. Pet Therapy group 6. Walking/Canteen group 7. OT Clinic group 8. Music/Movement group 9. Art Banner group 10. WRP meetings for GN and LS
F.4.a	Each State hospital shall develop and implement policies and procedures, consistent with generally accepted professional standards of care, related to the provision of rehabilitation therapy services that address, at a minimum:	Compliance: Partial.
F.4.a.i	the provision of direct services by rehabilitation therapy services staff;	Current findings on previous recommendations:

Section F: Specific Therapeutic and Rehabilitation Services

	<p>and</p>	<p>Recommendation 1, February 2007: Continue the process of developing, revising, and updating policies addressing this requirement.</p> <p>Findings: Currently, there are no policies/systems in place to ensure that Rehabilitation Therapy recommendations (e.g., for groups, objectives, Dining Plans, adaptive equipment) are included in the WRP, documented with findings/progress reported to the WRP monthly, or are implemented and appropriate.</p> <p>There are no policies in place that ensure standardization, quality, and timeliness of treatment plans and documentation of progress for individuals receiving direct (1:1) Occupational, Physical, and Speech Therapy. CPS procedures for Speech-Language Pathology, Hearing and Education Services describe basic requirements for progress notes/documentation, but do not speak to the means by which this information is communicated to the WRP, or standardized in format among therapists. Physical Therapy currently uses a flow sheet to document daily/monthly progress for direct treatment and for monthly progress for individuals with MET programs, but no policy to describe this process was made available to this reviewer.</p> <p>While a policy is in place to specify the number of active treatment and enrichment hours required, there is no policy (aside from the WRP Manual) that states attendance requirement at WRPCs for all rehabilitation therapists, including specialized team members (e.g., Physical and Nutritional Management Planning Team), in instances such as when an individual is in direct treatment or has physical/nutritional support needs.</p> <p>No audit tools exist for Rehabilitation Services to ensure provision of adequate direct treatment and oversight/monitoring of indirect treatment, except for the tool used by Physical Therapy. This tool appears to be adequate but the data collected in the Physical Therapy Outcomes Monitoring database is not</p>
--	------------	---

Section F: Specific Therapeutic and Rehabilitation Services

		<p>consistent with the audit tool, and there is no procedure or instructions in place to describe this process.</p> <p>The Mall Facilitator Monthly Mall Progress note instructions dictate how Rehabilitation Therapists who are facilitating groups should document progress, and the Psychosocial Rehabilitation Mall Manual describes the requirements regarding curriculum, lesson plan, and individual objectives.</p> <p>Recommendation 2, February 2007: Develop and implement policies and procedures related to dysphagia to include principles and language of the Wellness and Recovery Model.</p> <p>Findings: See D.4 and D.5 for findings regarding dysphagia policies and procedures.</p> <p>Other findings: The current Dining Plan appears to be focused on the needs of a developmental disabilities population, rather than an inpatient psychiatric rehabilitation population.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Revise and implement Rehabilitation Therapy Services Provision procedure to specify WRP attendance requirements per discipline, according to individualized needs (e.g., receiving direct treatment, with MET programs). 2. Revise and implement current Dining Plan (focused on dysphagia management) so that it is able to address any nutritional, physical, and/or communication support needs, with focus on support and function in addition to management of risk. 3. Revise and implement Rehabilitation Therapy procedure for Documentation, Assessments, and Progress Notes to include descriptions of time frames, format, and means of reporting findings to the WRPT for all Rehabilitation Therapy documentation of progress regarding direct treatment in
--	--	---

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Vocational Rehabilitation, Physical Therapy, Speech Therapy, and Occupational Therapy.</p> <ol style="list-style-type: none"> 4. Ensure that all Rehabilitation Therapy staff have received competency-based training on documentation of progress towards individual objectives using the Mall Facilitator Monthly Progress note. 5. Develop and implement an audit tool to ensure the adequate and timely provision and implementation of Rehabilitation Services, including direct treatment and indirect supports (e.g., Dining Plan, adaptive equipment), as well as corresponding documentation of supports and progress. 6. Establish inter-rater reliability among staff performing audit prior to implementation of this audit tool.
F.4.a.ii	<p>the oversight by rehabilitation therapists of individualized physical therapy programs implemented by nursing staff.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Continue to develop and implement a system to provide regular oversight by rehabilitation therapists to nursing staff implementing individualized physical therapy programs.</p> <p>Findings: There is currently no procedure in place that outlines and describes this system. Monitoring for Mobility Enhancement Team (MET)/Restorative Nursing database was reviewed and was found to track monthly documentation by Occupational or Physical therapist, but does not report whether programs are implemented as indicated, nor do they indicate whether corrective action or incidental training was necessary.</p> <p>Recommendation 2, February 2007: Develop and implement a monitoring system to ensure that oversight by rehabilitation therapists of individualized physical programs implemented by nursing staff is occurring.</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Findings: See Recommendation 1 above.</p> <p>Recommendation 3, February 2007: Ensure that there are an adequate number of specialty therapies to meet the needs of the individuals.</p> <p>Findings: One Occupational Therapist was transferred to the Physical Nutritional Management Planning Team but the facility continues to be understaffed in regards to Occupational and Physical Therapists and Speech Language Pathologists.</p> <p>Other findings: No instructions or training materials for MET programs were made available to this reviewer.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Recruit Occupational, Physical, and Speech Therapy staff. 2. Develop and implement a plan to ensure that in vivo monitoring of Physical Therapy programs occurs as needed. 3. Develop and implement corresponding MET monitoring tool and instructions.
F.4.b	Each State hospital shall provide competency-based training to nursing staff, as appropriate, on the use and care of adaptive equipment, transferring, and positioning, as well as the need to promote individuals' independence.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Continue to develop and implement a system to provide and document competency-based training regarding this requirement.</p> <p>Findings: Evidence of competency-based training for this requirement was not made available to this reviewer; training rosters and signatures were reviewed, but no</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<p>competency-based training materials were provided. Training records were provided for Dining Plan training for 26 individuals. However, only 15% of these individuals received return demonstration/competency-based training, and only 12% appeared to have actually achieved competence.</p> <p>NSH Training "Dysphagia Foundations" was provided 02/27/07 by NSH staff based on information from Bailey and Associates; according to report, 476 staff were trained and 473 passed, for a 99% pass rate.</p> <p>Recommendation 2, February 2007: Continue to develop and implement a monitoring system to ensure that competency-based training is provided for all the elements of this requirement.</p> <p>Findings: No procedure is in place that describes competency requirements/how competency is determined or addresses ongoing monitoring of Dining Plans or adaptive equipment. Training rosters were made available but no training materials or evidence of competency was provided to this reviewer.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none">1. Develop and implement competency-based training materials for individualized programs such as Dining Plan, MET programs, etc. that require return demonstration or test as needed to determine competence.2. Develop and implement a plan to ensure that in vivo monitoring of supports, plans and programs occurs as needed to ensure compliance with implementation and continued appropriateness of supports.
--	--	---

Section F: Specific Therapeutic and Rehabilitation Services

<p>F.4.c</p>	<p>Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Implement the Rehabilitation Therapy Assessment after review, revisions, and approval from the appropriate disciplines.</p> <p>Findings: See D.4 regarding this recommendation.</p> <p>Recommendation 2, February 2007: Develop and implement a system to monitor the elements of this requirement.</p> <p>Findings: Audit tools for monitoring services and implementation have not been developed for Rehabilitation Services, as discussed in F.4.a. Mall groups and corresponding documentation will be monitored as part of the facility Mall Alignment Monitoring process, but no internal monitoring system to ensure quality of supports/services is in place.</p> <p>Other findings: During observation of Mall Groups, it was noted that in general, Rehabilitation Therapists were engaged, enthusiastic, creative, and had excellent rapport with individuals. The Art Therapy banner program, OT clinic, and New START appeared to meet and even exceed generally accepted professional standards of care.</p> <p>Upon review of WRP signature pages for various groups reviewed, the following trends in attendance per discipline/specialty team were noted: Rehabilitation Therapy (Music, Dance/Movement, Art, Recreation, and OT)-94%; PT for individuals receiving direct treatment-0%; PT for individuals with MET referrals-0%; SLP for individuals in direct treatment-0%; PNMP therapist for individuals seen by PNMP team-14%. During the two WRPCs observed, it was</p>
--------------	---	---

Section F: Specific Therapeutic and Rehabilitation Services

		<p>noted that RTs were present and contributing at both meetings. However, during the meeting for an individual (LS) with significant active dysphagia issues, the Speech Therapist from the PNMP Team was not present to participate in team problem-solving and the determination of optimal supports related to dysphagia in order to ensure safety, quality of life, and independence. In addition, upon later review of the state consultant's report dated 12/06, it was noted that the consultants had made recommendations that were still not addressed at the time of the current WRPC. The WRP process is central to Psychiatric Rehabilitation, and it is essential that pertinent therapists are present at these meetings to ensure optimal collaboration, clinical reasoning, and communication among the WRP team.</p> <p>According to review of PT assessments, documentation for July 2007, and corresponding WRPs, it was noted that progress notes/monthly documentation were completed for 100% reviewed, but summary/report of findings were found in none of the WRPs reviewed. Review of WRP documents for individuals observed in direct treatment for SLP and Mall groups led by RTs revealed that only 33% of documentation of monthly progress and objectives were found in the WRPs.</p> <p>Upon review of WRPs for individuals observed in RT-led Mall groups, it was noted that none of the WRPs contained functional, meaningful and measurable outcomes related to group participation. However, 100% of individuals interviewed were able to state personal objectives for the group they were participating in. While PT assessments and MET programs had documented goals, objectives were not consistently measurable and functional (0% were both functional and measurable), and MET objectives addressed maintaining status, rather than improving function or maximizing quality of life, and treatment activities did not appear to be indicated to flow within the individuals' daily lives (e.g., performing range of motion during dressing activities).</p> <p>Of the six groups observed that were facilitated by RT, 17% had lesson plans,</p>
--	--	--

Section F: Specific Therapeutic and Rehabilitation Services

		<p>33% had a curriculum or course outline, and 100% had treatment rosters. None of the groups observed were using the Mall Facilitator Monthly Progress note per procedure.</p> <p>Upon review of the Monitoring for Dysphagia/Physical Nutrition Management Program database, it was noted that only 28% of individuals who require Dining Plans have had these plans completed and implemented, and 28% of individuals requiring plans have had training to staff regarding these plans by at least one member of the PNMP team.</p> <p>Dining Plan monitoring data was not available to this reviewer, but data was collected following in vivo observation by this reviewer of individuals eating lunch in A3 and A4. Only 11% of individuals with Dining Plans had complete implementation of plans during mealtimes. Liquids were not the correct/recommended consistency for 50% of individuals, adaptive equipment was incorrect/not present/not in use for 38% of individuals, and 73% were not in safe and functional alignment/positioning. One individual (JB) had excellent implementation of his Dining Plan, and it was noted that he was receiving 1:1 intervention from his Occupational Therapist. The OT section of his Comprehensive Team Assessment for Physical Nutritional Management was reviewed, and it was found that although the assessment tool itself does not allow for adequate documentation of function/clinical reasoning, the OT had documented clinical observations regarding motor planning, cues and attention. Dining room tables/bedside tables were not appropriate heights to accommodate wheelchairs, especially in A3.</p> <p>According to the Discipline Summary of Facilitator Hours database for the week of June 4-9 2007, the averages for number of hours of active treatment scheduled (per protocol) versus number of hours of active treatment provided are as follows (by discipline): Occupational Therapy-11%; Recreational Therapy-57%; Music Therapy-65%; Art Therapy-76%; and Dance/Movement Therapy-95%.</p>
--	--	---

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a plan to track Rehabilitation Therapy staff attendance at WRPCs as indicated per revised procedure. 2. Ensure that the audit tool recommended in F.4.a.i. includes a section to assess whether recommendations/objectives made by Rehabilitation Therapy as well as progress towards objectives are incorporated into the WRP. 3. Ensure that all Rehabilitation Therapists have received competency-based training on Psychosocial Mall Manual contents regarding the development of curricula, lesson plans, and course outlines.
F.4.d	<p>Each State hospital, consistent with generally accepted professional standards of care, shall ensure that each individual who requires adaptive equipment is provided with equipment that meets his/her assessed needs and promotes his/her independence, and shall provide individuals with training and support to use such equipment.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Continue to develop and implement a system to monitor this requirement.</p> <p>Findings: While a list of adaptive equipment per individual from Programs 1-5 was provided, there is not a system in place currently that monitors whether equipment is appropriate or in use.</p> <p>Recommendation 2, February 2007: Secure the needed vendors/specialists to ensure that appropriate and adequate equipment are provided to individuals.</p> <p>Findings: The facility reports that it continues to develop vendor lists.</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Recommendation 3, February 2007: Develop and implement a reliable and streamlined system for ordering adaptive equipment that is based on the recommendations of the appropriate clinical disciplines.</p> <p>Findings: See D.4 for findings regarding this recommendation.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none">1. Develop and implement competency-based training materials for use and implementation of individualized adaptive equipment that requires return demonstration or test as needed to determine competence.2. Develop and implement a plan to ensure that in vivo monitoring of adaptive equipment occurs as needed to ensure compliance with implementation and continued appropriateness of supports.3. Revise and implement current adaptive equipment list to track when a piece of equipment is ordered, as well as the date of training/implementation of the equipment.
--	--	--

Section F: Specific Therapeutic and Rehabilitation Services

F.5	Nutrition Services	
	<p>Each State hospital shall provide the individuals it serves, particularly those experiencing weight-related problems, adequate and appropriate dietary services consistent with generally accepted professional standards of care.</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Wen Pao, Director of Dietetics Kameo Campisi, Assistant Director of Dietetics 2. Conference call with the following Nutrition Services staff: Wen Pao (NSH) Kameo Campisi (NSH) Tai Kim (PSH) Maureen Townsend (ASH) Kitchie Miana (PSH) Jeanie Kim (PSH) Chris Elder-Marshall (MSH) Erin Dengate (ASH) 3. Jacqueline Bonanno, Certified Dietitian 4. Mitch Davis, Psych. Licensed Social Worker 5. Individual in Nutrition group <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Nutrition Care Process training 2. New Employee Training for Nursing Staff on Nutrition Care Process and Incorporation in to the WRP 3. Nutrition Group lesson plan 4. Smoking Cessation Overview Curriculum 5. Better Choices at Our Café lesson plan 6. Dysphagia Class Outline 7. Nutrition Information group lesson plan content 8. Solutions for Wellness lesson materials 9. DMH Wellness and Recovery Plan Manual (pp. 8-9,32, 42-43)

Section F: Specific Therapeutic and Rehabilitation Services

		<p>10. Statewide Dietetic Department Policy & Procedure "Weight Management" (DRAFT)</p> <p>11. Nutrition Care Process & Incorporation into the Wellness & Recovery Plan</p> <p>12. Statewide Dietetics Wellness and Recovery Plan Training Policy</p> <p>13. Dysphagia and Thickened Liquids post test and corresponding training rosters</p> <p><u>Observed:</u></p> <p>1. Nutrition Mall Group</p>
F.5.a	<p>Each State hospital shall modify policies and procedures to require that the therapeutic and rehabilitation service plans of individuals who experience weight problems and/or related health concerns include adequate strategies and methodologies to address the identified problems and that such strategies and methodologies are implemented in a timely manner, monitored appropriately, and revised, as warranted, consistent with generally accepted professional standards of care.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Ensure that all elements of this requirement are addressed in the monitoring system.</p> <p>Findings: Elements of this requirement are addressed in DMH Wellness and Recovery Plan Manual and Clinical Nutrition Weight Management Protocol.</p> <p>It was determined by conference call and interview that Dietitians currently perform meal monitoring to ensure in vivo implementation of Nutrition supports. However, this data is not currently reported and tracked as evidence of compliance with the requirement of this recommendation.</p> <p>Recommendation 2, February 2007: Continue to develop and implement creative Mall activities addressing weight and health issues.</p> <p>Findings: Curriculums, lesson plans and program outlines were reviewed and found to be informative and creative but not in the format specified by the Psychosocial</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Mall Manual. Upon observation of the Nutrition Mall group, an interview with an individual participant revealed that he had retained information learned in the group and made significant progress towards his personal objectives. It was noted that group facilitators had created adequate lesson plans, but were not documenting progress on individual objectives using the facility Mall Facilitator Monthly Progress notes.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a plan to ensure tracking of meal monitoring findings as evidence of in vivo implementation of Nutrition recommendations/supports. 2. Ensure that all Nutrition Services staff has received competency-based training on Psychosocial Mall Manual contents regarding the development of curricula, lesson plans, course outlines, and the use of Mall Facilitator Monthly Progress Notes. 3. Ensure that all current Mall group materials are in the formats specified within the Psychosocial Mall Manual.
F.5.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>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, February 2007:</p> <ol style="list-style-type: none"> 1. Finalize post-test and implement the competency-based nutrition curriculum to ensure that team members demonstrate competence in the dietary and nutritional issues and the development and implementation of strategies and methodologies to address such issues. 2. Develop and implement a system to monitor the elements of this requirement.

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Findings: The Nutrition Care Process & Incorporation into the Wellness & Recovery Plan training materials, rosters, training policy, and corresponding post-test (for competency-based requirement) were reviewed and found to correspond with policies and procedures related to dietary and nutritional issues.</p> <p>Other findings: Currently, the Nutrition Care Monitoring Tool does not assess for whether Nutrition recommendations are incorporated into the WRP. Following a conference call with dietitians from all four state facilities, it was determined that this component would be added to the current monitoring tool. This data/monitoring item will help to identify systemic issues that may affect implementation of Nutrition Care recommendations.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue current practice. 2. Revise and implement the Nutrition Care Monitoring Tool and instructions to include an assessment of whether Nutrition recommendations are incorporated into the WRP.
F.5.c	Each State hospital shall develop and implement policies and procedures to address the needs of individuals who are at risk for aspiration or dysphagia, including but not limited to, the development and implementation of assessments and interventions for mealtimes and other activities involving swallowing.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1 and 2, February 2007:</p> <ol style="list-style-type: none"> 1. Continue to revise policies and procedures in accordance with generally accepted standards of practice regarding risk of aspiration/dysphagia. 2. Continue to develop and implement 24-hour, individualized, dysphagia care plans with the assistance of a consultant with expertise in this area.

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Findings: Assessment of swallowing, dysphagia risk, aspiration risk, and mealtime interventions/supports do not fall within the scope of practice for Clinical Dietitians. The role of the Dietitian as a team member in serving individuals at risk for dysphagia and aspiration is well-established within current procedures related to dysphagia.</p> <p>Recommendation 3, February 2007: Continue to provide competency-based training to staff regarding risk of aspiration/dysphagia.</p> <p>Findings: Dietitians received competency-based training on Dysphagia and Thickened Liquids in 4/07 and 6/07 as well as Dysphagia Foundations; this was confirmed by a review of post-tests and corresponding training records.</p> <p>Recommendation 4 and 5, February 2007:</p> <ol style="list-style-type: none"> 4. Provide competency-based training on individualized, 24-hour dysphagia care plans to staff working with individuals at risk of aspiration/dysphagia. 5. Develop and implement a monitoring system for the elements of this requirement. <p>Findings: Competency-based training and monitoring has been initiated by Nursing and OT/PT/SLP; this type of training does not fall within the scope of practice for Clinical Dietitians.</p> <p>Compliance: Substantial.</p> <p>Current recommendations: Continue current practice for performing Nutrition assessments.</p>
--	--	---

Section F: Specific Therapeutic and Rehabilitation Services

<p>F.5.d</p>	<p>Each State hospital shall ensure that staff with responsibilities for assessments and interventions regarding aspiration and dysphagia has successfully completed competency-based training commensurate with their responsibilities.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Develop and implement a monitoring system to ensure the key elements of this requirement.</p> <p>Findings: See F.5.b and F.5.c for findings regarding this recommendation.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
<p>F.5.e</p>	<p>Each State hospital shall develop and implement policies and procedures requiring treatment of the underlying causes for tube feeding placement, and ongoing assessment of the individuals for whom these treatment options are utilized, to determine the feasibility of returning them to oral intake status.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1 and 2, February 2007:</p> <ol style="list-style-type: none"> 1. Continue to revise policies and procedures to reflect the elements of this requirement. 2. Finalize and implement a system to monitor all elements of this requirement. <p>Findings: Assessment of PO (by mouth) status does not fall within the scope of practice for Clinical Dietitians, but should be addressed by the WRPT with determination based on findings from Occupational Therapy, Physical Therapy, Speech Language Therapy, Physician, and Nursing assessments as well as objective diagnostic test findings.</p> <p>Other findings: Upon interview with staff, it was stated that a recommendation was made by a</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<p>state consultant for all individuals to receive continuous enteral tube feeding, specifically 22-hour feeding, with no one to receive bolus feedings. This was not confirmed by a review of Nursing Procedure for Enteral Nutrition, but was reported to be informal policy. Review of individuals receiving enteral nutrition (11 individuals for the facility) revealed that six were receiving 22-hour continuous feeding, two were receiving 20-hour continuous feeding, two were receiving 18-hour feeding, and one was receiving 13.5-hour feedings. No justification or rationale (e.g., volume intolerance) was provided for continuous feedings as opposed to bolus feedings, which tend to be more conducive to quality of life, mobility and function. Although this requirement is found in the section for Nutrition Services, this should be addressed within an existing facility-wide WRP policy/procedure/ monitoring tool.</p> <p>Compliance: Partial.</p> <p>Current recommendations: Collaborate with relevant disciplines (e.g., OT, PT, SLP, Nurses, Physicians) to develop and implement a plan/procedure to ensure ongoing assessment of the individuals receiving enteral nutrition, to determine the feasibility of returning them to oral intake status or justification of continued NPO (nothing by mouth) status.</p>
--	--	--

Section F: Specific Therapeutic and Rehabilitation Services

F.6	Pharmacy Services	
	<p>Each State hospital shall provide adequate and appropriate pharmacy services consistent with generally accepted professional standards of care. Each State hospital shall develop and implement policies and procedures that require:</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. John Banducci, Pharmacy Director 2. Pamela Moe, PharmD, Assistant Pharmacy Director <p><u>Reviewed:</u></p> <p>Policy #704, Pharmacy Monitoring of Allergies, Drug-Drug and Drug-Food Interactions (revised May 9, 2007)</p>
F.6.a	<p>Upon the prescription of a new medication, pharmacists to conduct reviews of each individual's medication regimen and, as appropriate, make recommendations to the prescribing physician about possible drug-to-drug interactions, side effects, and need for laboratory work and testing; and</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: The State must address issues related to recruitment and retention of staff needed to execute the EP.</p> <p>Findings: NSH has yet to implement this recommendation. The pharmacy service continues to be significantly understaffed. Since January 1, 2007, the facility has lost nine staff pharmacists (one retired and eight moved to CDCR). Although three pharmacists returned from CDCR (April to June 2007), and 3.1 FTE contract pharmacists have been hired, the current vacancy rates are 6.0 FTE for pharmacist I and one FTE for pharmacist II (out of 13.5 and two budgeted positions, respectively) as of June 30, 2007. Salary issues continue to be a significant barrier to recruitment and retention and have yet to be addressed.</p> <p>Recommendation 2, February 2007: Implement a system to monitor this requirement.</p> <p>Findings: The facility has revised its policy #704 regarding Pharmacy Monitoring of</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Allergies, Drug-Drug and Drug-Food Interactions (May 9, 2007). The revision codifies this requirement of the EP. However, the facility has yet to implement the recommendation regarding the development of tracking and monitoring systems.</p> <p>Recommendation 3, February 2007: Continue to develop, update and/or revise and implement policies and procedures to address the elements of this requirement.</p> <p>Findings: Same as above.</p> <p>Recommendation 4, February 2007: Implement the use of a database to monitor the elements of this requirement.</p> <p>Findings: NSH has yet to implement this requirement. NSH anticipates installation, in August 2007, of the database system that is under development at MSH. Policy #704 will be revised when MSH's database system has been installed at NSH.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none">1. The state must address issues related to recruitment and retention of pharmacy staff needed to execute the EP.2. Implement a system to monitor this requirement.3. Implement the use of a database to monitor the elements of this requirement and revise policy #704, accordingly.
--	--	---

Section F: Specific Therapeutic and Rehabilitation Services

<p>F.6.b</p>	<p>Physicians to consider pharmacists' recommendations, and for any recommendations not followed, document in the individual's medical record an adequate clinical justification.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Develop and implement a system to address this required element.</p> <p>Findings: NSH has yet to implement this recommendation. As mentioned earlier, NSH is currently awaiting installation of MSH's database system. It is anticipated that system will be installed at NSH in August 2007.</p> <p>Recommendation 2, February 2007: Develop and implement policies and procedures regarding this requirement.</p> <p>Recommendation 3, February 2007: Develop and implement a system to monitor the elements of this requirement.</p> <p>Recommendation 4, February 2007: Establish appropriate database to monitor the elements of this requirement.</p> <p>Recommendation 5, February 2007: The State must address issues related to recruitment and retention of need staff to execute the EP.</p> <p>Findings: Same as in F.6.a.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Same as above. 2. Assign responsibility and accountability to medical/psychiatry for plans of
--------------	---	---

Section F: Specific Therapeutic and Rehabilitation Services

		corrections for problems identified.
--	--	--------------------------------------

Section F: Specific Therapeutic and Rehabilitation Services

F.7	General Medical Services
	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Scott Anderson, MD, Chief Physician and Surgeon 2. Jeffrey Zwerin, D.O., Medical Director 3. David Thomas, MD, Assistant medical Director 4. S. Mohan, MD, Physician and Surgeon 5. Javed Iqbal, MD Staff Psychiatrist 6. Mu Chou, MD, Physician and Surgeon 7. Rodolfo Pineda, MD, Physician and Surgeon 8. Kluwinder Singh, MD, Staff Psychiatrist 9. Ted Lee, MD, Physician and Surgeon 10. Hong-Shen Ye, MD, Physician and Surgeon 11. Edward Goldstein, MD, Physician and Surgeon 12. Danielle Rebuschung, MD, Physician and Surgeon 13. Christian Mateesco, MD, Staff Psychiatrist <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Charts of ten individuals who were transferred to the medical unit of NSH and/or a regional medical facility during the past six months (SLS, BAJ, CKR, FAO, HTS, EH, VH, RET, JLS and MSD) 2. Diabetes Quality of Care Monitoring Form 3. Diabetes Quality of Care Monitoring summary data (January to June 2007) 4. Asthma & COPD Quality of Care Monitoring Form 5. Asthma & COPD Quality of Care Monitoring summary data (January to May 2007) 6. Medical Quality Management-Outside Transfer Monitoring Form 7. Medical Quality Management-Outside Transfer Monitoring summary data (January to March and May 2007) 8. NSH's data regarding After-Hours Coverage by Primary Care Physicians

Section F: Specific Therapeutic and Rehabilitation Services

<p>F.7.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>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Develop and implement a policy/procedure and/or duty statement that includes the facility's expectations regarding all the areas (1 through 10) listed above [in NSH Report 2—not replicated here].</p> <p>Findings: NSH has yet to implement this recommendation. Furthermore, the facility did not report on its plan to address the specific areas that were outlined in the last monitor's report (February 2007).</p> <p>Recommendation 2, February 2007: Continue to monitor the management of Diabetes Mellitus, Asthma/COPD and Outside transfers. Clarify the types of transfers that are being monitored, include specific parameters for timeliness and address inconsistent findings in that monitor.</p> <p>Findings: NSH used its monitoring tools regarding the management of Diabetes Mellitus and Asthma& COPD and Medical Quality Management/Outside Transfers. The following is a summary:</p> <p>Diabetes Quality of Care Monitor: According to the data provided by the facility, NSH reviewed an average of seven charts per month (January to June 2007) of individuals referred to the Diabetes clinic. The reported average sample size of 7% is inaccurate; the data indicate an average sample size of 4%. This small size represents a significant decrease in these reviews since the last progress report of February 2007 (100% sample was reported). The facility's data indicated a mean compliance rate of less than 4%. However, the facility's report did not comment on the decline of this item from the mean rate of 57% reported during the last review. In personal interviews, the</p>
--------------	--	--

Section F: Specific Therapeutic and Rehabilitation Services

		<p>facility representatives did not explain this difference when questioned by this monitor.</p> <p>Asthma & COPD Quality of Care Monitor: NSH reviewed an average of eight charts per month (January to May 2007), which represents a significant decrease from the 100% sample reported during the last review. The target population (N) was not identified, but appeared to be based on the number of individuals referred to the Asthma/COPD clinic. The data indicated a mean compliance rate of 3%. As mentioned above, the facility's report did not comment on the decline of the compliance rate from the mean rate of 45% that was reported during the last review. When questioned about this matter, the facility representatives did not explain this difference.</p> <p>Medical Quality Management-Outside Transfer Monitor: Using this instrument (January to March and May 2007), NSH reviewed an average of 10 transfers per month. The data indicated a mean compliance rate of less than 9%. This rate was reported at 47% during the last review. Again, the facility did not explain the apparent decrease in compliance since the monitor's report of February 2007.</p> <p>Recommendation 3, February 2007: Develop and implement other monitors to address quality of care as pertinent to the facility's population.</p> <p>Findings: The facility has yet to implement this recommendation.</p> <p>Recommendation 4, February 2007: Monitor at least 20% sample of all admission medical examinations and ensure that monitoring addresses completeness and quality of examination and appropriate follow up regarding deferral of items and refusal of examination.</p>
--	--	--

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Findings: NSH did not present data in this section. The data reported in D.1.c.i address this recommendation.</p> <p>Other findings: This monitor reviewed the charts of 10 individuals who were transferred to the medical unit of NSH and/or a regional medical facility during the past six months and interviewed the physicians and surgeons who were involved in their care. The following table outlines the individuals' initials, the reason for the transfer, the date/ and time of the medical evaluation upon the transfer and the date and time of actual transfer:</p> <table border="1" data-bbox="848 634 1856 1177"> <thead> <tr> <th>Initials</th> <th>Date of transfer</th> <th>Reason for Transfer</th> </tr> </thead> <tbody> <tr> <td>SLS</td> <td>1/4/07</td> <td>Hypoglycemia (diabetes mellitus)</td> </tr> <tr> <td>HTS</td> <td>3/7/07</td> <td>Abdominal pain (Bowel Obstruction)</td> </tr> <tr> <td>BAJ</td> <td>2/27/07</td> <td>Abdominal pain (appendicitis)</td> </tr> <tr> <td>CKR</td> <td>3/27/07</td> <td>Altered Mental Status (pneumonia)</td> </tr> <tr> <td>VH</td> <td>2/26/07</td> <td>Fever, arrhythmia, pneumonia (ruled/out endocarditis)</td> </tr> <tr> <td>RET</td> <td>2/27/07</td> <td>Recurring gangrene of toes, with confusion (toe amputation)</td> </tr> <tr> <td>FAO</td> <td>6/2/07</td> <td>Hematemesis (gastritis)</td> </tr> <tr> <td>JLS</td> <td>2/6/07</td> <td>Hypotension and bradycardia (complete left BBB)</td> </tr> <tr> <td>EH</td> <td>6/11/07</td> <td>? Seizure activity (lithium toxicity)</td> </tr> <tr> <td>MSD</td> <td>3/10/07</td> <td>Atrial Flutter (Paroxysmal Atrial Flutter)</td> </tr> </tbody> </table> <p>The review showed that in general, the facility provides adequate and timely care to these individuals. However, this monitor found a number of significant deficiencies that must be corrected in order to achieve substantial compliance with requirements of the EP. The following are examples:</p>	Initials	Date of transfer	Reason for Transfer	SLS	1/4/07	Hypoglycemia (diabetes mellitus)	HTS	3/7/07	Abdominal pain (Bowel Obstruction)	BAJ	2/27/07	Abdominal pain (appendicitis)	CKR	3/27/07	Altered Mental Status (pneumonia)	VH	2/26/07	Fever, arrhythmia, pneumonia (ruled/out endocarditis)	RET	2/27/07	Recurring gangrene of toes, with confusion (toe amputation)	FAO	6/2/07	Hematemesis (gastritis)	JLS	2/6/07	Hypotension and bradycardia (complete left BBB)	EH	6/11/07	? Seizure activity (lithium toxicity)	MSD	3/10/07	Atrial Flutter (Paroxysmal Atrial Flutter)
Initials	Date of transfer	Reason for Transfer																																	
SLS	1/4/07	Hypoglycemia (diabetes mellitus)																																	
HTS	3/7/07	Abdominal pain (Bowel Obstruction)																																	
BAJ	2/27/07	Abdominal pain (appendicitis)																																	
CKR	3/27/07	Altered Mental Status (pneumonia)																																	
VH	2/26/07	Fever, arrhythmia, pneumonia (ruled/out endocarditis)																																	
RET	2/27/07	Recurring gangrene of toes, with confusion (toe amputation)																																	
FAO	6/2/07	Hematemesis (gastritis)																																	
JLS	2/6/07	Hypotension and bradycardia (complete left BBB)																																	
EH	6/11/07	? Seizure activity (lithium toxicity)																																	
MSD	3/10/07	Atrial Flutter (Paroxysmal Atrial Flutter)																																	

Section F: Specific Therapeutic and Rehabilitation Services

		<ol style="list-style-type: none">1. The WRP did not identify the individual's behavior that has resulted in poor control of diabetes mellitus or include objectives/interventions to address this behavior (SLS).2. The nurse's documentation of the individual's status (abdominal pain) did not specify the nature and timing of a significant change in this status (vomiting) or indicate if a physician was notified of this change, and, if so, which physician (BAJ).3. There was inaccurate documentation of the exact time of initiating emergency medical response (CKR).4. The nursing staff did not notify a physician upon the occurrence of significant change in the physical condition (blood-stained vomitus) of the individual (FAO). The physician was notified several hours later upon recurrence of this condition.5. The physician did not document a physical examination upon ordering systemic antibiotic treatment for a condition that appeared to require face-to-face assessment (VH).6. The individual was not assessed for the benefits and risks of ongoing treatment with anticholinergic treatment in presence of a history of small bowel obstruction due to abdominal adhesions. This treatment was not discontinued until the individual suffered a recurrence (HTS).7. The individual was transferred to a general hospital promptly due to a condition that was later described as lithium toxicity. However, there is no record of attempts to obtain the lithium level at the general hospital. Additionally, the chart does not include any review of the circumstances that may have precipitated lithium toxicity (e.g. oral intake status). This review was necessary, especially due to laboratory evidence of rising lithium levels (without a corresponding increase in the dosage the lithium), which appeared to have culminated in toxicity (EH).8. Most of the charts reviewed contained no documentation of the exact timing of transfer to the outside facility.
--	--	---

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a policy/procedure and/or duty statement that includes the facility's expectations regarding all the areas (1 through 10) listed in NSH Report 2 of February 2007 (not replicated here). 2. Continue to monitor the management of Diabetes Mellitus, Asthma/COPD and Outside transfers and address inconsistent findings in these monitors. 3. Develop and implement other monitors to address quality of care as pertinent to the facility's population. 4. Monitor at least 20% sample of all admission medical examinations and ensure that monitoring addresses completeness and quality of examination and appropriate follow up regarding deferral of items and refusal of examination. 5. Ensure that WRPs address all identified medical needs as well as significant changes in the individual's behavior that contribute to a change in the physical status.
F.7.b	Each State hospital shall develop and implement protocols and procedures, consistent with generally accepted professional standards of care, that:	Please see sub-cells for compliance findings.
F.7.b.i	require the timely provision of initial and ongoing assessments relating to medical care, including but not limited to, vision care, dental care, and laboratory and consultation services;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Same as above.</p> <p>Findings:</p> <p>Recommendation 2, February 2007: Monitor the timeliness and quality of consultation referrals.</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Findings: NSH has yet to implement this recommendation.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Same as F.7.a. and D.1.c.i 2. Monitor the timeliness and quality of consultation referrals.
F.7.b.ii	<p>require the timely provision of medical care, including but not limited to, vision care, dental care, and laboratory and consultation services; timely and appropriate communication between nursing staff and physicians regarding changes in an individual's physical status; and the integration of each individual's mental health and medical care;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Same as above.</p> <p>Findings: Same as above.</p> <p>Other findings: NSH reports that the physicians and surgeons have been given training to attend WRPT meetings when clinically indicated.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Same as F.7.a.</p>
F.7.b.iii	<p>define the duties and responsibilities of primary care (non-psychiatric) physicians;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Same as above.</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Findings: Same as above.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Same as above.</p>
F.7.b.iv	<p>ensure a system of after-hours coverage by primary care physicians with formal psychiatric training (i.e., privileging and proctorship) and psychiatric backup support after hours; and</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Continue current practice.</p> <p>Findings: NSH's data regarding <i>After-Hours Coverage by Primary Care Physicians</i> indicate 100% compliance with this requirement of the EP (January to June 2007).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
F.7.b.v	<p>endeavor to obtain, on a consistent and timely basis, an individual's medical records after the individual is treated in another medical facility.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Monitor the timeliness and completeness of needed records.</p> <p>Findings: NSH has yet to implement this recommendation.</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Current recommendation: Monitor the timeliness and completeness of needed records.</p>
F.7.c	<p>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>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: 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.</p> <p>Findings: NSH has yet to implement this recommendation.</p> <p>Recommendation 2, February 2007: Improve integration of medical staff into the interdisciplinary functions of the WRP.</p> <p>Findings: The facility reported that training has been provided regarding this recommendation.</p> <p>Compliance: Partial.</p> <p>Current 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. Same as F.7.a.

Section F: Specific Therapeutic and Rehabilitation Services

		<p>3. Implement formalized mechanisms to improve integration of medical staff into the interdisciplinary functions of the WRP</p>
<p>F.7.d</p>	<p>Each State Hospital shall monitor, on a continuous basis, outcome indicators to identify trends and patterns in the individual's health status, assess the performance of medical systems, and provide corrective follow-up measures to improve outcomes.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Same as in F.7.a.</p> <p>Findings: Same as in F.7.a.</p> <p>Recommendation 2, February 2007: Develop and implement a formalized physician peer review system that utilizes indicators aligned with the standards and expectations outlined in F.7.a.</p> <p>Findings: NSH has yet to implement this recommendation. The facility's current peer review system appears to be limited to the previously mentioned monitoring, using the three quality of care monitors regarding Diabetes Mellitus, Asthma & COPD and Outside Transfers.</p> <p>Recommendations 3, 4, 5 and 6, February 2007:</p> <ol style="list-style-type: none"> 1. Collect data on the medical triggers identified in the Key Indicators. The facility may establish additional indicators of outcome to the individuals and the medical systems of care. 2. Identify trends and patterns based on clinical and process outcomes. 3. Provide corrective actions to address problematic trends and patterns. 4. Expedite efforts to automate data systems to facilitate data collection and analysis. <p>Findings: NSH has yet to implement these recommendations.</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none">1. Same as in F.7.a.2. Develop and implement a formalized physician peer review system that utilizes indicators aligned with the standards and expectations outlined in F.7.a.3. Collect data on the medical triggers identified in the Key Indicators. The facility may establish additional indicators of outcome to the individuals and the medical systems of care.4. Identify trends and patterns based on clinical and process outcomes.5. Provide corrective actions to address problematic trends and patterns.6. Expedite efforts to automate data systems to facilitate data collection and analysis.
--	--	--

Section F: Specific Therapeutic and Rehabilitation Services

F.8	Infection Control	
	<p>Each State hospital shall develop and implement infection control policies and procedures to prevent the spread of infections or communicable diseases, consistent with generally accepted professional standards of care.</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Robert Kolker, RN, PHN II <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. NSH Public Health/Infection Control Meeting minutes for December 2006, March 2007, and June 2007 2. Infection Control Data Collection tool for Infection Control policy review 3. Infection Control Auditing form and instructions 4. NSH Infection Control Admission PPD Auditing form and instructions 5. NSH Infection Control Annual PPD Auditing form and instructions 6. NSH Infection Control Positive PPD Auditing form and instructions 7. NSH Infection Control Refused PPD Auditing form and instructions 8. NSH Infection Control Hepatitis B Auditing form and instructions 9. NSH Infection Control Hepatitis C Auditing form and instructions 10. NSH Infection Control HIV Auditing form and instructions 11. NSH Infection Control MRSA Auditing form and instructions 12. TB summary form 13. Raw data for TB, Hepatitis B and C, HIV, and MRSA 14. NSH's progress report for Infection Control
F.8.a	<p>Each State hospital shall establish an effective infection control program that:</p>	<p>Compliance: Partial.</p>
F.8.a.i	<p>actively collects data regarding infections and communicable diseases;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Develop and implement a system to monitor the elements of this requirement.</p> <p>Findings:</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<p>NSH continues to develop monitoring instruments to demonstrate they collect data regarding infections and communicable diseases. Thus far they have developed instruments addressing the process of admission PPDs, positive PPDs, annual PPDs, and refusals of PPDs. In addition NSH has developed instruments to monitor individuals admitted or newly diagnosed with Hepatitis B, Hepatitis C, HIV, and MRSA. Although the data that NSH submitted in the progress report was incomplete, NSH has identified that there are a significant number of individuals who have refused their PPD that the units have not reported to the Infection Control Department. In addition, they have identified that there has been an increase in Hepatitis C converters (acquired while in the facility). However, since the facility does not screen annually for Hepatitis C, there may be more converters than currently identified.</p> <p>NSH need to continue to develop and implement monitoring tools for addressing compliance with the EP at both a systematic and an individual level.</p> <p>Recommendation 3, February 2007: Develop and implement a system to ensure that community labs and x-rays are forwarded to the public health department.</p> <p>Findings: The monitoring instruments that NSH have developed thus far have addressed the process to ensure that community labs and x-rays are forwarded to the public health department.</p> <p>Recommendation 4, February 2007: Develop and implement systems to monitor and track unit reporting and accessibility of community labs and x-rays.</p> <p>Findings: The current monitoring instruments include unit tracking and community labs and x-rays.</p>
--	--	--

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Recommendation 5, February 2007: Provide the appropriate information for the Monthly Key Indicators.</p> <p>Findings: This recommendation has not yet been addressed.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to develop and implement a system to monitor the elements of this requirement. 2. Provide the appropriate information for the monthly Key indicators. 3. Obtain consultation from an Infection Control expert to assist with the development of this requirement.
F.8.a.ii	assesses these data for trends;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Develop and implement a system to monitor the elements of this requirement.</p> <p>Findings: This recommendation has not yet been addressed.</p> <p>Recommendation 2, February 2007: Develop and implement a system to document identified trends, interventions/corrective actions, and follow-up.</p> <p>Findings: This recommendation has not yet been addressed.</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Other Findings: From my review of the Public Health/Infection Control Committee Meeting minutes, some trends were noted regarding poor immunization compliance, the increase in Hepatitis C converters, lack of HIV screening found in the unit records, and increase in cases of MRSA and pneumonias. However, the minutes did not contain consistent plans of actions developed and implemented addressing these problematic issues. I would recommend that documentation be formally maintained addressing the actions taken and the resulting outcomes of trends identified.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a system to monitor the elements of this requirement. 2. Develop and implement a system to document identified trends, interventions/corrective actions, and follow-up.
F.8.a.iii	initiates inquiries regarding problematic trends;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Develop and implement a system to monitor the elements of this requirement.</p> <p>Findings: This recommendation has not yet been addressed.</p> <p>Recommendation 2, February 2007: Develop and implement a system to document identified trends, interventions/corrective actions, and follow-up.</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Findings: This recommendation has not yet been addressed.</p> <p>Compliance: Noncompliance.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a system to monitor the elements of this requirement. 2. Develop and implement a system to document identified trends, interventions/corrective actions, and follow-up.
F.8.a.iv	identifies necessary corrective action;	Same as above.
F.8.a.v	monitors to ensure that appropriate remedies are achieved; and	Same as above.
F.8.a.vi	integrates this information into each State hospital's quality assurance review.	Same as above.

Section F: Specific Therapeutic and Rehabilitation Services

F.9	Dental Services
	<p>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> <p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Craig B. Story, D.D.S., Chief Dentist 2. Scott Anderson, M.D, Ph.D., Chief of Medical Ancillary Services 3. Greg Leonard, PT, Standards Compliance <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Memo dated December 22, 2006 regarding Adjustment of Clinical Schedules to Assure All Required Dental Services Are Performed 2. Summary of Dental Staff Recruitment Efforts 3. Documentation regarding Emergency Dental Crisis At DMH Hospitals 4. Dental Hygienist and Dental Assistant job descriptions and salary range for NSH 5. Documentation regarding efforts to achieve an Electronic Dental Record for DMH facilities 6. Memo dated May 10, 2007 regarding Clarification of What Type of Services the Dental Department Is Currently Offering 7. NSH progress report regarding the EP 8. Dental Clinic cancellation data from January through June 2007 9. Dental Clinic daily monitoring data from January through June 2007 10. NSH Refusal of Offered Dental Service/Treatment forms 11. Dental Treatment Intervention Request form 12. Proactive Dental Alert form 13. Refusal of Offered Dental Services monitoring form 14. Proactive Dental Alert monitoring form 15. Monitoring of Response to Dental Refusal Letters form and data 16. Dental Extractions monitoring data from January through June 2007 17. Charts of 35 individuals (JS, RM, MH, KS, ME, BC, CC, JP, JC, SD, GC, CM, JaS, EH, MW, RH, ML, KH, TR, JH, WC, DA, RB, MJ, JM, JoC, AV, MD, VC, BC, JG, CK, MG, RR, SW)

Section F: Specific Therapeutic and Rehabilitation Services

<p>F.9.a</p>	<p>Each State hospital shall retain or contract with an adequate number of qualified dentists to provide timely and appropriate dental care and treatment to all individuals it serves;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Separate refusals in the dental assessment data.</p> <p>Findings: The facility presented separated data regarding individuals who refuse dental appointments. However, it was not clear from the revised data if these individuals were included or excluded in the data regarding timely admission and annual exams. (See F.9.b.i.)</p> <p>Recommendation 2, February 2007: Continue to monitor this requirement.</p> <p>Findings: See below.</p> <p>Recommendation 3, February 2007: Ensure that the dental department has an adequate number of staff to deliver appropriate services.</p> <p>Findings: The following data is a summary of NSH's current and needed staffing regarding the dental department from January through June 2007.</p> <p>Data:</p> <table border="1" data-bbox="894 1227 1875 1382"> <thead> <tr> <th></th> <th>Jan</th> <th>Feb</th> <th>Mar</th> <th>Apr</th> <th>May</th> <th>Jun</th> </tr> </thead> <tbody> <tr> <td colspan="7" style="text-align: center;">Dentist (FTE)</td> </tr> <tr> <td>Needed</td> <td>3</td> <td>3</td> <td>3</td> <td>3</td> <td>3</td> <td>3</td> </tr> <tr> <td>Current</td> <td>2</td> <td>2</td> <td>2</td> <td>2</td> <td>2</td> <td>2</td> </tr> </tbody> </table>		Jan	Feb	Mar	Apr	May	Jun	Dentist (FTE)							Needed	3	3	3	3	3	3	Current	2	2	2	2	2	2
	Jan	Feb	Mar	Apr	May	Jun																								
Dentist (FTE)																														
Needed	3	3	3	3	3	3																								
Current	2	2	2	2	2	2																								

Section F: Specific Therapeutic and Rehabilitation Services

	Jan	Feb	Mar	Apr	May	Jun
Dental Hygienist (FTE)						
Needed	1.5	1.5	1.5	1.5	1.5	1.5
Current	0	0	0	0	0	0
	Jan	Feb	Mar	Apr	May	Jun
Dental Assistant (FTE)						
Needed	3.5	3.5	3.5	3.5	3.5	3.5
Current	2	2	2	2	2	2
	Jan	Feb	Mar	Apr	May	Jun
Psychiatric Technician Assistant (FTE)						
Needed	1.5	1.5	1.5	1.5	1.5	1.5
Current	1	1	1	1	1	1
	Jan	Feb	Mar	Apr	May	Jun
Office Technician (FTE)						
Needed	1	1	1	1	1	1
Current	0	0	0	0	0	0

A part-time intermittent dentist has been offered the position and is anticipated to start work in August or September 2007. In addition, a full-time dentist may also be hired in September or October 2007. Although interviews for dental assistants were conducted in February and March, none were hired. A dental assistant position is also anticipated to be filled by October. Regarding dental hygienists, there have been no applications received. The low salary was cited by the Chief Dentist as a major problem in securing this position. A request has been made to the Executive Policy Team to convert the psychiatric technician assistant (PTA) positions to dental assistant positions.

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Other findings:</p> <p>NSH's Dental Department has only been able to provide admissions and annual examinations and emergency dental treatment since January 8, 2007 due to staff shortages. However, much of the data provided by NSH indicated that dental services were in 100% compliance with several areas of the EP. From my interview with the Chief Dentist, it was reported that it has been the common practice to basically document what dental services were provided rather than a comprehensive list of dental services that are needed for each individual seen. As a result, there has been no tracking of services that are needed but not provided. Without this information, it is impossible to accurately interpret much of NSH's data. Consequently, most of the data provided by the Dental Department did not adequately represent the provision of dental services as outlined in the EP.</p> <p>In order to adequately assess the dental services at NSH, the dentists will need to conduct and document comprehensive dental assessments that address all the needed care and services for individuals. From my discussion of this issue with the Chief Dentist, it was agreed that the dentists would document all needed dental care and treatment for individuals. Then the provision of dental care and treatment would be re-evaluated in alignment with the requirements of the EP. Once this practice is established, the resulting data generated from the monitoring will provide more accurate and meaningful information regarding the services of the NSH Dental Department.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none">1. Ensure that comprehensive dental assessments are conducted and documented for each individual.2. Provide the Dental Department with assistance regarding presentation of data required by the EP.
--	--	---

Section F: Specific Therapeutic and Rehabilitation Services

		<p>3. Review and revise policies and procedures as needed to address this requirement.</p> <p>4. Develop and implement a system to monitor and track comprehensive dental services.</p>																																																
F.9.b	Each State hospital shall develop and implement policies and procedures that require:	Compliance: Partial.																																																
F.9.b.i	comprehensive and timely provision of dental services;	<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Continue to develop and implement a system and a database to monitor this requirement.</p> <p>Findings: The tables below summarize NSH's timely provision of admission and annual exams, respectively. It was not clear from the revised data provided by NSH if individuals who refused these exams (89 for admission exams and 225 for annual exams) were included in these data. Also it was not clear if missed clinic appointments were included in these data.</p> <table border="1"> <thead> <tr> <th></th> <th>Jan</th> <th>Feb</th> <th>Mar</th> <th>Apr</th> <th>May</th> <th>Jun</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td colspan="8" style="text-align: center;"><i>Admission Timeliness</i></td> </tr> <tr> <td>N</td> <td>39</td> <td>32</td> <td>38</td> <td>40</td> <td>43</td> <td>34</td> <td>37</td> </tr> <tr> <td>n</td> <td>39</td> <td>32</td> <td>38</td> <td>40</td> <td>43</td> <td>34</td> <td>37</td> </tr> <tr> <td>% S</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> </tr> <tr> <td>% C</td> <td>85</td> <td>80</td> <td>72</td> <td>86</td> <td>73</td> <td>90</td> <td>81</td> </tr> </tbody> </table> <p>N = Number of admissions - individuals with length of stay > 90-days</p>		Jan	Feb	Mar	Apr	May	Jun	Mean	<i>Admission Timeliness</i>								N	39	32	38	40	43	34	37	n	39	32	38	40	43	34	37	% S	100	100	100	100	100	100	100	% C	85	80	72	86	73	90	81
	Jan	Feb	Mar	Apr	May	Jun	Mean																																											
<i>Admission Timeliness</i>																																																		
N	39	32	38	40	43	34	37																																											
n	39	32	38	40	43	34	37																																											
% S	100	100	100	100	100	100	100																																											
% C	85	80	72	86	73	90	81																																											

Section F: Specific Therapeutic and Rehabilitation Services

		Annual Timeliness						
		Jan	Feb	Mar	Apr	May	Jun	Mean
N		55	50	57	64	94	86	68
n		51	47	46	60	86	73	61
% S		92	94	80	93	91	84	89
% C		72	74	71	73	72	69	72

N = Number of individuals in residence 1-year or longer.

From my review of 12 individuals' admission dental exams (JS, RM, MH, KS, ME, BC, CC, JP, JC, SD, GC, CM), I found that three individuals refused the admission dental appointment and one was not seen within 90 days of admission.

From my review of 17 individuals' last annual dental exams (JS, EH, MW, RH, ML, KH, TR, JH, WC, DA, RB, MJ, JM, JC, AV, MD, VC), five individuals refused and 4 were not seen in a timely manner.

Recommendation 2, February 2007:
Finalize and implement Dental Department policies and procedures.

Findings:
No data was provided regarding this recommendation by the facility. In addition, this recommendation was not included in the NSH's progress report.

Compliance:
Partial.

Current recommendation:

1. Clarify data regarding this cell.
2. Finalize and implement Dental Department policies and procedures.
3. Continue to monitor this requirement.

Section F: Specific Therapeutic and Rehabilitation Services

<p>F.9.b.ii</p>	<p>documentation of dental services, including but not limited to, findings, descriptions of any treatment provided, and the plans of care:</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Ensure that each element of this requirement is monitored individually and reported as such in the data.</p> <p>Findings: The monitoring instrument used by the Dental Department now includes each element of this requirement individually.</p> <p>Recommendation 2, February 2007: Continue to develop a system to include individuals' dental records in medical records or on a facility-computerized system for staff to have accessibility to this health care information.</p> <p>Findings: At the current time, all of the Dental Departments have reviewed a number of dental software packages and will be selecting one in the near future. However, from my review of 12 individual's dental records and the dental notes contained in their unit charts (ME, BC, CC, JP, JG, SD, GC, CK, MG, RR, SW, KH), I found inconsistent information for six individuals comparing the two sources. For example, not all appointment notes found in the dental records were included in the dental notes of the unit charts (RR, CK, JG, SD). An issue regarding consent for dental treatment was found in the dental record but not in the individual's dental note in the chart (GC). Also, an individual's fear of needles was noted in the dental record but was not found in the notes in the chart (MG). This information would be important for the WRPTs to know.</p> <p>A system needs to be developed and implemented to ensure that the same information contained in the dental records is also in the individual's unit chart. The WRPTs need to have access to this information.</p>
-----------------	---	--

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Recommendation 3, February 2007: Facility must address staffing issues to ensure adequate dental services are provided.</p> <p>Findings: See F.9.b.i.</p> <p>Other findings: Data provided by the facility regarding this requirement could not be interpreted. The data regarding treatment provided was a review of the treatment rendered not the treatment needed. Consequently, 100% compliance was reported using this method. However, since only admission, annual, and emergencies are currently being seen by the Dental Department, 100% compliance is not an accurate assessment of dental services.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a system to ensure that the same information contained in the dental records is also in the individual's unit chart. 2. Implement dental software package.
F.9.b.iii	use of preventive and restorative care whenever possible; and	<p>Findings:</p> <p>Recommendation 1, February 2007: Collect and report data separately for the elements of this requirement.</p> <p>Findings: See F.9.a under Other Findings.</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Recommendation 2, February 2007: Continue to monitor this requirement.</p> <p>Findings: The data submitted by NSH did not accurately address this requirement. NSH's data indicated 100% compliance for both preventative and restorative care. However, only provided preventative and restorative services were audited, rather than preventative and restorative services that were needed</p> <p>Recommendation 3, February 2007: Facility must address staffing issues to ensure adequate dental services are provided.</p> <p>Findings: See F.9.b.i.</p> <p>Compliance: Partial.</p> <p>Current recommendations: Collect and report accurate data separately for the elements of this requirement.</p>
F.9.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>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Continue monitoring this requirement.</p> <p>Findings: Data provided by NSH could not be interpreted. In addition, the monitoring instrument that the Dental Department is using does not align with the specific criteria for justification of an extraction.</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Compliance: Partial.</p> <p>Current recommendation:</p> <ol style="list-style-type: none"> 1. Align monitoring instrument with criteria for tooth extractions. 2. Present data according to standardized format. 3. Continue to monitor this requirement. 																																																															
F.9.c	<p>Each State hospital shall ensure that dentists demonstrate, in a documented fashion, an accurate understanding of individuals' physical health, medications, allergies, and current dental status and complaints.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Continue to monitor this requirement.</p> <p>Findings: The table below summarizes NSH data regarding the number of individuals attending a dental appointment (N) and the elements of this requirement. Rather than presenting the percentage of compliance for each item, NSH used raw numbers.</p> <table border="1" data-bbox="894 932 1875 1279"> <thead> <tr> <th>Criteria</th> <th>Jan</th> <th>Feb</th> <th>Mar</th> <th>Apr</th> <th>May</th> <th>Jun</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>232</td> <td>172</td> <td>204</td> <td>163</td> <td>101</td> <td>209</td> </tr> <tr> <td>n</td> <td>43</td> <td>32</td> <td>39</td> <td>36</td> <td>31</td> <td>56</td> </tr> <tr> <td>%S</td> <td>18</td> <td>18</td> <td>19</td> <td>22</td> <td>30</td> <td>26</td> </tr> <tr> <td>Physical health</td> <td>43</td> <td>32</td> <td>39</td> <td>36</td> <td>31</td> <td>56</td> </tr> <tr> <td>Medications</td> <td>43</td> <td>32</td> <td>39</td> <td>36</td> <td>31</td> <td>56</td> </tr> <tr> <td>Allergies</td> <td>43</td> <td>32</td> <td>39</td> <td>36</td> <td>31</td> <td>56</td> </tr> <tr> <td>Dental Status</td> <td>41</td> <td>31</td> <td>39</td> <td>36</td> <td>30</td> <td>55</td> </tr> <tr> <td>Complaints</td> <td>42</td> <td>31</td> <td>39</td> <td>36</td> <td>28</td> <td>42</td> </tr> </tbody> </table> <p>N = Number of individuals attending a dental appointment.</p>	Criteria	Jan	Feb	Mar	Apr	May	Jun	N	232	172	204	163	101	209	n	43	32	39	36	31	56	%S	18	18	19	22	30	26	Physical health	43	32	39	36	31	56	Medications	43	32	39	36	31	56	Allergies	43	32	39	36	31	56	Dental Status	41	31	39	36	30	55	Complaints	42	31	39	36	28	42
Criteria	Jan	Feb	Mar	Apr	May	Jun																																																											
N	232	172	204	163	101	209																																																											
n	43	32	39	36	31	56																																																											
%S	18	18	19	22	30	26																																																											
Physical health	43	32	39	36	31	56																																																											
Medications	43	32	39	36	31	56																																																											
Allergies	43	32	39	36	31	56																																																											
Dental Status	41	31	39	36	30	55																																																											
Complaints	42	31	39	36	28	42																																																											

Section F: Specific Therapeutic and Rehabilitation Services

		<p>From my review of 17 individuals' last annual dental exams (JS, EH, MW, RH, ML, KH, TR, JH, WC, DA, RB, MJ, JM, JC, AV, MD, VC), five individuals refused the appointment and 12 records contained documentation of the individuals' physical health, medication, allergies. However, the current dental status and dental complaints were not consistently documented.</p> <p>Compliance: Partial.</p> <p>Current recommendation:</p> <ol style="list-style-type: none"> 1. Present data according to standardized format. 2. Continue to monitor this requirement. 																								
F.9.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>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Continue to monitor this requirement.</p> <p>Findings: The following table summarizes NSH's data regarding the number of missed appointments (N) and reasons for missed appointments. The form used to track the reasons for appointment cancellations contained a number of additional issues that were placed in the "All other reasons" category. Including all reasons for cancellations in the data table would provide more meaningful and comprehensive information.</p> <table border="1" data-bbox="894 1190 1881 1383"> <thead> <tr> <th>Criteria</th> <th>Jan</th> <th>Feb</th> <th>Mar</th> <th>Apr</th> <th>May</th> <th>Jun</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>88</td> <td>75</td> <td>107</td> <td>72</td> <td>72</td> <td>75</td> <td>82</td> </tr> <tr> <td>Staffing issues (Unit Acuity / Short Staff)</td> <td>2</td> <td>2</td> <td>11</td> <td>5</td> <td>3</td> <td>4</td> <td>5</td> </tr> </tbody> </table>	Criteria	Jan	Feb	Mar	Apr	May	Jun	Mean	N	88	75	107	72	72	75	82	Staffing issues (Unit Acuity / Short Staff)	2	2	11	5	3	4	5
Criteria	Jan	Feb	Mar	Apr	May	Jun	Mean																			
N	88	75	107	72	72	75	82																			
Staffing issues (Unit Acuity / Short Staff)	2	2	11	5	3	4	5																			

Section F: Specific Therapeutic and Rehabilitation Services

		Transportation issues	0	0	0	0	0	0	0																																								
		All other reasons	86	73	96	67	69	71	77																																								
		<p>N = Total missed appointments.</p> <p>From my interview with the Chief Dentist, transportation has not been an issue for missed appointments. From my review of the Dental Clinic Cancellation tracking forms for January through June 2007, individual refusals appeared to be the major reason for a missed dental clinic appointment, followed by being out to court.</p> <p>The facility has initiated sending letters to the units of individuals who refused their dental appointments. However, this system has not been formalized or consistently implemented. The table below summarizes NSH's data regarding communication to the WRPTs regarding dental refusals for each month (N).</p> <table border="1"> <thead> <tr> <th>Criteria</th> <th>Jan</th> <th>Feb</th> <th>Mar</th> <th>Apr</th> <th>May</th> <th>Jun</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>Number of Refusals</td> <td>53</td> <td>34</td> <td>55</td> <td>44</td> <td>37</td> <td>24</td> <td>41</td> </tr> <tr> <td># Letters Sent to Unit</td> <td>34</td> <td>28</td> <td>43</td> <td>32</td> <td>21</td> <td>17</td> <td>29</td> </tr> <tr> <td># Returned Completed</td> <td>17</td> <td>11</td> <td>15</td> <td>16</td> <td>4</td> <td>0</td> <td>11</td> </tr> <tr> <td>% Completed</td> <td>50</td> <td>39</td> <td>34</td> <td>50</td> <td>19</td> <td>0</td> <td>32</td> </tr> </tbody> </table> <p>% Completed = # Returned Completed / # Letters Sent to Unit.</p> <p>NSH needs to formalize a system addressing dental refusals. There is currently no written protocol addressing this issue nor anyone specified on the unit to be responsible to ensure that the WRPTs receive this information.</p>								Criteria	Jan	Feb	Mar	Apr	May	Jun	Mean	Number of Refusals	53	34	55	44	37	24	41	# Letters Sent to Unit	34	28	43	32	21	17	29	# Returned Completed	17	11	15	16	4	0	11	% Completed	50	39	34	50	19	0	32
Criteria	Jan	Feb	Mar	Apr	May	Jun	Mean																																										
Number of Refusals	53	34	55	44	37	24	41																																										
# Letters Sent to Unit	34	28	43	32	21	17	29																																										
# Returned Completed	17	11	15	16	4	0	11																																										
% Completed	50	39	34	50	19	0	32																																										

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Compliance: Partial.</p> <p>Current recommendation:</p> <ol style="list-style-type: none"> 1. Include all items from the monitoring instrument regarding missed dental clinic appointments in the data for this requirement. 2. Formalize system addressing WRPT communication regarding dental refusals. 3. Continue to monitor this requirement.
F.9.e	<p>Each State hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to overcome individual's refusals to participate in dental appointments.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Implement a system to monitor this requirement.</p> <p>Findings: No data was provided regarding this recommendation.</p> <p>Recommendation 2, February 2007: Continue to develop and implement a facility-wide system to facilitate communication with Dental and the Wellness and Recovery teams regarding individualized strategies to address refusals of dental appointments and treatments</p> <p>Findings: On May 30, 2007 Dr. Story, Chief Dentist addressed the Wellness and Recovery Planning consultation group. The presentation focused on how the Treatment Intervention and Individual Refusal of Offered Dental Treatment forms are to be used. Dr. Story also presented the Proactive Dental Treatment forms and how they are to be used to encourage individuals to keep their next scheduled dental appointment. Thus far, there has been no indication that dental refusals are being addressed by the WRPTs. Development and</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<p>implementation of this system needs to continue.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none">1. Continue to 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.2. Implement a system to monitor this requirement.
--	--	---

Section G: Documentation

G	Documentation	
		<p>Summary of Progress:</p> <ol style="list-style-type: none"> 1. Many of the discipline-specific assessments are completed in a timely manner. 2. Despite severe staffing shortages, NSH continues to conduct self-assessment of the current system. However, much work has yet to be done to implement improvements in the documentation of disciplinary assessments and services.
	<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>Current findings on previous recommendations:</p> <p>Recommendations 1, 2 and 3, February 2007:</p> <ol style="list-style-type: none"> 1. Revise, update, and implement policies and procedures related to documentation to include specific criteria required. 2. Ensure that all monitoring instruments regarding disciplinary assessments are aligned with requirements of the EP 3. Provide ongoing training regarding documentation requirements. <p>Findings: NSH has yet to implement these recommendations. The previously mentioned findings of deficiencies in the documentation of admission and integrated assessments (D.1. through D.7) and the main components of integrated therapeutic and rehabilitation services (C.2.b. through C.2.i) and specific therapeutic and rehabilitation services (F.1. through F.7) must be corrected to achieve substantial compliance with this requirement.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Revise, update, and implement policies and procedures related to documentation to include specific criteria required.

Section G: Documentation

		<ol style="list-style-type: none">2. Ensure that all monitoring instruments regarding disciplinary assessments are aligned with requirements of the EP3. Provide ongoing training regarding documentation requirements.
--	--	--

Section H: Restraints, Seclusion, and PRN and Stat Medication

H	Restraints, Seclusion, and PRN and Stat Medication	
		<p>Summary of Progress:</p> <ol style="list-style-type: none"> 1. NSH has developed and revised a number of policies and procedures regarding PRN/ Stat medications and restraints and seclusion in alignment with the EP. 2. NSH continues its commitment to decreasing the use of seclusion and restraints. 3. NSH has implemented a number of competency-based training classes in alignment with the requirements of the EP.
	<p>Each State hospital shall ensure that restraints, seclusion, psychiatric PRN medications, and Stat medications are used consistent with generally accepted professional standards of care.</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Amarpreet Singh, MD, Chief of Staff 2. Michelle Patterson, RN, Nursing Quality Improvement 3. Eve Arcala, RN, Nursing Quality Improvement Coordinator 4. Kathleen Patterson, PhD, Acting Senior Psychologist <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. NSH data graphs regarding PRN usage and seclusion and restraints 2. NSH progress report 3. NSH Nursing Policies #1506.1, Safety Restraint; #113, Care of the Individuals in Bed-Bound Status; #1506, Behavioral Seclusion or Restraint; 4. NSH Medical Staff Rules and Regulations 203, Administration of PRN/Stat Medications 5. NSH Standards Compliance Department Nursing Quality Improvement Seclusion and Restraint Review form, revised 7/10/07 6. Staff training rosters for Seclusion and Restraint, Dr. Colleen Love's training 7. Emergency Intervention Report form, revised 8. Safety Restraints Reduction Monitoring form, revised 9. Safety Restraint Observation Monitoring Form

Section H: Restraints, Seclusion, and PRN and Stat Medication

		<p>10. New Hire Validation Tracking form 11. DMH Statewide 24-Hour Audit Monitoring Form 12. Direct Observation Checklists of Competencies for Registered Nurses 13. Weekly Safety Restraint Re-Assessment Log data for June 2007 14. List of Individuals who use side rails 15. Charts for the following 26 individuals: SB, DK, GB, JB, CH, LK, EL, EH, DC, VH, MW, SS, CR, SP, GL, SG, QE, JM, RM, JW, CC, AS, HV, SL, JR, KS 16. Activity sheets for individuals on Unit A4</p> <p><u>Observed:</u> 1. Individuals on unit A4 and A9</p>
<p>H.1</p>	<p>Each State hospital shall revise, as appropriate, and implement policies and procedures regarding the use of seclusion, restraints, psychiatric PRN medications, and Stat Medications consistent with generally accepted professional standards of care. In particular, the policies and procedures shall expressly prohibit the use of prone restraints, prone containment and prone transportation and shall list the types of restraints that are acceptable for use.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Continue to revise, implement, and retrain staff regarding policies and procedures addressing the use of seclusion, restraints, psychiatric PRN medications, and Stat medication in accordance with generally, accepted standards of practice.</p> <p>Findings: NSH has revised the medical staff rules and regulations #203, Administration of PRN/Stat Medications in alignment with the EP. In addition, the Psychiatrists Progress Note template was developed with guidelines to specifically address PRN and Stat medications and the rationale for their usage. In addition, NSH administrative directive (AD) 761 prohibits the use of prone restraints. However, Posey vests, Geri chairs and Broda chairs were not included in the list of approved behavioral restraint devices in section III, Definitions. These devices are being used on the medical units. Nursing Policy # 1506, Behavioral Seclusion or Restraints, was developed in alignment with the EP and will be effective on July 27, 2007.</p>

Section H: Restraints, Seclusion, and PRN and Stat Medication

		<p>Other findings: From my interviews and observations on Unit A4, there is little to no monitoring of the restraint usage on the medical units. Monitoring of these units need to be included in alignment with the requirements of the EP.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Include all restraint devices in AD 761. 2. Develop and implement a system to monitor and track restraint and seclusion use on the medical units.
H.2	Each State hospital shall ensure that restraints and seclusion:	<p>Compliance: Partial.</p>
H.2.a	are used in a documented manner and only when individuals pose an imminent danger to self or others and after a hierarchy of less restrictive measures has been considered in a clinically justifiable manner or exhausted;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Continue to develop and implement a system to monitor the key elements of this requirement.</p> <p>Findings: NSH revised the Nursing Quality Improvement Seclusion and Restraint review form/monitoring instrument. However, the instrument does not address if restraints or seclusion was used for imminent harm to self or others. From my review of the instrument, there is no item addressing the documented clinical justification for the use of seclusion and/or restraints. Consequently, no data was provided by NSH regarding this requirement.</p> <p>Recommendations 2, 3 and 4, February 2007:</p> <ol style="list-style-type: none"> 2. Continue to revise policies and procedures to include implementing seclusion

Section H: Restraints, Seclusion, and PRN and Stat Medication

		<p>and restraints only after a hierarchy of less restrictive measures has been considered in a clinically justifiable manner or exhausted with supporting documentation to be in the medical records.</p> <ol style="list-style-type: none"> 3. Retrain staff regarding new policies and procedures regarding the use of seclusion and restraint. 4. Revise forms used to document use of seclusion and restraint to include documentation of less restrictive measures used prior to restrictive procedures being implemented. <p>Findings: Nursing Policy 1506 was developed to adequately address this recommendation and will be effective date July 27, 2007. Staff training rosters indicated that staff were trained on the new policy and procedures for seclusion and restraints. In addition, the Emergency Intervention Report form has been modified to include the criteria in recommendation #4. Approval for the modification is currently in process and anticipated to be implemented August 1, 2007.</p> <p>Other findings: There was no monitoring data regarding this requirement.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Revise the monitoring tool to include the elements of this requirement. 2. Begin monitoring this requirement and provide data.
H.2.b	are not used in the absence of, or as an alternative to, active treatment, as punishment, or for the convenience of staff;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Develop and implement a system to monitor the key elements of this</p>

		<p>requirement.</p> <p>Findings: NSH reported in their revised progress report that the criteria addressing this section of EP were added to the revised monitoring instrument that was implemented July 2007. However, from my review of the supporting documents, I found no instrument that included the elements of this requirement. Consequently, no data was provided regarding this requirement.</p> <p>Recommendation 2, February 2007: Continue to provide ongoing training for staff regarding therapeutic interactions and interventions.</p> <p>Findings: ART (Aggression Reduction Training) was developed in cooperation with Dr Charles Scott from UC Davis and is a mandated annual training for staff. In addition, therapeutic interactions and interventions are also discussed during mandated annual PMAB staff training. Also, Dr. Colleen Love from ASH provided a presentation for the nursing staff during the annual Napa State Hospital Visiting Scholars Day on May 17, 2007.</p> <p>Although these trainings have been provided annually, they have had little impact on changing communication in relation to the use of seclusion and/or restraints. The fact that most of the nursing staff at NSH have little to no psychiatric nursing experience warrants an intensive curriculum addressing therapeutic interactions and interventions. From my discussion with the Executive Director, a plan is being developed to bring a psychiatric nursing curriculum to NSH to increase the staff's therapeutic skills.</p> <p>Recommendation 3, February 2007: Increase the number of therapeutic Mall activities to provide adequate treatment options to individuals.</p>
--	--	--

		<p>Findings: The table below summarizes the average scheduled Mall hours per individual per week and the actual average number of Mall hours attended.</p> <table border="1" data-bbox="907 376 1892 682"> <thead> <tr> <th></th> <th>Jan</th> <th>Feb</th> <th>Mar</th> <th>Apr</th> <th>May</th> <th>Jun</th> </tr> </thead> <tbody> <tr> <td colspan="7" style="text-align: center;">Monthly Averages of Scheduled and Attended Active Treatment</td> </tr> <tr> <td>N</td> <td>1171</td> <td>1166</td> <td>1163</td> <td>1152</td> <td>1158</td> <td>1144</td> </tr> <tr> <td>n</td> <td>1171</td> <td>1166</td> <td>1163</td> <td>1152</td> <td>1158</td> <td>1144</td> </tr> <tr> <td>% S</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> </tr> <tr> <td>Sche- duled</td> <td>8.6</td> <td>8.2</td> <td>7.7</td> <td>8.1</td> <td>9.2</td> <td>8.6</td> </tr> <tr> <td>Actual</td> <td>2.3</td> <td>3.8</td> <td>3.7</td> <td>3.8</td> <td>4.2</td> <td>3.8</td> </tr> </tbody> </table> <p>N= Census NSH (As reported in number of hours per week of scheduled and attended treatment Mall hours)</p> <p>From my review, there has basically been no increase in Mall hours since my last visit.</p> <p>Recommendation 4, February 2007: Develop and implement a system to address the use of "soft tie" restraints to ensure that policies and procedures are being followed.</p> <p>Findings: The Safety Observation Record was revised and implemented July 1 and adequately addresses this recommendation. Also, the Safety Restraints Monitoring form was developed but has not yet been implemented. Training rosters indicated that staff was provided training on accurate documentation on the Safety Observation Record. No data has been generated as of yet since this was recently implemented.</p>		Jan	Feb	Mar	Apr	May	Jun	Monthly Averages of Scheduled and Attended Active Treatment							N	1171	1166	1163	1152	1158	1144	n	1171	1166	1163	1152	1158	1144	% S	100	100	100	100	100	100	Sche- duled	8.6	8.2	7.7	8.1	9.2	8.6	Actual	2.3	3.8	3.7	3.8	4.2	3.8
	Jan	Feb	Mar	Apr	May	Jun																																													
Monthly Averages of Scheduled and Attended Active Treatment																																																			
N	1171	1166	1163	1152	1158	1144																																													
n	1171	1166	1163	1152	1158	1144																																													
% S	100	100	100	100	100	100																																													
Sche- duled	8.6	8.2	7.7	8.1	9.2	8.6																																													
Actual	2.3	3.8	3.7	3.8	4.2	3.8																																													

		<p>Other findings:</p> <p>From my observations on Unit A4, I noted that there were a number of individuals who were in some type of restraint device. From the review of the activity forms, many of these individuals have not been released from their restraints every two hours as required by NSH's restraint policy. The supervising RN on the unit reported that due to staff shortages, releasing individuals as required is frequently not done. When asked, the unit's Program Director stated he was not aware of this issue. Unquestionably there is a significant lack of oversight and monitoring on this unit.</p> <p>From my review of 11 individuals on various NSH units (SB, DK, GB, JB, CH, LK, EL, EH, DC, VH, and MW) who were placed in restraints and/or seclusion several times within the past six months, I found the documentation for two individuals did not support the decision to place the individuals in seclusion or restraints. In the case of SB, the progress note stated that he kept "resurfacing at the nursing station for something to eat and ignoring staff's redirection." A short time later the notes indicated that he lit a cigarette during fresh air break and refused to put it out. The next note indicated that SB was placed into seclusion and given Ativan 2 mg. The progress notes clearly indicated that the staff member was irritated with this individual and got into a power struggle.</p> <p>In the case of DC, the progress notes indicated that he was found naked in his room, "quiet and not agitated." He was carried to a seclusion room and was noted to be cooperative, quiet, and not struggling. DC was placed in five-point restraints. Within minutes he was noted to be screaming and struggling at the restraints. The documentation indicated that he received Thorazine, Ativan and Zyprexa by injection and remained in restraints for at least the next six hours.</p>
--	--	--

Section H: Restraints, Seclusion, and PRN and Stat Medication

		<p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that the monitoring instrument includes all elements of this requirement. 2. Develop and implement intensive training regarding therapeutic interactions and interventions. 3. Monitor the elements of this requirement. 4. Initiate Safety Restraints monitoring system. 5. Develop and implement a system to track and monitor restraint use on the medical units.
H.2.c	are not used as part of a behavioral intervention; and	<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Continue ongoing monitoring to ensure compliance with this requirement.</p> <p>Findings: PBST members received training on 5/10/07 regarding writing PBS plans and Behavior Guidelines that are in compliance with this requirement. Of the six PBS plans that have been active during this monitoring period, four were in compliance with this requirement. Two PBS plans that were written in April for individuals with severe self-injurious behaviors contained references to emergency procedures in a Crisis Interventions Section. However, both plans were revised in May in compliance with this requirement.</p> <p>In addition, the unit Psychologists were trained in this requirement by Interim Senior Supervising Psychologists during the May /June meeting of the Monthly Program Psychologist Training. The Interim Senior Supervising Psychologist monitors the PBS plans and Behavior Guidelines submitted by unit psychologists each month. During this monitoring period, 58 out of 78 (74%) of Behavior Guidelines monitored were in compliance with this requirement. Five of the</p>

Section H: Restraints, Seclusion, and PRN and Stat Medication

		<p>twenty that contained Crisis Interventions as part of the Behavior Guidelines were either closed or revised after the May/June training. The remaining 15 will be addressed to comply with this requirement.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
H.2.d	<p>are terminated as soon as the individual is no longer an imminent danger to self or others.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Continue ongoing monitoring to ensure compliance with this requirement.</p> <p>Findings: The data submitted by NSH did not accurately reflect this requirement. Data for seclusion and restraints need to be reported separately. In addition, number of incidents of seclusion/restraints should be used as the target population rather than orders for seclusion /restraints. From my review, there were a significant number of orders for restraints that were extensions of the original order and not separate incidents. Reporting incidents using physician orders alone will not yield accurate data.</p> <p>From my review of 11 individuals (SB, DK, GB, JB, CH, LK, EL, EH, DC, VH, and MW) who were placed in seclusion and/or restraints, I found that all were released when the documentation indicated that they were no longer a threat to self or others. I also noted that individuals who were placed in seclusion were released more quickly than individuals who were placed in restraints.</p> <p>Recommendation 2, February 2007: Implement monitoring system to identify specific problematic trends related</p>

Section H: Restraints, Seclusion, and PRN and Stat Medication

		<p>to this key element to ensure effective plans of corrections.</p> <p>Findings:</p> <p>NSH revised the Nursing Quality Improvement Seclusion or Restraint Review form and implemented it July 1, 2007. Since it was only recently implemented, no problematic trends related to this requirement have been identified. However, if trends are identified, they should be presented at the monthly Nursing Quality Improvement meeting in Central Nursing Services.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Revise data to accurately reflect this requirement. 2. Identify specific problematic trends related to this key element to ensure effective plans of corrections. 3. Continue to monitor this requirement.
H.3	<p>Each State hospital shall comply with 42 C.F.R. § 483.360(f), requiring assessments by a physician or licensed clinical professional of any individual placed in seclusion or restraints within one hour. Each State hospital shall also ensure that any individual placed in seclusion or restraints is continuously monitored by a staff person who has successfully completed competency-based training on the administration of seclusion and restraints.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Implement a system to monitor and ensure compliance with all of the elements of this requirement.</p> <p>Findings: The data provided by NSH regarding assessment by a physician or licensed clinical professional within one hour of being placed in restraints or seclusion could not be interpreted. In addition, no data regarding competency-based training was provided. An automated system is currently being implemented in the Nursing Education Department that will track staff training.</p>

Section H: Restraints, Seclusion, and PRN and Stat Medication

		<p>From my review of 35 incidents of restraints and seclusion for 11 individuals (SB, DK, GB, JB, CH, LK, EL, EH, DC, VH, and MW), I found that in 27 incidents the individual was seen within one hour by either a physician or nurse.</p> <p>Compliance: Partial.</p> <p>Current recommendation:</p> <ol style="list-style-type: none"> 1. Continue to implement automated system to track staff training. 2. Monitor this requirement and provide data. 3. Separate restraint and seclusion data.
H.4	<p>Each State hospital shall ensure the accuracy of data regarding the use of restraints, seclusion, psychiatric PRN medications, or Stat medications.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Continue to implement an automated system to ensure accuracy of data regarding the use of restraints, seclusion, psychiatric PRN medications, or Stat medications.</p> <p>Findings: The automated system for collection of PRN and Stat medications is implemented. However, the procedure for validating the data has not been implemented as of yet. No data was provided by NSH regarding a system addressing the accuracy of seclusion and restraint data.</p> <p>Recommendation 2, February 2007: Address the issue of an increase in prescribing PRNs rather than Stat medications regarding the requirements of the EP.</p> <p>Findings: The NSH progress report did not accurately address this recommendation. There continues to be a number of PRN medications that are used as</p>

Section H: Restraints, Seclusion, and PRN and Stat Medication

		<p>emergency medications. However, they are being logged as PRNs. Consequently, the data regarding PRN and Stat medications will not be reliable.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Implement a procedure to validate the PRN and Stat data. 2. Develop and implement a system to ensure accuracy of data regarding the use of restraints and seclusion. 3. Address the issue of an increase in prescribing PRNs rather than Stat medications regarding the requirements of the EP.
H.5	<p>Each State hospital shall revise, as appropriate, and implement policies and procedures to require the review within three business days of individuals' therapeutic and rehabilitation service plans for any individuals placed in seclusion or restraints more than three times in any four-week period, and modification of therapeutic and rehabilitation service plans, as appropriate.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, February 2007:</p> <ol style="list-style-type: none"> 1. Revise appropriate policies and procedures to ensure compliance with this requirement. 2. Develop and implement a monitoring system to ensure that there is a review within three business days of individuals' therapeutic and rehabilitation service plans for any individuals placed in seclusion or restraints more than three times in any four-week period, and modification of therapeutic and rehabilitation service plans, as appropriate. <p>Findings: NSH has revised Nursing Policy #1506: Behavioral Seclusion or Restraint to adequately reflect this requirement. NSH had added this criterion to the Emergency Intervention Report form clinical review section, which will include the documentation of any action taken. The new form is in the approval process and the target date for implementation is August 1. In addition, NSH is working with information systems regarding the possibility of obtaining this information electronically based on the WaRMSS Quick Hits. However, there</p>

Section H: Restraints, Seclusion, and PRN and Stat Medication

		<p>has been no implementation of WRP reviews for individuals meeting this criteria.</p> <p>From my review of 11 individuals (SB, DK, GB, JB, CH, LK, EL, EH, DC, VH, and MW) who have had three incidents of seclusion and/or restraints in a four-week period, there was no documentation that their WRPs were reviewed.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a monitoring system to address this requirement. 2. Monitor and provide data regarding this requirement.
H.6	Each State hospital shall develop and implement policies and procedures consistent with generally accepted professional standards of care governing the use of psychiatric PRN medication and Stat medication, requiring that:	<p>Compliance: Partial.</p>
H.6.a	such medications are used in a manner that is clinically justified and are not used as a substitute for adequate treatment of the underlying cause of the individual's distress.	<p>Findings on previous recommendations:</p> <p>Recommendations 1 and 2, February 2007:</p> <ol style="list-style-type: none"> 1. Same as in F.1.b 2. Develop and implement triggers for review by TRC and follow-through. <p>Findings: Data provided by NSH could not be accurately interpreted. No information was provided regarding policy/procedures addressing this requirement. In addition, NSH did not address the development and implementation of triggers for review by TRC and follow-through.</p>

Section H: Restraints, Seclusion, and PRN and Stat Medication

		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement triggers for review by TRC and follow-through. 2. Provide data addressing this requirement.
H.6.b	PRN medications, other than for analgesia, are prescribed for specified and individualized behaviors.	Same as above.
H.6.c	PRN medications are appropriately time limited.	Currently orders for PRN medication are reviewed and renewed by the physician not more than every 30 days. Although the Medical Staff R&R 203 specifies discontinuation of PRN medications when no longer indicated, it does not specify the 30 day review and renewal.
H.6.d	nursing staff assess the individual within one hour of the administration of the psychiatric PRN medication and Stat medication and documents the individual's response.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Implement a monitoring system to ensure that nursing staff assesses the individual within one hour of the administration of the psychiatric PRN medication and Stat medication and documents the individual's response.</p> <p>Findings: The data provided by NSH could not be interpreted. From my review of 50 incidents of PRNs administered to 18 individuals (SB, DK, GB, JB, CH, LK, EL, EH, CC, MW, VH, AS, DC, HV, SL, JR, KS, and CR) I found documentation indicating that the individual was assessed within one hour in 21 of the incidents.</p> <p>From my review of 20 incidents of Stat medications administered to the same 18 individuals listed above, I found that in 18 incidents the individual was assessed within one hour.</p> <p>Recommendation 2, February 2007: Continue to provide staff training regarding policies/procedure changes and</p>

Section H: Restraints, Seclusion, and PRN and Stat Medication

		<p>the documentation of specific indicators describing an individual's response to PRN and Stat medications.</p> <p>Findings: NSH has implemented a mandatory annual medication administration class that includes review of requirements for PRN and Stat medication, including the documentation of the individual's response. This training will be ongoing.</p> <p>Recommendation 3, February 2007: Continue to monitor this requirement.</p> <p>Findings: No data was provided by NSH regarding individuals' response to PRN and Stat medication administration. See F.3.a.iii.</p> <p>Compliance: Partial.</p> <p>Current recommendations: Monitor and provide data for this requirement.</p>
H.6.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>Current findings on previous recommendations:</p> <p>Recommendations, February 2007: Same as in F.1.b and H.6.a.</p> <p>Findings: Same as in D.1.f, F.1.b and H.6.a.</p> <p>Compliance: Partial.</p>

Section H: Restraints, Seclusion, and PRN and Stat Medication

		<p>Current recommendations: Same as in D.1.f, F.1.b and H.6.a.</p>
H.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>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Implement a permanent training database to ensure compliance with this requirement.</p> <p>Findings: See 3.h.i.</p> <p>Recommendation 2, February 2007: Continue to develop and implement competency-based training regarding the elements of this requirement.</p> <p>Findings: The data provided by NSH did not address this recommendation.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to implement a permanent training database to ensure compliance with this requirement. 2. Continue to develop and implement competency-based training regarding the elements of this requirement.
H.8	<p>Each State hospital shall:</p>	<p>Compliance: Partial.</p>
H.8.a	<p>develop and implement a plan to reduce the</p>	<p>Current findings on previous recommendations:</p>

Section H: Restraints, Seclusion, and PRN and Stat Medication

	<p>use of side rails as restraints in a systematic and gradual way to ensure individuals' safety; and</p>	<p>Recommendation 1, February 2007: Implement a system to monitor this requirement.</p> <p>Findings: The data provided by NSH could not be interpreted. However, a monitoring tool, the Safety Restraints Reduction Monitoring Form, has been recently implemented on the SNF unit.</p> <p>Recommendation 2, February 2007: Evaluate, obtain, and maintain appropriate equipment needs for those individuals that warrant the use of side rails.</p> <p>Findings: The facility ordered 22 high/low beds on 7/5/07. The delivery date is approximately September 1, 2007. These beds will replace the side rail beds that are being used as a restraint.</p> <p>Recommendation 3, February 2007: Continue to develop, implement, and regularly review individualized plans for the reduction of side rails.</p> <p>Findings: There was no data provided addressing this recommendation.</p> <p>Current recommendations:</p> <ol style="list-style-type: none">1. Implement a system to monitor this requirement.2. Monitor and provide data regarding this requirement.
--	---	--

Section H: Restraints, Seclusion, and PRN and Stat Medication

<p>H.8.b</p>	<p>ensure that, as to individuals who need side rails, their therapeutic and rehabilitation service plans expressly address the use of side rails, including identification of the medical symptoms that warrant the use of side rails, methods to address the underlying causes of such medical symptoms, and strategies to reduce the use of side rails, if appropriate.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Implement a system to monitor the elements of this requirement.</p> <p>Findings: This recommendation has not been addressed by NSH.</p> <p>Recommendation 2, February 2007: Provide training to appropriate staff regarding individuals who need side rails, their therapeutic and rehabilitation service plans expressly address the use of side rails, including identification of the medical symptoms that warrant the use of side rails, methods to address the underlying causes of such medical symptoms, and strategies to reduce the use of side rails, if appropriate.</p> <p>Findings: The data provided by NSH did not accurately address all the elements of this requirement. In addition, there was no data regarding staff training regarding side rail use. NSH has ordered 22 high/low beds to replace the beds with side rails.</p> <p>From my review of four individuals requiring the use of side rails (HV, SL, JR, and CR) the required documentation as outlined in the EP was not found in the individuals charts.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a system addressing the elements of this requirement. 2. Monitor and provide data.
--------------	--	---

Section I: Protection from Harm

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. NSH has taken measures that have been largely effective to ensure that all incidents are reported on an incident reporting form and logged into the SIR database. 2. The incident reporting forms reviewed were accurate, with only one exception. 3. The Standards Compliance Office is producing a report identifying repeat victims and aggressors and is sharing this report with Program Directors. 4. The Standards Compliance Office has provided trend reports on aggression by program for each month in 2007 and total number of incidents by month for the period January 2006 through June 2007. 5. The hospital has instituted annual refresher training for staff in abuse and neglect. A spot review of training records indicates that training is occurring on time. 6. The hospital has taught the first class of 14 police officers using the Incident Management curriculum. These classes will be conducted twice a month through the end of the year. Program Directors will be given the option of having Unit Supervisors attend this training. 7. The Environmental Risk Reduction Project was developed on a model that combines programmatic insight into suicide hazards with superior craftsmanship. The work of this group in assessing environments for hazards, tracking modifications to the environment across the entire hospital, and designing and negotiating the manufacture of objects and furniture that meet the challenges of the forensic hospital environment is noteworthy.

Section I: Protection from Harm

I.1	Incident Management	
	<p>Each State hospital shall develop and implement across all settings, including school settings, an integrated incident management system that is consistent with generally accepted professional standards of care.</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. D. Hauscarriague, Senior Special Investigator 2. D. Grundman, Special Investigator 3. D. Matteucci, Hospital Administrator 4. M. McQueeney, Assistant Hospital Administrator 5. C. Black, Standards Compliance Director 6. M. Stolp, Program Director 7. D. Pike, Chief of Police* 8. K. Cooper, Program Director* 9. T. Kyle, Hospital Police Lieutenant* 10. M. Leyva, Central Office* 11. D. Percy, HR Director <p>* Contributors to the discussion on incident definitions. Not interviewed separately.</p> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. 15 Hospital Police investigations 2. 29 investigations from the Office of the Special Investigator (SI), including five deaths 3. SIR database reports 4. Hospital Police investigation log 5. Training and background check records for 12 staff members 6. Aggregate training data 7. 15 Special Incident Reports (SIRs) for completeness and accuracy 8. Mortality Review Committee Minutes for January through April
I.1.a	<p>Each State hospital shall review, revise, as appropriate, and implement incident management</p>	<p>Compliance: Partial.</p>

Section I: Protection from Harm

	<p>policies, procedures and practices that are consistent with generally accepted professional standards of care. Such policies, procedures and practices shall require:</p>	
I.1.a.i	<p>that each State hospital not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of individuals;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Ensure that New Employee Orientation training and annual refresher abuse/neglect training includes a review of ADs #435 and #437.</p> <p>Findings: This recommendation has been implemented.</p> <p>Other findings: New employee orientation includes a two-hour training on Client Abuse Reporting and Investigations, taught, at least in part, by the Senior Special Investigator. The one-hour annual training, begun in January 2007, is taught by staff of the Training Department.</p> <p>Current recommendation: Ensure that revised SIR definitions are reviewed at both orientation and annual abuse/neglect training.</p>
I.1.a.ii	<p>identification of the categories and definitions of incidents to be reported, and investigated; immediate reporting by staff to supervisory personnel and each State hospital's executive director (or that official's designee) of serious incidents, including but not limited to, death, abuse, neglect, and serious injury, using standardized reporting across all settings,</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Hospital police will share their incident log each month with the Standards Compliance Office. Standards Compliance will review the data and communicate with the hospital police about any discrepancies. Appropriate corrections will be made.</p>

Section I: Protection from Harm

	including school settings;	<p>Findings: This recommendation has been implemented and the results show improvement. Ten randomly selected hospital police investigations from April and May 2007 were matched against the SIR database. In eight of the ten, there was a corresponding entry in the SIR database. The exceptions were the 5/21/07 incident involving HC and the 4/19/07 incident involving KD.</p> <p>Each of the 29 SI investigations reviewed had a corresponding incident report. This finding is consistent with the hospital's self-assessment.</p> <p>Recommendation 2, February 2007: Continue work on incident definitions.</p> <p>Findings: Work on incident definitions is nearly complete. Approval is pending; once obtained, the definitions can be published.</p> <p>Other findings: A 6/24/07 incident describes the failure of the on-call physician to respond to a request made in person to him to attend to a medical emergency. This incident is "typed" (classified as) "failure to follow policy" rather than "neglect." No work had been done to investigate this incident at the time of our tour, a month later. Another incident on 2/16/07, in which a physician threatened to break an individual's hand, was determined to be unfounded because there was no evidence of "mental suffering" on the part of the victim. These two incidents illustrate the need for swift action on the revised definitions.</p> <p>As reported earlier, some individuals are being restrained with soft ties in beds and chairs, but the safeguards around the use of restraints are not being observed. The physical abuse definition</p>
--	----------------------------	--

Section I: Protection from Harm

		<p>specifically cites the misuse of restraint as abuse. Staff and SIs need to understand the new SIR definitions, and the definitions need to be taught in the new employee orientation and at the annual refresher training.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Obtain approval for the revised definitions as quickly as possible, and promulgate them. 2. Provide clear direction to the Special Investigators and staff supervising or reviewing investigations to use the revised definitions in determining whether allegations of abuse and neglect are substantiated. 3. Include the new SIR definitions in the new employee orientation and at the annual refresher training. 4. Ensure that all employees receive notification of the new SIR definitions. 5. Ensure that the "type" of incident reflects the new SIR definitions.
I.1.a.iii	<p>mechanisms to ensure that, when serious incidents such as allegations of abuse, neglect, and/or serious injury occur, staff take immediate and appropriate action to protect the individuals involved, including removing alleged perpetrators from direct contact with the involved individuals pending the outcome of the facility's investigation;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Provide a copy of the Hospital Police Investigation data report each month to Standards Compliance to enable that department to match the data against its database in order to be sure that all situations that require an SIR have one completed and logged into the Standards Compliance database.</p> <p>Findings: Implementation of this recommendation has resulted in improved performance. See I.1.a.ii.</p>

		<p>Other findings: A review of the relevant section of employee records of three staff members who were found to have engaged in misconduct indicated that they were subjects of discipline. One staff member received a 5% pay reduction for one year due to allegations and findings of physical abuse of an individual; another was terminated for allegations and findings of breach of boundaries with an individual; and a third received a "letter of instruction" for alleged failure to report an incident.</p> <p>Several SI investigations that I reviewed documented that the staff member involved was or was not removed from the unit. For example, in the 12/30/06 incident in which TG alleged that excessive force was used during a take-down, the staff member was not moved off the unit. During the investigation of the 3/1/07 allegation of physical and verbal abuse by EH, the named staff member was reassigned until the investigation was completed. In a 3/31/07 incident of witnessed physical abuse, the named staff member was placed on administrative leave.</p> <p>In the hospital police investigations and the SI investigations reviewed I found no evidence that attention to the medical needs of individuals was denied or delayed.</p> <p>Current recommendation:</p> <ol style="list-style-type: none"> 1. Continue the current practice of matching the hospital police log against the SIR database to ensure that incident reports were completed and logged into the database for all events that meet the SIR definitions. 2. In all incidents of abuse, document whether the named staff member was reassigned or remained on the unit.
--	--	--

Section I: Protection from Harm

<p>I.1.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>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Include in the training not only hospital police but all staff members who may be investigating incidents and those who may be supervising and reviewing the investigations. This would include, but not be limited to, Program Directors, Hospital Administrators, Executive Directors and Central Office staff involved in incident management.</p> <p>Findings: The first two-day training for police officers occurred in July 2007. Fourteen of the approximately 75 officers were trained. The next classes are scheduled for August 2007 and will continue through December 2007 with two classes scheduled each month. The plan includes training for executive and clinical administrators and Program Directors. If a Program Director requests it, Unit Supervisors will also receive training, according to the Special Investigator. The police officers reportedly found the class helpful and appreciated the training opportunity.</p> <p>Recommendation 2, February 2007: Provide "Train the Trainer" training for staff providing the abuse/neglect training at orientation and at the annual refresher to ensure they understand the content and can explain it when necessary in simple, straightforward language.</p> <p>Findings: In an interview, the Senior Special Investigator explained that he includes real-life illustrations of abuse and neglect situations and facilitates discussion around the issues presented in his examples.</p> <p>The Senior Special Investigator completed the Incident Management</p>
-----------------	---	--

		<p>System Instructor's Workshop in April 2007.</p> <p>Recommendation 3, February 2007: Develop a database capable of identifying with accuracy staff persons who have missed specific trainings.</p> <p>Findings: Each of the Program Directors has access to the training database. Staff are expected to take the annual training around the time of their birth date (up to one month before or after their birth month).</p> <p>Orientation training is tracked and the report indicates for each new employee whether a class was satisfactorily completed and, if not, which elements of the course are incomplete. The NSH Compliance report tracks the training history of every staff member and indicates when an employee is out of compliance. This report indicates that no more than 2.5% of the relevant staff was out of compliance on abuse/neglect training in any one of the five programs at the time the data was collected. [Date not specified on the report.]</p> <p>Recommendation 4, February 2007: Develop a system whereby staff members and their supervisors are notified when a staff member has missed training and which ensures that the training is attended in a timely manner.</p> <p>Findings: This recommendation has been implemented. See the finding above.</p> <p>Other findings: A small sample of training records evidenced no problems in providing annual training. A review of the training records of 12 staff members revealed that seven had taken A/N training in 2007. The remaining</p>
--	--	---

Section I: Protection from Harm

		<p>five had not yet had annual training because their birth month is later in the year.</p> <table border="1" data-bbox="1012 302 1715 532"> <thead> <tr> <th>Staff initials</th> <th>Last A/N training</th> <th>Birth month</th> </tr> </thead> <tbody> <tr> <td>RG</td> <td>7/2004</td> <td>November</td> </tr> <tr> <td>--R</td> <td>2/03</td> <td>December</td> </tr> <tr> <td>RJ</td> <td>8/05</td> <td>October</td> </tr> <tr> <td>AH</td> <td>9/02</td> <td>November</td> </tr> <tr> <td>LN</td> <td>11/04</td> <td>July</td> </tr> </tbody> </table> <p>Current recommendations: Continue current practice.</p>	Staff initials	Last A/N training	Birth month	RG	7/2004	November	--R	2/03	December	RJ	8/05	October	AH	9/02	November	LN	11/04	July
Staff initials	Last A/N training	Birth month																		
RG	7/2004	November																		
--R	2/03	December																		
RJ	8/05	October																		
AH	9/02	November																		
LN	11/04	July																		
I.1.a.v	<p>notification of all staff when commencing employment and adequate training thereafter of their obligation to report abuse or neglect to each State hospital and State officials. All staff persons who are mandatory reporters of abuse or neglect shall sign a statement that shall be kept with their personnel records evidencing their recognition of their reporting obligations. Each State hospital shall not tolerate any mandatory reporter's failure to report abuse or neglect;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Employ a system that accurately tracks attendance at training and advises employees and supervisors to ensure attendance.</p> <p>Findings: This recommendation has been implemented. A new database tracks trainings attended and is capable of producing a report that identifies courses missed for any staff member.</p> <p>Other findings: There is some evidence that investigators are aware of the responsibility to report a failure to report an allegation of abuse. In a 3/4/07 incident, GA alleged to a physician that he had been raped. The physician failed to report the allegation for three days. A SIR was written on the failure to report. At the close of the investigation, the Medical Director required the physician to attend additional</p>																		

Section I: Protection from Harm

		<p>training and review the relevant policies.</p> <p>Current recommendation:</p> <ol style="list-style-type: none"> 1. Continue to review SIRs for staff failure to report an incident in a timely manner. Continue to identify delayed reporting when conducting incident investigations, including those completed by the hospital police. 2. Complete an incident reporting form for all instances of delayed reporting or failure to report, including those identified in a hospital police or SI investigation.
I.1.a.vi	<p>mechanisms to inform individuals and their conservators how to identify and report suspected abuse or neglect;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Develop a clinical record monitoring system that identifies those individuals who have not signed the rights acknowledgement at the time of their annual review.</p> <p>Findings: Implementation of this recommendation has begun recently. Documentation was provided that indicated that the record of every individual is being reviewed and individuals are asked to sign the form, if they have not done so in the past year.</p> <p>The hospital added a cell to the Admission Audit form to check whether the individual was made aware of his/her rights within 24 hours of admission.</p> <p>Recommendation 2, February 2007: Develop and use a sign-off sheet where private conservators indicate they have been advised of the rights of the individuals in care and have received a copy of the "How to File a Complaint" procedures.</p>

Section I: Protection from Harm

		<p>Findings: The Social Work department identified 12 individuals who have private conservators and sent certified letters to them in June 2007 informing them of the rights of individuals and of their right to file a complaint. The letter asked for an acknowledgement in a tear-off section at the bottom of the form. At the time of the tour, no acknowledgments had yet been received.</p> <p>Recommendation 3, February 2007: Add a cell on the Admission and Annual Audit form to indicate that the conservator has been made aware of the rights of individuals served and how to file a complaint.</p> <p>Findings: In view of the small number of individuals with private conservators, the method used to comply with the spirit of the recommendation is appropriate.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Repeat the rights mailing to private conservators each year. 2. Continue the audit of clinical records for rights acknowledgement forms to ensure that all are current.
I.1.a.vii	posting in each living unit and day program site a brief and easily understood statement of individuals' rights, including information about how to pursue such rights and how to report violations of such rights;	<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007 Continue current practice.</p> <p>Findings: All units visited had a rights poster on the wall. All individuals I spoke with privately could explain the procedure for making a complaint.</p>

Section I: Protection from Harm

		<p>Current recommendation: Continue current practice.</p>
I.1.a.viii	<p>procedures for referring, as appropriate, allegations of abuse or neglect to law enforcement; and</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007 Continue current practice.</p> <p>Findings: All incidents that might constitute a crime are investigated by the hospital police. A determination is made by the officer and supervisor whether to forward the case to the District Attorney.</p> <p>Other findings: A review of 15 hospital police investigations of peer-to-peer aggression indicated that either there were no injuries to the involved parties, the parties did not wish to press charges, the parties would not cooperate in the investigation or the aggressive event could be considered a misdemeanor but was not reported to the District Attorney because the Napa County DA does not file misdemeanor charges against NSH individuals. In none of the incidents reviewed were individuals seriously injured.</p> <p>Current recommendation: Clearly document the reason why cases are closed without referral to the District Attorney in the Disposition section of the report.</p>
I.1.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</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Ensure that AD 355 is reviewed during abuse/neglect orientation and</p>

Section I: Protection from Harm

	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.	annual training. Findings: This recommendation has been implemented. Current recommendation: Continue current practice.
I.1.b	Each State hospital shall review, revise, as appropriate, and implement policies and procedures to ensure the timely and thorough performance of investigations, consistent with generally accepted professional standards of care. Such policies and procedures shall:	Compliance: Partial.
I.1.b.i	require investigations of all deaths, as well as allegations of abuse, neglect, serious injury, and theft. The investigations shall be conducted by qualified investigator(s) who have no reporting obligations to the program or elements of the facility associated with the allegation and have expertise in conducting investigations and working with persons with mental disorders;	Current findings on previous recommendations: Recommendation 1, February 2007: Ensure that investigation files are complete. This includes Headquarters briefing forms. Findings: Headquarters briefing forms were not included in the investigation report files I reviewed. This finding is not consistent with the hospital's self-assessment that indicated all reviewed investigation files (average sample= 29%, with no more than 2 investigation forms audited for any single month) were complete in the period February through June 2007. Recommendation 2, February 2007: Open discussions with the Patients Rights Advocate (PRA) to identify a system to provide feedback at the close of those investigations that originated in the PRA Office. This system should likewise ensure that

Section I: Protection from Harm

		<p>all allegations received through the PRA Office are filed on an SIR and SOC 341, as appropriate.</p> <p>Findings: Discussions with the PRA on a proposed mechanism for feedback using the recently revised Headquarters Reportable Brief form was initiated in mid-June 2007. Closure on the issue is expected soon.</p> <p>Recommendation 3, February 2007: Critically review abuse/neglect allegations to ensure that all staff members are subject to the same level of corrective actions regardless of rank.</p> <p>Findings: The hospital held a discussion about the supervisory response to abuse and neglect on July 12, 2007 at the General Management meeting. This was followed on July 18 by a memo that states, in small part, that the hospital maintains a zero tolerance for abuse and neglect by any employee, regardless of rank. It further states that supervisors will "apply the principles of progressive discipline."</p> <p>Recommendation 4, February 2007: Identify and implement a death review process that measures the actions of staff, regardless of rank, against professional standards, performance expectations, and dependent adult abuse and neglect definitions.</p> <p>Findings: The Mortality Review Committee minutes provide sufficient information to indicate that the clinical record was reviewed and discussion followed. The February minutes recommend that the Bioethics Committee clarify "procedures and opportunities for terminal</p>
--	--	--

Section I: Protection from Harm

		<p>care planning" including revisions that may be necessary to Administrative Directives to expand the physician's role in discussing with patients the risks and benefits of various choices.</p> <p>Other findings: A review of the Special Investigator incident log for January through May 2007 indicates that nine of the 32 incidents were referred back to the Program Director for action. Since the Program Director supervises the staff in question, this practice violates this section of the Enhancement Plan. It must be noted, however, that there are only two Special Investigators at NSH. It would be impossible for these men to personally investigate every death and incident of staff misconduct and complete their other duties, which include new staff orientation training. Thus, the practice of referring investigations back to the program was the product of necessity. During the January-February 2007 visit, the addition of two additional investigators was anticipated shortly. These hirings did not occur. No additional staff are expected to be hired until January 2008.</p> <p>The SI investigation of the death of PL on 1/24/07 was incomplete. This monitor's review of the SI investigation regarding the death showed that the investigation failed to address serious process deficiencies that required further inquiry as well as recommendations for corrective actions (e.g. inaccurate documentation by third parties in the nursing department and an entry by the on-call physician that did not appear to be corroborated by autopsy findings).</p> <p>Current recommendations:</p> <ol style="list-style-type: none">1. Hire additional Special Investigators as quickly as possible.2. Give secretarial and other support to the Office of Special Investigator to assist them in meeting their work demands.3. Assign Standards Compliance to review the investigations and
--	--	---

Section I: Protection from Harm

		<p>completed monitoring forms to improve objectivity. While the number of investigations remains small, a sample of at least 50% should be used.</p> <p>4. Officers approving investigation reports need to read them critically.</p>
I.1.b.ii	<p>ensure that only the State Hospital staff who have successfully completed competency-based training on the conduct of investigations be allowed to conduct investigations of allegations of petty theft and all other unusual incidents;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Approve the curriculum.</p> <p>Findings: The curriculum has been approved and the first class has been conducted. See I.1.a.iv, Recommendation 1 for further details.</p> <p>Recommendation 2, February 2007: Mandate that Program Directors and any other staff who will be investigating, supervising or reviewing incident investigations be trained in this curriculum.</p> <p>Findings: See I.1.a.iv, Recommendation 1 for further details.</p> <p>Current recommendations: Continue the Incident Management training as planned.</p>
I.1.b.iii	<p>investigations required by paragraph I.1.b.i, (above) provide for the safeguarding of evidence;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Continue current practice.</p> <p>Findings:</p>

Section I: Protection from Harm

		<p>In my review of 29 Special Investigator and 15 hospital police investigations, I found no instances where evidence was not safeguarded.</p> <p>Other findings: On six of 13 hospital police investigation monitoring forms, the items related to evidence were incorrectly scored as a "No" when they should have been scored "Not Applicable." [One investigation did not have a monitoring form attached and one had an incomplete form, resulting in the review of 13 rather than 15 investigation forms.]</p> <p>Current recommendation: Provide guidance for police officers completing and supervising the monitoring forms to reduce errors.</p>
I.1.b.iv	<p>investigations required by paragraph I.1.b.i, (above) require the development and implementation of standardized procedures and protocols for the conduct of investigations that are consistent with generally accepted professional standards. Such procedures and protocols shall require that:</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Continue the review of investigations by hospital police supervisors and continue to require the supervisor's signature indicating that the investigation meets professional standards.</p> <p>Findings: All Special Investigator investigations and hospital police investigations reviewed included the signature of a supervising officer.</p> <p>Other findings: Problems in some SI investigations are discussed in this section of the report. These deficiencies were not identified and addressed by the police officer who approved the final investigation reports.</p>

Section I: Protection from Harm

		<p>Current recommendation: Identify shortcomings in investigations and provide assistance and mentoring as appropriate.</p>
<p>I.1.b. iv.1</p>	<p>investigations commence within 24 hours or sooner, if necessary, of the incident being reported</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Hire and train the new Special Investigators as quickly as possible.</p> <p>Findings: This recommendation has not been implemented. New Special Investigators will most likely not be hired until early 2008.</p> <p>Other findings: There is some evidence that notification of abuse/neglect allegations are not being forwarded to the Office of Special Investigator in a timely manner. For example, the 3/1/07 allegation of physical abuse by EH was faxed to the Hospital Police Dispatch on 3/2/07, but was not received by the Office of Special Investigator until 3/16/07. Similarly, an allegation of physical abuse reported on 2/7/07 on behalf of RJ was not referred to the Special Investigator until 2/15/07.</p> <p>A similar problem is evident in a review of the Hospital Police (HP) investigation log for May 2007 that indicates that they were notified of seven of the incidents within five days of the date reported, 14 incidents were forwarded to HP within 6-15 days, 18 incidents within 16-30 days, and five were forwarded 30 days or more after the incident.</p> <p>Current recommendation:</p> <ol style="list-style-type: none"> 1. Hire and train the new Special Investigators as quickly as possible. 2. Determine the reason for the delay in some cases reaching the

Section I: Protection from Harm

		<p>Special Investigator's office and the Hospital Police and take action to remedy the problem.</p>
<p>I.1.b. iv.2</p>	<p>investigations be completed within 30 business days of the incident being reported, except that investigations where material evidence is unavailable to the investigator, despite best efforts, may be completed within 5 business days of its availability;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Continue to triage investigations as long as the Office of Special Investigator is not fully staffed.</p> <p>Findings: The Office continues to triage investigations because of staffing limitations. Those cases considered least serious are sent back to the Program after a preliminary investigation consisting of interviews of the principals, sometimes over the phone. The Special Investigator log indicates that nine of the 32 cases worked on from January 1 through mid-May (28%) were referred back to the Program.</p> <p>Other findings: 19 of the 29 investigations reviewed (66%) were completed within 30 business days. This finding is consistent with the hospital data which indicates a 76% compliance rate on the 24 investigations sampled in the months January through May 2007. The rate for January and February was 100%, but fell to 60% for the final three months of the period.</p> <p>Current recommendation:</p> <ol style="list-style-type: none"> 1. Continue triaging cases when absolutely necessary. 2. Ensure that Special Investigators use the revised SIR definitions to prevent cases that should be substantiated from being sent back to the program.

Section I: Protection from Harm

<p>I.1.b. iv.3</p>	<p>each investigation result in a written report, including a summary of the investigation, findings and, as appropriate, recommendations for corrective action. The report's contents shall be sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly and separately:</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation February 2007: Construct a uniform investigation file that captures all of the corrective actions taken in response to an incident.</p> <p>Findings: This recommendation has been partially implemented. Some investigation reports included documentation that the report was forwarded to Human Resources or to the Program Director or another supervisor for action. However, NSH still does not have a system for impartially reviewing incidents for corrective actions, i.e., a review system that includes administrators and clinicians not supervising the staff or individuals involved in the incident.</p> <p>Some corrective measures are documented on the Headquarters Reportable Brief form. Since this form was introduced in the spring and there is a 90-day time period for completion, it is too early to evaluate whether the form has served one of its purposes-- provoking thoughtful identification of factors contributing to an incident.</p> <p>Other findings: Two investigations of verbal abuse reviewed (3/5/07 incident involving TK and the 2/16/07 incident involving EP) were determined to be unfounded based on penal law that requires some evidence of mental suffering on the part of the victim. Penal law is not the appropriate measure in a SI investigation of abuse/neglect.</p> <p>NSH has not developed a system for the identification of programmatic and systemic incident review. One method to ensure this kind of review is through an Incident Review Committee that meets regularly and reviews incidents, investigations, data reports and trend</p>
------------------------	---	---

Section I: Protection from Harm

		<p>and pattern reports when they become available.</p> <p>Current recommendation:</p> <ol style="list-style-type: none"> 1. Ensure that the rationale for determinations (substantiated or not) references the revised SIR definitions and the level of proof. 2. Consider forming an Incident Review Committee.
I.1.b. iv.3 (i)	each allegation of wrongdoing investigated;	<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Continue current practice.</p> <p>Findings: In two of the investigation reports reviewed, additional allegations surfaced during the investigations that were not investigated. In a physical abuse investigation (12/30/06 incident involving TG), a second allegation was made that the staff person involved threatened to have TG's pain medication discontinued. There was no investigation of this allegation of psychological abuse. In an investigation of verbal abuse (3/16/07 involving JC) there is a <u>suggestion</u> of drug use on the unit. This was not explored to determine if staff were actually indicating they knew about drug use.</p> <p>Current recommendation: Ensure that information that surfaces during the investigation of another incident and that may constitute an incident in its own right is identified, reported and investigated.</p>
I.1.b. iv.3 (ii)	the name(s) of all witnesses;	<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Consider other individuals and staff, beyond those identified on the</p>

Section I: Protection from Harm

		<p>incident report, who may have heard or seen an incident. Document attempts to find these persons and interview them.</p> <p>Findings: This recommendation has been inconsistently implemented.</p> <p>Other findings: Several of the incidents reviewed occurred in public areas where there may have been staff or individuals who heard or saw the incident, but there is no documentation that this possibility was explored. For example:</p> <ul style="list-style-type: none">• The investigation of the 2/23/07 allegation made by SC that she was physically injured when she was being forced to accept medication documents that the IM medication was administered in the dayroom. [There was no discussion of the privacy violation that is evident.]• JC alleged on 3/11/07 that a named staff member made fun of him and others on the unit. The only persons interviewed were the alleged victim and the alleged perpetrator. <p>EL alleged that he was injured by staff he could not identify. He had two black eyes, but was known to engage in self-injurious behavior. There was no attempt to identify anyone who could shed light on the origin of EL's injuries. [Incident date was 2/11/07.]</p> <p>In contrast to the above, in the investigation of verbal abuse made by JC on 3/16/07 documentation states, "There were no other staff or clients in the immediate area."</p> <p>Current recommendation: Consider other individuals and staff, beyond those identified on the</p>
--	--	--

Section I: Protection from Harm

		incident report, who may have heard or seen an incident. Document attempts to find these persons and interview them.
I.1.b. iv.3 (iii)	the name(s) of all alleged victims and perpetrators;	<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Continue current practice.</p> <p>Findings: All investigations reviewed clearly identified all alleged victims and perpetrators.</p> <p>Current recommendation: Continue current practice.</p>
I.1.b. iv.3 (iv)	the names of all persons interviewed during the investigation;	<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Be cognizant of the location of interviews both while conducting the investigation and in reviewing completed investigations to ensure privacy wherever possible.</p> <p>Findings: Several SI investigations specifically noted that privacy was a consideration when conducting interviews.</p> <p>Other findings: In five of the SI investigations, one or more staff members were interviewed by telephone. While this practice is favored as a time-saving measure, it is poor practice nonetheless. This is particularly the case when the phone interview occurs considerably after the event in question. This occurred in the investigation of the 2/6/07 allegation</p>

Section I: Protection from Harm

		<p>of physical abuse made on behalf of JM. A staff witness was interviewed by phone seven weeks after the incident on 4/2/07.</p> <p>Current recommendation: Avoid phone interviews unless there is no reasonable alternative.</p>
<p>I.1.b. iv.3 (v)</p>	<p>a summary of each interview;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Continue current practice.</p> <p>Findings: All SI investigations reviewed included a summary of each interview.</p> <p>Other findings: As noted in I.1.b.iv.3(iv), some interviews are being conducted weeks after the event. Other examples include the following:</p> <ul style="list-style-type: none"> • MR alleged on 3/6/07 that a named staff member scratched him with a key. MR was not interviewed until 3/29/07. • No interview of the physician who is alleged to have failed to respond to a medical emergency on 6/24/07 had been completed at the time of the tour a month later. • A staff witness to an alleged incident of physical abuse that was reported on 3/16/07 involving SC was not interviewed until 4/20/07, and the interview was conducted over the phone. <p>Current recommendation: Conduct interviews as close to the time an incident is reported as possible.</p>

Section I: Protection from Harm

<p>I.1.b. iv.3 (vi)</p>	<p>a list of all documents reviewed during the investigation;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Continue current practice.</p> <p>Findings: A list of documents reviewed is included in the investigation.</p> <p>Other findings: At the time of the investigation of an incident occurring on 2/11/07 that involved EL alleging he was hurt by two staff, EL was found to have two black eyes. EL was inconsistent in interviews saying the injury was caused by staff and also saying he was hit by a train. The investigator determined that the allegation was not substantiated and might have been self-inflicted. This determination was made without reading EL's record to determine if eye injuries were consistent with his pattern of self-injurious behavior and without consulting his treating clinicians.</p> <p>Current recommendation: Consult WRPs, other documents, and clinicians as necessary during investigations.</p>
<p>I.1.b. iv.3 (vii)</p>	<p>all sources of evidence considered, including previous investigations and their results, involving the alleged victim(s) and perpetrator(s);</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Document in the investigation that the incident history of the victim and the alleged perpetrator was reviewed and indicate the findings from this search.</p> <p>Findings: This recommendation has been partially implemented.</p>

Section I: Protection from Harm

		<p>Other findings: In many of the investigations reviewed, the investigator has indicated that there is "no prior contact", meaning that the victim and the alleged perpetrator are not in the SI investigation database.</p> <p>Current recommendation: Continue current practice. When it is operational, run the victims and alleged perpetrators through the incident management database, which will provide a more comprehensive view of the incident history of the persons involved.</p>
<p>I.1.b. iv.3 (viii)</p>	<p>the investigator's findings, including findings related to the substantiation of the allegations as well as findings about staff's adherence to programmatic requirements; and</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Use DMH definitions in writing rationales for determinations. Apply the facts of the case to the definitions.</p> <p>Findings: This recommendation has not been implemented.</p> <p>Other findings: As noted in I.1.b.iv.3, some investigations are being judged using penal law rather than SIR definitions.</p> <p>Several investigations fail to make a convincing rationale for the determination (substantiated or unsubstantiated). For example: A physician made an allegation on behalf of JM stating that he saw a staff member "forcefully swing" JM out of a doorway on 2/6/07. The physician stated that his stomach sank when he saw the encounter. The alleged perpetrator said he gently redirected JM. Two staff witnesses were interviewed by phone six and seven weeks later. One</p>

Section I: Protection from Harm

		<p>could not remember the incident, but knew he did not witness abuse. The second said the staff member in question just put his hand on JM's shoulder. The investigator concluded the allegation was not substantiated. He reasoned, "Because the staff placed his hand on JM's shoulder, together with JM's unsteady gait (a fact that did not appear in the body of the report), it could have appeared to the reporter that [the staff] used excessive force."</p> <p>Current recommendation: Exercise caution in writing determination rationales to ensure they are based on findings in the report and address conflicting evidence.</p>
<p>I.1.b. iv.3 (ix)</p>	<p>the investigator's reasons for his/her conclusions, including a summary indicating how potentially conflicting evidence was reconciled; and</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Ensure that investigation reports explicitly discuss conflicting information and how it is being reconciled or, if reconciliation is not possible, why one set of facts is believed credible and another is not.</p> <p>Findings: Conflicting evidence was not addressed in some investigations. For example: A staff member alleged he saw two named staff use excessive force in hyper-extending HP's arms behind his back on 12/31/06. The reporting staff member was providing 1:1 supervision of HP. One of the staff alleged to have used excessive force said that the reporting staff member did not see the incident because he was on a bathroom break. This conflicting evidence was not reconciled, but the case was determined unsubstantiated.</p> <p>Current recommendation: Ensure that investigation reports explicitly discuss conflicting information and how it is being reconciled or, if reconciliation is not</p>

Section I: Protection from Harm

		possible, why one set of facts is believed credible and another is not.
I.1.b. iv.4	staff supervising investigations review the written report, together with any other relevant documentation, to ensure that the investigation is thorough and complete and that the report is accurate, complete, and coherent. Any deficiencies or areas of further inquiry in the investigation and/or report shall be addressed promptly. As necessary, staff responsible for investigations shall be provided with additional training and/or technical assistance to ensure the completion of investigations and investigation reports consistent with generally accepted professional standards of care.	<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Look carefully for these types of problems and correct them and any others before investigation reports are finalized.</p> <p>Findings: The deficiencies in the investigations cited in this portion of the report were not identified and corrected by the staff supervising the investigations and written reports.</p> <p>Current recommendation: Look carefully for problems in the investigation and in the written report and correct them before investigation reports are finalized.</p>
I.1.c	Each State Hospital shall ensure that whenever disciplinary or programmatic action is necessary to correct a situation or prevent reoccurrence, each State hospital shall implement such action promptly and thoroughly, and track and document such actions and the corresponding outcome.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Undertake a review of the physician's actions cited above and determine if the response taken (or the lack of action taken) is consistent with the disciplinary actions in similar incidents that did not involve physicians.</p> <p>Findings: There was no evidence produced that this recommendation was specifically addressed.</p> <p>Recommendation 2, February 2007: Consider the advisability of putting in writing minimum disciplinary measures to be taken for specific violations involving abuse and neglect</p>

Section I: Protection from Harm

		<p>to ensure even-handedness.</p> <p>Findings: The memo dated July 18, 2007 set a minimum expectation that an employee "whose act or omission is found to constitute neglect or abuse will receive a written counseling which will be filed in the official personnel file."</p> <p>Recommendation 3, February 2007: Compile a complete investigation file.</p> <p>Findings: Completed Headquarters Reportable Brief forms should be placed in completed investigation files, so that there is one place where a full account of an incident investigation can be found.</p> <p>Other findings: See I.1.a.iii for findings related to disciplinary actions in instances of staff misconduct.</p> <p>Compliance: Partial.</p> <p>Current recommendations: Consider instituting an Incident Review Committee (by whatever name), one of the duties of which would be the identification of programmatic and systemic corrective actions.</p>
I.1.d	<p>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>	<p>Compliance: Partial.</p> <p>To varying degrees, all of the hospitals are waiting for the WaRMSS</p>

Section I: Protection from Harm

		<p>Incident Management System to be up and running before they start producing regular, periodic reports using the incident variables identified in the EP. NSH is producing some limited trend information, as indicated in the cells below.</p>
I.1.d.i	type of incident;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Create a timeline for the development of an integrated incident management system.</p> <p>Findings: Testing for the statewide Incident Management System reportedly will begin in November 2007 and should be operational in January-February 2008.</p> <p>Recommendation 2, February 2007: Begin producing monthly reports on incidents by type and level of injury initially.</p> <p>Findings: This recommendation has been partially implemented. The Standards Compliance Office has produced a quarterly report of victims of repeat aggression that included the level of injury.</p> <p>Recommendation 3, February 2007: Ensure that the reports identify persons being hurt and persons doing the hurting, particularly those whose names appear repeatedly.</p> <p>Findings: This recommendation has been implemented. NSH is producing a quarterly report that identifies victims and aggressors. See I.2.a.iii.</p>

Section I: Protection from Harm

		<p>Recommendation 4, February 2007: Distribute these reports to those persons who can initiate a clinical and/or administrative response and monitor its effectiveness.</p> <p>Findings: The reports cited above have been distributed to the Program Directors.</p> <p>Other findings: The Standards Compliance Office has also produced a trend report that tracks the total number of unique incidents by month for the period January 2006 through June 2007. 618 unique incidents were reported in the first six months of 2007 compared with 456 incidents in the same period in 2006—a 36% increase.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue current practice of trending incidents. 2. An appropriate committee, perhaps the Risk Reduction Committee or Incident Review Committee if established, should review this trend report and match it with type and injury level data to understand the dimensions and implications of this increase in incidents.
I.1.d.ii	staff involved and staff present;	<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Continue to work on the capacity to generate useful reports on a regular basis.</p> <p>Finding: NSH is producing a monthly listing of incidents that identifies the</p>

Section I: Protection from Harm

		<p>staff members alleged to have engaged in misconduct. This information is not reviewed over time in order to identify patterns. The capacity to produce reports that identify staff indirectly involved will be available when the new Incident Management System is operational early in 2008.</p> <p>Current recommendation:</p> <ol style="list-style-type: none"> 1. Continue work on the Incident Management System and make it available to the hospitals as soon as possible. 2. Begin producing monthly reports that will serve as the basis for tracking and trending.
I.1.d.iii	individuals directly and indirectly involved;	<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Same as above.</p> <p>Finding: The monthly investigation tracking log identifies the individuals involved in incidents.</p> <p>Other findings: Identification of individuals indirectly involved in incidents will be available when the WaRMSS Incident Management System is operating.</p> <p>Current recommendation: Continue current practice of identifying individuals involved in incidents. Look for patterns among individuals who appear frequently.</p>

Section I: Protection from Harm

I.1.d.iv	location of incident;	<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Same as above.</p> <p>Finding: Incident trending by location is not yet occurring.</p> <p>Current recommendation:</p> <ol style="list-style-type: none"> 1. Consider the variables that the EP identifies as requiring tracking and trending. Identify those that would be most helpful to the hospital and begin tracking those variables initially. 2. Undertake more comprehensive tracking when the Incident Management System comes online.
I.1.d.v	date and time of incident;	<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Same as above.</p> <p>Finding: The Investigations Tracking log produced monthly identifies the date of the incident.</p> <p>Other findings: Data regarding time of incidents for the period January–June 2007 compiled by the Standards Compliance Office indicates that nearly one-third of the incidents (31.89%) occurred in the three-hour period between 5:00 and 8:00PM.</p> <p>Current recommendation:</p> <ol style="list-style-type: none"> 1. See I.1.d.iv recommendations.

Section I: Protection from Harm

		<p>2. Present the data on time of incidents to the Cooperative Council. It may be useful to the members in their work as Peacemakers.</p>
I.1.d.vi	cause(s) of incident; and	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Commit to doing a thorough causal analysis that concludes in a written report for very serious incidents.</p> <p>Findings: This recommendation has been partially implemented. With the introduction of the revised Headquarters Reportable Brief form, hospitals are asked to identify the factors that contributed to the serious incident. It is too early to determine if the form is being completed in such a way that it fulfills this objective.</p> <p>Recommendation 2, February 2007: Consider permitting "cause" to be labeled "unknown" for those incidents that are not serious (as defined above) and where the cause is not apparent.</p> <p>Findings: Some investigations reviewed listed "unknown" as the cause.</p> <p>Other findings: The cause of some investigations is still being determined by guesses on the part of the investigator, e.g. retaliation for losing a grounds card. In other investigations the cause is identified as "false report." This can be construed as implying malicious intent, when the investigator does not mean to imply such. <i>It has been agreed for all hospitals that the intent of this section of the EP will be met if the "Contributing Factors" section of the HQ briefing form is completed</i></p>

Section I: Protection from Harm

		<p><i>conscientiously.</i></p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Complete Headquarters Reportable Brief forms thoughtfully. Monitor the forms to ensure that they are completed so as to fulfill the intent of this section of the EP. 2. Avoid guessing the cause of an incident when there is no evidence to support the guess.
I.1.d.vii	outcome of investigation.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Develop a report form that included essential basic information, type of incident, location and date and disposition as a first step in supplying the hospital with regular incident data.</p> <p>Findings: This recommendation has been implemented. The investigation tracking log identifies the incident type, date, individuals involved and the disposition/outcome.</p> <p>Recommendation 2, February 2007: Provide the names of alleged victims and perpetrators in incidents involving serious injury, death, abuse and neglect in a separate report that also includes type and date, so that the hospital can begin to identify repeat victims and aggressors.</p> <p>Findings: This recommendation has been implemented. NSH prepared and distributed to Program Directors a list of victims of more than one assault during the period April 1, 2007 through June 30, 2007. This list included the location, time of the assault and level of treatment</p>

Section I: Protection from Harm

		<p>required. There is as yet no analysis of patterns and no expectation of a response from the WRT of those individuals who appear repeatedly over time.</p> <p>Current recommendations: Determine what response(s) the hospital expects when an individual repeatedly is identified as an aggressor or a victim over time.</p>
I.1.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>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Continue current practice.</p> <p>Findings: The facility has identified a series of courses (F category) that non-clinical providers of Mall groups must take. This curriculum includes elder/dependent abuse/neglect training and Mental Health 101.</p> <p>Other findings: Review of the personnel files of 12 staff members indicated that documentation of background checks was available in the files of all but three staff who were hired many years ago. The HR Director said that in the recent past hospital police ran background checks on all staff hired before background checks were required and keeps this information in its database.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>

Section I: Protection from Harm

I.2	Performance Improvement	
	<p>Each State hospital shall develop, revise as appropriate, and implement performance improvement mechanisms that enable it to comply fully with this Plan, to detect timely and adequately problems with the provision of protections, treatment, rehabilitation, services and supports, and to ensure that appropriate corrective steps are implemented. Each State hospital shall establish a risk management process to improve the identification of individuals at risk and the provision of timely interventions and other corrective actions commensurate with the level of risk. The performance improvement mechanisms shall be consistent with generally accepted professional standards of care and shall include:</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. C. Black, Standards Compliance Director 2. D. Matteucci, Hospital Administrator <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Aggregate trigger data 2. Trigger threshold definitions 3. WaRMSS Trigger Response Administrative Directive 4. Close observation ACT monitoring sheets 5. Comparison of selected trigger and SIR data
I.2.a	<p>Mechanisms for the proper and timely identification of high-risk situations of an immediate nature as well as long-term systemic problems. These mechanisms shall include, but not be limited to:</p>	<p>Compliance: Partial.</p> <p>NSH is dependent on the WaRMSS Quick Hits module for capturing the majority of trigger data. This system was supposed to be operational by July 1, but technical problems have slowed getting the system online. In the meantime, NSH has developed systems for monitoring restraint and seclusion use and, more recently, enhanced supervision.</p>
I.2.a.i	<p>data collection tools and centralized databases to capture and provide information on various categories of high-risk situations;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Identify for hospital administrators and Program Directors the individuals who are hitting triggers in a timely manner.</p>

Section I: Protection from Harm

		<p>Findings: This recommendation has been implemented for one protection from harm trigger and for restraint and seclusion use.</p> <p>Recommendation 2, February 2007: Identify and promulgate expectations regarding the treatment response when an individual hits a trigger. This may include a list of possible actions to take, but the list should be specific to each Key Indicator.</p> <p>Findings: This recommendation has been implemented for one protection from harm trigger.</p> <p>Recommendation 3, February 2007: Develop a system for receiving feedback from the units on the measures taken.</p> <p>Findings: This recommendation has been implemented for one protection from harm trigger.</p> <p>Recommendation 4, February 2007: Develop a system for monitoring (on a sample basis) implementation of these measures.</p> <p>Findings: This recommendation has been implemented in a limited fashion as described below.</p> <p>Other findings:</p>
--	--	--

Section I: Protection from Harm

		<p>The hospital has identified the individuals who have reached Trigger #12, one-to-one observation. Four administrative/clinical teams (ACTs) reviewed eight individuals on this enhanced observation status between May 24 and June 22, 2007. Work was begun on a second set of reviews in July.</p> <p>The teams complete a form for each individual that questions whether the behavior warranting the increased supervision is referenced as a focus of hospitalization, whether there is a crisis intervention plan, behavioral guidelines or a positive behavioral support plan. The form concludes with the comments and recommendations of the ACT.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue current use of ACT as related to Trigger #12. 2. Identify an equally effective method for ensuring an appropriate response when an individual reaches other protection from harm triggers.
I.2.a.ii	<p>establishment of triggers and thresholds that address different levels of risk, as set forth in Appendix A; and</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: See I.2.a.i.</p> <p>Recommendation 2, February 2007: Continue the work of reviewing and revising ADs that deal with Key Indicators.</p> <p>Findings: The WaRMSS Trigger Response Administrative Directive has an effective date of July 1, 2007. This AD outlines the initial response when a trigger behavior occurs, noting that it will be guided by the individual's assessed needs and by policy and procedures. Subsequent</p>

Section I: Protection from Harm

		<p>sections provide direction to WRTs and clinical and administrative leadership on fulfilling their responsibilities once the WaRMSS system is operational.</p> <p>Current recommendations: Continue work on the WaRMSS Incident Management System so that it becomes available as soon as possible.</p>
I.2.a.iii	<p>identification of systemic trends and patterns of high risk situations.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Use the SIR database to produce reports that identify high-risk individuals (repeat victims and repeat perpetrators) and high-risk situations (location, time, shift, weekend vs. weekdays, etc.) Distribute widely the information that does not include individuals' names. Distribute reports with individuals' names to the appropriate clinicians and administrators who can effect change. Monitor on a selective basis the implementation and effectiveness of corrective actions.</p> <p>Findings: This recommendation has been partially implemented.</p> <p>Other findings: NSH prepared and distributed to Program Directors a list of victims of more than one assault during the period April 1, 2007 through June 30, 2007. This list included the location, time of the assault and level of treatment required. An unduplicated count reveals that 17 individuals met this criterion. 15 of the 17 were the victims in two or three assaults. One individual was involved in five and another in eight. This report was also completed for the first quarter of 2007 and for the one-year period January 2006 through December 31, 2006.</p>

Section I: Protection from Harm

		<p>The trigger report is distributed monthly to managers and clinical leadership.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue current practice of identifying individuals who are repeat victims and aggressors. 2. Identify individuals who appear repeatedly over time using the earlier and current report. 3. Develop a system to ensure that victimization is addressed in an individual's WRP when it is recurring.
I.2.b	<p>Mechanisms for timely interventions and other corrective actions by teams and disciplines to prevent or minimize risk of harm to individuals. These mechanisms shall include, but not be limited to:</p>	<p>Compliance: Partial.</p>
I.2.b.i	<p>a hierarchy of interventions by clinical teams that correspond to triggers and thresholds;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation February 2007: Continue work on developing a system for identifying persons who hit a trigger, for developing a menu of possible responses and a method for the return of information regarding the implementation of the response to Standards Compliance.</p> <p>Finding NSH reports that information from the new HQ Reportable Brief form will be helpful in identifying a hierarchy of interventions in response to triggers and other threshold markers. Presently NSH does not use a menu of interventions to track a WRPT's response when an individual reaches a trigger.</p>

Section I: Protection from Harm

		<p>Current recommendation: Consider whether an interim measure may be necessary in devising a menu of responses for when an individual reaches a trigger, as waiting for HQ Reportable Briefs as the source from which to draw this menu may delay the development.</p>
I.2.b.ii	<p>timely corrective actions by teams and/or disciplines to address systemic trends and patterns;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Enlarge the sample of individuals interviewed and use follow-up questions to identify the source of the problem. For example, if individuals are signing the form indicating they were advised of their rights, but are also indicating on the survey that they were not taught their rights, is the problem that they do not understand the form and it is not explained?</p> <p>Findings: The hospital reported that in the last six months, 114 individuals from Programs 1,2, and 3 responded to a survey by the Cooperative Council which asked whether they were taught what constitutes abuse and neglect and whether they were taught what their rights are:</p> <ul style="list-style-type: none"> • 63 individuals responded yes (55%) • 45 responded no (39%) • 6 did not respond with a reasonable answer (5%). <p>Recommendation 2, February 2007: Identify and implement measures to address the survey items that are of the most concern.</p> <p>Findings: Specific staff and administrators are invited to the Cooperative</p>

Section I: Protection from Harm

		<p>Council and asked to explain situations/delays/policies that are of concern to the members. For example, the Hospital Administrator will be at an early August meeting. During the Cooperative Council meeting I attended, there was a general sense that the administration is responsive to their requests for information.</p> <p>Recommendation 3, February 2007: Initiate reviews of logs and charts and interviews on the units to detect under-reporting of incidents.</p> <p>Findings: This recommendation has been partially implemented. Standards Compliance staff review the HSS log, NOD log and Patrol log looking for incidents. Standards Compliance has not done random interviews.</p> <p>Current recommendations: Continue current practice in reviewing logs for incidents that require reporting. Initiate random interviews when staffing permits.</p>
I.2.b.iii	<p>formalized systems for the notification of teams and needed disciplines to support appropriate interventions and other corrective actions;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Begin work on a system for notifying programs and disciplines of individuals and situations that require their attention because triggers have been hit as recommended in I.2.a.i.</p> <p>Findings: This recommendation has been implemented for those individuals who reach the enhanced supervision trigger as described earlier.</p> <p>Current recommendation: 1. Continue the work of the Administrative/Clinical Team.</p>

Section I: Protection from Harm

		<p>2. Identify an equally effective method for ensuring an appropriate response when an individual reaches other protection from harm triggers.</p>
I.2.b.iv	<p>formalized systems for feedback from teams and disciplines to the standards compliance department regarding completed actions; and</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007 Continue work on the development of a feedback loop. Perhaps initially a simple check-off sheet returned to Standards Compliance, in which the unit indicates from a menu of possible actions the one taken, returned to Standards Compliance, could be an initial step before a full data system is available.</p> <p>Findings: As documented previously, NSH has developed an effective system for monitoring the use of enhanced supervision. Responses to other protection from harm triggers are not monitored.</p> <p>Current recommendation: See I.2.b.iii.</p>
I.2.b.v	<p>monitoring and oversight systems to support timely implementation of interventions and corrective actions and appropriate follow up.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: See I.2.b.iv.</p> <p>Findings: See I.2.b.iv</p> <p>Current recommendation: See I.2.b.iii.</p>

Section I: Protection from Harm

<p>I.2.c</p>	<p>Utilize, on an ongoing basis, appropriate performance improvement mechanisms to assess and address the facility's compliance with its identified service goals.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Continue work in improving the self-assessment tools as suggested in this report.</p> <p>Findings: The major self-assessment tool presently in use related to incident management and performance improvement is the Investigations Monitoring form. Overall, the form is scored generously by officers. For examples, in response to the question whether standardized procedures and established protocols were followed, 100% compliance was recorded. However, some investigations evidenced a failure to seek additional witnesses, failure to review necessary documents and seek the opinion of treating clinicians, the interview of witnesses over the phone and many weeks after the event and inadequate, unconvincing rationales for determinations. These practices are not in compliance with standard investigation procedures.</p> <p>Recommendation 2, February 2007: Begin to validate the data using staff members not directly involved with the issue.</p> <p>Findings: This recommendation has not been implemented as the investigator who handles the investigation completes the form and supervisors are not identifying errors in the forms. There is no independent review of a sample of the forms and investigations.</p> <p>Compliance: Partial.</p>
--------------	--	--

Section I: Protection from Harm

		<p>Current recommendations:</p> <ol style="list-style-type: none">1. Agree on standard procedures for investigations.2. Implement impartial validation of a sample of the forms.
--	--	--

Section I: Protection from Harm

I.3	Environmental Conditions	
	<p>Each State hospital shall develop and implement a system to review regularly all units and areas of the hospital to which individuals being served have access to identify any potential environmental safety hazards and to develop and implement a plan to remedy any identified issues, consistent with generally accepted professional standards of care. Such a system shall require that:</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. M. McQueeney, Assistant Hospital Administrator 2. V. Garcia, Chief of Plant Operations 3. L. Radford, Supervising RN in the Environmental Risk Reduction Project <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Environmental Issues/Risk Report for June 2007 2. Environment of Care Risk Reduction Tracking Sheet for June 2007 3. Environment of Care Executive Summary January—June 2007 <p><u>Toured:</u></p> <ol style="list-style-type: none"> 1. Six residential units 2. Environmental Risk Reduction Project worksite
I.3.a	<p>Potential suicide hazards are identified and prioritized for systematic corrective action, and such action is implemented on a priority basis as promptly as feasible;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Determine whether the plastic holders for toilet seat covers constitute a hazard.</p> <p>Findings: NSH determined that the plastic covers were a suicide hazard and has found a substitute.</p> <p>Recommendation 2, February 2007: Continue work on identifying and correcting suicide and self-injury hazards.</p>

		<p>Findings: NSH has identified and ranked environmental risks using a five-point scale following a review of every space on every living unit. Each Unit Supervisor was given a copy of the risk assessment for his/her unit.</p> <p>Recommendation 3, February 2007: Ask individuals to identify uncorrected hazards—perhaps using the Cooperative Council survey.</p> <p>Findings: The Cooperative Council had input on several risk-reduction projects, including the design of the new wardrobes.</p> <p>Other findings: The work done by the Environmental Risk Reduction Project is impressive. It has identified environmental risks on all units, shared this information, worked on designing alternatives, removed many hazards and replaced them with safe substitutes. These include shower heads, shower valves, grab bars, and modules (partitions) for toilets, spring-operated hinges replacing “arm” door closures, and smoke detector covers in high-risk areas. They have designed a wardrobe that eliminates features that have been used in hanging suicides (not necessarily in this hospital) and have bargained with the Department of Corrections to produce it.</p> <p>I saw these environmental modifications as I toured the units.</p> <p>The Environment of Care Inspection Checklist Executive Summary for the period January—June 2007 indicates significant improvement over the previous six months. With the exception of three items (bedrooms and bathrooms are free of contraband, bubble mirrors have clear visibility and problems with the mounting apparatus of fire</p>
--	--	---

Section I: Protection from Harm

		<p>extinguishers), the remaining 22 items on the checklist related to suicide and risk prevention scored 90% or better, with 14 items scoring 100%.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue the work of the Environmental Risk Reduction Project. 2. Share the work of this project with other hospitals.
I.3.b	<p>All areas of the hospital that are occupied by individuals being served have adequate temperature control and deviations shall be promptly corrected;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Enforce procedures for the unannounced review of environmental conditions monthly by program administrators and aggregate the resulting data.</p> <p>Findings: Deliberations on this recommendation will begin in August 2007 with the Clinical Management Team. A review on three units revealed that daily environmental rounds had been completed on the previous day on each.</p> <p>Recommendation 2, February 2007: Establish a short checklist to ensure the availability of necessary supplies and acceptable unit conditions at the change of shift. This should ensure quick identification of problems like those in the bathroom of A-9 cited above [in previous report].</p> <p>Findings: An inventory of supplies is not done daily, but is completed on a regular</p>

Section I: Protection from Harm

		<p>basis. All units I visited had fully equipped bathrooms and all individuals interviewed said they had all the personal hygiene supplies they needed. Those individuals questioned explained the procedure for getting hygiene supplies and said they had never been denied or gone without these items.</p> <p>Recommendation 3, February 2007: Focus attention on the personal hygiene of individuals who need assistance/guidance as an integral part of wellness and recovery.</p> <p>Findings: A 96% sample of individuals admitted during the period January through June 2007 indicated that 98% had Activities of Daily Living addressed in their WRPs. This is consistent with my review of nine WRPs, all of which had objectives related to personal hygiene/ activities of daily living.</p> <p>Compliance: Partial.</p> <p>Current recommendations: Continue current practice and plans.</p>
I.3.c	Each State hospital reviews, revises, as appropriate, and implements procedures and practices so that individuals who are incontinent are assisted to change in a timely manner;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Add "skin checks" to the "action codes" on the incontinent flow sheet.</p> <p>Findings: This recommendation was completed.</p>

		<p>Recommendation 2, February 2007: Add two additional issues to the hospital monitoring tool:</p> <ul style="list-style-type: none"> • Bowel and Bladder sheet completed every 2 hours • Skin checks completed <p>Findings: This recommendation was completed.</p> <p>Recommendation 3, February 2007: Include incontinence care in the WRP for those individuals for whom it is a problem.</p> <p>Findings: A review of the WRPs of six individuals identified as incontinent revealed that five of the six WRPs contained objectives and interventions related to incontinence. There was a bowel and bladder assessment flow sheet available for five of the six individuals also.</p> <p>The hospital's self-assessment of 15 variables related to the care of persons with incontinence indicates that it is least effective in specifying the frequency with which individuals should be checked to ensure they are clean and dry. 97–98% of the individuals checked were clean, dry and odor-free.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue current practice of addressing incontinence in the WRP and monitoring effectiveness of interventions. 2. Review relevant documents to ensure they specify the frequency with which the individual should be checked to ensure he/she is
--	--	--

Section I: Protection from Harm

		clean and dry.
I.3.d	<p>Each State hospital thoroughly reviews and revises, as appropriate, its policy and practice regarding sexual contact among individuals served at the hospital. Each State hospital shall establish clear guidelines regarding staff response to reports of sexual contact and monitor staff response to incidents. Each State hospital documents comprehensively therapeutic interventions in the individual's charts in response to instances of sexual contact; and</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, February 2007: Focus attention on the clinical team's response to incidents of sexual activity.</p> <p>Findings: The hospital implemented this recommendation and conducted a review of 100% of the 25 sexual incidents reported between January and June 2007. [In March there were no sexual incidents reported.] Documentation of a nursing assessment and of the provision of sexual education scored most poorly. While a physician and the family were notified, and the physician documented his/her evaluation in 100% of the cases, in only 53% of the incidents was the psychiatrist notified "for the evaluation of appropriate psychological care."</p> <p>Recommendation 2, February 2007: DMH should continue work on clear and comprehensive guidelines regarding sexual activity among individuals in care.</p> <p>Findings: This work is still pending.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Focus attention on ensuring that nurses assess individuals involved in sexual incidents and document the sexual education provided or at least offered.

Section I: Protection from Harm

		<p>2. Ensure that psychiatrists are notified of sexual incidents and that they document their evaluations and recommendations.</p>
<p>I.3.e</p>	<p>Each State hospital develops and implements clear guidelines stating the circumstances under which it is appropriate to utilize staff that is not trained to provide mental health services in addressing incidents involving individuals. Each State hospital ensures that persons who are likely to intervene in incidents are properly trained to work with individuals with mental health concerns.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Continue current practice.</p> <p>Findings: The facility has identified a series of courses (F category) that non-clinical providers of Mall groups must take. This curriculum includes elder/dependent abuse/neglect training and Mental Health 101, CPR and Positive Behavior Management.</p> <p>Not all staff who may teach Mall groups have completed the curriculum.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Continue to train non-clinical Mall group providers.</p>

Section J: First Amendment and Due Process

J	First Amendment and Due Process	
		<p>Summary of Progress:</p> <ol style="list-style-type: none"> 1. The Cooperative Council meets in regularly scheduled meetings where individuals abide by rules that respect the right of each to speak uninterrupted. 2. The Council regularly surveys individuals about quality of life issues. It is an effective voice articulating the concerns of individuals. 3. The Peacemaker project identifies for special recognition those individuals whose actions model courage in speaking the truth and whose behavior models peaceful problem resolution.
	<p>Each State hospital unconditionally permits individuals to exercise their constitutional rights of free speech, including the right to petition the government for redress of grievances without State monitoring, and provides them due process.</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Five individuals during unit tours <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Complaints forwarded from the Department of Justice 2. Cooperative Council Survey data <p><u>Observed and Participated in:</u></p> <ol style="list-style-type: none"> 1. Meeting of the Cooperative Council
		<p>Current findings on previous recommendations:</p> <p>Recommendation, February 2007: Address these issues with the Cooperative Council, explaining what the hospital is doing and plans to do in response.</p>

		<p>Findings: This recommendation addressed four issues: the use of Tagalog by staff in front of individuals who do not understand the language; the commerce in drugs; the perception that discharge criteria do not remain fixed and thus discharge is a moving target; and the adverse effect numerous staff resignations was having on their recovery. At the July 2007 meeting, the individuals indicated that the use of Tagalog is still a problem. The individuals present praised the increased effort to reduce drugs coming into the facility, including the use of two dogs. Problems meeting discharge criteria were not discussed at the most recent meeting. A staffing shortage among hospital police was a major concern as it resulted in the closing of the visitors center some days, shortening hours on other days and resulted in delays in packages from family and friends reaching the intended individual because there was no officer in the package room to inspect them.</p> <p>Other findings: Below are selected results of surveys conducted in August, December 2006 and March 2007:</p> <table border="1" data-bbox="1003 966 1858 1349"> <thead> <tr> <th></th> <th>March 2007</th> <th>Dec. 2006</th> <th>Aug. 2006</th> </tr> </thead> <tbody> <tr> <td>I feel safe here.</td> <td>n=384</td> <td>n=283</td> <td>n=378</td> </tr> <tr> <td></td> <td>%yes =81</td> <td>%yes=81</td> <td>%yes=76</td> </tr> <tr> <td>I have input into hospital rules & policies</td> <td>n=337 %yes=65</td> <td>n=274 %yes=65</td> <td>n=372 %yes=77</td> </tr> <tr> <td>My unit's rules are fair</td> <td>n=377 %yes=83</td> <td>n= 312 %yes=82</td> <td>n=388 %yes=81</td> </tr> </tbody> </table>		March 2007	Dec. 2006	Aug. 2006	I feel safe here.	n=384	n=283	n=378		%yes =81	%yes=81	%yes=76	I have input into hospital rules & policies	n=337 %yes=65	n=274 %yes=65	n=372 %yes=77	My unit's rules are fair	n=377 %yes=83	n= 312 %yes=82	n=388 %yes=81
	March 2007	Dec. 2006	Aug. 2006																			
I feel safe here.	n=384	n=283	n=378																			
	%yes =81	%yes=81	%yes=76																			
I have input into hospital rules & policies	n=337 %yes=65	n=274 %yes=65	n=372 %yes=77																			
My unit's rules are fair	n=377 %yes=83	n= 312 %yes=82	n=388 %yes=81																			

Section J: First Amendment and Due Process

		<p>Staff ensure rules are followed</p>	<p>n=395 %yes=88</p>	<p>n=314 %yes=89</p>	<p>n=393 %yes=86%</p>
<p>Individuals raised concerns that the hospital is going to institute a policy that will not permit them to have personal computers. Reportedly, community-use computers will be available. Individuals were concerned that there would not be enough computers to give all the individuals reasonable access for periods of time long enough to work on their legal papers. Concerns were also raised about how the hospital would accommodate the need for confidentiality with multiple-user computers.</p> <p>Compliance: Partial.</p> <p>Current recommendation:</p> <ol style="list-style-type: none"> 1. Address the concerns raised about the coming prohibition of personal computers with the Council and individuals at large. 2. Continue being responsive to the concerns of individuals and provide administrative leaders to answer questions. 					
<p>MES 0709</p>					