

REPORT 5
NAPA STATE HOSPITAL

July 21-25, 2008

THE HUMAN POTENTIAL CONSULTING GROUP
ALEXANDRIA, VIRGINIA

NOTE

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

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

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Acronyms used in this report:

AA	Alcoholics Anonymous
AD	Administrative Directive
ADCAP	Audit-driven corrective action plan
ADR	Adverse drug reaction
AIMS	Abnormal Involuntary Movement Scale
A/N	Abuse/Neglect
ASH	Atascadero State Hospital
BCC	Behavioral Consultation Committee
BMI	Body Mass Index
CA	Clinical Administrator
CEU	Continuing Education Units
CIS	Clinical Information System
CIPRTA	Comprehensive Integrated Physical Rehabilitation Therapy Assessment
CM	Court Monitor
CME	Continuing Medical Education
COPD	Chronic Obstructive Pulmonary Disease
COT	Community Outpatient Treatment
CPR	Cardio-pulmonary resuscitation
CRIPA	Civil Rights of Institutionalized Persons Act
DCAT	Developmental and Cognitive Abilities Team (check)
DMH	Department of Mental Health
DOJ	Department of Justice
DSM-IV-TR	Diagnostic and Statistical Manual of Mental Disorders—Fourth Edition (Text Revision)
DUE	Drug Utilization Evaluation
EKG	Electrocardiogram
EMS	Emergency Medical Service
EP	Enhancement Plan
FRP	Forensic Review Panel

GAF	Global Assessment of Functioning [Score]
H&P	History and Physical [Examination]
HIMD	Health Information Management Department
HIV	Human Immunodeficiency Virus
HSS	Health Services Specialist
IA-RTS	Integrated Assessment—Rehabilitation Therapy Section
IC	Infection Control
IDN	Inter-Disciplinary Note
IPA	Integrated Assessment: Psychology section
IRC	Incident Review Committee
IT	Information Technology
LTBI	Latent tuberculosis infection
LVN	Licensed Vocational Nurse
MAPP	My Activity and Participation Plan
MAR	Medication Administration Report
MAS	Medical Ancillary Services
MEC	Medical Executive Committee
MIRC	Mortality Interdisciplinary Review Committee
MMSE	Mini Mental Status Examination
MOD	Medical Officer of the Day
MRSA	Methicillin-resistant Staphylococcus aureus
MSH	Metropolitan State Hospital
MTR	Medication Treatment Record
MVR	Medication Variance Report
NA	Narcotics Anonymous
NCMT	Nutrition Care Monitoring Tool
NCS	Neuropsychological Consultation Service
NGA	New generation antipsychotic
NOC	Nocturnal shift
NP	Nursing Policy

NPO	Nulla per Os (nothing by mouth)
NSH	Napa State Hospital
NST	Nutritional Status Type
OSI	Office of Special Investigations
OT	Occupational Therapy/Therapist
PBS	Positive Behavior Support
PC	Penal Code
PFA	Psychology Focused Assessment
PMAB	Prevention and Management of Assaultive Behavior
POST	Physical, Occupational, and Speech/Language Pathology
PPD	Purified Protein Derivative (skin test for tuberculosis)
PPN	Physicians Progress Note
PRA	Patients' Rights Advocate
PRN	Pro re nata (as needed)
PSH	Patton State Hospital
PSR	Psychosocial Rehabilitation
PT	<ul style="list-style-type: none"> • Physical Therapy/Therapist (in Sections D.4 and F.4) • Psychiatric Technician (in Sections D.3 and F.3)
P&T	Pharmacy and Therapeutics [Committee]
RD	Registered Dietician
RIAT	Rehabilitation Integrated Assessment Team
RMS	Records Management System
RPR	Rapid plasma regain (test for syphilis)
RN	Registered nurse
SA	Substance abuse
SAMHSA	Substance Abuse and Mental Health Services Administration
SLP	Speech Language Pathology/Pathologist
SO	Special Order
SOCRATES	Stages of Change Readiness and Treatment Eagerness Scale
TB	Tuberculosis

TD	Tardive dyskinesia
TRC	Therapeutic Review Committee
URICA	University of Rhode Island Change Assessment [Scale]
WaRMSS	Wellness and Recovery Model Support System
WRP	Wellness and Recovery Plan
WRPC	Wellness and Recovery Planning Conference
WRPT	Wellness and Recovery Planning Team

Introduction

A. Background Information

The evaluation team, consisting of Court Monitor (Mohamed El-Sabaawi, MD) and four expert consultants (Vicki Lund, PhD, MSN, ARNP; Ramasamy Manikam, PhD; Elizabeth Chura, MSRN; and Monica Jackman, OTR/L) visited Napa State Hospital (NSH) from July 21 to 25, 2008 to evaluate the facility's progress regarding compliance with the Enhancement Plan (EP). The evaluators' objective was to develop a detailed assessment of the status of compliance with all action steps of the EP.

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

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

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

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

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

B. Methodology

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

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

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

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

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

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

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

C. Statistical Reporting

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

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

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

D. Findings

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

1. Key Indicator Data

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

- a. The number of individuals testing positive for street drugs has declined markedly over the past year.
- b. The facility is reporting more medication variances; given the concern that variances were underreported, this is a positive development. However, the number of documentation errors in particular is high.
- c. The use of restraints has declined.
- d. The incidence of MRSA has not increased.
- e. There has been a decline in the use of older anticonvulsants.

- f. There has been a spike in the number of falls resulting in injury.
- g. The incidence of aspiration pneumonia and pressure sores has increased.
- h. From the data, it appears that PRN and Stat medications are being categorized properly.

2. Monitoring, mentoring and self-evaluation

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

- a. NSH has developed most of the structures and processes that are required for implementation of the EP. At this juncture, the facility needs to focus its efforts on using the EP processes and monitoring data to refine the quality of clinical services to the individuals.
- b. Regarding the process of self-assessment, this monitor has requested the following:
 - i. For data demonstrating compliance rates of less than 90%, all facilities should provide the following information:
 - Comparison of the mean compliance rates for the main indicators in the entire review period from the current to the previous periods;
 - Comparison of the mean compliance rates for the main indicators and sub-indicators (if they were presented) from the last month of the current review period to the last month of the previous review period;
 - A review of the facility's assessment of barriers towards compliance; and
 - A plan of correction.
 - ii. For data demonstrating compliance rates of 90% or more, all facilities should provide comparisons of mean compliance rates for the entire review period from the current to the previous periods.
 - iii. For data derived from the DMH standardized auditing tools, all facilities should present data using the same configuration of indicators/sub-indicators for corresponding requirements of the EP.
- c. NSH has presented data comparing the compliance rates from the last month of the current review period to the last month of the last review period as requested. In addition, the facility presented information on the barriers towards compliance, as indicated and plans of correction, as applicable. However, the facility did not consistently provide comparisons of the mean compliance rates for the entire review period compared to the previous period as requested.
- d. With few exceptions, the NSH has used standardized auditing tools for all applicable sections of the EP.
- e. NSH has improved the sampling methodology during this review period. However, further work is needed to ensure acceptable samples of appropriately defined target populations across the board.
- f. All facilities must ensure that discipline chiefs and senior executives review the monitoring data on a monthly basis at the facility level and that results of these reviews are used to enhance service delivery within each facility. As mentioned in earlier reports by this monitor, the monitoring data across hospitals should be reviewed quarterly by the State with its Chief

CRIPA Consultant so that the aggregate data can be used to enhance the mental health services provided throughout the DMH system.

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

3. Implementation of the EP

NSH has developed most of the structures and processes that are required for implementation of the EP. At this juncture, the facility needs to focus its efforts on using the EP processes and monitoring data to refine the quality of clinical services to the individuals.

- a. Since the last review period, NSH has made progress relative to EP requirements in many areas. This progress is elaborated upon in the body of the report. Please refer to the Summary of Progress at the beginning of Sections C, D, E, F, H, I and J for progress highlights.
- b. NSH has yet to implement mechanisms to improve nursing and medical attention to changes in the physical status of individuals and nurse-physician communications regarding ongoing care and follow up care upon return of individuals from outside hospitalization.
- c. NSH has yet to make significant progress in the current incident and risk management systems. The facility needs to implement an updated system, including identification of triggers and thresholds regarding high-risk behavior, establishment of levels of interventions corresponding to the level of risk and appropriate notification and follow up mechanisms. The interventions and follow up should include, but not be limited, to the following:
 - i. First-level response by the WRPTs, including timely review of incidents and analysis of contributing factors, timely and appropriate use of Stat and PRN medications, judicious use of restrictive interventions in accord with current DMH procedures and use of positive behavior supports whenever indicated as well as other corrective actions, as needed;
 - ii. Second-level review by clinical leadership;
 - iii. Outside consultations, if necessary; and
 - iv. An oversight mechanism to review trends and patterns and initiate systemic performance improvement projects.
- d. Given that the EP provides the basis for the mental health services delivered in the California DMH State Hospitals, it is the monitor's recommendation that the DMH seriously consider standardizing across all hospitals the Administrative Directives that impact these services.
- e. Functional/clinical outcomes of the current structural changes have yet to be finalized and implemented to guide further implementation.
- f. A well-functioning PSR Mall that meets the specific needs of the individuals is the centerpiece of the Wellness and Recovery Planning model. Progress remains to be made towards this goal, specifically in the areas of:

- i. Mall hours: 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:

DMH PSR MALL HOURS REQUIREMENTS

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
Before 8am: Supplemental Activities	Supplemental Activities	Supplemental Activities				
8am - 6pm: Active Treatment						
Official Mall Hours: Groups A: morning group B: morning group						
LUNCH	LUNCH	LUNCH	LUNCH	LUNCH		
C: afternoon group D: afternoon group						
Individual Therapy Non-ABCD hours						
After 6pm: Supplemental Activities						

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

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

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

- ii. **Progress notes:** NSH has yet to implement a requirement for providers of mall groups and individual therapy to complete and make available to each individual's Wellness and Recovery Planning Team (WRPT) the DMH-revised PSR Mall Facilitator Monthly Progress Note prior to regularly scheduled WRPCs. Without the information in the monthly progress notes, the WRPT has almost no basis for revising an individual's objectives and interventions. All hospitals must fully implement the PSR Mall Facilitator Monthly Progress Note in their PSR Malls for all groups and individual therapies.
- iii. **Cognitive screening for PSR Mall groups:** PSR Mall groups should be presented in terms of the cognitive levels of the individuals at the hospital. Individuals can be stratified at three cognitive levels: (a) advanced (above average), (b) average, and (c) challenged (below average). A cognitive screening protocol, utilizing generally accepted testing methods, can be used to determine these levels for those individuals whose primary or preferred language is English.

The cognitive screening protocol will also provide information for the WRPT psychologist to determine whether a referral

to the DCAT and/or neuropsychological service is required. All State hospitals must ensure that cognitive screening has been completed for all individuals and that their Mall groups are aligned with their cognitive levels.

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

4. Staffing

The NSH staffing table below shows the staffing pattern at the hospital as of June 30, 2008. These data were provided by the facility. The table shows that there continues to be shortages of staff in several key areas, including senior and staff psychiatrists, senior psychologists, pharmacy staff and health record technicians.

Identified Clinical Positions	Allocated Positions	Filled Positions	Vacant Positions	Vacancy Rate
Assistant Coordinator of Nursing Services	5.0	3.0	2.0	40.00%
Assistant Director of Dietetics	3.0	2.0	1.0	33.33%
Chief Dentist	1.0	1.0	0.0	0.00%
Chief Physician & Surgeon	1.0	0.0	1.0	100.00%
Chief Psychologist	1.0	1.0	0.0	0.00%
Clinical Dietician	10.6	7.5	3.1	29.25%
Clinical Laboratory Technologist	3.0	4.0	-1.0	-33.33%
Clinical Social Worker	61.9	59.8	2.1	3.39%
Coordinator of Nursing Services	1.0	1.0	0.0	0.00%
Coordinator of Volunteer Services	1.0	1.0	0.0	0.00%

Identified Clinical Positions	Allocated Positions	Filled Positions	Vacant Positions	Vacancy Rate
Dental Assistant	3.0	4.0	-1.0	-33.33%
Dental Hygienist	1.0	1.0	0.0	0.00%
Dentist	2.0	2.0	0.0	0.00%
Food Service Technician I	90.0	89.5	0.5	0.56%
Hospital Worker	5.0	5.0	0.0	0.00%
Health Record Technician I	14.0	9.0	5.0	35.71%
Health Record Technician II Sp	1.0	1.0	0.0	0.00%
Health Record Technician II Sup	1.0	1.0	0.0	0.00%
Health Record Technician III	1.0	0.0	1.0	100.00%
Health Services Specialist	29.0	29.0	0.0	0.00%
Institution Artist Facilitator	1.0	1.0	0.0	0.00%
Licensed Vocational Nurse	55.0	47.8	7.2	13.09%
Medical Transcriber	7.0	6.0	1.0	14.29%
Sr. Medical Transcriber	3.0	3.0	0.0	0.00%
Nurse Instructor	9.0	5.0	4.0	44.44%
Nurse Practitioner	7.0	6.0	1.0	14.29%
Nursing Coordinator	7.0	7.0	0.0	0.00%
Office Technician	40.0	42.0	-2.0	-5.00%
Pathologist	1.0	0.0	1.0	100.00%
Pharmacist I	13.5	5.0	8.5	62.96%
Pharmacist II	2.0	0.0	2.0	100.00%
Pharmacy Services Manager	1.0	1.0	0.0	0.00%
Pharmacy Technician	15.0	11.5	3.5	23.33%
Physician & Surgeon	22.0	18.4	3.6	16.36%
Podiatrist	1.0	1.0	0.0	0.00%
Pre-licensed Psychiatric Technician	12.6	5.0	7.6	60.32%
Program Assistant	7.0	4.0	3.0	42.86%
Program Consultant (RT, PSW)	2.0	1.0	1.0	50.00%
Program Director	7.0	5.0	2.0	28.57%
Psychiatric Nursing Education Director	2.0	1.0	1.0	50.00%
Psychiatric Technician*	309.5	275.9	33.6	10.86%

Identified Clinical Positions	Allocated Positions	Filled Positions	Vacant Positions	Vacancy Rate
Psychiatric Technician Assistant	238.4	233.6	5.4	2.27%
Psychiatric Technician Instructor	3.0	3.0	0.0	0.00%
Psychologist-HF, (Safety)	55.8	60.75	-4.95	-8.87%
Public Health Nurse II/I	3.0	3.0	0.0	0.00%
Radiologic Technologist	2.0	2.0	0.0	0.00%
Registered Nurse*	383.8	378.6	5.2	1.35%
Registered Nurse, Pre-Registered	3.0	3.0	0.0	0.00%
Rehabilitation Therapist	70.7	65.3	5.4	7.64%
Special Investigator	4.0	4.0	0.0	0.00%
Supervising Special Investigator	1.0	1.0	0.0	0.00%
Sr. Psychiatrist	15.3	1.0	14.3	93.46%
Sr. Psychologist	17.6	11.0	6.6	37.50%
Sr. Psychiatric Technician (Safety)	63.0	60.0	3.0	4.76%
Sr. Voc. Rehab. Counselor/Voc. Rehab.	1.0	1.0	0.0	0.00%
Staff Psychiatrist	64.9	49.5	15.4	23.73%
Supervising Psychiatric Social Worker	5.5	0.0	5.5	100.00%
Supervising Registered Nurse	18.0	14.0	4.0	22.22%
Supervising Rehabilitation Therapist	5.0	20.0	5.0	100.00%
Teacher-Adult Educ./Vocational Instructor	9.1	9.0	0.1	1.10%
Unit Supervisor	28.0	28.0	0.0	0.00%
Vocational Instructor/Carpentry	1.0	1.0	0.0	0.00%
Vocational Instructor/Upholstery	1.0	1.0	0.0	0.00%

*Plus Psychiatric Technician - 23.5 hourly FTE

*Plus Registered Nurse - 18 hourly FTE

In order to meet the Enhancement Plan requirements, the overall numbers of nursing staff must increase and the skill mix must 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.

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

E. Monitor's Evaluation of Compliance

The status of compliance is assessed considering the following factors:

1. An objective review of the facility's data and records;
2. Observations of individuals, staff and service delivery processes;
3. Interviews with individuals, staff, facility and State administrative and clinical leaders;
4. An assessment of the stability of the facility's current structure and functions in terms of potential for self-sustenance in order adequately meet the needs of individuals currently and in the future;
5. Assessment of trends and patterns of change rather than single and/or temporary occurrences of compliance or noncompliance that are inconsistent with these patterns and trends;
6. When no instance requiring implementation of a specific requirement was found in the baseline assessment, the compliance was rated as Not Applicable for this evaluation.
7. At least two of the hospitals (i.e., PSH and ASH) have reached substantial compliance in one section of the EP. Once a hospital reaches substantial or full compliance in a section of the EP, the CM begins maintenance evaluation of that section for 18 consecutive months. If the hospital maintains substantial or full compliance during the 18-month period, the CM's evaluation of that section will cease, and it will be up to DMH to provide oversight evaluation and ensure future maintenance. Thus, DMH should

be prepared to assume this responsibility in terms of trained personnel to assume this responsibility as each section of the EP achieves maintenance status at each hospital.

F. Next Steps

1. The Court Monitor's team is scheduled to tour Metropolitan State Hospital September 8-12, 2008.for a follow-up evaluation.
2. The Court Monitor's team is scheduled to reevaluate Napa State Hospital January 26-30, 2009.
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.

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 has improved the structure and functions of its WRP training program. 2. NSH has improved the process of the WRPCs (except for the medical units). 3. NSH has established a requirement to ensure timely implementation of the WRP reviews in all programs. 4. NSH has achieved substantial compliance with the staffing ratios on both the admissions and long-term units. 5. NSH has improved the scheduling of individuals for the required active treatment hours. 6. NSH has converted its WRPs from Word format to the new WaRMSS module. 7. NSH has improved the content of the WRPs in the areas of case formulation and documentation of interventions. 8. NSH has improved the process of analysis of self-assessment data. 9. NSH has begun to gather process outcome data regarding substance recovery program.
1. Interdisciplinary Teams		
C.1	<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. Karen Phillips, PhD, Master WRP Trainer 2. Katie Cooper, PsyD, Enhancement Plan Coordinator <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. NSH WRP Content and Process Curriculum, revised 2. Lesson Plan: WRP Training: WaRMSS, WRP Content and WRPC Process 3. WRPC Feedback: In Vivo Observation

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<ol style="list-style-type: none"> 4. Formal Checklist for Engaging the Individual in the WRP Process 5. NSH WRPC Checklists (7-Day, 14-Day, 30-Day and 90-Day) 6. NSH WRP Preparation Worksheets (Medical/Ancillary, PT/LVN and RN) 7. NSH outlines of responsibilities of WRPT members during the WRPC (Psychologist, Rehabilitation Therapist, Social Worker, OT/LVN and RN) 8. NSH data regarding competency-based training of the WRPTs 9. DMH WRP Process Observation Monitoring Form 10. DMH WRP Process Observation Monitoring Form Instructions 11. NSH WRP Process Observation Monitoring summary data (January to May 2008) 12. DMH Clinical Chart Auditing Form 13. DMH Clinical Chart Auditing Form Instructions 14. NSH Clinical Chart Auditing Form summary data (January to May 2008) 15. DMH WRP Psychiatry Team Leadership Monitoring Form 16. DMH WRP Psychiatry Team Leadership Monitoring Form Instructions 17. NSH WRP Psychiatry Team Leadership summary data (March to May 2008) 18. NSH data regarding staffing ratios <p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. WRPC (Program II, unit T-3) for quarterly review of JAY 2. WRPC (Program II, unit T-3) for 14-day review of CD 3. WRPC (Program V, unit Q-1) for 14-day review of SLC 4. WRPC (Program I, unit 6) for monthly review of RB 5. WRPC (Program II, unit T-17) for monthly review of BGP 6. WRPC (Program IV, unit A-4) for monthly review of RM 7. WRPC (Program I, unit Q-4) for quarterly review of RP 8. WRPC (Program IV unit A-4) for quarterly review of RLM
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<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>Recommendations 1 and 6, January 2008:</p> <ul style="list-style-type: none"> • Implement the MSH training modules regarding Engagement, Case Formulation, Foci/Objectives/Interventions and Discharge Planning. • Ensure that training on the process of WRP addresses and corrects the deficiencies listed by this monitor above. <p>Findings:</p> <p>NSH has yet to implement this recommendation. Plans are underway to begin implementation of the MSH WRP training modules in August 2008. Since the last review, the facility has provided alternative training under the leadership of the WRP Master Trainer and strengthened its training program as follows:</p> <ol style="list-style-type: none"> 1. The position of WRP Master Trainer was established and filled by a Senior Psychologist. 2. Three new WRP trainers have been assigned full-time to the Treatment Enhancement Office (a Social Worker, Registered Nurse and Psychiatric Technician) for the current total of five full-time WRP trainers. 3. NSH WRP Content and Conference Process curriculum has been revised to ensure alignment with the WaRMSS WRP module and includes more detail, clinical examples, and explanations. 4. The facility has completed the WRP Conference Process Training for all WRPTs (#53). 5. The facility has added the following components to the training program: <ol style="list-style-type: none"> a. New Employee training in the NSH WRP Content and Conference Process monthly; b. In Vivo WRP Conference Mentoring by the WRP trainers (each of the five trainers is assigned to 10-11 WRPTs and gives verbal and written feedback to the teams);
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		<p>c. Review of the self-assessment auditing data by the WRP trainers and use of this information to inform the In Vivo training;</p> <p>d. Provision of the Knowledge Assessment Test to all WRPT members and NSH leadership staff with individual remediation as needed; and</p> <p>e. Use of the facility's Learning Lab as a "hotline" with WRP trainers available to the WRPTs by phone and e-mail for consultation Monday to Friday.</p> <p>6. The facility plans to implement a new module to improve linkages between assessments, foci, objectives and interventions.</p> <p>7. All WRPs have been transferred from a Word format into the WaRMSS WRP module. The WRP trainers have provided mentoring to team members in the Learning Lab to accomplish this project. All WRPs are now created in WaRMSS. The WaRMSS system supports the following:</p> <p>a. Opening objectives for each open focus;</p> <p>b. Development of interventions for each objective;</p> <p>c. Use of the PSR Mall Facilitator Progress Notes for each active treatment intervention; and</p> <p>d. Facilitation of the required frequency of WRP reviews.</p> <p>8. The facility began the process of assisting WRPTs to align the WRP interventions and the activity schedule captured in the MAPP system.</p> <p>The facility has indicated that changes in its WRP training program have addressed (or will address) the deficiencies outlined by this monitor as follows:</p> <table border="1" data-bbox="989 1263 1883 1411"> <thead> <tr> <th data-bbox="989 1263 1430 1339">Deficiency outlined by the monitor</th> <th data-bbox="1430 1263 1883 1339">Changes to training made by the facility</th> </tr> </thead> <tbody> <tr> <td data-bbox="989 1339 1430 1411">1. <i>The teams did not consistently identify key</i></td> <td data-bbox="1430 1339 1883 1411">The In Vivo WRPC training has emphasized the function of the</td> </tr> </tbody> </table>	Deficiency outlined by the monitor	Changes to training made by the facility	1. <i>The teams did not consistently identify key</i>	The In Vivo WRPC training has emphasized the function of the
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		<p><i>questions/issues to be discussed with the individual.</i></p>	<p>pre-meeting.</p>
		<p>2. <i>The updates of the present status were finalized exclusively on the basis of the disciplines' assessments and did not incorporate the individual's input.</i></p>	<p>The MSH Engagement module that focuses on obtaining individual's input during the WRPC will be implemented in August 2008.</p>
		<p>3. <i>There was no mechanism to conduct data-based review of the individual's progress in Mall groups.</i></p>	<p>The In Vivo WRPC training will focus on use of PSR Mall Facilitator Notes in the conference process.</p>
		<p>4. <i>The teams did not consistently revise/update the case formulation, foci, objectives and interventions;</i></p> <p>5. <i>The reviews of foci, objectives and interventions were not consistently informed by the assessments and the case formulations; and</i></p> <p>6. <i>One team did not prioritize interventions to address the individual's needs (speech language consultation for an individual suffering from hearing and speech</i></p>	<p>The In Vivo WRPC training has emphasized the function of the pre-meeting regarding presentation of the assessments' results.</p> <p>WRP training efforts have begun to improve the understanding of linkages (within the WRP) and implications for treatment.</p> <p>A new training module on WRP Linkages will be added in the next review period.</p>

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		<p><i>impairments.</i></p>	
		<p>7. <i>The reviews of the discharge criteria were either generic or did not occur, and the teams did not discuss with the individual progress needed to met each criterion.</i></p>	<p>Senior Social Workers will emphasize the need to discuss individual progress toward discharge and what is needed to meet each criterion during WRP mentoring.</p> <p>WRPT training has focused on addressing progress toward discharge.</p> <p>The MSH Module, Discharge Planning will be implemented.</p>
		<p>Recommendation 2, January 2008: Ensure that Senior Psychiatrists are assigned to all programs in the facility.</p> <p>Findings: Senior Psychiatrists were assigned to four of the facility's five programs during this reporting period. The facility plans to assign Senior Psychiatrists to all five programs as of July 2008.</p> <p>Recommendation 3, January 2008: Ensure that all senior clinicians have received training based on the MSH modules as well as training in the clinical Chart Auditing process.</p> <p>Findings: NSH reported that 16 senior clinicians, representing the disciplines of psychology, social work and rehabilitation therapy, have been designated to be clinical chart auditors. These senior clinicians</p>	

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		<p>completed training in NSH WRPC Content and Process (in April 2008). The WRP Master Trainer will train the clinicians in the MSH modules beginning in July 2008.</p> <p>Recommendation 4, January 2008: Increase training sessions to all WRPTs in the facility and provide data to that effect.</p> <p>Findings: NSH has implemented this recommendation. During this reporting period, the facility provided 566 hours of training, compared to 162 hours during the previous reporting period. The training was provided in the following areas: WRP Content and Process, In Vivo WRPC Mentoring, Learning Lab, New Employee training and WRP Knowledge Assessment (testing).</p> <p>Recommendation 5, January 2008: Provide data regarding competency-based training to all WRPTs in the facility.</p> <p>Findings: During this period, 509 staff were tested, 407 passed and 102 failed for an overall pass rate of 80%. During the previous review period, 39 staff took the knowledge assessment and 4 staff passed</p> <p>Recommendation 7, January 2008: Ensure that Clinical Chart Auditing is based on at least a 20% sample.</p> <p>Findings: NSH used the DMH WRP Clinical Chart Auditing Form to assess compliance with this requirement. The facility reviewed an average sample of 8% of the quarterly and annual WRPs due each month (January to May 2008). The following are the indicators and</p>
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		<p>corresponding compliance rates. The data showed improved compliance since the last review period.</p> <table border="1" data-bbox="991 302 1887 639"> <tr> <td data-bbox="991 302 1087 451">1.</td> <td data-bbox="1087 302 1793 451"><i>Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary and appropriate psychiatric and medical care</i></td> <td data-bbox="1793 302 1887 451">5%</td> </tr> <tr> <td data-bbox="991 451 1087 639">2.</td> <td data-bbox="1087 451 1793 639"><i>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</i></td> <td data-bbox="1793 451 1887 639">40%</td> </tr> </table> <p>The facility's data analysis showed mixed changes in the mean sub-indicator compliance rates from the last month of the previous review period, December 2007, to the last month of this review period, May 2008, as follows:</p> <ol style="list-style-type: none"> 1. Item 1: from 0% to 9%; and 2. Item 2: from 68% to 52%. <p>Other findings: During this review period, NSH has established a requirement to ensure timely implementation of the WRP reviews in all programs.</p> <p>The monitor and his consultants attended seven WRPCs that were held in different mental health units and one meeting on a medical unit. In general, the meetings on the mental health units showed progress in the process of the team meetings. The following are examples of areas of progress:</p> <ol style="list-style-type: none"> 1. Timeliness of the meetings; 2. Attendance by core members; 	1.	<i>Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary and appropriate psychiatric and medical care</i>	5%	2.	<i>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</i>	40%
1.	<i>Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary and appropriate psychiatric and medical care</i>	5%						
2.	<i>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</i>	40%						

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		<ol style="list-style-type: none"> 3. Team leadership by the team psychiatrists or covering psychologists; 4. Review of WRP attachments and task tracking forms; 5. Presentation of assessment results by WRPTs; 6. Review of risk factors prior to the individual's arrival; 7. Update of the present status section of the case formulation during the meeting and of other sections of the case formulation prior to the meeting; 8. Engagement of the individual during the meetings; 9. Review of the diagnosis, objectives and interventions; 10. Update of the individual's life goals; 11. Review of BY CHOICE participation and point allocation; 12. Attempts to review the individual's attendance (and participation) at the assigned groups; and 13. Revision of objectives and interventions. <p>However, the meetings showed process deficiencies in the following areas:</p> <ol style="list-style-type: none"> 1. Participation by PTs; 2. Identification of key questions or issues to be discussed with the individual prior to the individual's arrival; 3. Review of progress in each objective with the individual; 4. Review of the individual's participation in active treatment using the PSR Mall progress notes; 5. Review with the individual of progress towards discharge using individualized criteria; 6. Revision of objectives and Mall interventions to ensure proper alignment; 7. Use of the updated life goals and strengths in the development/revision of objectives and interventions; and 8. Most aspects of WRP model on the medical unit (e.g. Program IV, unit A-4).
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		<p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Implement the MSH WRP training modules, update these modules as needed and provide a specific outline of any updates and additions to these modules. 2. Ensure that training on the process of WRP addresses and corrects the deficiencies listed by this monitor above. 3. Ensure that Senior Psychiatrists are assigned to all programs in the facility. 4. Ensure that all senior clinicians have received training based on the MSH modules as well as training in the clinical Chart Auditing process. 5. Provide data regarding competency-based training to all WRPTs in the facility. 6. Monitor this requirement using the DMH Clinical Chart Auditing Form based on at least a 20% sample and provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). 7. Provide a summary outline of any improvements in practice made as a result of review by the facility of internal monitoring data.
C.1.b	Be led by a clinical professional who is involved in the care of the individual.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, January 2008: Monitor this requirement using the Psychiatry Team Leadership Monitoring Form and ensure a sample size of at least 20%.</p> <p>Findings: NSH initiated this monitoring in December 2007. The facility used the</p>

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		<p>DMH WRP Team Leadership Audit Form, based on an average sample of 15% of the target (two observations per unit team by senior supervising psychiatrists per month). The following table summarizes the data:</p> <table border="1" data-bbox="989 337 1885 902"> <tr> <td>1.</td> <td><i>The team psychiatrist was present.</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>The team psychiatrist elicited the participation of all disciplines.</i></td> <td>32%</td> </tr> <tr> <td>3.</td> <td><i>The team psychiatrist ensured the assessments from other disciplines were integrated into the case formulation.</i></td> <td>13%</td> </tr> <tr> <td>4.</td> <td><i>The team psychiatrist ensured the "Present Status" section in the Case Formulation was updated.</i></td> <td>10%</td> </tr> <tr> <td>5.</td> <td><i>The team psychiatrist ensured that the interventions were linked to the measurable objectives.</i></td> <td>9%</td> </tr> <tr> <td>6.</td> <td><i>The team psychiatrist ensured the individuals participated on the treatment, rehabilitation and enrichment activities which are goal directed, individualized, based on a thorough knowledge of the individuals psychosocial history and previous response.</i></td> <td>37%</td> </tr> </table> <p>NSH conducted data analysis showing that compliance has changed from the last month of the prior review period, December 2007, to the last month of the current review period, May 2008, as follows:</p> <ol style="list-style-type: none"> 1. Item 1: from 62% to 100%; 2. Item 2: from 37% to 32%; 3. Item 3: from 25% to 15%; 4. Item 4: from 12% to 13%; 5. Item 5: from 0% to 10%; and 6. Item 6: from 25% to 41% <p>NSH also used the DMH WRP Observation Monitoring Form to assess compliance (January to May 2008). The average sample was 22% of the</p>	1.	<i>The team psychiatrist was present.</i>	100%	2.	<i>The team psychiatrist elicited the participation of all disciplines.</i>	32%	3.	<i>The team psychiatrist ensured the assessments from other disciplines were integrated into the case formulation.</i>	13%	4.	<i>The team psychiatrist ensured the "Present Status" section in the Case Formulation was updated.</i>	10%	5.	<i>The team psychiatrist ensured that the interventions were linked to the measurable objectives.</i>	9%	6.	<i>The team psychiatrist ensured the individuals participated on the treatment, rehabilitation and enrichment activities which are goal directed, individualized, based on a thorough knowledge of the individuals psychosocial history and previous response.</i>	37%
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		<p>WPRCs held each month. The following is an outline of the indicator and sub-indicators, with corresponding mean compliance rates:</p> <table border="1" data-bbox="991 302 1885 529"> <tr> <td data-bbox="991 302 1087 376">1.</td> <td data-bbox="1087 302 1793 376"><i>Each team is led by a clinical professional who is involved in the care of the individual:</i></td> <td data-bbox="1793 302 1885 376"></td> </tr> <tr> <td data-bbox="991 376 1087 451">1.a</td> <td data-bbox="1087 376 1793 451"><i>The clinical professional is a core team member for the individual.</i></td> <td data-bbox="1793 376 1885 451">81%</td> </tr> <tr> <td data-bbox="991 451 1087 529">1.b</td> <td data-bbox="1087 451 1793 529"><i>This person is the identified facilitator or the team leader appointed a team facilitator.</i></td> <td data-bbox="1793 451 1885 529">48%</td> </tr> </table> <p>The facility conducted data analysis showing that the mean compliance rate for this reporting period was essentially unchanged from the last review period (47% compared to 45%). However, the compliance rates for the sub-items have increased from the last month of the prior review period, December 2007, to the last month of the current review period, May 2008 as follows:</p> <ol style="list-style-type: none"> 1. Item 1.a: from 64% to 92%; and 2. Item 1.b: from 36% to 54%. <p>Recommendation 2, January 2008: 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 facility plans to begin implementation in September 2008.</p> <p>Recommendation 3, January 2008: Finalize the draft Medical Staff Manual and ensure alignment with EP requirements.</p> <p>Findings:</p>	1.	<i>Each team is led by a clinical professional who is involved in the care of the individual:</i>		1.a	<i>The clinical professional is a core team member for the individual.</i>	81%	1.b	<i>This person is the identified facilitator or the team leader appointed a team facilitator.</i>	48%
1.	<i>Each team is led by a clinical professional who is involved in the care of the individual:</i>										
1.a	<i>The clinical professional is a core team member for the individual.</i>	81%									
1.b	<i>This person is the identified facilitator or the team leader appointed a team facilitator.</i>	48%									

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		<p>NSH has yet to implement this recommendation. The Medical Director has reportedly drafted an outline of the Medical Staff Manual that aligns with the EP. This will be completed during the next review period.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Monitor this requirement using WRP Process Observation and Team Leadership Monitoring Forms based on samples of 20% and 100%, respectively. 2. Continue data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). 3. Develop and implement a peer mentoring system to ensure competency in team leadership skills. 4. Finalize the draft Medical Staff Manual and ensure alignment with EP requirements.
C.1.c	Function in an interdisciplinary fashion.	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, January 2008:</p> <ul style="list-style-type: none"> • Monitor this requirement using the DMH WRP Process Observation Form based on at least a 20% sample. • Provide data analysis addressing sub-items of this requirement. The analysis must evaluate areas of low compliance and delineate areas of relative improvement. <p>Findings: NSH used the DMH WRP Observation Monitoring Form (January to May 2008) to assess compliance with this requirement. The average sample was 22% of the WPRCs held each month. The following are the</p>

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		<p>indicator, sub-indicators and corresponding mean compliance rates:</p> <table border="1" data-bbox="991 264 1885 643"> <tr> <td data-bbox="991 264 1087 305">2.</td> <td data-bbox="1087 264 1791 305"><i>Each team functions in an interdisciplinary fashion.</i></td> <td data-bbox="1791 264 1885 305"></td> </tr> <tr> <td data-bbox="991 305 1087 415">2.a</td> <td data-bbox="1087 305 1791 415"><i>The core team members participate by presenting or updating discipline-specific and or holistic assessment data</i></td> <td data-bbox="1791 305 1885 415">7%</td> </tr> <tr> <td data-bbox="991 415 1087 492">2.b</td> <td data-bbox="1087 415 1791 492"><i>The team reviews and updates the DMH WRPC Task Tracking form.</i></td> <td data-bbox="1791 415 1885 492">26%</td> </tr> <tr> <td data-bbox="991 492 1087 566">2.c</td> <td data-bbox="1087 492 1791 566"><i>Team members present their assessments and consultations as listed in the task tracking form</i></td> <td data-bbox="1791 492 1885 566">12%</td> </tr> <tr> <td data-bbox="991 566 1087 643">2.d.</td> <td data-bbox="1087 566 1791 643"><i>Team members discuss the individual's specific outcomes for the WRP review period.</i></td> <td data-bbox="1791 566 1885 643">6%</td> </tr> </table> <p>The facility conducted data analysis showing that with one exception, the sub-item compliance rates have increased from the last month of the prior review period, December 2007, to the last month of the current review period, May 2008 as follows:</p> <ol style="list-style-type: none"> 1. Item 2.a: from 5% to 8%; 2. Item 2.b: from 14% to 32%; 3. Item 2.c: from 6% to 14%; and 4. Item 2.d: decreased from 11% to 4%. <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Monitor this requirement using process observation based on at least a 20% sample. 2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). 	2.	<i>Each team functions in an interdisciplinary fashion.</i>		2.a	<i>The core team members participate by presenting or updating discipline-specific and or holistic assessment data</i>	7%	2.b	<i>The team reviews and updates the DMH WRPC Task Tracking form.</i>	26%	2.c	<i>Team members present their assessments and consultations as listed in the task tracking form</i>	12%	2.d.	<i>Team members discuss the individual's specific outcomes for the WRP review period.</i>	6%
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2.d.	<i>Team members discuss the individual's specific outcomes for the WRP review period.</i>	6%															

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<p>C.1.d</p>	<p>Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary, and appropriate psychiatric and medical care.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, January 2008:</p> <ul style="list-style-type: none"> • Monitor this requirement using the Clinical Chart Auditing Form based on at least a 20% sample. • Provide data analysis addressing sub-items of this requirement. The analysis must evaluate areas of low compliance and delineate areas of relative improvement. <p>Findings:</p> <p>Using the DMH WRP Clinical Chart Auditing Form, NSH assessed its compliance based on an average sample of 8% of quarterly and annual WRPs due for the month (January to May 2008). The following is a summary of the data:</p> <table border="1" data-bbox="989 743 1885 1230"> <tr> <td data-bbox="989 743 1087 894">1.</td> <td data-bbox="1087 743 1791 894"><i>Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary, and appropriate psychiatric and medical care.</i></td> <td data-bbox="1791 743 1885 894"></td> </tr> <tr> <td data-bbox="989 894 1087 1045">1.a</td> <td data-bbox="1087 894 1791 1045"><i>The present status and previous response to treatment sections of the case formulation are aligned with the assessments (focused assessment of compliance)</i></td> <td data-bbox="1791 894 1885 1045">12%</td> </tr> <tr> <td data-bbox="989 1045 1087 1230">1.b</td> <td data-bbox="1087 1045 1791 1230"><i>A review of assessments, WRP and WRP attachments indicate that the information in the WRP is supported by the assessments and DMH PSR Mail Facilitator Monthly Progress Notes (Global assessment of compliance)</i></td> <td data-bbox="1791 1045 1885 1230">8%</td> </tr> </table> <p>Data analysis by NSH showed that compliance for the sub-items has increased from the last month of the prior review period, December 2007, to the last month of the current review period, May 2008 as follows:</p>	1.	<i>Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary, and appropriate psychiatric and medical care.</i>		1.a	<i>The present status and previous response to treatment sections of the case formulation are aligned with the assessments (focused assessment of compliance)</i>	12%	1.b	<i>A review of assessments, WRP and WRP attachments indicate that the information in the WRP is supported by the assessments and DMH PSR Mail Facilitator Monthly Progress Notes (Global assessment of compliance)</i>	8%
1.	<i>Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary, and appropriate psychiatric and medical care.</i>										
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1.b	<i>A review of assessments, WRP and WRP attachments indicate that the information in the WRP is supported by the assessments and DMH PSR Mail Facilitator Monthly Progress Notes (Global assessment of compliance)</i>	8%									

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		<ol style="list-style-type: none"> 1. Item 1.a: from 0% to 31%; and 2. Item 1.b: from 0% to 10%. <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Monitor this requirement using the Clinical Chart Audit form based on at least a 20% sample. 2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).
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, January 2008: Ensure recruitment of senior clinicians to fill current vacancies.</p> <p>Findings: NSH reported the following:</p> <ol style="list-style-type: none"> 1. Effective July 2008, all programs have a senior psychiatrist. 2. All disciplines with the exception of nursing have senior clinicians assigned to monitor and mentor the WRP process. 3. The nursing seniors will be appointed and function in the capacity of seniors beginning August 1, 2008. <p>Recommendations 2 and 3, January 2008:</p> <ul style="list-style-type: none"> • Monitor this requirement using the WRP Observation Monitoring Form based on at least a 20% sample. • Provide data analysis addressing sub-items of this requirement. The analysis must evaluate areas of low compliance and delineate

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		<p>areas of relative improvement.</p> <p>Findings: NSH used the DMH WRP Observation Monitoring Form to assess compliance based on an average sample of 22% of the WRPCs held each month. The following is a summary of the data (January to May 2008):</p> <table border="1" data-bbox="991 451 1881 974"> <tr> <td data-bbox="991 451 1087 636">3.</td> <td data-bbox="1087 451 1791 636"><i>Each member of the team participates appropriately in competently and knowledgeably assessing the individual on an ongoing basis and in developing, monitoring, and, as necessary revising the therapeutic and rehabilitative services.</i></td> <td data-bbox="1791 451 1881 636"></td> </tr> <tr> <td data-bbox="991 636 1087 821">3.a</td> <td data-bbox="1087 636 1791 821"><i>Each team member presents relevant and appropriate content for the discipline-specific assessments. The Psychiatric Technician presents global observations of the individual for the WRP review period.</i></td> <td data-bbox="1791 636 1881 821">3%</td> </tr> <tr> <td data-bbox="991 821 1087 898">3.b</td> <td data-bbox="1087 821 1791 898"><i>Team members present their assessments and consultations as listed in the Task Tracking Form.</i></td> <td data-bbox="1791 821 1881 898">10%</td> </tr> <tr> <td data-bbox="991 898 1087 974">3.c</td> <td data-bbox="1087 898 1791 974"><i>Team members discuss the individual's specific outcomes for the WRP review period.</i></td> <td data-bbox="1791 898 1881 974">5%</td> </tr> </table> <p>NSH's data analysis showed the following:</p> <ol style="list-style-type: none"> 1. The compliance rates for two sub-items have increased from the last month of the prior review period, December 2007, to the last month of the current review period, May 2008: item 3.a from 1% to 3% (albeit marginal improvement) and item 3.b from 7% to 14%. 2. The compliance rate for sub-item 3.c has decreased from 11% in the last month of the prior review period, December 2007, to 6% in the last month of the current review period. 	3.	<i>Each member of the team participates appropriately in competently and knowledgeably assessing the individual on an ongoing basis and in developing, monitoring, and, as necessary revising the therapeutic and rehabilitative services.</i>		3.a	<i>Each team member presents relevant and appropriate content for the discipline-specific assessments. The Psychiatric Technician presents global observations of the individual for the WRP review period.</i>	3%	3.b	<i>Team members present their assessments and consultations as listed in the Task Tracking Form.</i>	10%	3.c	<i>Team members discuss the individual's specific outcomes for the WRP review period.</i>	5%
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3.a	<i>Each team member presents relevant and appropriate content for the discipline-specific assessments. The Psychiatric Technician presents global observations of the individual for the WRP review period.</i>	3%												
3.b	<i>Team members present their assessments and consultations as listed in the Task Tracking Form.</i>	10%												
3.c	<i>Team members discuss the individual's specific outcomes for the WRP review period.</i>	5%												

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		<p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure recruitment of senior clinicians to fill current vacancies. 2. Monitor this requirement using the Clinical Chart Audit form based on at least a 20% sample. 3. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).
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>Recommendations 1 and 2, January 2008:</p> <ul style="list-style-type: none"> • Monitor this requirement using the WRP Observation Monitoring Form based on at least a 20% sample. • Provide data analysis addressing sub-items of this requirement. The analysis must evaluate areas of low compliance and delineate areas of relative improvement. <p>Findings: NSH used the DMH Observation Monitoring Form and reported a compliance rate of 2% for this requirement. The rate reported during the last review period was 0%, but compliance has decreased from 11% (December 2007) to 4% (May 2008).</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Monitor this requirement using the WRP Observation Monitoring Form based on at least a 20% sample. 2. Provide data analysis addressing sub-items of this requirement.

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		<p>The analysis must evaluate areas of low compliance and delineate areas of relative improvement.</p>
<p>C.1.g</p>	<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, January 2008: Utilize the WaRMSS WRP Module to facilitate scheduling and coordination of assessments, WPRT meetings and progress reviews.</p> <p>Findings: NSH has implemented this recommendation.</p> <p>Recommendation 2, January 2008: Ensure that WRPs are completed and reviewed per the schedule established in the DMH WRP manual in all units.</p> <p>Findings: NSH has implemented this recommendation. The WRPC frequency schedule has been implemented on all units at NSH. During the previous review period, 44 WRPTs had implemented the required WRP schedule. Effective with the current review period, all WRPTs at the facility (#53) are required to implement the WRP schedule specified in the EP.</p> <p>Recommendations 3 and 4, January 2008:</p> <ul style="list-style-type: none"> • Monitor this requirement using the WRP Observation Monitoring Form based on at least a 20% sample. • Provide data analysis addressing sub-items of this requirement. The analysis must evaluate areas of low compliance and delineate areas of relative improvement <p>Findings: NSH used this process to assess compliance (January to May 2008). The following is a summary of the data:</p>

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		<table border="1"> <tr> <td data-bbox="989 228 1087 415">5.</td> <td data-bbox="1087 228 1793 415"><i>The team identified someone to be responsible for the scheduling and coordination of assessments and team meetings, the drafting of integrated treatment plans, and the scheduling and coordination of necessary progress reviews.</i></td> <td data-bbox="1793 228 1881 415"></td> </tr> <tr> <td data-bbox="989 415 1087 565">5.a</td> <td data-bbox="1087 415 1793 565"><i>There is an identified WRP recorder who is responsible for the scheduling and coordination of assessments and WRPCs. This person typically records the WRP.</i></td> <td data-bbox="1793 415 1881 565">78%</td> </tr> <tr> <td data-bbox="989 565 1087 824">5.b</td> <td data-bbox="1087 565 1793 824"><i>The identified recorder drafts the WRP on the computer and obtains all necessary signatures on the completed WRP, schedules the next conference date and time, Fills out the appointment card for the next WRPC for the individual and fills out the WRPC Task Tracking form at the conference.</i></td> <td data-bbox="1793 565 1881 824">10%</td> </tr> </table>	5.	<i>The team identified someone to be responsible for the scheduling and coordination of assessments and team meetings, the drafting of integrated treatment plans, and the scheduling and coordination of necessary progress reviews.</i>		5.a	<i>There is an identified WRP recorder who is responsible for the scheduling and coordination of assessments and WRPCs. This person typically records the WRP.</i>	78%	5.b	<i>The identified recorder drafts the WRP on the computer and obtains all necessary signatures on the completed WRP, schedules the next conference date and time, Fills out the appointment card for the next WRPC for the individual and fills out the WRPC Task Tracking form at the conference.</i>	10%
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5.b	<i>The identified recorder drafts the WRP on the computer and obtains all necessary signatures on the completed WRP, schedules the next conference date and time, Fills out the appointment card for the next WRPC for the individual and fills out the WRPC Task Tracking form at the conference.</i>	10%									
<p>NSH's data analysis showed the following:</p> <ol style="list-style-type: none"> 1. The compliance rate for sub-item 5.a has increased from the last month of the prior review period, December 2007, to the last month of the current review period, May 2008 (61% to 87%). 2. The compliance rate for sub-item 5.b has been essentially unchanged from the last month of the prior review period, December 2007, to the last month of the current review period, May 2008: <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Monitor this requirement using the WRP Observation Monitoring 											

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		<p>Form based on at least a 20% sample.</p> <p>2. Provide data analysis addressing sub-items of this requirement. The analysis must evaluate areas of low compliance and delineate areas of relative improvement</p>																								
<p>C.1.h</p>	<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>Recommendations 1, 2 and 3 January 2008:</p> <ul style="list-style-type: none"> • Continue to monitor attendance by all core members of the WRPTs. • Address and correct factors related to low attendance rates of Psychiatric Technicians. • Utilize the WaRMSS WRP Module to ensure adequate sample sizes. <p>Findings: NSH has provided data that address the above recommendations. The data showed that the attendance rates have improved since the last review period for all core members. The following is a summary of the data for each review period:</p> <table border="1" data-bbox="991 894 1831 1239"> <thead> <tr> <th></th> <th>July to December 2007</th> <th>January to May 2008</th> </tr> </thead> <tbody> <tr> <td>Individual</td> <td>72%</td> <td>81%</td> </tr> <tr> <td>Psychiatrist</td> <td>68%</td> <td>82%</td> </tr> <tr> <td>Psychologist</td> <td>74%</td> <td>84%</td> </tr> <tr> <td>Social Worker</td> <td>61%</td> <td>76%</td> </tr> <tr> <td>Rehabilitation Therapist</td> <td>65%</td> <td>80%</td> </tr> <tr> <td>Registered Nurse</td> <td>55%</td> <td>82%</td> </tr> <tr> <td>Psychiatric Technician</td> <td>4%</td> <td>16%</td> </tr> </tbody> </table> <p>Compliance: Partial.</p>		July to December 2007	January to May 2008	Individual	72%	81%	Psychiatrist	68%	82%	Psychologist	74%	84%	Social Worker	61%	76%	Rehabilitation Therapist	65%	80%	Registered Nurse	55%	82%	Psychiatric Technician	4%	16%
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		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to monitor attendance by all core members of the WRPTs. 2. Address and correct factors related to low attendance rates of Psychiatric Technicians. 																																																																																																		
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 recommendation:</p> <p>Recommendation, January 2008: Continue recruitment efforts to ensure compliance with this recommendation in both admissions and long-term WRPTs.</p> <p>Findings: The following is a summary of the facility's data for this review period:</p> <table border="1" data-bbox="989 711 1749 979"> <thead> <tr> <th></th> <th>Jan</th> <th>Feb</th> <th>Mar</th> <th>Apr</th> <th>May</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>MDs</td> <td>1:14</td> <td>1:15</td> <td>1:15</td> <td>1:16</td> <td>1:16</td> <td>1:15</td> </tr> <tr> <td>PhDs</td> <td>1:14</td> <td>1:14</td> <td>1:14</td> <td>1:16</td> <td>1:14</td> <td>1:14</td> </tr> <tr> <td>SWs</td> <td>1:13</td> <td>1:13</td> <td>1:13</td> <td>1:14</td> <td>1:14</td> <td>1:13</td> </tr> <tr> <td>RTs</td> <td>1:13</td> <td>1:13</td> <td>1:13</td> <td>1:15</td> <td>1:15</td> <td>1:14</td> </tr> <tr> <td>RNs</td> <td>1:14</td> <td>1:14</td> <td>1:14</td> <td>1:16</td> <td>1:16</td> <td>1:15</td> </tr> <tr> <td>PTs</td> <td>1:14</td> <td>1:14</td> <td>1:14</td> <td>1:16</td> <td>1:16</td> <td>1:15</td> </tr> </tbody> </table> <table border="1" data-bbox="989 1016 1749 1284"> <thead> <tr> <th></th> <th>Jan</th> <th>Feb</th> <th>Mar</th> <th>Apr</th> <th>May</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>MDs</td> <td>1:27</td> <td>1:25</td> <td>1:25</td> <td>1:25</td> <td>1:27</td> <td>1:26</td> </tr> <tr> <td>PhDs</td> <td>1:27</td> <td>1:27</td> <td>1:26</td> <td>1:26</td> <td>1:25</td> <td>1:26</td> </tr> <tr> <td>SWs</td> <td>1:26</td> <td>1:29</td> <td>1:26</td> <td>1:27</td> <td>1:27</td> <td>1:27</td> </tr> <tr> <td>RTs</td> <td>1:25</td> <td>1:26</td> <td>1:25</td> <td>1:24</td> <td>1:24</td> <td>1:25</td> </tr> <tr> <td>RNs</td> <td>1:24</td> <td>1:23</td> <td>1:23</td> <td>1:23</td> <td>1:23</td> <td>1:23</td> </tr> <tr> <td>PTs</td> <td>1:24</td> <td>1:23</td> <td>1:23</td> <td>1:23</td> <td>1:23</td> <td>1:23</td> </tr> </tbody> </table> <p>NSH's data showed that during this review period, the facility has improved the staffing ratios and achieved substantial compliance with</p>		Jan	Feb	Mar	Apr	May	Mean	MDs	1:14	1:15	1:15	1:16	1:16	1:15	PhDs	1:14	1:14	1:14	1:16	1:14	1:14	SWs	1:13	1:13	1:13	1:14	1:14	1:13	RTs	1:13	1:13	1:13	1:15	1:15	1:14	RNs	1:14	1:14	1:14	1:16	1:16	1:15	PTs	1:14	1:14	1:14	1:16	1:16	1:15		Jan	Feb	Mar	Apr	May	Mean	MDs	1:27	1:25	1:25	1:25	1:27	1:26	PhDs	1:27	1:27	1:26	1:26	1:25	1:26	SWs	1:26	1:29	1:26	1:27	1:27	1:27	RTs	1:25	1:26	1:25	1:24	1:24	1:25	RNs	1:24	1:23	1:23	1:23	1:23	1:23	PTs	1:24	1:23	1:23	1:23	1:23	1:23
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		<p>this requirement in both admission and long-term units.</p> <p>Compliance: Substantial.</p> <p>Current recommendations: Continue current practice and provide data regarding staffing ratios on the admissions and long-term units.</p>
C.1.j	<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 recommendation:</p> <p>Recommendation, January 2008: Same as in C.1.a through C.1.f.</p> <p>Findings: Same as in C.1.a through C.1.f.</p> <p>Other findings: NSH presented data regarding competency-based training of WRPT members as measured by the WRP knowledge assessment test. However, the data were inconsistent with those provided in C.1.a for the same process.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Same as in C.1.a through C.1.f. 2. Ensure accuracy of data regarding competency-based training of WRPT members as measured by the WRP Knowledge assessment test.

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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. Eleven individuals: BW, CD, CP, ER, FK, JC, JW, LG, PD, VB and WW 2. Alisha McPherson, RN, HSS, WRP Trainer 3. Andrea Brandom, RT 4. Anne Hoff, PhD, Senior Supervising Psychologist 5. Beverly Lynn, Acting Senior Rehabilitation Therapist 6. Camille Gentry, Acting Senior Rehabilitation Therapist 7. Cara Rodriguez, Social Worker 8. Carmen Caruso, Clinical Administrator 9. Christopher Fisher, PhD, Psychologist 10. Cindy Black, Director of Standards Compliance 11. Craig Saewong, Acting Assistant Director of Dietetics 12. Debby Wenkley, Unit Supervisor 13. Donald Koeplin, PhD, Psychologist 14. Donna Robeson, LCSW 15. Emily Freiman, RT 16. Eytan Bercovith, PhD, Psychologist 17. Heidi Vogelsang, Registered Dietitian 18. Hollie Bloom, LCSW 19. Ingrid Lacey, Rehabilitation Therapist 20. Jane Adams, LCSW, Acting Senior Supervisor, Social Work 21. Jim Jones, PhD, Chief of Psychology 22. Jo Ethany 23. Julie Winn, PhD, Psychologist 24. Karen Phillips, PhD, Master WRP Trainer 25. Kathleen Elbert, Art Therapist 26. Katie Cooper, PsyD, Enhancement Plan Coordinator 27. Lee Hamilton, MD, Staff Psychiatrist 28. Leslie Cobb, Teacher, Speech Pathologist 29. Lydia Mendoza, RN

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		<p>30. Lynn Wurzel, Registered Dietitian 31. Malia Haas, LCSW, Acting Senior Supervisor, Social Work 32. Maria Cortez, LVN 33. Marlene Salvador, MD 34. Michael Comini, MSW, Section Leader 35. Mike Stolp, Program Director 36. Monique Jansma, LCSW, Acting Senior Supervisor, Social Work 37. Noriko Takenawa, Registered Dietitian 38. Pat White, PhD, Senior Psychologist, PBS Team Member 39. Patricia Tyler, Acting Medical Director 40. Phyllis Moore, Acting Senior Rehabilitation Therapist 41. Preciosa Perdiguerra, RN 42. Rebecca Baumer, RN, LCSW, Acting Senior Supervisor, Social Work 43. Reggie Ott, Chief of Rehabilitation Services 44. Robert Newman, Acting Senior Rehabilitation Therapist 45. Robert Schaufenbil, Acting Senior Rehabilitation Therapist 46. Ruby Ventura, Psychiatry Technician Assistant 47. Saakski Arora, MT, WRP Trainer 48. Sophie Tranel, PT 49. Tammerra Murray, SRN 50. Terese Mesa, PT, WRP Trainer 51. Thomas Hulsey, Unit Supervisor 52. Tom Graf, Unit Supervisor 53. Tony Rabin, PhD, Mall Director 54. Wen Pao, Director of Dietetics 55. Wendy Gardiner, Teacher</p> <p><u>Reviewed:</u> 1. The charts of the following 230 individuals: AA, AAC, AB, AC, AE, AGV, AIR, ALR, ALW, AM, AMM, AMS, AMW, AP, AS, AT, ATB, ATM, AVC, AWD, AWT, BAP, BJ, BMC, BTM, CA, CAG, CAW, CC, CCR, CDC, CDV, CDW, CH, CHH, CM, CO, CR, CWE, CWP, DC, DDM, DEA, DG, DHB, DHS, DKRH, DLH, DM, DMP, DP, DR, DSA, DSH,</p>
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		<p>EAB, EAG, EE, EER, EGP, EH, EL, ELC, ELH, EM, EP, EPR, EPY, ERC, ETR, EWK, EWT, EY, FAG, FAS, FCP, FES, FG, FGP, FL, FLK, FLW, FM, FP, FS, FST, FT, GBL, GDM, GH, HCH, HCM, HH, HLA, HM, HRD, HS, HSS, IRS, JA, JAA, JAG, JAS, JB, JCL, JCT, JD, JDS, JDT, JE, JEC, JED, JEG, JEW, JH, JHH, JJY, JKD, JL, JM, JM, JS, JSL, JV, JVM, JWM, JWS, JY, KDC, KDN, KFR, KH, KJN, KLF, KND, LAC, LC, LDC, LER, LF, LFC, LG, LGB, LJ, LK, LL, LLS, LMZ, LNZ, LPO, LR, LRW, MAM, MB, MD, MDC, MEP, MHJ, MO, MP, MQT, MS, MWS, NDW, NW, OB, OGJ, OH, PA, PAM, PB, PCB, PEM, PFM, PG, PLB, PMN, PWB, RA, RAA, RAL, RAM, RB, RC, RCB, RCC, RD, RG, RGW, RH, RJM, RJT, RK, RL, RM, RME, RMT, RP, RR, RRT, RT, RTP, RZ, SB, SEB, SEF, SET, SHA, SHS, SLC, SM, SN, SS, SSP, SWS, TCG, TDF, TEG, TEH, TLJ, TLN, TMR, TR, TTN, VZ, WA, WCF, WD, WV, WZ and ZEK</p> <ol style="list-style-type: none"> 2. Active Treatment Course Outline for Bed-Bound Individuals 3. Case Formulation Helplist 4. Completed Group/Activity Request Forms 5. Completed PSR Mall Facilitator Consultation 6. DMH Chart Auditing Form 7. DMH Chart Auditing Form Instructions 8. NSH Chart Auditing summary data (January to May 2008) 9. DMH Clinical Chart Auditing Form 10. DMH Clinical Chart Auditing Form Instructions 11. NSH Clinical Chart Auditing Form summary data (January to May 2008) 12. DMH WRP Process Observation Monitoring Form 13. DMH WRP Process Observation Monitoring Form Instructions 14. NSH WRP Process Observation Monitoring summary data (January to May 2008) 15. DMH WRP Substance Abuse Monitoring Form 16. DMH WRP Substance Abuse Monitoring Form Instructions 17. NSH Substance Abuse Monitoring summary data (January to May 2008)
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		<ol style="list-style-type: none"> 18. Examples of Case Formulation 19. Facilitating Wellness Group Completed Post-Tests 20. Individual's PSR Mall Monthly Progress Note (template) 21. Lesson Plan: Personal Recovery 22. Lesson Plan: Wellness and Recovery Orientation 23. Lesson Plan: WRP Linkages 24. List of Active Facilitators 25. List of Administrative and Support Staff Providing Active Treatment Services 26. List of Cancelled Appointments 27. List of Credentialing/Privileging For Substance Abuse 28. List of Individuals Assessed to Need Family Therapy 29. List Of Individuals Who Received Physical, And/Or Speech Therapy Direct Treatment From January-May 2008 30. List of Individuals with High BMIs 31. List of Individuals with Mall Group Hours Attended 32. List of Scheduled Exercise Groups 33. List of Scheduled Versus Missed Appointments 34. List of Supplemental/Leisure Activities 35. Mall Course Outlines 36. Mall Facilitator Training and Development Roster 37. Mall Group Provider Training and Development Roster 38. Mall Provider List 39. Mall Services Tasks for Senior Supervising Clinicians 40. NSH draft AD, Comprehensive Substance Recovery Services 41. NSH MAPP data regarding active treatment hours scheduled and attended (January to May 2008) 42. NSH's General Management Meeting Minutes (May 2008) 43. Program 4 Procedure Manual 44. PSR Mall Schedules 45. Psychosocial Enrichment Activity List 46. Sample Objectives and Interventions for Individuals with Cognitive and Developmental Issues
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		<p>47. Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES)</p> <p>48. Substance Abuse Provider Summary</p> <p>49. Therapeutic Milieu Outcome Measures</p> <p>50. Training Issues for Psychologists: Cognitive Impairment</p> <p>51. University of Rhode Island Change Assessment Scale (URICA)</p> <p>52. Verification of Competency for Providing Substance Abuse Groups</p> <p><u>Observed</u></p> <ol style="list-style-type: none"> 1. WRPC (Program II, unit T-3) for quarterly review of JAY 2. WRPC (Program II, unit T-3) for 14-day review of CD 3. WRPC (Program V, unit Q-1) for 14-day review of SLC 4. WRPC (Program I, unit T- https://bancaincasa.sba.bcc.it/certificatoC6) for monthly review of RB 5. WRPC (Program II, unit T-17) for monthly review of BGP 6. WRPC (Program IV, unit A-4) for monthly review of RM 7. WRPC (Program I, unit Q-4) for quarterly review of RP 8. WRPC (Program IV unit A-4) for quarterly review of RLM 9. WRPC for GMW 10. WPRC for RAB 11. PSR Mall group: Communication Skills through Drama 12. PSR Mall group: Communication Skills through Drumming 13. PSR Mall group: Communication through Art 14. PSR Mall group: Enhancement Motivation 15. PSR Mall group: Leisure Exploration 16. PSR Mall group: Mental Health Through Laughter 17. PSR Mall group: Mural Painting 18. PSR Mall group: New Start for Mental Health 19. PSR Mall group: Relaxation 20. PSR Mall group: Social Skills Through Improvisational Theater 21. PSR Mall group: Stretching/Relaxation 22. PSR Mall group: Suicide Prevention Education Awareness Keys
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		<p>23. PSR Mall group: Vocational Rehabilitation 24. BY CHOICE Redemption Center</p>						
<p>C.2.a</p>	<p>Individuals have substantive input into the therapeutic and rehabilitation service planning process, including but not limited to input as to mall groups and therapies appropriate to their WRP.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, January 2008: Continue WRP training that focuses on the process of engaging the individual in providing substantive input.</p> <p>Findings: Same as in C.1.a. In addition, the WRP Master Trainer has initiated a program to educate NSH individuals regarding the WRP model and developed a curriculum for this program. The facility plans to provide WRP Engagement Mall groups based on this curriculum.</p> <p>Recommendations 2 and 3, January 2008:</p> <ul style="list-style-type: none"> • Monitor this requirement using the Observation Monitoring Auditing Form based on at least a 20% sample. • Provide data analysis addressing sub-items of this requirement. The analysis must evaluate areas of low compliance and delineate areas of relative improvement. <p>Findings: NSH used the DMH Observation Monitoring Form to assess compliance (January to May 2008) based on an average sample size of 22%. The following is a summary of the data:</p> <table border="1" data-bbox="995 1192 1887 1416"> <tr> <td data-bbox="995 1192 1089 1341">6.</td> <td data-bbox="1089 1192 1793 1341"><i>Individuals have substantive input into the therapeutic and rehabilitation service planning process, including but not limited to input as to mall groups and therapies appropriate to their WRP.</i></td> <td data-bbox="1793 1192 1887 1341"></td> </tr> <tr> <td data-bbox="995 1341 1089 1416">6.a</td> <td data-bbox="1089 1341 1793 1416"><i>The WRPT asks the individual for his or her input into the evaluation of progress on each objective,</i></td> <td data-bbox="1793 1341 1887 1416">14%</td> </tr> </table>	6.	<i>Individuals have substantive input into the therapeutic and rehabilitation service planning process, including but not limited to input as to mall groups and therapies appropriate to their WRP.</i>		6.a	<i>The WRPT asks the individual for his or her input into the evaluation of progress on each objective,</i>	14%
6.	<i>Individuals have substantive input into the therapeutic and rehabilitation service planning process, including but not limited to input as to mall groups and therapies appropriate to their WRP.</i>							
6.a	<i>The WRPT asks the individual for his or her input into the evaluation of progress on each objective,</i>	14%						

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			<p><i>as clinically indicated.</i></p>	
		6.b	<p><i>When the individual has achieved an objective, at the current WRPC, the WRPT discusses with the individual the groups available for the next objective. The individual makes a choice from several equivalent options.</i></p>	8%
		6.c	<p><i>The WRPT reviews the By Choice points, preferences and allocation with the individual. The individual determines how he or she will allocate the points between WRPCs.</i></p>	29%
		6.d	<p><i>When the individual identifies cultural preferences, the team updates the case formulation and may incorporate them into the individual's WRP objectives and interventions, as relevant.</i></p>	18%
		<p>The facility conducted data analysis showing that compliance has improved from the last month of the prior review period, December 2007, to the last month of the current review period, May 2008, as follows:</p> <ol style="list-style-type: none"> 1. Item 6.a: from 9% to 20%; 2. Item 6.b: from 4% to 15%; 3. Item 6.c: from 22% to 34%; 4. Item 6.d: from 6% to 35%. <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue current training and mentoring regarding engagement of individuals and initiate training using the MSH module regarding engagement of the individuals. 		

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		<p>2. Monitor this requirement using process observation based on at least a 20% sample.</p> <p>3. Provide data analysis that evaluates low compliance and delineates areas of relative improvement (during the reporting period and compared to the last period).</p>
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 recommendation:</p> <p>Recommendation, January 2008: Monitor this requirement using the Chart Auditing Form based on at least a 20% sample.</p> <p>Findings: NSH used the DMH Chart Auditing Form to assess compliance with the requirements in C.2.b.i to C.2.b.iii (January to May 2008). Based on a sample size of 88%, the facility reported a compliance rate of 96% for this requirement. The compliance rate was 83% for the last review period.</p> <p>The facility's data are presented below in each corresponding cell (C.2.b.ii and C.2.b.iii).</p> <p>Other findings: This monitor reviewed the charts of 10 individuals (AWD, CC, CWE, EAB, EGP, FCP, HM, JB, RJT and RR). The review found compliance in all cases except one (RR).</p> <p>Compliance: Substantial.</p>

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		<p>Current recommendations: Continue to monitor this requirement.</p>
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 recommendation:</p> <p>Recommendation, January 2008: Monitor this requirement using the Chart Auditing Form based on at least a 20% sample.</p> <p>Findings: The facility reported a compliance rate of 90% for this requirement. The average sample size was 19%. The mean compliance rate was 57% for the last review period.</p> <p>Other findings: Reviews of 10 charts found compliance in all cases except one (RR).</p> <p>Compliance: Substantial.</p> <p>Current recommendations: Continue to monitor this requirement and ensure a sample size of at least 20%.</p>
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 recommendation:</p> <p>Recommendation, January 2008: Monitor this requirement using the Chart Auditing Form based on at least a 20% sample.</p>

		<p>Findings:</p> <table border="1" data-bbox="995 264 1654 495"> <thead> <tr> <th>WRP Review</th> <th>Mean sample size</th> <th>Mean compliance rate</th> </tr> </thead> <tbody> <tr> <td>14-Day</td> <td>8%</td> <td>10%</td> </tr> <tr> <td>Monthly</td> <td>20%</td> <td>29%</td> </tr> <tr> <td>Quarterly</td> <td>24%</td> <td>28%</td> </tr> <tr> <td>Annual</td> <td>26%</td> <td>22%</td> </tr> </tbody> </table> <p>The following summarizes the facility's data analysis and actions to improve compliance:</p> <ol style="list-style-type: none"> 1. 14-Day WRPCs: <ol style="list-style-type: none"> a. The compliance rate has decreased from the last month of the prior review period, December 2007, to the last month of the current review period, May 2008 (17% to 8%). b. The low compliance could be attributed to one program not holding the 42-day (third 14-day) conference consistently. c. Beginning in July 2008, the Clinical Administrator has changed oversight of scheduling and holding WRPCs to improve compliance. 2. Monthly WRPCs: The compliance rate has increased from the last month of the prior review period, December 2007 (3%), to the last month of the current review period, May 2008 (55%). 3. Quarterly WRPCs: The compliance rate has increased from the last month of the prior review period, December 2007 (3%), to the last month of the current review period, May 2008 (50%). 4. Annual WRPCs: <ol style="list-style-type: none"> a. The compliance rate has increased from the last month of the prior review period, December 2007 (5%), to the last month of the current review period, May 2008 (50%). b. The Clinical Administrator (CA) will designate a staff in each program to track WRP frequency and provide findings to the 	WRP Review	Mean sample size	Mean compliance rate	14-Day	8%	10%	Monthly	20%	29%	Quarterly	24%	28%	Annual	26%	22%
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		<p>CA, the Chief of Psychiatry and the Program Directors.</p> <p>Other findings: Chart reviews by this monitor found compliance in seven cases (CC, EAB, EGP, FCP, JB, RJT and RR) and partial compliance in three (AWD, CWE and HM).</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Monitor this requirement using process observation based on at least a 20% sample. 2. Provide data analysis that evaluates low compliance and delineates areas of relative improvement (during the reporting period and compared to the last period).
C.2.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, January 2008: Continue and strengthen the WRP training curriculum to ensure that:</p> <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. <p>Findings: In January 2008, NSH began utilizing the NSH WRP Content and Process curriculum that incorporated development of the case formulation based on assessments and the development of foci, objectives and interventions.</p>

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		<p>As mentioned earlier, the facility plans to implement the MSH modules (case formulation and foci and objectives) in August 2008.</p> <p>Recommendations 2 and 3, January 2008:</p> <ul style="list-style-type: none"> • Monitor this requirement using the Clinical Chart Auditing Form based on at least a 20% sample. • Provide data analysis addressing sub-items of this requirement. The analysis must delineate areas of low compliance and areas of relative improvement. <p>Findings:</p> <p>NSH used the DMH Clinical Chart Auditing Form to assess compliance (January to May 2008). The average sample was 8% of the quarterly and annual WRPs per month. The following is a summary of the data:</p> <table border="1" data-bbox="995 781 1885 1416"> <tr> <td data-bbox="995 781 1089 971">2.</td> <td data-bbox="1089 781 1793 971"><i>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.</i></td> <td data-bbox="1793 781 1885 971"></td> </tr> <tr> <td data-bbox="995 971 1089 1081">2.a</td> <td data-bbox="1089 971 1793 1081"><i>When a cognitive disorder is identified on Axis I, it is written in Focus I, and has at least one objective with an appropriately linked intervention.</i></td> <td data-bbox="1793 971 1885 1081">3%</td> </tr> <tr> <td data-bbox="995 1081 1089 1192">2.b</td> <td data-bbox="1089 1081 1793 1192"><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.</i></td> <td data-bbox="1793 1081 1885 1192">48%</td> </tr> <tr> <td data-bbox="995 1192 1089 1302">2.c</td> <td data-bbox="1089 1192 1793 1302"><i>When a mental retardation is identified on Axis II, all interventions are aligned with the cognitive functioning level of the individual.</i></td> <td data-bbox="1793 1192 1885 1302">0%</td> </tr> <tr> <td data-bbox="995 1302 1089 1416">2.d</td> <td data-bbox="1089 1302 1793 1416"><i>When seizure disorder is identified on Axis III, it is written in Focus 6, and has at least one objective with an appropriately linked intervention.</i></td> <td data-bbox="1793 1302 1885 1416">15%</td> </tr> </table>	2.	<i>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.</i>		2.a	<i>When a cognitive disorder is identified on Axis I, it is written in Focus I, and has at least one objective with an appropriately linked intervention.</i>	3%	2.b	<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.</i>	48%	2.c	<i>When a mental retardation is identified on Axis II, all interventions are aligned with the cognitive functioning level of the individual.</i>	0%	2.d	<i>When seizure disorder is identified on Axis III, it is written in Focus 6, and has at least one objective with an appropriately linked intervention.</i>	15%
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		<p>NSH conducted data analysis showing improvement in compliance for sub-indicators 2.b (68% to 75%) and 2.d (50% to 100%) from December 2007 to May 2008. For items 2.a and 2.c, the random sample did not include adequate numbers of the target population. The mean compliance for all sub-indicators increased from 11% in the last review period to 40% in the current review period. The facility determined that the WRPTs often did not open a focus of hospitalization for diagnoses of cognitive disorders and that the interventions were often not aligned with the cognitive levels of individuals diagnosed with mental retardation. Corrective actions included training (in May 2008) for psychologists that focused on these deficiencies.</p> <p>Other findings: This monitor reviewed the charts of several individuals diagnosed with a variety of cognitive and seizure disorders. The reviews found some improvement in the documentation (in the case formulation) of the status of some individuals suffering from cognitive and/or seizure disorders as well as attempts to develop objectives and interventions based on learning outcomes for some individuals suffering from seizure disorders. However, the review also found a pattern of persistent deficiencies that must be corrected to achieve substantial compliance in this area. The following is an outline of these deficiencies:</p> <ol style="list-style-type: none"> 1. Individuals diagnosed with cognitive impairments (AMM, CAG, DHB, FST, JA, LPO, MHJ, MQT, OGJ and TLN); <ol style="list-style-type: none"> a. The WRPs did not include foci, objectives or interventions to address the needs of individuals diagnosed with Dementia Due to General Medical Condition without Behavioral Disturbance (TLN), Cognitive Disorder, NOS (CAG and LPO), and Borderline Intellectual Functioning (AMM). b. The WRPs included objectives related to diagnoses of Dementia
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		<p>Due to <i>General Medical Condition with Behavioral Disturbance (FST) and Cognitive Disorder, NOS (DHB)</i> that were generic and did not address the cognitive impairment. The WRP included an intervention that was inappropriately labeled as cognitive remediation (FST).</p> <ul style="list-style-type: none"> c. The WRPs did not include interventions to assess the risks of ongoing treatment with high-risk medications, including diazepam, chlorpromazine, clonazepam, benztropine, phenytoin and lorazepam (PRN) for individuals diagnosed with <i>Dementia Due to General Medical Condition with (FST, JA and MHJ)</i> and without (<i>OGJ</i>) <i>Behavioral Disturbance and Mild Mental Retardation (MQT)</i>. d. There was evidence of limited offerings of cognitive remediation groups to meet the needs of the relatively large number of individuals diagnosed with cognitive impairments in the facility. e. The present status section of the case formulation did not specify the cognitive status of individuals diagnosed with a <i>Dementia (FST and TLN)</i>. f. In general, the WRPs did not include adequate measures/ consultations to assess, determine the etiology of and/or finalize diagnoses of <i>Cognitive Disorder, NOS (e.g. CAG, DHB and LPO)</i>. <p>2. Individuals diagnosed with seizure disorders (<i>JB, JEC, MHJ, OGJ, PG AND SWS</i>):</p> <ul style="list-style-type: none"> a. The WRPs did not include specific morphological diagnosis regarding the type of seizure disorder in all charts reviewed. b. The WRPs included objectives that were not meaningful for some individuals, such as continuing to cooperate with taking medications and laboratory work (<i>OGJ</i>). c. The WRP did not include objectives with learning outcomes for individuals (<i>MHJ and OGJ</i>). d. The present status sections of the WRPs did not address the
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		<p>status of the individual's seizure activity and/or related risks during the previous interval (PG).</p> <p>e. The WRPs did not include objectives/ interventions to assess the risks of treatment with older anticonvulsant medications, and to minimize impact on the individual's behavior and cognitive status. Examples include individuals receiving phenytoin (JB, JEC and PG), primidone (SWS), and combinations of phenytoin and clonazepam (MHJ) and phenytoin and phenobarbital (MHJ).</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue and strengthen 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. Monitor this requirement using the Clinical Chart Auditing Form based on at least a 20% sample. 3. Provide data analysis that evaluates low compliance and delineates areas of relative improvement (during the reporting period and compared to the last period).
C.2.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>

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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, January 2008: Implement training on the Case Formulation Module for all WRPTs and ensure that the training includes clinical case examples.</p> <p>Findings: Same as in C.1.a.</p> <p>Recommendations 2 and 3, January 2008:</p> <ul style="list-style-type: none"> • Monitor this requirement using the Clinical Chart Auditing Form based on at least a 20% sample. • Provide data analysis addressing sub-items of this requirement. The analysis must evaluate areas of low compliance and delineate areas of relative improvement. <p>Findings: NSH used the DMH Clinical Chart Auditing Form to assess compliance (January to May 2008). The average sample was 8% of the Quarterly and Annual WRPs. The following is a summary of the data regarding this requirement.</p> <table border="1" data-bbox="995 1044 1885 1414"> <tr> <td data-bbox="995 1044 1087 1192">3.</td> <td data-bbox="1087 1044 1793 1192"><i>The case formulation is derived from analyses of the information gathered from interdisciplinary assessments, including diagnosis and differential diagnosis.</i></td> <td data-bbox="1793 1044 1885 1192"></td> </tr> <tr> <td data-bbox="995 1192 1087 1414">3.a</td> <td data-bbox="1087 1192 1793 1414"><i>All six sections of the case formulation (i.e., pertinent history, predisposing, precipitating, perpetuating factors, previous treatment and present status) are aligned with the Integrated Assessment and/or additional discipline-specific assessments, including</i></td> <td data-bbox="1793 1192 1885 1414">61%</td> </tr> </table>	3.	<i>The case formulation is derived from analyses of the information gathered from interdisciplinary assessments, including diagnosis and differential diagnosis.</i>		3.a	<i>All six sections of the case formulation (i.e., pertinent history, predisposing, precipitating, perpetuating factors, previous treatment and present status) are aligned with the Integrated Assessment and/or additional discipline-specific assessments, including</i>	61%
3.	<i>The case formulation is derived from analyses of the information gathered from interdisciplinary assessments, including diagnosis and differential diagnosis.</i>							
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		3.b	<p><i>All six sections of the case formulation indicate interdisciplinary participation and are not written from the point of view of one discipline.</i></p>	21%
<p>NSH's data analysis showed that compliance rate has increased from December 2007, to May 2008 as follows:</p> <ol style="list-style-type: none"> 1. Item 3.a: from 18% to 41%; and 2. Item 3.b: from 9% to 56%. <p>The compliance data for the requirements in C.2.d.ii to C.2.d.vi are entered for each corresponding cell below. The sub-indicators are listed, as necessary. The facility anticipates enhanced compliance in response to WRP training activities.</p> <p>Other findings: Chart reviews and WRPCs attended by this monitor and his consultants demonstrated that NSH has made progress as follows:</p> <ol style="list-style-type: none"> 1. A draft of the case formulation was prepared prior to the meeting and the WRPTs reviewed the draft during the meeting. 2. The case formulations were completed in the 6-p format. 3. The content of the present status section of the formulation was, in general, more comprehensive compared to the last review. Examples of improved documentation were found in the charts of JB, OGJ and MHJ. 4. In general, the pertinent history and precipitating factors were more inclusive of needed information compared to the last review. 5. In general, there was improved linkage within different components of the formulations and between the material in the case formulations and other key components of foci of hospitalization, objectives and interventions 6. In general, substance abuse was addressed as a precipitating and a 				

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		<p>perpetuating factor.</p> <p>However, the content of many formulations showed that the facility has to make further progress regarding the following:</p> <ol style="list-style-type: none"> 1. The present status sections did not include sufficient review and analysis of the following: <ol style="list-style-type: none"> a. Use of restrictive interventions; b. Clinical progress regarding a variety of disorders and high-risk behaviors; and c. Clinical progress towards individualized discharge criteria. 2. There was inadequate linkage between the material in the case formulations and the individual's life goals and strengths as utilized in the objectives and interventions. <p>These deficiencies must be corrected in order to achieve substantial compliance with this requirement.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Implement training on the Case Formulation Module for all WRPTs and ensure that the training includes clinical case examples. 2. Monitor this requirement using the Clinical Chart Auditing Form based on at least a 20% sample. 3. Provide data analysis that evaluates low compliance and delineates areas of relative improvement (during the reporting period and compared to the last period). 															
C.2.d.ii	include a review of: pertinent history; predisposing, precipitating and perpetuating factors; previous treatment history, and present status;	<table border="1"> <tr> <td>4.a</td> <td><i>Pertinent history</i></td> <td>18%</td> </tr> <tr> <td>4.b</td> <td><i>Predisposing factors</i></td> <td>12%</td> </tr> <tr> <td>4.c</td> <td><i>Precipitating factors</i></td> <td>5%</td> </tr> <tr> <td>4.d</td> <td><i>Perpetuating factors</i></td> <td>5%</td> </tr> <tr> <td>4.e</td> <td><i>Previous treatment</i></td> <td>8%</td> </tr> </table>	4.a	<i>Pertinent history</i>	18%	4.b	<i>Predisposing factors</i>	12%	4.c	<i>Precipitating factors</i>	5%	4.d	<i>Perpetuating factors</i>	5%	4.e	<i>Previous treatment</i>	8%
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4.e	<i>Previous treatment</i>	8%															

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		<table border="1"> <tr> <td data-bbox="993 188 1094 232">4.f</td> <td data-bbox="1094 188 1797 232"><i>Present status</i></td> <td data-bbox="1797 188 1892 232">2%</td> </tr> </table>	4.f	<i>Present status</i>	2%			
4.f	<i>Present status</i>	2%						
		<p>The compliance rates for all sub-indicators for the last month of the prior review period, December 2007, compare to those for the last month of the current review period, May 2008, as follows:</p> <ol style="list-style-type: none"> 1. Item 4.a: from 4% to 25%; 2. Item 4.b: from 9% to 16%; 3. Item 4.c: from 9% to 9%; 4. Item 4.d: from 0% to 0%; 5. Item 4.e: from 0% to 16%; and 6. Item 4.f: from 0% to 3% <p>NSH conducted adequate analysis of the factors contributing to low compliance in each of the sub-indicators.</p>						
C.2.d.iii	consider biomedical, psychosocial, and psychoeducational factors, as clinically appropriate, for each category in § [III.B.4.b] above;	<table border="1"> <tr> <td data-bbox="993 784 1094 899">5.a</td> <td data-bbox="1094 784 1797 899"><i>There is a completed DMH WRP Case Formulation Worksheet, and</i></td> <td data-bbox="1797 784 1892 899">8%</td> </tr> <tr> <td data-bbox="993 899 1094 938">5.b</td> <td data-bbox="1094 899 1797 938"><i>The information is included in the case formulation</i></td> <td data-bbox="1797 899 1892 938">5%</td> </tr> </table> <p>The compliance rate has increased from December 2007 to May 2008 as follows:</p> <ol style="list-style-type: none"> 1. Item 5.a: from 0% to 29%; and 2. Item 5.b: from 0% to 21%. 	5.a	<i>There is a completed DMH WRP Case Formulation Worksheet, and</i>	8%	5.b	<i>The information is included in the case formulation</i>	5%
5.a	<i>There is a completed DMH WRP Case Formulation Worksheet, and</i>	8%						
5.b	<i>The information is included in the case formulation</i>	5%						
C.2.d.iv	consider such factors as age, gender, culture, treatment adherence, and medication issues that may affect the outcomes of treatment and rehabilitation interventions;	<table border="1"> <tr> <td data-bbox="993 1195 1094 1310">6.a</td> <td data-bbox="1094 1195 1797 1310"><i>All five factors: age, gender, culture, treatment adherence, and medication issues (are included)</i></td> <td data-bbox="1797 1195 1892 1310">25%</td> </tr> <tr> <td data-bbox="993 1310 1094 1421">6.b</td> <td data-bbox="1094 1310 1797 1421"><i>(The formulation) addresses how they affect treatment and rehabilitation outcomes</i></td> <td data-bbox="1797 1310 1892 1421">6%</td> </tr> </table>	6.a	<i>All five factors: age, gender, culture, treatment adherence, and medication issues (are included)</i>	25%	6.b	<i>(The formulation) addresses how they affect treatment and rehabilitation outcomes</i>	6%
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6.b	<i>(The formulation) addresses how they affect treatment and rehabilitation outcomes</i>	6%						

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		<p>The compliance rate has increased from December 2007 to May 2008 as follows:</p> <ol style="list-style-type: none"> 1. Item 6.a: from 9% to 53%; and 2. Item 6.b: from 0% to 22%. 															
C.2.d.v	<p>support the diagnosis by diagnostic formulation, differential diagnosis and Diagnostics and Statistical Manual DSM-IV-TR (or the most current edition) checklists; and</p>	<table border="1"> <tr> <td>7.a</td> <td><i>There is a completed DSM IV- TR Checklist that was completed prior to the 7-day WRP, and thereafter</i></td> <td>23%</td> </tr> <tr> <td>7.b</td> <td><i>There is a completed DSM IV- TR Checklist completed when there is a change of a psychiatric diagnosis.</i></td> <td>8%</td> </tr> </table> <p>The compliance rate has increased from December 2007 to May 2008 as follows:</p> <ol style="list-style-type: none"> 1. Item 7.a: from 0% to 33%; and 2. Item 7.b: from 0% to 25%. 	7.a	<i>There is a completed DSM IV- TR Checklist that was completed prior to the 7-day WRP, and thereafter</i>	23%	7.b	<i>There is a completed DSM IV- TR Checklist completed when there is a change of a psychiatric diagnosis.</i>	8%									
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7.b	<i>There is a completed DSM IV- TR Checklist completed when there is a change of a psychiatric diagnosis.</i>	8%															
C.2.d.vi	<p>enable the interdisciplinary team to reach sound determinations about each individual's treatment, rehabilitation, enrichment and wellness needs, the type of setting to which the individual should be discharged, and the changes that will be necessary to achieve discharge.</p>	<table border="1"> <tr> <td>8.a</td> <td><i>The present status section addresses the following: Treatment, Rehabilitation and Enrichment</i></td> <td>16%</td> </tr> <tr> <td>8.b</td> <td><i>The case formulation identifies required changes in individual and systems to optimize treatment, rehabilitation and enrichment outcomes</i></td> <td>15%</td> </tr> <tr> <td>8.c</td> <td><i>The case formulation documents a pathway to the discharge setting</i></td> <td>14%</td> </tr> <tr> <td>8.d</td> <td><i>There is evidence of proper analysis of the following information: of identification of foci, objectives treatment, rehabilitation, and enrichment interventions and there is linkage between the case formulation and the foci of hospitalization, life goals and objectives and interventions.</i></td> <td>15%</td> </tr> <tr> <td>8.e</td> <td><i>There is proper linkage within different sections of</i></td> <td>13%</td> </tr> </table>	8.a	<i>The present status section addresses the following: Treatment, Rehabilitation and Enrichment</i>	16%	8.b	<i>The case formulation identifies required changes in individual and systems to optimize treatment, rehabilitation and enrichment outcomes</i>	15%	8.c	<i>The case formulation documents a pathway to the discharge setting</i>	14%	8.d	<i>There is evidence of proper analysis of the following information: of identification of foci, objectives treatment, rehabilitation, and enrichment interventions and there is linkage between the case formulation and the foci of hospitalization, life goals and objectives and interventions.</i>	15%	8.e	<i>There is proper linkage within different sections of</i>	13%
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		<table border="1"> <tr> <td data-bbox="989 190 1094 269"></td> <td data-bbox="1094 190 1797 269"><i>the case formulation when a factor in one section is related to a factor in another section</i></td> <td data-bbox="1797 190 1894 269"></td> </tr> <tr> <td data-bbox="989 269 1094 492">8.f</td> <td data-bbox="1094 269 1797 492"><i>There is evidence of proper analysis of the following information: of identification of foci, objectives treatment, rehabilitation, and enrichment interventions and there is linkage between the case formulation and the foci of hospitalization, life goals and objectives and interventions.</i></td> <td data-bbox="1797 269 1894 492">8%</td> </tr> <tr> <td data-bbox="989 492 1094 675">8.g</td> <td data-bbox="1094 492 1797 675"><i>The case formulation identifies 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.</i></td> <td data-bbox="1797 492 1894 675">19%</td> </tr> </table>		<i>the case formulation when a factor in one section is related to a factor in another section</i>		8.f	<i>There is evidence of proper analysis of the following information: of identification of foci, objectives treatment, rehabilitation, and enrichment interventions and there is linkage between the case formulation and the foci of hospitalization, life goals and objectives and interventions.</i>	8%	8.g	<i>The case formulation identifies 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.</i>	19%	
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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>Compliance rates showed mixed changes from December 2007 to May 2008 as follows:</p> <ol style="list-style-type: none"> 1. Item 8.a: from 40% to 34%; 2. Item 8.b: from 9% to 29%; 3. Item 8.c: from 27% to 23%; 4. Item 8.d: from 36% to 38%; 5. Item 8.e: from 0% to 34%; 6. Item 8.f: from 18% to 25%; and 7. Item 8.g: from 36% to 22%. <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: 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>										

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		<p>Other findings: NSH presented compliance data based on the DMH Clinical Chart Auditing Form (January to May 2008). The average sample was 24% of the WRPs due by month. The following is a summary:</p> <table border="1" data-bbox="995 375 1885 902"> <tr> <td data-bbox="995 375 1087 561">4.</td> <td data-bbox="1087 375 1793 561"><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></td> <td data-bbox="1793 375 1885 561"></td> </tr> <tr> <td data-bbox="995 561 1087 639">4.a</td> <td data-bbox="1087 561 1793 639"><i>There is a focus of hospitalization for each axis I, II, and III diagnosis</i></td> <td data-bbox="1793 561 1885 639">21%</td> </tr> <tr> <td data-bbox="995 639 1087 678">4.b</td> <td data-bbox="1087 639 1793 678"><i>There is a focus for each discharge criteria</i></td> <td data-bbox="1793 639 1885 678">16%</td> </tr> <tr> <td data-bbox="995 678 1087 717">4.c</td> <td data-bbox="1087 678 1793 717"><i>Each focus has an objective and an intervention</i></td> <td data-bbox="1793 678 1885 717">20%</td> </tr> <tr> <td data-bbox="995 717 1087 829">4.d</td> <td data-bbox="1087 717 1793 829"><i>Each intervention includes the name of the staff responsible for implementation, the group name and the group time/day.</i></td> <td data-bbox="1793 717 1885 829">22%</td> </tr> <tr> <td data-bbox="995 829 1087 902">4.e</td> <td data-bbox="1087 829 1793 902"><i>Each objective includes a staff intervention in the therapeutic milieu.</i></td> <td data-bbox="1793 829 1885 902">30%</td> </tr> </table> <p>The compliance rates increased from December 2007 to May 2008 for all sub-indicators as follows:</p> <ol style="list-style-type: none"> 1. Item 4.a: from 15% to 29%; 2. Item 4.b: from 13% to 35%; 3. Item 4.c: from 16% to 34%; 4. Item 4.d: from 17% to 39%; and 5. Item 4.e: from 18% to 57%. <p>Record review of individuals participating in Rehabilitation Therapist led PSR Mall groups found that 19% had WRP documentation of focus, none had WRP documentation of objectives and 24% had WRP documentation of interventions.</p>	4.	<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>		4.a	<i>There is a focus of hospitalization for each axis I, II, and III diagnosis</i>	21%	4.b	<i>There is a focus for each discharge criteria</i>	16%	4.c	<i>Each focus has an objective and an intervention</i>	20%	4.d	<i>Each intervention includes the name of the staff responsible for implementation, the group name and the group time/day.</i>	22%	4.e	<i>Each objective includes a staff intervention in the therapeutic milieu.</i>	30%
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		<p>Review of records for individuals receiving direct Occupational, Physical, and Speech Therapy found that 20% of assessments had documentation of focus, none had documentation of objectives and 40% had documentation of interventions. However, only 5% of records reviewed showed WRP inclusion of foci, objectives, and interventions.</p> <p>Review of records for individuals with Rehabilitation IA-RTS and type D.4.d assessments found that 74% of assessments had an appropriate focus written, none had adequate objectives and 62% had evidence of appropriate interventions.</p> <p>Review of records for individuals with Rehabilitation Therapy Focused Assessments found that 84% of assessments had an appropriate focus written, 32% had adequate objectives and 37% had evidence of appropriate interventions. However, only 5% of records reviewed showed WRP inclusion of foci, objectives, and interventions.</p> <p>Upon record review of sample of Nutrition Care assessments completed across assessment sub-types, it was noted that 69% of corresponding WRP documents contained Nutrition Care recommendations for focus and 49% contained WRP inclusion of at least one objective and intervention aligned with the focus.</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),	Please see sub-cells for compliance findings.

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	<p>addresses the individual's motivation for engaging in wellness activities, and leads to improvement in the individual's mental health, health and well being, consistent with generally accepted professional standards of care. Specifically, the interdisciplinary team shall:</p>							
C.2.f.i	<p>develop and prioritize reasonable and attainable goals/objectives (e.g., at the level of each individual's functioning) that build on the individual's strengths and address the individual's identified needs and, if any identified needs are not addressed, provide a rationale for not addressing the need;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, January 2008:</p> <ol style="list-style-type: none"> 1. Monitor this requirement using the Chart Auditing Form based on at least a 20% sample. 2. Provide data analysis addressing sub-items of this requirement. The analysis must evaluate areas of low compliance and delineate areas of relative improvement. <p>Findings:</p> <p>NSH used the DMH Chart Auditing Form to assess compliance (January to May 2008) regarding C.2.f.i through C.2.f.v. The average sample was 24% of the WRPs due each month. The following is a summary of the data for this requirement. The data for C.2.f.ii to C.2.f.v are presented in each corresponding cell below, with the sub-indicators identified as necessary.</p> <table border="1" data-bbox="995 1079 1887 1414"> <tr> <td data-bbox="995 1079 1089 1341">5.</td> <td data-bbox="1089 1079 1793 1341"><i>The team has developed and prioritized reasonable and attainable goals/objectives (e.g. at the level of each individuals functioning) that builds on the individuals strengths and addresses the individuals identified needs and, if any identified needs are not addressed, provide a rationale for not addressing the need.</i></td> <td data-bbox="1793 1079 1887 1341"></td> </tr> <tr> <td data-bbox="995 1341 1089 1414">5.a</td> <td data-bbox="1089 1341 1793 1414"><i>All objectives for Focus 1, 3, and 5 are linked to the individual's stage of change</i></td> <td data-bbox="1793 1341 1887 1414">19%</td> </tr> </table>	5.	<i>The team has developed and prioritized reasonable and attainable goals/objectives (e.g. at the level of each individuals functioning) that builds on the individuals strengths and addresses the individuals identified needs and, if any identified needs are not addressed, provide a rationale for not addressing the need.</i>		5.a	<i>All objectives for Focus 1, 3, and 5 are linked to the individual's stage of change</i>	19%
5.	<i>The team has developed and prioritized reasonable and attainable goals/objectives (e.g. at the level of each individuals functioning) that builds on the individuals strengths and addresses the individuals identified needs and, if any identified needs are not addressed, provide a rationale for not addressing the need.</i>							
5.a	<i>All objectives for Focus 1, 3, and 5 are linked to the individual's stage of change</i>	19%						

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		5.b	<i>The individual's strengths are used in the interventions.</i>	33%
		5.c	<i>There is documented rationale in the focus area if any focus of hospitalization does not have an objective or an intervention.</i>	3%
	<p>Compliance rates increased from December 2007 to May 2008 as follows:</p> <ol style="list-style-type: none"> 1. Item 5.a: from 17% to 29%; 2. Item 5.b: from 19% to 65% <p>NSH's data analysis showed that the WRPTs often did not provide a rationale for not having an objective or intervention for all foci. However, improvement was demonstrated in providing the stages of change and including the individual's strengths when developing the interventions.</p> <p>NSH also used the DMH WRP Observation Monitoring Form (January to May 2008). The average sample was 22% of the WRPCs due each month. The following is a summary of the data:</p>			
		7.	<i>The treatment plan includes the individual's strengths related to each enrichment, treatment, or rehabilitation objective.</i>	
		7.a	<i>Strengths are identified and incorporated into the interventions offered.</i>	10%
		7.b	<i>The strengths are related to each treatment, rehabilitation or enrichment objective.</i>	6%
	<p>The compliance rate for item 7.a increased from 9% (December 2007) to 14% (May 2008). Item 7.b remained unchanged at 9%. Analysis of the data suggested that the WRPTs incorporated strengths into the</p>			

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		<p>WRP, but did not discuss this with the individuals during the WRPC and the strengths were not adequately linked to the objective. The facility reported that beginning in August 2008, WRP trainers and designated WRP nursing seniors will train the PT/LVN primaries in the WRPC process. In addition, the PT/LVN will be required to complete the NSH Strengths Survey with individuals on their caseload.</p> <p>Recommendation 3, January 2008: Ensure that senior clinicians provide needed supervision and mentoring to improve compliance.</p> <p>Findings: The facility reported that senior clinicians from psychology, social work and rehabilitation therapy services began providing WRP mentoring services in May 2008. Effective August 2008, the facility will implement a system for the senior nursing clinicians to provide mentoring to WRPT nursing members, including both registered nurses and psychiatric technicians, and the Psychiatry Seniors will begin mentoring WRPT psychiatrists in the WRPC process.</p> <p>Other findings: This monitor reviewed the charts of six individuals (AWD, BJ, CWE, EL, FGP and HCM). The review found partial compliance in all cases.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Monitor this requirement using the Chart Auditing Form based on at least a 20% sample. 2. Provide data analysis that evaluates low compliance and delineates areas of relative improvement (during the reporting period and compared to the last period).
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		<p>3. Ensure that senior clinicians provide needed supervision and mentoring to improve compliance.</p>												
<p>C.2.f.ii</p>	<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 recommendation:</p> <p>Recommendation, January 2008: Same as above.</p> <p>Findings:</p> <table border="1" data-bbox="995 561 1894 1159"> <tr> <td data-bbox="995 561 1094 711">6.</td> <td data-bbox="1094 561 1797 711"><i>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).</i></td> <td data-bbox="1797 561 1894 711"></td> </tr> <tr> <td data-bbox="995 711 1094 899">6.a</td> <td data-bbox="1094 711 1797 899"><i>There are specific groups or individual therapy linked to specific objectives that focus on treatment (e.g., treatment of a specific medical or psychiatric condition) and are provided in the PSR Mall.</i></td> <td data-bbox="1797 711 1894 899">1%</td> </tr> <tr> <td data-bbox="995 899 1094 1049">6.b</td> <td data-bbox="1094 899 1797 1049"><i>There are specific skills training and support groups identified in the interventions that are linked to specific objectives and are provided in the PSR Mall.</i></td> <td data-bbox="1797 899 1894 1049">46%</td> </tr> <tr> <td data-bbox="995 1049 1094 1159">6.c</td> <td data-bbox="1094 1049 1797 1159"><i>There are specific leisure and recreation groups specified in the interventions that are linked to objective derived to focus 10.</i></td> <td data-bbox="1797 1049 1894 1159">41%</td> </tr> </table> <p>The compliance rate has increased from December 2007 to May 2008 as follows:</p> <ol style="list-style-type: none"> 1. Item 6.b: from 27% to 72%; and 2. Item 6.c: from 19% to 77%. 	6.	<i>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).</i>		6.a	<i>There are specific groups or individual therapy linked to specific objectives that focus on treatment (e.g., treatment of a specific medical or psychiatric condition) and are provided in the PSR Mall.</i>	1%	6.b	<i>There are specific skills training and support groups identified in the interventions that are linked to specific objectives and are provided in the PSR Mall.</i>	46%	6.c	<i>There are specific leisure and recreation groups specified in the interventions that are linked to objective derived to focus 10.</i>	41%
6.	<i>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).</i>													
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6.b	<i>There are specific skills training and support groups identified in the interventions that are linked to specific objectives and are provided in the PSR Mall.</i>	46%												
6.c	<i>There are specific leisure and recreation groups specified in the interventions that are linked to objective derived to focus 10.</i>	41%												

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		<p>Other findings: Chart reviews by this monitor found compliance in all cases (AWD, BJ, CWE, EL, FGP and HCM).</p> <p>Compliance: Partial.</p> <p>Current recommendations: Same as in C.2.f.i.</p>
C.2.f.iii	write the objectives in behavioral, observable, and/or measurable terms;	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: Same as above.</p> <p>Findings: NSH reported a mean compliance rate of 10% for this requirement. The compliance rate has increased from 8% in December 2007 to 22% in May 2008.</p> <p>Other findings: Reviews by this monitor found partial compliance in four charts (AWD, BJ, EL and FGP) and non-compliance in two (CWE and HCM).</p> <p>Compliance: Partial.</p> <p>Current recommendations: Same as in C.2.f.i.</p>
C.2.f.iv	include all objectives from the individual's current stage of change or readiness for rehabilitation, to the maintenance stage for	<p>Current findings on previous recommendation:</p>

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	<p>each focus of hospitalization, as clinically appropriate;</p>	<p>Recommendation, January 2008: Same as above.</p> <p>Findings: NSH reported a mean compliance rate of 16% for this requirement. The compliance rate has increased from 16% in December 2007 to 29% in May 2008.</p> <p>Other findings: This monitor found compliance in three charts (BJ, FGP and HCM) and non-compliance in three (AWD, CWE and EL).</p> <p>Compliance: Partial.</p> <p>Current recommendations: Same as in C.2.f.i.</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 recommendation:</p> <p>Recommendation, January 2008: Same as above.</p> <p>Findings: NSH did not present data for the relevant sub-indicators. Overall, the mean compliance rate was 18%.</p> <p>Other findings: This monitor found compliance in all charts reviewed (AWD, BJ, CWE, EL, FGP and HCM).</p> <p>Compliance: Partial.</p>

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		<p>Current recommendations: Same as in C.2.f.i.</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, January 2008: Correct factors related to inadequate documentation of scheduled hours on the WRPs and the discrepancies between WRP and MAPP data.</p> <p>Findings: Beginning in May 2008, WRP trainers reportedly met with WRPT members and began the process of aligning the WRP data with the MAPP schedules. This process began after development and implementation of a new Mall schedule in order to increase individuals' hours of active treatment and align the treatment with assessed needs. The Mall Director trained the WRPT members in June 2008 to be able to directly enter changes in group membership and changes in providers.</p> <p>Recommendation 2, January 2008: Continue to monitor hours of active treatment (scheduled and attended) and provide data regarding number of individuals, hours scheduled and hours attended as well as analysis and corrective actions to ensure that individuals attend the required hours.</p> <p>Findings: NSH data (January to May 2008) are summarized as follows:</p> <table border="1" data-bbox="993 1263 1738 1416"> <thead> <tr> <th rowspan="2"></th> <th colspan="2">Number of individuals by category</th> </tr> <tr> <th>Scheduled hours</th> <th>Attended hours</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>1133</td> <td>1133</td> </tr> <tr> <td>Hours:</td> <td></td> <td></td> </tr> </tbody> </table>		Number of individuals by category		Scheduled hours	Attended hours	N	1133	1133	Hours:		
	Number of individuals by category												
	Scheduled hours	Attended hours											
N	1133	1133											
Hours:													

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0-5	112	587
6-10	249	298
11-15	290	59
16-20	482	88

NSH's plan of improvement includes Motivational Interviewing training to all WRPT members and non-clinical providers.

Other findings:

This monitor reviewed six charts (AWD, BJ, CWE, EL, FGP and HCM) to assess documentation of active treatment hours listed on the most recent WRP and corresponding MAPP data regarding hours scheduled and attended. The reviews found that the facility has made progress in increasing the number of hours scheduled since the last reporting period and in correcting the discrepancies between WRP and MAPP data. However, the facility has yet to make progress in increasing the number of hours attended. See C.2.w for a review of the facility's efforts to address barriers regarding the individuals' participation in WRP interventions.

Individual	WRP scheduled	MAPP scheduled	MAPP attended
AWD	20	23	4
BJ	20	20	2
CWE	17	16	0
EL	17	19	3
FGP	19	22	11
HCM	19	24	7

Compliance:

Partial.

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		<p>Current recommendation: Continue to monitor hours of active treatment (scheduled and attended) and provide data regarding number of individuals, hours scheduled and hours attended as well as analysis and corrective actions to ensure that individuals attend the required hours.</p>
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 recommendations:</p> <p>Recommendation 1, January 2008: Monitor this requirement based on at least a 20% sample.</p> <p>Findings: NSH used the DMH Chart Auditing Form to assess compliance (January to May 2008). The relevant average sample was 22% of the WRPs due (in Program IV). The mean compliance rate was 2%. Of the 169 individuals eligible to go into the community, 51 individuals have been able to attend community groups, which is an increase from 25 in the last review period. The facility's analysis showed that WRPTs had difficulty consistently specifying the facilitator, time, and location of the groups for which the individual was scheduled.</p> <p>Recommendation 2, January 2008: Address and correct factors related to lack of programs.</p> <p>Findings: NSH's corrective actions included the following:</p> <ol style="list-style-type: none"> 1. The facility began to train staff to provide community integration groups. 2. Procedures for determining the number of staff needed to provide community integration activities were established. 3. Facilitators identified alternative means of transportation for community integration activities, including using the bus, walking,

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		<p>and vans.</p> <p>Other findings: This monitor reviewed the charts of six individuals who were admitted under civil commitment (CM, JHH, LAC, RP, RT and TTN). The reviews found compliance in three charts (CM, RP and RT) and non-compliance in three (JHH, LAC and TTN).</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Monitor this requirement based on at least a 20% sample. 2. Provide data analysis that evaluates low compliance and delineates areas of relative improvement (during the reporting period and compared to the last period).
C.2.f.viii	<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, January 2008: Ensure full implementation of the PSR Mall Facilitator Monthly Progress Note.</p> <p>Findings: NSH reported that beginning March 2008, the facility implemented a requirement for senior supervising clinicians to oversee and ensure that each facilitator completes PSR Mall Facilitator Monthly Progress Notes. The facility conducted audits and reviews showing the following:</p> <ol style="list-style-type: none"> 1. Thirty percent of the individuals had at least one PSR Mall Facilitator Monthly Progress Note (Mall progress note) documented (based on an audit of a 10% sample).

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		<p>2. Individuals had Mall progress notes for 9% of their total active treatment interventions.</p> <p>3. The Mall progress notes were discussed in the WRPs of only 5% of the individuals.</p> <p>Recommendation 2, January 2008: Monitor this requirement using the WRP Mall Alignment Checklist and provide corrective actions to improve compliance.</p> <p>Findings: NSH used the DMH WRP Mall Alignment Monitoring Form to assess compliance (January to May 2008) based on a sample of 20 charts (2% of the average monthly population). The facility reported a mean compliance rate of 32%. The compliance rate has decreased from 45% in December 2007 to 25% in May 2008. As mentioned earlier, beginning in May 2008, the WRP trainers began meeting with WRPT members to improve alignment of WRPs with Mall schedules.</p> <p>Other findings: Reviews by this monitor found compliance in two charts (EL and HCM), partial compliance in three (AWD, BJ and FGP) and non-compliance in one (CWE).</p> <p>Compliance: Partial.</p> <p>Current recommendations: Monitor this requirement using the WRP Mall Alignment Checklist and implement corrective actions to improve compliance.</p>
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,	Please see sub-cells for compliance findings.

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	<p>as determined by the scheduled monitoring of identified criteria or target variables, consistent with generally accepted professional standards of care. Specifically, the interdisciplinary team shall:</p>										
<p>C.2.g.i</p>	<p>revise the focus of hospitalization, objectives, as needed, to reflect the individual's changing needs and develop new interventions to facilitate attainment of new objectives when old objectives are achieved or when the individual fails to make progress toward achieving these objectives;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, January 2008:</p> <ul style="list-style-type: none"> • Monitor this requirement using both clinical chart and process observation auditing based on at least a 20% sample. • Provide data analysis addressing sub-items of this requirement. The analysis must evaluate areas of low compliance and delineate areas of relative improvement. <p>Findings: Using the DMH Process Monitoring Form (January to May 2008), NSH reviewed an average sample of 22% of the WRPCs due each month. The following summarizes the compliance findings:</p> <table border="1" data-bbox="995 894 1885 1344"> <tr> <td data-bbox="995 894 1087 1117">8.</td> <td data-bbox="1087 894 1793 1117"><i>The team revised the focus of hospitalization, objectives, as needed, to reflect the individual's changing needs and developed new interventions to facilitate attainment of new objectives when old objectives are achieved or when the individual fails to make progress toward achieving these objectives.</i></td> <td data-bbox="1793 894 1885 1117"></td> </tr> <tr> <td data-bbox="995 1117 1087 1227">8.a</td> <td data-bbox="1087 1117 1793 1227"><i>When an objective has been achieved the team develops a new objective and associated intervention(s) for that focus of hospitalization.</i></td> <td data-bbox="1793 1117 1885 1227">10%</td> </tr> <tr> <td data-bbox="995 1227 1087 1344">8.b</td> <td data-bbox="1087 1227 1793 1344"><i>When an individual has not shown progress on an objective for two months the team revises or develops a new objective or a new intervention.</i></td> <td data-bbox="1793 1227 1885 1344">2%</td> </tr> </table> <p>Compliance increased from December 2007 to May 2008 as follows:</p>	8.	<i>The team revised the focus of hospitalization, objectives, as needed, to reflect the individual's changing needs and developed new interventions to facilitate attainment of new objectives when old objectives are achieved or when the individual fails to make progress toward achieving these objectives.</i>		8.a	<i>When an objective has been achieved the team develops a new objective and associated intervention(s) for that focus of hospitalization.</i>	10%	8.b	<i>When an individual has not shown progress on an objective for two months the team revises or develops a new objective or a new intervention.</i>	2%
8.	<i>The team revised the focus of hospitalization, objectives, as needed, to reflect the individual's changing needs and developed new interventions to facilitate attainment of new objectives when old objectives are achieved or when the individual fails to make progress toward achieving these objectives.</i>										
8.a	<i>When an objective has been achieved the team develops a new objective and associated intervention(s) for that focus of hospitalization.</i>	10%									
8.b	<i>When an individual has not shown progress on an objective for two months the team revises or develops a new objective or a new intervention.</i>	2%									

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		<p>1. Item 8.a: from 10% to 18%; and 2. Item 8.b: from 0% to 5%.</p> <p>The facility's analysis showed that WRPTs often did not address a lack of progress on objectives. The facility's plan of improvement was to continue in vivo monitoring focused on this requirement.</p> <p>Using the Clinical Chart Auditing Form and based on a sample of 8% of the WRPs due each month, NSH presented compliance data (January to May 2008) that are summarized as follows:</p> <table border="1" data-bbox="995 634 1885 1083"> <tr> <td data-bbox="995 634 1089 857">9.</td> <td data-bbox="1089 634 1793 857"><i>The team revised the focus of hospitalization, objectives, as needed, to reflect the individual's changing needs and developed new interventions to facilitate attainment of new objectives when old objectives are achieved or when the individual fails to make progress toward achieving these objectives.</i></td> <td data-bbox="1793 634 1885 857"></td> </tr> <tr> <td data-bbox="995 857 1089 971">9.a</td> <td data-bbox="1089 857 1793 971"><i>When an objective has been achieved the team develops a new objective and associated intervention(s) for that focus of hospitalization.</i></td> <td data-bbox="1793 857 1885 971">25%</td> </tr> <tr> <td data-bbox="995 971 1089 1083">9.b</td> <td data-bbox="1089 971 1793 1083"><i>When an individual has not shown progress on an objective for two months the team revises or develops a new objective or a new intervention.</i></td> <td data-bbox="1793 971 1885 1083">8%</td> </tr> </table> <p>The compliance rate has increased from December 2007 May 2008 as follows:</p> <p>1. Item 9.a: from 20% to 48%; and 2. Item 9.b: from 9% to 27%.</p> <p>Other findings: Chart reviews by this monitor found compliance in four cases (AWD,</p>	9.	<i>The team revised the focus of hospitalization, objectives, as needed, to reflect the individual's changing needs and developed new interventions to facilitate attainment of new objectives when old objectives are achieved or when the individual fails to make progress toward achieving these objectives.</i>		9.a	<i>When an objective has been achieved the team develops a new objective and associated intervention(s) for that focus of hospitalization.</i>	25%	9.b	<i>When an individual has not shown progress on an objective for two months the team revises or develops a new objective or a new intervention.</i>	8%
9.	<i>The team revised the focus of hospitalization, objectives, as needed, to reflect the individual's changing needs and developed new interventions to facilitate attainment of new objectives when old objectives are achieved or when the individual fails to make progress toward achieving these objectives.</i>										
9.a	<i>When an objective has been achieved the team develops a new objective and associated intervention(s) for that focus of hospitalization.</i>	25%									
9.b	<i>When an individual has not shown progress on an objective for two months the team revises or develops a new objective or a new intervention.</i>	8%									

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		<p>BJ, EL and FGP) and non-compliance in two (CWE and HCM).</p> <p>Sixty-seven percent of records of individuals receiving direct Physical, Occupational and/or Speech Therapy contained evidence that treatment modalities and interventions were modified as needed in response to individuals' needs, though none of these records contained WRP documentation of revision of focus, objectives, and/or interventions according to individualized needs</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Monitor this requirement using both clinical chart and process observation auditing based on at least a 20% sample. 2. Provide data analysis that evaluates low compliance and delineates areas of relative improvement (during the reporting period and compared to the last period).
C.2.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, January 2008: Implement corrective actions to ensure:</p> <ol style="list-style-type: none"> a. Review by the WRPTs of the use of seclusion/restraints and the circumstances related to such use; and b. Timely and appropriate modification of the WRPs in response to the review. <p>Findings: NSH did not adequately address this recommendation.</p> <p>Recommendations 2 and 3, January 2008:</p> <ul style="list-style-type: none"> • Continue to monitor this requirement using observation and chart

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		<p>auditing based on at least a 20% sample.</p> <ul style="list-style-type: none"> • Provide data analysis addressing sub-items of this requirement. The analysis must evaluate areas of low compliance and delineate areas of relative improvement. <p>Findings: Using the DMH Observation Monitoring Form (January to May 2008), NSH reviewed an average sample of 22% of the WRPCs due each month. The following is a summary of the compliance rates:</p> <table border="1" data-bbox="995 561 1885 1010"> <tr> <td data-bbox="995 561 1089 784">9.</td> <td data-bbox="1089 561 1793 784"><i>The team revised the focus of hospitalization, objectives, as needed, to reflect the individual's changing needs and developed new interventions to facilitate attainment of new objectives when old objectives are achieved or when the individual fails to make progress toward achieving these objectives.</i></td> <td data-bbox="1793 561 1885 784"></td> </tr> <tr> <td data-bbox="995 784 1089 898">9.a</td> <td data-bbox="1089 784 1793 898"><i>When an objective has been achieved the team develops a new objective and associated intervention(s) for that focus of hospitalization.</i></td> <td data-bbox="1793 784 1885 898">16%</td> </tr> <tr> <td data-bbox="995 898 1089 1010">9.b</td> <td data-bbox="1089 898 1793 1010"><i>When an individual has not shown progress on an objective for two months the team revises or develops a new objective or a new intervention.</i></td> <td data-bbox="1793 898 1885 1010">11%</td> </tr> </table> <p>The facility has had mixed change in compliance rates (December 2007 to May 2008) as follows:</p> <ol style="list-style-type: none"> 1. Item 9.a: from 18% to 12%; and 2. Item 9.b: from 3% to 23%. <p>NSH reported that WRP trainers will provide in vivo training to WRPTs using an attachment that has been opened for a high-risk behavior or trigger.</p>	9.	<i>The team revised the focus of hospitalization, objectives, as needed, to reflect the individual's changing needs and developed new interventions to facilitate attainment of new objectives when old objectives are achieved or when the individual fails to make progress toward achieving these objectives.</i>		9.a	<i>When an objective has been achieved the team develops a new objective and associated intervention(s) for that focus of hospitalization.</i>	16%	9.b	<i>When an individual has not shown progress on an objective for two months the team revises or develops a new objective or a new intervention.</i>	11%
9.	<i>The team revised the focus of hospitalization, objectives, as needed, to reflect the individual's changing needs and developed new interventions to facilitate attainment of new objectives when old objectives are achieved or when the individual fails to make progress toward achieving these objectives.</i>										
9.a	<i>When an objective has been achieved the team develops a new objective and associated intervention(s) for that focus of hospitalization.</i>	16%									
9.b	<i>When an individual has not shown progress on an objective for two months the team revises or develops a new objective or a new intervention.</i>	11%									

		<p>NSH used the DMH Chart Auditing Form (January to May 2008). The average sample was 24% of the WRPs due each month. The mean compliance rate for this requirement was 6%. The compliance rate has decreased from 45% (December 2007) to 23% (May 2008).</p> <p>Recommendation 4, January 2008: Revise the current monitoring tool to include individuals whose functional status has improved.</p> <p>Findings: NSH did not address this recommendation.</p> <p>Other findings: This monitor reviewed the charts of six individuals who have experienced the use of seclusion and/or restraint during this review period (AS, AVC, CDC, KDC, JJY and PLB). The review found the following pattern:</p> <ol style="list-style-type: none"> 1. The circumstances regarding the use of the restrictive intervention were adequately addressed in four charts (AS, CDC, JJY and PLB). 2. Only two charts included documentation of treatment provided during these occurrences (AS and CDC). 3. Only one chart documented the WRPT's plan to modify treatment in order to reduce the risk of future occurrences (AS). <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Implement corrective actions to ensure: <ol style="list-style-type: none"> a. Review by the WRPTs of the use of seclusion/restraints and the circumstances related to such use; and
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		<p>b. Timely and appropriate modification of the WRPs in response to the review.</p> <ol style="list-style-type: none"> 2. Continue to monitor this requirement using observation and chart auditing based on at least a 20% sample. 3. Provide data analysis that evaluates low compliance and delineates areas of relative improvement (during the reporting period and compared to the last period). 4. Revise the current monitoring tool to include individuals whose functional status has improved. 			
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, January 2008: Implement training of the WRPTs based on the MSH module regarding discharge planning.</p> <p>Findings: Same as in C.1.a.</p> <p>Recommendations 2 and 3, January 2008:</p> <ul style="list-style-type: none"> • Continue to monitor this requirement using observation and chart auditing based on at least a 20% sample. • Provide data analysis addressing sub-items of this requirement. The analysis must evaluate areas of low compliance and delineate areas of relative improvement <p>Findings: NSH used the DMH Observation Monitoring Form (January to May 2008) and reviewed an average sample of 22% of the WRPCs held each month. The following summarizes the compliance findings:</p> <table border="1" data-bbox="995 1339 1797 1414"> <tr> <td data-bbox="995 1339 1087 1414">10.</td> <td data-bbox="1087 1339 1797 1414"><i>The review process includes an assessment of progress related to discharge to the most integrated</i></td> <td data-bbox="1797 1339 1896 1414"></td> </tr> </table>	10.	<i>The review process includes an assessment of progress related to discharge to the most integrated</i>	
10.	<i>The review process includes an assessment of progress related to discharge to the most integrated</i>				

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		<table border="1"> <tr> <td data-bbox="989 191 1089 269"></td> <td data-bbox="1089 191 1797 269"><i>setting appropriate to meet the individuals assessed needs, consistent with his/her legal status.</i></td> <td data-bbox="1797 191 1896 269"></td> </tr> <tr> <td data-bbox="989 269 1089 342">10.a</td> <td data-bbox="1089 269 1797 342"><i>The team reviews all Foci that are barriers to discharge.</i></td> <td data-bbox="1797 269 1896 342">19%</td> </tr> <tr> <td data-bbox="989 342 1089 456">10.b</td> <td data-bbox="1089 342 1797 456"><i>The team reviews the PSR Mall Facilitator's Monthly Notes for all objectives related to discharge.</i></td> <td data-bbox="1797 342 1896 456">1%</td> </tr> </table>		<i>setting appropriate to meet the individuals assessed needs, consistent with his/her legal status.</i>		10.a	<i>The team reviews all Foci that are barriers to discharge.</i>	19%	10.b	<i>The team reviews the PSR Mall Facilitator's Monthly Notes for all objectives related to discharge.</i>	1%	<p>The compliance rate has been essentially unchanged from December 2007 to May 2008. The facility's analysis recognized that the WRPTs did not adequately utilize the PSR Mall Facilitator Progress notes nor focus sufficiently on progress toward discharge.</p> <p>Recommendation 4, January 2008: Ensure that senior clinicians provide needed supervision and mentoring to improve compliance.</p> <p>Findings: Same as C.2.f.i, Recommendation 3.</p> <p>Other findings: Reviewing the charts of six individuals, this monitor assessed the documentation of individualized discharge criteria and the discussion of the individual's progress towards discharge. The review found the following pattern:</p> <ol style="list-style-type: none"> 1. The discharge criteria were sufficiently individualized in only one chart (EL). 2. The WRPs documented the WRPT's discussion of the individual's progress towards discharge in only two charts (AWD and EL). <p>Compliance: Partial.</p>
	<i>setting appropriate to meet the individuals assessed needs, consistent with his/her legal status.</i>											
10.a	<i>The team reviews all Foci that are barriers to discharge.</i>	19%										
10.b	<i>The team reviews the PSR Mall Facilitator's Monthly Notes for all objectives related to discharge.</i>	1%										

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		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Implement training of the WRPTs based on the MSH module regarding discharge planning. 2. Continue to monitor this requirement using process observation based on at least a 20% sample. 3. Provide data analysis that evaluates low compliance and delineates areas of relative improvement (during the reporting period and compared to the last period).
C.2.g.iv	<p>base progress reviews and revision recommendations on data collected as specified in the therapeutic and rehabilitation service plan.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, January 2008: Same as in C.2.g.i.</p> <p>Findings: Same as in C.2.g.i.</p> <p>Recommendation 2, January 2008: Same as in C.2.f.viii.</p> <p>Findings: Same as in C.2.f.viii.</p> <p>Other findings: The facility's process observation data showed compliance rates of 1% and 2% with the two sub-indicators regarding this requirement, with only minor increase in compliance from December 2007 to May 2008.</p> <p>This monitor reviewed six charts (AWD, BJ, CWE, EL, FGP and HCM). The review found that Mall progress notes were available only in three charts (BJ, CWE and FGP). However, the content of these notes was inadequate to inform the WRPTs of the individual's actual progress.</p>

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		<p>None of the charts reviewed included evidence that the information in the progress notes was incorporated in the WRP reviews.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Same as in C.2.g.i. 2. Same as in C.2.f.viii. 3. Revise the current format of the Mall Facilitator note to ensure that the notes adequately inform the WRPTs of the individual's progress.
C.2.h	Individuals in need of positive behavior supports in school or other settings receive such supports consistent with generally accepted professional standards of care.	See cells F.2.a and F.2.a.i for findings and recommendations related to positive behavior supports.
C.2.i	Adequate active psychosocial rehabilitation is provided, consistent with generally accepted professional standards of care, that:	Compliance: Partial.
C.2.i.i	is based on the individual's assessed needs and is directed toward increasing the individual's ability to engage in more independent life functions;	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, January 2008:</p> <ul style="list-style-type: none"> • Assess the WRP for integration of this element of the assessments into the WRP. • Ensure that there is a match among the WRP, Mall activity schedule, and the group individuals attend. <p>Findings: Using item #2 (<i>Is based on the individual's assessed needs and is directed toward increasing the individual's ability to engage in more</i></p>

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		<p><i>independent life functions</i>) from the DMH WRP Mall Alignment Monitoring Form, NSH analyzed its compliance based on an average sample of 2% of WRPs due for the month (January to May 2008), reporting a mean compliance rate of 20% (NSH's mean compliance rate for the previous review was 26%). The compliance rate for the last month of the previous review period was 60% and the compliance rate for the last month of the current review period is 10%.</p> <p>NSH has introduced a number of steps to improve the compliance rate to address this recommendation, including increasing the number of Mall groups to meet the needs of individuals, holding monthly Mall provider meetings to review and align treatment services suitable to individuals' needs, and having a Senior Supervising staff member 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>This monitor reviewed 15 charts (ALR, BAP, CAW, CR, DM, JAA, JL, LL, LMZ, LRF, OH, RA, RCB, SB and WV). Three of the charts (BAP, CAW, and LMZ) did not contain the individual's Mall schedule. Information in two of the WRPs in the charts (CR and OH) showed that active interventions were offered in accordance with the individual's level of functioning, stage of change, and discharge needs, and matched with the individual's PSR Mall services. The remaining ten WRPs (ALR, DM, JAA, JL, LL, LRF, RA, RCB, SB and WV) showed a number of discrepancies between the individual's needs and the services offered.</p> <p>Other findings: According to findings from record reviews of individuals participating in Rehabilitation Therapist-led PSR Mall groups, 93% of PSR Mall group objectives and interventions were aligned with assessment findings regarding individual needs and strengths.</p>
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		<p>Review of records for individuals receiving direct Physical, Occupational and/or Speech Therapy found that 90% of treatment activities were aligned with assessment findings of individual needs.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Assess the WRP for integration of this element of the assessments into the WRP. 2. Ensure that there is a match among the WRP, Mall activity schedule, and the group individuals attend.
C.2.i.ii	Has documented objectives, measurable outcomes, and standardized methodology	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, January 2008: Ensure that learning outcomes are developed and are stated in measurable terms.</p> <p>Findings: Using item #3 (<i>Has documented objectives, measurable outcomes, and standardized methodology</i>) from the DMH WRP Mall Alignment Monitoring Form, NSH analyzed its compliance based on an average sample of 2% of WRPs due for the month (January to May 2008), reporting a mean compliance rate of 40% (NSH's mean compliance rate for the previous review was 12%). NSH's compliance rate for the last month of the previous period was 5% and is 0% for the last month of this review period.</p> <p>This monitor reviewed 14 charts (AWD, CCR, FLW, FS, JAA, JCL, LMZ, LRF, MD, NDW, OH, RA, RME and WV). Seven of the WRPs in the charts (CCR, FLW, FS, JAA, NDW, RA and WV) stated the learning outcomes in measurable terms and the remaining seven (AWD, JCL, LMZ, LRF, MD, OH and RME) did not.</p>

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		<p>Recommendation 2, January 2008: Ensure that the DMH PSR Mall Facilitator Monthly Progress Note is implemented and made available to the teams for tracking outcomes related to the WRP.</p> <p>Findings: NSH analyzed its adherence to this recommendation by reviewing 10% of the charts of individuals residing in the facility in May 2008. The facility's data showed that only 9% of the individuals had progress notes for their active treatments, and only 5% of the notes were discussed in the individual's WRP. NSH's Monthly Mall Progress Note system is not fully automated. According to the Mall Director, NSH has assigned Senior Supervising staff to facilitate timely delivery of the Mall progress notes.</p> <p>This monitor reviewed 14 charts (AWT, CAW, CCR, EP, FAG, FES, JAA, JL, JS, JV, MD, RAA, SB and WV). Ten of the charts (CAW, CCR, FAG, FES, JAA, JS, MD, RAA, SB and WV) contained at least one progress note, but only two of them (FAG and RAA) had integrated the notes in the individual's Present Status section of his/her WRP. Four of the charts (AWT, EP, JL and JV) did not contain any Mall progress notes.</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	Is aligned with the individual's objectives that are identified in the individual's Wellness and Recovery Plan	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: Ensure that all therapies and rehabilitation services provided in the</p>

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		<p>Malls are aligned with the assessed needs of the individuals.</p> <p>Findings: Using item #4 (<i>Is aligned with the individual's objectives that are identified in the individual's Wellness and Recovery Plan</i>) from the DMH WRP Mall Alignment Monitoring Form, NSH analyzed its compliance based on an average sample of 2% of WRPs due for the month (January to May 2008), reporting a mean compliance rate of 49% (NSH's mean compliance for the previous review period was 19%). NSH's compliance for the last month of the previous period was 25% and compliance for the last month of this review period is 55%. As part of the plan of improvement, Mall providers meet monthly to ensure that active treatments are aligned with individuals' objectives. In addition, NSH has assigned Senior Supervising clinicians to oversee Mall progress note compliance.</p> <p>This monitor reviewed four charts (EH, JA, TLB and VBH). Identified therapies and services in one chart (TLB) were aligned with the individual's assessed needs, and the prescribed groups and services matched with the Mall and/or recreational and leisure schedules. The therapies and services for JA did not fully meet the individual's needs as there was a mismatch between the objectives and interventions. The therapies and services for EH and TLB were aligned with the individuals' needs; however the services prescribed were not aligned with the Mall schedule.</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;	Current findings on previous recommendations:

		<p>Recommendation 1, January 2008: Ensure that the individual's strengths, preferences, and interests are clearly specified in the interventions in the individual's WRP in accordance with the DMH WRP manual.</p> <p>Findings: Using item #5 (<i>The individual's strengths are used in the interventions</i>) from the DMH WRP Chart Audit Form, NSH analyzed its compliance based on an average sample of 24% of the WRPs due for the month (January to May 2008), reporting a mean compliance rate of 30%</p> <p>This monitor reviewed 12 charts (AWD, CCR, FLW, JAA, JCL, JSL, MD, OH, RA, RME, SHS and WV). Nine of the WRPs in the charts (AWD, CCR, FLW, JAA, JSL, RA, RME, SHS and WV) specified the individual's strengths, preferences, and interests in the intervention sections of the individual's WRP. The remaining three (JCL, MD and OH) failed to include the individual's strengths, preferences, and/or interests in the interventions.</p> <p>Recommendation 2, January 2008: 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: Using item #5 (<i>Provider utilizes the individual's strengths, preferences, and interests</i>) from the DMH WRP Mail Alignment Monitoring Form, NSH analyzed its compliance based on an average sample of 2% of the individuals residing in the facility for the month (January to May 2008), reporting a mean compliance rate of 30% (NSH's mean compliance rate for the previous review period was 14%). NSH's compliance for the last month of the previous review period was 25% and is 40% for the last month of this review period.</p>
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		<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	<p>focuses on the individual's vulnerabilities to mental illness, substance abuse, and readmission due to relapse, where appropriate;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, January 2008:</p> <ul style="list-style-type: none"> • 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. • Present monitoring data regarding the recommendation to include in the present status an update on the current status of these vulnerabilities. <p>Findings:</p> <p>Using item #6 (<i>Focuses on the individual's vulnerabilities to mental illness, substance abuse, and readmission due to relapse, when appropriate</i>) from the DMH WRP Mall Alignment Monitoring Form, NSH analyzed its compliance based on an average sample of 2% of the charts audited for the month (January to May 2008), reporting a mean compliance rate of 36% (NSH's mean compliance rate for the previous review period was 6%). NSH's compliance for the last month of the previous review period was 10% and 25% for the last month of this review period.</p> <p>This monitor reviewed 17 charts (AWT, CCR, EER, EWK, FLW, JAA, JAS, JCL, JSL, LL, LRF, MAA, MD, SEB, SHA, WA and WV). Three of</p>

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		<p>the WRPs in the charts (EER, EWK and SEB) included the individual's vulnerabilities in the case formulation under predisposing, precipitating, and perpetuating factors, and where appropriate updated the current status of these vulnerabilities in the present status section of the WRP. The remaining 14 (AWT, CCR, FLW, JAA, JAS, JCL, JSL, LL, LRF, MAA, MD, SHA, WA and WV) did not fully describe the individual's vulnerabilities or update the current status of the individual's vulnerabilities.</p> <p>Recommendation 3, January 2008: Complete substance abuse training on all stages of change to all group facilitators.</p> <p>Findings: This monitor's review of documentation (training documentation and substance abuse provider summary) found that NSH has provided training on all stages of change to its substance abuse group facilitators. The Substance Abuse providers list contained 78 names, of which four were trained in all stages, nine were trained up to the Action stage, and the rest were trained up to the Contemplation stage. NSH currently has 63 certified substance abuse group facilitators, and 44 of them currently are facilitating Substance Abuse Recovery groups.</p> <p>According to the Mall Director, four of the Substance Abuse Recovery groups are facilitated in Spanish.</p> <p>According to the Clinical Administrator, Carmen Caruso, the Discipline Chiefs review and update the Substance Abuse Recovery Provider Summary Report each month.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Address and correct factors related to low compliance with the
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		<p>requirement to include the individual's vulnerabilities in the case formulation under predisposing, precipitating, and perpetuating factors.</p> <ol style="list-style-type: none"> 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, January 2008:</p> <ul style="list-style-type: none"> • Assess all individuals suspected of cognitive disorders, mental retardation and developmental disabilities and other conditions that may adversely impact an individuals' cognitive status. • Ensure that individuals' cognitive functioning is taken into consideration when assigning them to activities. • Ensure that Mall activities are designed to meet differing cognitive strengths and limitations. <p>Findings:</p> <p>This monitor's documentation review (Integrated Assessments-Psychology Section, Focused Psychological Assessments, WRPs, and Mall Course Catalogues) and interview of WRPT members, Mall group facilitators, and the Mall Director found that cognitive screening assessments are conducted on all individuals upon admission to the facility using the Integrated Assessment: Psychology Section. The results of these assessments are given to the WRPTs. Cognitive assessments are also conducted when referrals are made for psychological assessments. In addition, the DCAT conducts cognitive assessments on individuals thought to be displaying behavioral characteristics indicative of changes in cognitive functioning. According to the Mall Director, individuals' cognitive status is also</p>

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		<p>discussed at the Monthly Provider meetings.</p> <p>Using data from the cognitive screening, NSH analyzed the cognitive levels of individuals in the facility and the numbers of Mall groups that were required to appropriately serve the individuals. Based on the results of the analysis, NSH determined that 1189 Mall sessions were needed for all cognitive levels, 484 Mall sessions at the Challenged cognitive level, and 174 Mall sessions at the Average or Advanced cognitive levels.</p> <p>Using item #7 (<i>Is provided in a manner consistent with each individual's cognitive strengths and limitations</i>) from the DMH WRP Mall Alignment Monitoring Form, NSH analyzed its compliance based on an audit of an average sample of 2% of the individuals in the facility for the month (January to May 2008), reporting a mean compliance rate of 15% (the mean compliance for the previous review period was 25%). The mean compliance reported for the last month of the previous review period was 25% and the mean compliance reported for the last month of the current review period is 20%.</p> <p>According to the Mall Director, as of August 2008, the Psychology Department is to send detailed information on individuals' cognitive levels to the Mall Director and the WRPTs to inform them of the specific needs of the individuals appropriate to the assessed cognitive levels. The Mall Director believes that having the information on individuals' cognitive levels should improve the ability of the WRPTs to assign individuals to Mall groups based on their cognitive strengths and limitations.</p> <p>This monitor reviewed 12 charts (EPY, EWT, FAG, HLA, HRD, JE, JEW, RCB, RCC, RJM, TEG and TMR). The groups stated in the intervention sections in eight of the WRPs in the charts (EPY, EWT, FAG, HLA, JE, JEW, TEG and TMR) were aligned with the individuals' cognitive</p>
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		<p>strengths and limitations. The remaining four (HRD, RCB, RCC, and RJM) were not.</p> <p>Recommendation 4, January 2008: Ensure that the WRPTs use the WRP Treatment Activity Request Form when a group is not available that matches the individual's cognitive strengths and limitations.</p> <p>Findings: This monitor's documentation review (WRP Treatment Activity Request Forms, Mall groups) found that there were 13 new groups/individual therapy services requests during this review period. The Mall Director had addressed these requests by setting up 12 new groups to meet the needs of the individuals, and working on getting the remaining sex offender treatment service for the remaining request.</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, January 2008:</p> <ul style="list-style-type: none"> • Implement the PSR Mall Facilitator Monthly Progress Notes. • Automate this system to make it feasible for the group facilitators

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		<p>and individual therapists to provide progress reports in a timely manner.</p> <p>Findings: NSH has implemented the PSR Mall Facilitator Monthly Progress Note system across the facility. NSH audited 20% of the individuals in each of the five programs to address this recommendation, reporting 9% compliance. The table below showing the number of progress notes due for 20% of the individuals in each program (N), the number of progress notes available to the WRPTs (n) in each program, and the percentage of compliance obtained (%C) is a summary of the facility's data.</p> <table border="1" data-bbox="995 634 1797 789"> <thead> <tr> <th></th> <th>P1</th> <th>P2</th> <th>P3</th> <th>P4</th> <th>P5</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>707</td> <td>537</td> <td>869</td> <td>695</td> <td>765</td> <td></td> </tr> <tr> <td>n</td> <td>80</td> <td>93</td> <td>44</td> <td>20</td> <td>93</td> <td></td> </tr> <tr> <td>%C</td> <td>11</td> <td>17</td> <td>5</td> <td>3</td> <td>12</td> <td>9</td> </tr> </tbody> </table> <p>NSH had integrated the Monthly Mall Progress Note process in the WaRMSS system; however, it appears the system still is not fully functional as the facilitators have to manually write the notes.</p> <p>Other findings: According to record review of individuals participating in Rehabilitation Therapist-led PSR Mall groups, 10% had evidence of completed Mall Facilitator Monthly Progress notes and none had documentation of progress in the present status section of the WRP.</p> <p>Review of records for individuals receiving direct Physical and Speech Therapy found that 90% of records contained documentation of progress and 5% had documentation of progress in the present status section of the WRP.</p>		P1	P2	P3	P4	P5	Mean	N	707	537	869	695	765		n	80	93	44	20	93		%C	11	17	5	3	12	9
	P1	P2	P3	P4	P5	Mean																								
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		<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	<p>is provided five days a week, for a minimum of four hours a day (i.e., two hours in the morning and two hours in the afternoon each weekday), for each individual or two hours a day when the individual is in school, except days falling on state holidays;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, January 2008: Mandate that all staff at NSH, other than those who attend to emergency medical needs of individuals, will provide services at the PSR Mall. This includes clinical, administrative and support staff.</p> <p>Findings: This monitor's interview of the Chief of Psychology and the Mall Director revealed that at the General Management Meeting the Executive Director at NSH had mandated all staff, other than those who attend to individuals' emergency medical needs, to provide PSR Mall services. This monitor's documentation review (provider participation data) found that 72 of 243 administrative and support staff provided at least one hour of active treatment (this is an increase from 57 during the previous review period), as did 44 of the WRPT psychiatrists (an increase from 10 from the previous review period), 163 of the 381 WRPT LVNs and Psychiatric Technicians (an increase from 108 from the previous review period), and 145 of the 358 WRPT RNs (an increase from 97 from the previous period). According to the Mall Director, all WRPT Psychologists, Social Workers, and Rehabilitation Therapists provided active treatment services during this review period.</p> <p>This monitor's review of the hours of Mall services provided during the week of May 5 (May 5-9, 2008) by the various disciplines found that none of the disciplines had provided the expected hours of service. The hours of services provided by the disciplines ranged from a low of</p>

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		<p>0.7 hours (Psychiatrists) and a high of 7.7 hours (Rehabilitation Therapists).</p> <p>Recommendation 2, January 2008: Ensure that all requests for new Mall groups and individual therapies are implemented.</p> <p>Findings: This monitor's documentation review (completed Activity Request Forms) found that NSH had received requests for 13 new groups. The Mall Director has developed and implemented course lessons for 12 groups. The one unfulfilled request is for a sex offender treatment, and the Mall Director is working on getting the individual the service.</p> <p>This monitor's review of Mall groups offered in NSH and information received from individuals in the facility found that there is an urgent need for Pain Management and Sex Offender Mall groups. Providers must have qualifications and specialized training to facilitate these groups. According to Tony Rabin, Mall Director, and Katie Cooper, Enhancement Plan Coordinator, NSH has had difficulty hiring and keeping providers qualified to facilitate these groups. NSH should find ways to provide these Mall groups/services so that individuals with chronic pain are not suffering needlessly and that individuals needing Sex Offender services can meet their goals and be discharged in a timely manner.</p> <p>Current recommendations:</p> <ol style="list-style-type: none">1. 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.2. Ensure that all requests for new Mall groups and individual therapies are implemented.
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<p>C.2.i.ix</p>	<p>is provided to individuals in bed-bound status in a manner and for a period that is commensurate with their medical status;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: Ensure that bed-bound individuals receive appropriate services following EP guidelines including hours of services.</p> <p>Findings: This monitor's documentation review (charts of individuals who were bed-bound and hours of services provided, course outline, and Procedure Manual), interview of the Mall Director, and visits to Units A-3 and A-4 where bed-bound individuals usually reside found that NSH had three bed-bound individuals (BK, JC and JM) in February and March 2008. NSH has developed standardized protocols for use with bed-bound individuals and the three individuals had received bed-side PSR services. However, the individuals did not receive the required hours of services.</p> <p>According to the Mall Director, as of June 2008, reports on the status of bed-bound individuals are sent to the Clinical Administrator on a monthly basis for review and action at the leadership meeting.</p> <p>This monitor interviewed A-3 and A-4 unit staff (Lydia Mendoza, RN, Marlene Salvador, MD, and Tammerra Murray, SRN). The staff reported that there were no bed-bound individuals at the time of this visit. The three bed-bound individuals in the unit in February and March 2008 have improved enough to be mobile or have moved out of the unit. The staff was familiar with the course lessons and activities used with bed-bound individuals. This monitor reviewed JC's chart; it contained progress notes showing that bed-side Mall services were provided when he was non-ambulatory.</p> <p>This monitor reviewed three course outlines developed for bed-bound individuals (Bedside Reality Orientation, Bedside Leisure and Bedside</p>
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		<p>Support). Facilitators for these groups were Rehabilitation Therapists. Activities outlined in the course included storytelling, Memory Scrapbook, card games, personal interest books, current event discussions and prayers.</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>Recommendation 1, January 2008: Ensure that Mall group activities routinely take place as scheduled.</p> <p>Findings: This monitor's documentation review (Mall course schedule and Mall cancellation data) and interview of the Mall Director found that NSH offers Mall services five days a week (M-F), four hours a day with two hours in the morning and two hours in the afternoon. NSH analyzed cancellation of scheduled Mall sessions, reporting an average cancellation rate of 12% (ranging from 10% to 14% per month, from January to May 2008). A review of the reasons for the cancellations found that 55% of the cancellations were due to staffing shortage. The table below showing the number of Mall sessions scheduled for the month (N), the number of Mall sessions cancelled for the month (n), and the percentage of Mall sessions (%C) is a summary of the facility's data.</p> <table border="1" data-bbox="995 1227 1797 1382"> <thead> <tr> <th></th> <th>Jan</th> <th>Feb</th> <th>Mar</th> <th>Apr</th> <th>May</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>1470</td> <td>1446</td> <td>1486</td> <td>1262</td> <td>1817</td> <td></td> </tr> <tr> <td>n</td> <td>150</td> <td>207</td> <td>183</td> <td>170</td> <td>221</td> <td></td> </tr> <tr> <td>%C</td> <td>10</td> <td>14</td> <td>12</td> <td>13</td> <td>12</td> <td>12</td> </tr> </tbody> </table>		Jan	Feb	Mar	Apr	May	Mean	N	1470	1446	1486	1262	1817		n	150	207	183	170	221		%C	10	14	12	13	12	12
	Jan	Feb	Mar	Apr	May	Mean																								
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		<p>This monitor's review of the list of the reasons for Mall group cancellations found that 21% of the group cancellations were due to "other" reasons. NSH should identify these reasons and take corrective actions.</p> <p>NSH's Mall session cancellation during the previous review period ending in December 2007 was 13% (ranging from 11% to 14%). The Mall Director plans on hiring a Mall Coordinator who, as part of his/her job, will identify substitute providers to reduce/eliminate cancellations when the primary and/or co-providers are not available to conduct the Mall sessions</p> <p>Recommendations 2 and 3, January 2008:</p> <ul style="list-style-type: none"> • Inform the WRPT when an individual is not engaging in the assigned treatment. • Implement the plan to assist individuals not going to assigned treatment activities. <p>Findings:</p> <p>This monitor's review of Mall courses and interview of the Mall Director found that WRPTs are informed through the Mall Monthly Progress Notes when individuals are not engaged in their assigned treatments.</p> <p>NSH audited the hours of Mall groups attended by individuals in their assigned Mall groups. The table below showing the number of individuals in the facility (N) for the month, categories of hours (in five hour increments), and the number of individuals participating in the various categories for the month is a summary of the facility's data.</p> <table border="1" data-bbox="995 1300 1818 1412"> <thead> <tr> <th></th> <th>Jan</th> <th>Feb</th> <th>Mar</th> <th>Apr</th> <th>May</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>1082</td> <td>1128</td> <td>1135</td> <td>1156</td> <td>1162</td> <td>1133</td> </tr> <tr> <td>0 - 5</td> <td>643</td> <td>493</td> <td>519</td> <td>822</td> <td>459</td> <td>587</td> </tr> </tbody> </table>		Jan	Feb	Mar	Apr	May	Mean	N	1082	1128	1135	1156	1162	1133	0 - 5	643	493	519	822	459	587
	Jan	Feb	Mar	Apr	May	Mean																	
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		<table border="1"> <tr> <td>6 - 10</td> <td>257</td> <td>322</td> <td>295</td> <td>225</td> <td>393</td> <td>298</td> </tr> <tr> <td>11 - 15</td> <td>132</td> <td>184</td> <td>183</td> <td>79</td> <td>217</td> <td>59</td> </tr> <tr> <td>16 - 20</td> <td>50</td> <td>129</td> <td>138</td> <td>30</td> <td>93</td> <td>88</td> </tr> </table> <p>As the table above shows, participation of individuals in their Mall groups is poor. Only 13% of the individuals attend between 11 and 20 hours of their assigned groups, 26% attend between 6 and 10 hours, and over 52% of them attend 0-5 hours.</p> <p>NSH has developed and implemented more than 140 new Mall groups (Variety Hour and Motivation Enhancement) to assist individuals not going to assigned treatment activities. NSH also increased (from six in the previous review to 12 during this review) the number of providers trained in Narrative Restructuring Therapy.</p> <p>This monitor observed the "Motivation Enhancement" group. An announcement was made through the public announcement system prior to the beginning of the group to alert participants. The facilitator and co-facilitator were well prepared with lesson plans and handouts (developed at the challenged level and pre-contemplative stage). Attendance was high and the individuals were actively engaged in the group.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that Mall group activities routinely take place as scheduled. 2. Inform the WRPT when an individual is not engaging in the assigned treatment. 3. Implement the plan to assist individuals not going to assigned treatment activities 	6 - 10	257	322	295	225	393	298	11 - 15	132	184	183	79	217	59	16 - 20	50	129	138	30	93	88
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C.2.i.xi	includes, in the evenings and weekends, additional activities that enhance the individual's quality of life; and	Current findings on previous recommendations:																					

		<p>Recommendations 1 and 2, January 2008:</p> <ul style="list-style-type: none"> • Plan and organize these activities such that there is minimal interruption, individuals are reinforced to participate regularly in these activities, and as much as possible eliminate competing activities that act as a barrier for individuals to participate in such activities. • Increase the number of hours of enrichment activities per individual provided in the evenings and on weekends. <p>Findings:</p> <p>This monitor's interview of the Mall Director found that NSH has named a Supplemental Activity Coordinator (as of April 8, 2008) to take charge of Supplemental Activity Planning and Programming. This monitor spoke with the Supplemental Activity Coordinator and he had a number of ideas to improve the quality of activities offered, training of providers, and participation of individuals in the activities.</p> <p>According to the Mall Director, activities are offered in the evenings on weekdays and on the weekends, there are no barriers for individuals to participate in these activities, and individuals are encouraged to participate by the unit staff and reinforced both by the WRPTs and unit staff. NSH has added a number of new activities including fitness centers, wellness centers, exercise activities, and "Laughter Club" activities facilitated by individuals on the weekends. NSH has just started to document individuals' participation in these activities and does not have a summary of individuals' hours of participation in supplemental, enrichment, and recreational activities.</p> <p>This monitor interviewed four individuals (ER, FK, JC and VB). These individuals reported that they have the opportunity to participate in a variety of supplemental activities on the evenings and weekends. They reported participating in a number of activities including volleyball games, walks and fitness activities, though not consistently. This</p>
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		<p>monitor reviewed the list of Supplemental/Leisure activities for July 2008. The list showed 44 activities conducted for the month.</p> <p>This monitor reviewed 13 charts (BTM, CCR, DDM, DLH, DSA, EER, EWK, FAG, GBL, JAS, SEB, SHS and WD). None of the charts contained Rehab Quarterly Progress Notes on supplemental activities. Three of the WRPs in the charts had documentation on the individual's supplemental activities in the Present Status section and/or objectives and interventions. According to the Mall Director, NSH is working to get the supplemental activity progress note process integrated into the WaRMSS system.</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	is consistently reinforced by staff on the therapeutic milieu, including living units.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, January 2008: Ensure that all WRPs have therapeutic milieu interventions clearly specified in the intervention sections.</p> <p>Findings: This monitor reviewed 19 charts (BTM, CAW, CCR, DDM, DFA, EWK, FAG, HA, HR, HSS, JAS, MER, NHB, RA, RAL, TEG, TN, WD and WTA). Seven of the WRPs in the charts (BTM, CAW, HR, RAL, TN, WD and WTA) had documented therapeutic milieu interventions in the intervention sections of the WRPs. The remaining 12 (CCR, DDM, DFA,</p>

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		<p>EWK, FAG, HA, HSS, JAS, MER, NHB, RA and TEG) did not do so.</p> <p>Recommendation 2, January 2008: 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: Using item #12 from the DMH WRP Chart Audit Form (<i>Adequate active psychosocial rehabilitation is consistently reinforced by staff on the therapeutic milieu, including living units</i>) NSH analyzed its compliance using a mean sample of 24% of WRPs due for the month (January to May 2008), reporting a mean compliance rate of 29% (NSH's mean compliance rate for the previous review was 14%). NSH's compliance rate for the last month of the previous review period was 17% and is 58% for the last month of this review period.</p> <p>NSH also used item #12 from the DMH WRP Therapeutic Milieu Observation Form (<i>Staff are observed discussing mall activities with individuals</i>) to analyze its compliance, observing a mean sample of 93% of the number of units in the facility for the month (March to May 2008) and reporting a mean compliance rate of 18% (NSH's mean compliance rate for the previous review was 3%). NSH's compliance rate for the last month of the previous review was 0% and is 25% for the last month of this review period.</p> <p>This monitor interviewed four individuals (BW, FK, JW and LG) to address this recommendation. Two of them (FK and JW) reported that unit staff talk to them about their PSR services and encourage and motivate them to participate in their services. This monitor attended two WRPCs and the WRPT members reviewed the individuals' Mall group attendance and participation and gave them feedback and encouragement to continue or improve their attendance and</p>
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		<p>participation in their chosen groups.</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>Recommendations 1-3, January 2008:</p> <ul style="list-style-type: none"> • Continue to provide training to Mall facilitators to conduct the activities appropriately. • Develop the system to track and review participation of individuals in scheduled group exercise and recreational activities. • Implement corrective action if participation is low. <p>Findings:</p> <p>This monitor's documentation review (Training Curriculum and Attendance Roster) found that NSH has scheduled and implemented training sessions for its Mall facilitators and providers of exercise and recreational activities to improve the quality of their facilitation. According to the Mall Director, in May 2008 NSH's Sports Committee developed training for its "Rehabilitation Therapists Professional Group." The training dealt with safety issues (hot weather, attire, and footwear) during participation in sports exercise and recreation activities.</p> <p>NSH has elected to track participation of individuals in their enrolled activities through review of the Monthly Mall Facilitator Progress Notes during the individual's WRPC.</p>

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		<p>NSH has made an initial attempt at increasing individuals' participation in the activities offered by enrolling individuals with high BMI's in exercise groups. The table below showing the BMI categories, the number of individuals within each category, and the number and percentage of those individuals who are enrolled in the exercise groups is a summary of the facility's data (modified by this monitor).</p> <table border="1" data-bbox="995 451 1654 678"> <thead> <tr> <th>BMI Category</th> <th># of Individuals in Category</th> <th># Enrolled in Exercise Groups</th> </tr> </thead> <tbody> <tr> <td>25 - 30</td> <td>335</td> <td>289 (86%)</td> </tr> <tr> <td>31 - 35</td> <td>194</td> <td>156 (80%)</td> </tr> <tr> <td>36 - 40</td> <td>64</td> <td>55 (86%)</td> </tr> <tr> <td>>40</td> <td>61</td> <td>52 (85%)</td> </tr> </tbody> </table> <p>According to the Mall Director, NSH needed 139 exercise groups per week for individuals to participate in at least one exercise group per week. NSH offered 325 exercise groups per week in April and May 2008.</p> <p>This monitor reviewed a number of Lesson Plans developed and implemented for the exercise/leisure groups. The lesson plan on "Exercise/Walk" was written for individuals across cognitive levels and stages of change. The activity was scheduled for 30 minutes with the main goal being improvement in individuals' physical health.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to provide training to Mall facilitators to conduct the activities appropriately. 2. Develop the system to track and review participation of individuals in scheduled group exercise and recreational activities. 	BMI Category	# of Individuals in Category	# Enrolled in Exercise Groups	25 - 30	335	289 (86%)	31 - 35	194	156 (80%)	36 - 40	64	55 (86%)	>40	61	52 (85%)
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		3. Implement corrective action if participation is low.
C.2.k	Individuals who have an assessed need for family therapy services receive such services in their primary language, as feasible, consistent with generally accepted professional standards of care and that these services, and their effectiveness for addressing the indicated problem, are comprehensively documented in each individual's chart.	<p>Current findings on previous recommendations:</p> <p>Recommendations 1-3, January 2008:</p> <ul style="list-style-type: none"> • Continue to assess family therapy needs of individuals and/or their families. • Document the education provided and the community referrals made for those who are in need of therapy/services. • Document status of efforts to provide family therapy in the primary/preferred languages of these families. <p>Findings:</p> <p>This monitor's documentation review (30-Day Psychosocial Assessment, WRPC Family/Significant Other Input Form) and interview of Social Work staff found that NSH continues to assess family therapy needs of individuals and/or their families, using Question #23 from the WRPC Family Significant Other Input Form ("Do you feel family therapy would help you assist and support your family member upon discharge?") and questions from the 30-Day Psychosocial Assessments. NSH has informed families on the availability of family therapy services through announcements during the Monthly NAMI meetings. According to the Social Work staff, training on assessing family therapy needs has been provided to all Social Workers at NSH. NSH has received one referral for couple therapy (MS, referral received on June 6, 2008). NSH also has developed a list of Spanish-speaking individuals suitable for family therapy services and is awaiting consent for release of information. NSH plans to use staff from Social Work, Psychology, and Psychiatry to provide Family Therapy Services in the preferred/primary language of the individual and/or the family. NSH has planned to have Senior Supervising Social Work staff review Social History assessments on a monthly basis and provide feedback to examiners and WRPTs on family therapy assessments and referrals.</p>

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		<p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to assess family therapy needs of individuals and/or their families. 2. Document the education provided and the community referrals made for those who are in need of therapy/services. 									
C.2.1	<p>Each individual's therapeutic and rehabilitation service plan identifies general medical diagnoses, the treatments to be employed, the related symptoms to be monitored by nursing staff (i.e., registered nurses ["RNs"], licensed vocational nurses ["LVNs"] and psychiatric technicians) and the means and frequency by which such staff shall monitor such symptoms, consistent with generally accepted professional standards of care.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, January 2008: Provide training addressing this requirement.</p> <p>Findings: NSH did not provide data addressing this recommendation.</p> <p>Recommendation 2, January 2008: Continue to monitor this requirement.</p> <p>Findings: The facility used the DMH Integration of Medical Conditions into WRP Audit Form, based on an average sample of 18% of all individuals with at least one diagnosis listed on Axis III that had a WRP due each month (March through May 2008). The following table summarizes the data:</p> <table border="1" data-bbox="995 1190 1894 1414"> <tr> <td>1.</td> <td><i>All medical conditions listed in Axis III are included on the Medical Conditions form</i></td> <td>71%</td> </tr> <tr> <td>2.</td> <td><i>The WRP includes each medical condition listed on the Medical Conditions form</i></td> <td>59%</td> </tr> <tr> <td>3.</td> <td><i>There is an appropriate focus statement for each medical condition or diagnosis</i></td> <td>63%</td> </tr> </table>	1.	<i>All medical conditions listed in Axis III are included on the Medical Conditions form</i>	71%	2.	<i>The WRP includes each medical condition listed on the Medical Conditions form</i>	59%	3.	<i>There is an appropriate focus statement for each medical condition or diagnosis</i>	63%
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		<table border="1"> <tr> <td data-bbox="989 193 1073 266">4.</td> <td data-bbox="1073 193 1770 266"><i>There is an appropriate objective for each medical condition or diagnosis</i></td> <td data-bbox="1770 193 1881 266">73%</td> </tr> <tr> <td data-bbox="989 266 1073 339">5.</td> <td data-bbox="1073 266 1770 339"><i>There are appropriate intervention(s) for each objective</i></td> <td data-bbox="1770 266 1881 339">73%</td> </tr> </table>	4.	<i>There is an appropriate objective for each medical condition or diagnosis</i>	73%	5.	<i>There are appropriate intervention(s) for each objective</i>	73%												
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<p>NSH's data analysis demonstrated that improvement was noted in all the areas listed above. NSH indicated that its efforts regarding training and mentoring by the WRP trainers, senior clinicians, nursing and management resulted in the increase in compliance rates.</p>																				
<p>This monitor's review of 40 individuals' WRPs (AHS, AMM, ARM, ATB, AWD, BJ, BMR, BSS, CCR, CDW, CIC, CWE, DEB, DJT, DP, EH, FCP, GPB, HCM, HSS, JA, JEG, JRM, JRQ, KMG, LLS, MEP, PJN, RLW, RR, RS, RTP, SMP, SWS, TBH, TDN, TLB, TOM, VH and WJB) found that 21 had appropriate focus statements, objectives and interventions and 28 had all Axis III diagnoses listed in the medical conditions form.</p>																				
<p>Other findings: Due to a data collection error, no data was provided by NSH regarding IDTs reviewing, assessing, and developing strategies to overcome individuals' refusals of medical procedures. However, in March 2008 the facility implemented an interdisciplinary workgroup focused on addressing policy and procedures relating to treatment non-adherence</p>																				

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		<p>and refusals. NSH indicated that data will be presented during the next review.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Present data regarding WRPs and refusals. 2. Continue to monitor this requirement.
C.2.m	The children and adolescents it serves receive, consistent with generally accepted professional standards of care:	<p>The requirements of Section C.2.m are not applicable because NSH does not serve children and adolescents.</p>
C.2.m.i	Therapy relating to traumatic family and other traumatic experiences, as clinically indicated; and	
C.2.m.ii	reasonable, clinically appropriate opportunities to involve their families in treatment and treatment decisions.	
C.2.n	Policies and procedures are developed and implemented consistent with generally accepted professional standards of care to ensure appropriate screening for substance abuse, as clinically indicated.	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: Finalize and implement the policy and procedure regarding screening and assessment for substance use disorders.</p> <p>Findings: In July 2008, NSH finalized an AD, Comprehensive Substance Recovery Services, which contains the policy and procedure. Some aspects of the policy and procedure were implemented prior to its final approval. These included the appointment of a Chief of Substance Recovery</p>

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		<p>Services, an increase in substance abuse groups, monitoring and auditing of substance recovery services, alignment of pharmacy services and the establishment of an Interdisciplinary Substance Recovery/Pain Management Consultation Service. However, the facility has yet to fully implement this AD.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Implement the policy and procedure regarding screening and assessment for substance use disorders.</p>
C.2.o	<p>Individuals who require treatment for substance abuse are provided appropriate therapeutic and rehabilitation services consistent with generally accepted professional standards of care.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, January 2008: 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.</p> <p>Findings: NSH has piloted two clinical outcome tools, URICA and SOCRATES, to determine their validity for use at the facility. The facility has begun to train all Substance Abuse curriculum-trained staff on how to administer the clinical outcome tools as pre and post-tests for individuals attending Substance Abuse groups.</p> <p>NSH is in the process of finalizing the following process outcomes:</p> <ol style="list-style-type: none"> 1. Number of individuals screened for substance abuse per month; 2. Number of individuals with positive screens who have received substance abuse assessment as evidenced by chart audits;

		<p>3. Number of individuals with substance abuse who have Focus 5 staged, with at least one objective and one intervention linked to their stage of change; and</p> <p>4. Number of Substance Recovery groups.</p> <p>NSH has presented the following process outcome data:</p> <p>1. Number of individuals screened for substance abuse per month (limited to urine drug screens):</p> <table border="1" data-bbox="1039 560 1669 828"> <thead> <tr> <th>Month</th> <th>Number of screens</th> <th>Number testing positive</th> </tr> </thead> <tbody> <tr> <td>January</td> <td>162</td> <td>6</td> </tr> <tr> <td>February</td> <td>130</td> <td>5</td> </tr> <tr> <td>March</td> <td>139</td> <td>2</td> </tr> <tr> <td>April</td> <td>184</td> <td>5</td> </tr> <tr> <td>May</td> <td>192</td> <td>1</td> </tr> </tbody> </table> <p>2. A total of 57 Substance Recovery groups are currently being provided. Four of these Substance Recovery groups are provided in Spanish (for monolingual individuals or those who prefer Spanish). Eighty-two percent of Substance Recovery groups are categorized by stage of change and cognitive level.</p> <p>Recommendations 2 and 3, January 2008:</p> <ul style="list-style-type: none"> • Ensure monitoring of substance use disorders using the DMH WRP Clinical Chart Audit and the Substance Abuse Audit Forms, based on a sample of at least 20% of individuals diagnosed with these disorders. • Provide data analysis addressing sub-items of this requirement. The analysis must evaluate areas of low compliance and delineate areas of relative improvement. 	Month	Number of screens	Number testing positive	January	162	6	February	130	5	March	139	2	April	184	5	May	192	1
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		<p>Findings: NSH used the DMH Substance Abuse Audit Form to assess compliance (January to May 2008). The average sample was 12% of all individuals with a current diagnosis of substance abuse as listed in the WRP or Integrated Psychiatric Assessment or if admitted before January 2007, the last monthly Psychiatric Progress Note. The following is a summary of the data:</p> <table border="1" data-bbox="997 487 1890 1015"> <tr> <td>1.</td> <td><i>Substance abuse is integrated into the case formulation and discussed in the present status.</i></td> <td>54%</td> </tr> <tr> <td>2.</td> <td><i>There is an appropriate Focus statement listed under Focus #5.</i></td> <td>84%</td> </tr> <tr> <td>3.</td> <td><i>There is at least one objective related to the individual's stage of change.</i></td> <td>85%</td> </tr> <tr> <td>4.</td> <td><i>There are interventions that are appropriately linked to the active objective(s).</i></td> <td>82%</td> </tr> <tr> <td>5.</td> <td><i>The active treatment for substance abuse that is specified in the WRP is aligned with the individual's mall schedule.</i></td> <td>65%</td> </tr> <tr> <td>6.</td> <td><i>The discharge criteria related to substance abuse are individualized and written in behavioral, observable and/or measurable terms.</i></td> <td>54%</td> </tr> </table> <p>NSH conducted data analysis showing that compliance rates have increased from December 2007 to May 2008 as follows:</p> <ol style="list-style-type: none"> 1. Item 1: from 42% to 35%; 2. Item 2: from 60% to 90%; 3. Item 3: from 58% to 93%; 4. Item 4: from 53% to 88%; 5. Item 5: from 33% to 49%; and 6. Item 6: from 5% to 62%. 	1.	<i>Substance abuse is integrated into the case formulation and discussed in the present status.</i>	54%	2.	<i>There is an appropriate Focus statement listed under Focus #5.</i>	84%	3.	<i>There is at least one objective related to the individual's stage of change.</i>	85%	4.	<i>There are interventions that are appropriately linked to the active objective(s).</i>	82%	5.	<i>The active treatment for substance abuse that is specified in the WRP is aligned with the individual's mall schedule.</i>	65%	6.	<i>The discharge criteria related to substance abuse are individualized and written in behavioral, observable and/or measurable terms.</i>	54%
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		<p>Data analysis showed that WRPTs did not consistently address substance abuse in the Present Status section of the case formulation. As a corrective action, the facility plans to ensure that the discipline seniors will review WRPs and provide staff mentoring to improve compliance.</p> <p>Other findings: This monitor reviewed the charts of six individuals (AWD, BJ, CWE, FCP, FGP and HCM). The review found that all WRPs included documentation of the substance abuse diagnosis and corresponding focus, objectives and interventions. Regarding the linkage between the stages of change and objectives/interventions, there was compliance in two charts (BJ and FGP), partial compliance in three (CWE, FCP and HCM) and non-compliance in one (AWD).</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Finalize and utilize clinical outcomes for individuals and process outcomes for the program. 2. Ensure monitoring of substance use disorders using the DMH WRP Clinical Chart Audit and the Substance Abuse Audit Forms, based on a sample of at least 20% of individuals diagnosed with these disorders. 3. Provide data analysis addressing sub-items of this requirement. The analysis must evaluate areas of low compliance and delineate areas of relative improvement.
C.2.p	Group facilitators and therapists providing therapeutic and rehabilitation services (in groups or individual therapy) are verifiably competent regarding selection and implementation of	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: Implement the newly developed system and report data on the</p>

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	<p>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>competency of providers of PSR Mall services.</p> <p>Findings: This monitor's documentation review (Training and Development Roster and Mall Course Facilitator Consultation Forms) and interview with Social Work staff found that NSH conducted training sessions (May 1, 2008) for Mall group facilitators. NSH plans to assess PSR Mall service providers at least once in two months. NSH evaluated 94 Mall sessions (a sample of 2%) during this review period, reporting a mean compliance rate of 100% across the categories audited (Instructional Categories, Course Structure, Instructional Techniques, and Learning Process) with inter-rater agreement of 100%.</p> <p>This monitor reviewed 12 of the completed Mall Course Facilitator Consultation Forms. Three were fully completed with checks in all the required sections. Four of them were incomplete, including not documenting if a lesson plan was available and/or followed. One stated that the group was ended early due to "extreme heat." The remaining three had documentation stating that the groups were not conducted (one facilitator reportedly had "team duties", one facilitator was attending a training session, and the other stated that the session was not held because it "had to do with polydipsia").</p> <p>This monitor observed a number of Mall groups (New Start for Mental Health, Stretching/ Relaxation, Mental Health Through Laughter, Enhancement Motivation, Social Skills Through Improvisational Theater, and Suicide Prevention Education Awareness Keys), including one that was facilitated by an individual (FK). In all cases, the facilitators were prepared with lesson plans and handouts; the individuals were engaged; and the facilitators modified their questioning to suit the individuals' levels of understanding and used appropriate instructional methodology (role-play, prompting and coaching, and modeling) and resources (reading, video, music, and</p>
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		<p>activities)</p> <p>Compliance: Substantial.</p> <p>Current recommendation:</p> <ol style="list-style-type: none"> 1. Continue current practice. 2. Same as in C.2.g.iv.
C.2.q	<p>Group facilitators and therapists providing therapeutic and rehabilitation services in the field of substance abuse should be certified substance abuse counselors.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1-3, January 2008:</p> <ul style="list-style-type: none"> • Ensure that all providers complete the NSH substance abuse training, and provide data to show that training has occurred. • Clarify and streamline staff competency criteria to ensure their alignment with the current training curriculum. • Provide data showing the competency and quality of services provided by the facilitators trained in the Substance Abuse treatment curriculum. <p>Findings:</p> <p>This monitor's documentation review (substance abuse training documentation, substance abuse facilitator monitoring, and NSH's progress report) found that NSH has conducted training/certification for Substance Abuse Recovery facilitators. At the time of this review, NSH had 63 certified staff in Substance Abuse Recovery. Forty-four of these staff have been facilitating Substance Abuse recovery groups. However, this monitor's review of NSH's Substance Abuse Provider Summary found two staff members listed who were not credentialed and/or trained in Substance Abuse Recovery. NSH has four Substance Abuse recovery groups that are conducted in Spanish.</p> <p>According to the Mall Director, the Substance Abuse provider training</p>

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		<p>is being revised to include motivational strategies at the pre-contemplation and contemplation stages. As part of its plan for improvement, NSH has its Discipline Chiefs review and update the Substance Recovery Provider Summary Report on a monthly basis. They are also to provide a plan to the Medical Director showing how they intend to achieve training competency of the providers and improve the quality of their facilitation on a monthly basis.</p> <p>This monitor reviewed documentation of ten audits conducted by NSH on Substance Abuse Recovery group facilitation. The data from all ten audits found that the facilitators conducting the Substance Abuse Recovery groups met at least the minimal quality standards.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that all providers complete the NSH substance abuse training and provide data to show that training has occurred. 2. Clarify and streamline staff competency criteria to ensure their alignment with the current training curriculum. 3. Provide data showing the competency and quality of services provided by the facilitators trained in the Substance Abuse treatment curriculum.
C.2.r	Transportation and staffing issues do not preclude individuals from attending appointments.	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, January 2008:</p> <ul style="list-style-type: none"> • Review reasons for cancellations and assess and correct factors contributing to such events. • Complete and implement the Medical Scheduler.

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Findings:
 This monitor's documentation review (list of appointments scheduled vs cancelled, NSH's progress report) and interview of the Mall Director found that 5056 appointments were scheduled between January and May 2008. Two hundred and twelve of the 5056 scheduled appointments were not kept. The table below showing the months, the number of scheduled appointments per month, the number of cancelled appointments per month, and the reasons for cancellation of scheduled appointments is a summary of the facility's data.

Month	Appointments		Reasons for Cancellation
	Scheduled	Cancelled	
Jan	966	37	37 staffing 0 transportation
Feb	1040	17	14 staffing 3 transportation
Mar	989	66	64 staffing 2 transportation
Apr	1097	49	46 staffing 3 transportation
May	964	43	43 staffing 0 transportation

As seen in the table above, transportation was not a significant reason for most of the cancellations, but staffing was. According to the Mall Director, NSH has made it the responsibility of the Program Directors to ensure that staff is available to transport individuals to their scheduled appointments.

Analysis of NSH's data by this monitor found that individuals' refusals to attend appointments continue to be a significant factor (this reason was also a major factor in the last review). In addition, "MD not available" and "MD canceled" were reasons frequently cited for

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		<p>cancellations of scheduled appointments.</p> <p>In two of the cases (CE and SB, appointment dates, January 31, 2008), "MD with DOJ" was cited as the reason for cancellation of scheduled appointments. Court Monitor visits are scheduled ahead of time and staff should request, through their administrators, a change in time and/or date of any meetings with the CM that may conflict with service delivery.</p> <p>According to the Mall Director, NSH now provides unit-based medical care (following reassignment of physicians and surgeons to units), which results in fewer appointments and transportation needs for individuals to attend their appointments. According to the Mall Director, NSH has made Program Directors responsible for getting nursing staff to accompany individuals to their appointments. However, this does not solve one of the primary reasons (physician non-availability and physician cancellations) for cancellations of scheduled appointments.</p> <p>NSH has yet to complete and implement the Medical Scheduler. The Medical Scheduler is still to be fully integrated with the WaRMSS.</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.
C.2.s	Adequate oversight to treatment, rehabilitation and enrichment groups is provided to ensure that individuals are assigned to groups that are appropriate to their assessed needs, that groups	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: Develop and implement monitoring systems that address the required</p>

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	<p>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>elements.</p> <p>Findings: Using item #10 from the DMH WRP Clinical Chart Audit Form, NSH assessed its compliance based on an average sample of 8% of the WRPs due for the month (January to May 2008). The table below with its indicators and sub-indicators and corresponding mean compliance is a summary of the data.</p> <table border="1" data-bbox="991 524 1887 1232"> <tr> <td data-bbox="991 524 1087 894">10.</td> <td data-bbox="1087 524 1793 894"><i>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.</i></td> <td data-bbox="1793 524 1887 894"></td> </tr> <tr> <td data-bbox="991 894 1087 1044">10.a</td> <td data-bbox="1087 894 1793 1044"><i>The individual's cognitive functioning level, needs, and strengths (as documented in the case formulation) are aligned with the group assignments.</i></td> <td data-bbox="1793 894 1887 1044">25%</td> </tr> <tr> <td data-bbox="991 1044 1087 1156">10.b</td> <td data-bbox="1087 1044 1793 1156"><i>For each Axis I, II and III diagnoses, the interventions are related to excesses and deficits associated with each diagnosis.</i></td> <td data-bbox="1793 1044 1887 1156">40%</td> </tr> <tr> <td data-bbox="991 1156 1087 1232">10.c</td> <td data-bbox="1087 1156 1793 1232"><i>All interventions are offered at the cognitive functioning level of the individual</i></td> <td data-bbox="1793 1156 1887 1232">33%</td> </tr> </table> <p>NSH's mean compliance for the last review was 0% and the mean compliance for this review is 36%. According to the Mall Director, the plan of improvement is to have the WRP trainers to provide WRPTs consultation/training on properly linking the various elements from</p>	10.	<i>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.</i>		10.a	<i>The individual's cognitive functioning level, needs, and strengths (as documented in the case formulation) are aligned with the group assignments.</i>	25%	10.b	<i>For each Axis I, II and III diagnoses, the interventions are related to excesses and deficits associated with each diagnosis.</i>	40%	10.c	<i>All interventions are offered at the cognitive functioning level of the individual</i>	33%
10.	<i>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.</i>													
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10.c	<i>All interventions are offered at the cognitive functioning level of the individual</i>	33%												

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		<p>objectives and interventions to PSR Mall services. Furthermore, the Chief of Psychology is to provide WRPTs with individuals' cognitive assessments data, and the Senior Psychologists will provide WRPTs with training on developing interventions appropriate to an individual's cognitive level..</p> <p>This monitor reviewed 12 charts (EPY, EWT, FAG, HLA, HRD, JE, JEW, RCB, RCC, RJM, TEG and TMR). Eight of them (EPY, EWT, FAG, HLA, JE, JEW, TEG and TMR) had proper case formulation, identified the individual's needs and strengths, specified interventions related to the individuals' excesses and deficits associated with the diagnosis, and the Mall groups were aligned with the individual's needs. The remaining four (HRD, RCB, RCC and RJM) had one or more elements missing and/or not aligned with the individual's needs.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Develop and implement monitoring systems that address the required elements.</p>
C.2.t	Treatment, rehabilitation and enrichment services are monitored appropriately against rational, operationally defined target variables and revised as appropriate in light of significant developments, and the individual's progress, or lack thereof;	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: Ensure that the newly developed process is fully implemented and addresses all of the elements of this requirement.</p> <p>Findings: Using item #11 from the DMH WRP Clinical Chart Audit Form, NSH assessed its compliance based on an average sample of 8% of the WRPs due for the month (January to May 2008). The table below with its indicators and sub-indicators and corresponding mean compliance is a</p>

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		<p>summary of the data.</p> <table border="1" data-bbox="991 263 1881 1049"> <tr> <td data-bbox="991 263 1087 451">11.</td> <td data-bbox="1087 263 1793 451"><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></td> <td data-bbox="1793 263 1881 451"></td> </tr> <tr> <td data-bbox="991 451 1087 526">11.a</td> <td data-bbox="1087 451 1793 526"><i>Each objective is observable, measurable and behavioral.</i></td> <td data-bbox="1793 451 1881 526">10%</td> </tr> <tr> <td data-bbox="991 526 1087 639">11.b</td> <td data-bbox="1087 526 1793 639"><i>All groups and individual therapies are linked directly to the foci, objective and interventions specified in the individual's WRP.</i></td> <td data-bbox="1793 526 1881 639">47%</td> </tr> <tr> <td data-bbox="991 639 1087 753">11.c</td> <td data-bbox="1087 639 1793 753"><i>There is a DMH PSR Mail Facilitator Monthly Progress Note for each active treatment in the individual's WRP.</i></td> <td data-bbox="1793 639 1881 753">5%</td> </tr> <tr> <td data-bbox="991 753 1087 938">11.d</td> <td data-bbox="1087 753 1793 938"><i>If the individual has not made progress on an objective in 2 months, the objective and/or intervention is revised, or there is documentation of clinically justifiable reasons for continuing with the objective.</i></td> <td data-bbox="1793 753 1881 938">6%</td> </tr> <tr> <td data-bbox="991 938 1087 1049">11.e</td> <td data-bbox="1087 938 1793 1049"><i>If the individual has met the objective, a new objective and related interventions have been developed and implemented.</i></td> <td data-bbox="1793 938 1881 1049">24%</td> </tr> </table> <p data-bbox="991 1084 1881 1263">NSH's mean compliance for the previous review was 0% and the mean compliance for this review is 19%. According to the Clinical Administrator, the plan of improvement includes further training, mentoring, and monitoring with feedback to address the elements in this recommendation.</p> <p data-bbox="991 1305 1881 1412">This monitor reviewed 13 charts (AWD, BTM, EP, HLA, LNZ, NW, RAL, RB, RJM, RMT, SEB, TEG and TMR). One of them (SEB) had revised the objectives and interventions based on the individual's progress or</p>	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>		11.a	<i>Each objective is observable, measurable and behavioral.</i>	10%	11.b	<i>All groups and individual therapies are linked directly to the foci, objective and interventions specified in the individual's WRP.</i>	47%	11.c	<i>There is a DMH PSR Mail Facilitator Monthly Progress Note for each active treatment in the individual's WRP.</i>	5%	11.d	<i>If the individual has not made progress on an objective in 2 months, the objective and/or intervention is revised, or there is documentation of clinically justifiable reasons for continuing with the objective.</i>	6%	11.e	<i>If the individual has met the objective, a new objective and related interventions have been developed and implemented.</i>	24%
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>																			
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		<p>lack of progress. The remaining 12 (AWD, BTM, EP, HLA, LNZ, NW, RAL, RB, RJM, RMT, TEG and TMR) did not satisfy the elements required to meet compliance with this requirement, including the absence of Mall progress notes, objectives not observable and/or measurable, the assigned groups were not directly linked to the individual's objectives and interventions, and the objectives and/or interventions were not modified if there was progress or lack of progress in two months.</p> <p>Compliance: Partial.</p> <p>Current recommendations: Ensure that the newly developed process is fully implemented and addresses all of the elements of this requirement.</p>
C.2.u	<p>Individuals are educated regarding the purposes of their treatment, rehabilitation and enrichment services. They will be provided a copy of their WRP when appropriate based on clinical judgment.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, January 2008: Fully implement the Wellness and Recovery Orientation Mall curriculum.</p> <p>Findings: NSH has implemented this recommendation. In addition, the facility has developed and implemented a Personal Recovery curriculum to provide ongoing education for individuals (21 sessions are currently scheduled).</p> <p>Recommendation 2, January 2008: Develop and implement a tool to address both elements of this requirement.</p> <p>Findings: NSH currently has adequate mechanisms to track this requirement.</p>

		<p>The facility has a tracking sheet to ensure that all newly admitted individuals receive education on the Wellness and Recovery Planning process and the signature page of the WRP contains information about whether or not the individual was offered and received a copy of the WRP. This information is monitored by the WRP Chart Audit.</p> <p>Recommendation 3, January 2008: Increase the number of Mall groups that are provided to educate individuals regarding the purposes of their treatment, rehabilitation and enrichment services.</p> <p>Findings: NSH has increased the number of these groups. The following table illustrates a significant increase during this review period.</p> <table border="1" data-bbox="991 743 1873 899"> <thead> <tr> <th colspan="4">Mall Term</th> </tr> <tr> <th>Oct-Dec 2007</th> <th>Jan-Mar 2008</th> <th>Apr-Jun 2008</th> <th>Current: Jul-Sep 2008</th> </tr> </thead> <tbody> <tr> <td>3</td> <td>3</td> <td>24</td> <td>24</td> </tr> </tbody> </table> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Provide information regarding number of groups offered, number of individuals attending WRP education, the type of groups offered that provide this education and criteria used to determine target individuals for each type. 2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). 	Mall Term				Oct-Dec 2007	Jan-Mar 2008	Apr-Jun 2008	Current: Jul-Sep 2008	3	3	24	24
Mall Term														
Oct-Dec 2007	Jan-Mar 2008	Apr-Jun 2008	Current: Jul-Sep 2008											
3	3	24	24											

Section C: Integrated Therapeutic and Rehabilitation Services Planning

<p>C.2.v</p>	<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, January 2008: Ensure full implementation of the curriculum regarding medication education.</p> <p>Findings: NSH did not address this recommendation.</p> <p>Recommendations 2 and 3, January 2008:</p> <ul style="list-style-type: none"> • Increase the number of Mall groups that offer education regarding medication management. • Develop and implement a process for assessing medication education. The facility may utilize the process developed at MSH. <p>Findings: NSH has implemented this recommendation. The following table illustrates a significant increase in the number of groups offered by term:</p> <table border="1" data-bbox="991 932 1873 1084"> <thead> <tr> <th colspan="4">Mall Term</th> </tr> <tr> <th>Oct-Dec 2007</th> <th>Jan-Mar 2008</th> <th>Apr-Jun 2008</th> <th>Current: Jul-Sep 2008</th> </tr> </thead> <tbody> <tr> <td>8</td> <td>9</td> <td>37</td> <td>37</td> </tr> </tbody> </table> <p>NSH has implemented a new Mall scheduling process in March 2008 to identify the number of medication education sessions needed. Based on that assessment, NSH has offered 37 groups during the current review period.</p> <p>Compliance: Partial.</p>	Mall Term				Oct-Dec 2007	Jan-Mar 2008	Apr-Jun 2008	Current: Jul-Sep 2008	8	9	37	37
Mall Term														
Oct-Dec 2007	Jan-Mar 2008	Apr-Jun 2008	Current: Jul-Sep 2008											
8	9	37	37											

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Provide information regarding number of groups offered by the facility, number of individuals attending these groups and criteria used to determine individuals in need (and the number of these individuals). 2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).
C.2.w	<p>Interdisciplinary teams review, assess, and develop positive clinical strategies to overcome individual's barriers to participation in therapeutic and rehabilitation services.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, January 2008: Finalize process to provide Key Indicator data regarding individuals' non-adherence to interventions in the WRP.</p> <p>Findings: NSH has yet to implement this recommendation.</p> <p>Recommendation 2, January 2008: Continue NRT and 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 continued to provide NRT. The facility has increased the number of trained providers of this therapy from four to six. The number of individuals served has increased from seven to 11. The facility has yet to provide information to ensure that therapy is provided to individuals who trigger non-adherence to WRP in the key indicator.</p> <p>Recommendation 3, January 2008: Implement curriculum to enhance motivation of individuals.</p>

		<p>Findings: The facility developed a program to provide active treatment designed to enhance individuals' motivation to participate in active WRP activities. This program includes the development of curricula and scheduling of these activities. NSH reported that in the current term, there are 143 sessions scheduled of activities designed to enhance motivation to participate in treatment.</p> <p>Recommendation 4, January 2008: Monitor compliance with this requirement.</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. Finalize process to provide key indicator data regarding individuals' non-adherence to interventions in the WRP. 2. Provide information to demonstrate that NSH's current program to motivate individuals addresses barriers towards individuals' participation in their WRPs, including Mall groups. 3. Provide data regarding: <ol style="list-style-type: none"> a. All systematic methods of behavior change including Motivational Interviewing, Narrative Restructuring Therapy and other cognitive behavioral interventions that are provided (with number of providers); b. The number of individuals receiving these interventions; and c. The number of individuals who trigger non-adherence to WRP in the key indicators.
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D. Integrated Assessments		
D	<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 on Psychiatric Assessments and Diagnoses:</p> <ol style="list-style-type: none"> 1. In general, NSH has made some progress in the quality of admission and integrated psychiatric assessments. 2. NSH has begun implementation of the new DMH template for admission psychiatric assessments. Proper implementation of this template can significantly enhance the quality of admission risk assessment in the State's facilities. 3. NSH has improved presentation and analysis of self-assessment data in this section. <p>Summary of Progress on Psychological Assessments:</p> <ol style="list-style-type: none"> 1. NSH completed the required educational and intellectual assessments for individuals under 22 years of age in a timely manner. 2. NSH completed 95% of the Integrated Assessment: Psychological Section due. 3. NSH has set up a system of monitoring and mentoring that allows Senior Psychologists to review and provide corrective feedback on all Psychology Integrated Assessments, and all Focused Psychological Assessments before the assessments are finalized. 4. NSH has made strong improvements with mean compliance rates above 90% in many of the recommendations. 5. NSH has reviewed and/or revised all the Integrated Assessments: Psychology Section of individuals admitted prior to June 1, 2006. <p>Summary of Progress on Nursing Assessments:</p> <p>The documentation of allergies and vital signs on the Admission and Integrated Nursing Assessments has achieved substantial compliance.</p>

Section D: Integrated Assessments

		<p>Summary of Progress on Rehabilitation Therapy Assessments:</p> <ol style="list-style-type: none">1. The revised IA-RTS was implemented in January 2008, and all Rehabilitation Therapy focused assessments were implemented in April 2008.2. Audit tools for the IA-RTS and focused assessments have been implemented. A D4 Monitoring tool has been developed and implemented that aligns with Enhancement Plan requirements.3. Audit data analysis to identify systemic trends and mentoring based on audit results on an individual basis has been initiated. <p>Summary of Progress on Nutrition Assessments:</p> <ol style="list-style-type: none">1. Training is provided for Clinical Dietitians regarding areas which fall below substantial compliance on an individual basis with corrective action as indicated on performance evaluations.2. Low staffing continues to affect the timeliness of Nutrition Care assessments. Currently, staffing is at 71%. <p>Summary of Progress on Social History Assessments:</p> <p>NSH's audit data showed improvement compared to the previous review period for a number of indicators; however, the improvement was not consistently observed in the charts reviewed.</p> <p>Summary of Progress on Court Assessments:</p> <ol style="list-style-type: none">1. NSH has improved the quality of court reports regarding PC 1026 and PC 1370 commitments.2. NSH has strengthened the oversight function by the FRP.
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Section D: Integrated Assessments

1. Psychiatric Assessments and Diagnoses		
	<p>Each State hospital shall provide all of the individuals it serves with routine and emergency psychiatric assessments and reassessments consistent with generally accepted professional standards of care; and,</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Patricia Tyler, MD, Acting Medical Director 2. Richard Forde, MD, Acting Chief of Psychiatry <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. The charts of the following 48 individuals: AS, AVC, AWD, BW, CC, CDC, CH, CHB, CRS, CWE, DFH, EAB, ESJ, FCP, FGP, GWK, HM, HMS, JB, JC, JJY, JML, KDC, KDL, LGS, LLS, LMK, LPO, MD, MQT, NF, NNM, PLB, QE, RA, REA, RGW, RJR, RJT, RJW, RR, RS, RZ, SB, SWC, TA, TJS and TS 2. DMH new template for the Admission Psychiatric Assessment 3. DMH Admission Assessment Instructions 4. DMH Admission Psychiatric Assessment Auditing Form 5. NSH Admission Psychiatric Assessment summary data (January to May 2008) 6. DMH Integrated Psychiatric Assessment Auditing Form 7. NSH Integrated Psychiatric Assessment Auditing summary data (January to May 2008) 8. NSH Admission Medical Assessment Auditing Form 9. NSH Admission Medical Assessment Auditing summary data (January to May 2008) 10. DMH Monthly Physician Progress Note (PPN) Auditing Form 11. DMH Weekly PPN Auditing Form 12. NSH Weekly PPN Auditing summary data (January to May 2008) 13. NSH Monthly PPN Auditing summary data (April and May 2008) 14. DMH Physician Transfer Note Auditing Form 15. NSH Physician Transfer Note Auditing summary data (January to May 2008)

Section D: Integrated Assessments

<p>D.1.a</p>	<p>Each State hospital shall use the diagnostic criteria in the most current Diagnostics and Statistical Manual of Mental Disorders ("DSM") for reaching the most accurate psychiatric diagnoses.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, January 2008: Continue to monitor this requirement using the DMH Admission Assessment, Integrated Psychiatric Assessment and Monthly Progress Note auditing forms based on at least a 20% sample.</p> <p>Findings: NSH used the DMH Admission and Integrated Psychiatric Assessment and Monthly Physician Progress Note Auditing Forms to assess compliance (January to May 2008). The average samples were 82% (of all admission assessments), 62% (of all integrated assessments) and 12% (of all monthly notes on individuals who have been hospitalized for more than 90 days), respectively. The following is a summary of the data and the facility's analysis, as applicable.</p> <table border="1" data-bbox="991 782 1890 898"> <tr> <th colspan="3">Admission Assessment</th> </tr> <tr> <td>4.b</td> <td><i>DSM-IV diagnosis consistent with history and presentation</i></td> <td>97%</td> </tr> </table> <table border="1" data-bbox="991 935 1890 1240"> <tr> <th colspan="3">Integrated Assessment</th> </tr> <tr> <td>2.b</td> <td><i>Statements from the individual are included, if available.</i></td> <td>70%</td> </tr> <tr> <td>2.d</td> <td><i>Includes diagnosis and medications given at previous facility are included</i></td> <td>58%</td> </tr> <tr> <td>7.</td> <td><i>Includes diagnostic formulation</i></td> <td>38%</td> </tr> <tr> <td>8.</td> <td><i>Includes differential diagnosis</i></td> <td>42%</td> </tr> <tr> <td>9.</td> <td><i>Includes current psychiatric diagnoses</i></td> <td>75%</td> </tr> </table> <p>NSH's report did not include data on the indicators regarding documentation of all five axes diagnoses and consistency of diagnosis with current history and presentation.</p>	Admission Assessment			4.b	<i>DSM-IV diagnosis consistent with history and presentation</i>	97%	Integrated Assessment			2.b	<i>Statements from the individual are included, if available.</i>	70%	2.d	<i>Includes diagnosis and medications given at previous facility are included</i>	58%	7.	<i>Includes diagnostic formulation</i>	38%	8.	<i>Includes differential diagnosis</i>	42%	9.	<i>Includes current psychiatric diagnoses</i>	75%
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9.	<i>Includes current psychiatric diagnoses</i>	75%																								

Section D: Integrated Assessments

		<p>The facility's analysis showed that mean compliance rates increased from December 2007 to May 2008 as follows:</p> <ol style="list-style-type: none"> 1. Item 7: from 42% to 48%; 2. Item 8: from 26% to 39%; and 3. Item 9: from 53% to 100%. <p>No comparison was available for items 2.b and 2.d.</p> <p>The facility reported that since April 2008, the Senior Psychiatrists have been meeting weekly with each psychiatrist in their programs and reviewing audit results from the previous month, comparing that psychiatrist's results to the facility as a whole and discussing necessary steps to improve compliance.</p> <table border="1" data-bbox="991 743 1887 1122"> <thead> <tr> <th colspan="3">Monthly PPN</th> </tr> </thead> <tbody> <tr> <td data-bbox="991 784 1087 894">3.b.1</td> <td data-bbox="1087 784 1793 894"><i>The note includes the 5-Axis diagnosis and this is consistent with the current presentation and recent developments</i></td> <td data-bbox="1793 784 1887 894">87%</td> </tr> <tr> <td data-bbox="991 894 1087 971">3.b.2</td> <td data-bbox="1087 894 1793 971"><i>If there is a NOS diagnosis or no diagnosis on Axis I, there is documentation that justifies the diagnosis</i></td> <td data-bbox="1793 894 1887 971">46%</td> </tr> <tr> <td data-bbox="991 971 1087 1122">3.b.3</td> <td data-bbox="1087 971 1793 1122"><i>Deferred and rule-out diagnosis are resolved within 60 days of initiation of the diagnosis and there is a clear description of the rationale for the specific resolution</i></td> <td data-bbox="1793 971 1887 1122">58%</td> </tr> </tbody> </table> <p>No comparison was available for these items.</p> <p>In addition to the above-mentioned corrective action, the facility reported that it has begun to hold monthly meetings with Senior Psychologists, Senior Psychiatrists and Chief of Psychiatry to review the status of individuals having current deferred, R/O, NOS or no diagnosis on Axis I.</p>	Monthly PPN			3.b.1	<i>The note includes the 5-Axis diagnosis and this is consistent with the current presentation and recent developments</i>	87%	3.b.2	<i>If there is a NOS diagnosis or no diagnosis on Axis I, there is documentation that justifies the diagnosis</i>	46%	3.b.3	<i>Deferred and rule-out diagnosis are resolved within 60 days of initiation of the diagnosis and there is a clear description of the rationale for the specific resolution</i>	58%
Monthly PPN														
3.b.1	<i>The note includes the 5-Axis diagnosis and this is consistent with the current presentation and recent developments</i>	87%												
3.b.2	<i>If there is a NOS diagnosis or no diagnosis on Axis I, there is documentation that justifies the diagnosis</i>	46%												
3.b.3	<i>Deferred and rule-out diagnosis are resolved within 60 days of initiation of the diagnosis and there is a clear description of the rationale for the specific resolution</i>	58%												

		<p>Recommendation 3, January 2008: Provide ongoing feedback and mentoring by senior psychiatrists to correct the deficiencies outlined by this monitor (D.1.c.i through D.1.c.iii).</p> <p>Findings: NSH reported that the facility's five senior psychiatrists (one per program) have begun a new process of reviewing audit data on practitioners' compliance with all psychiatry audits on a monthly basis and more often if needed, and providing feedback to staff psychiatrists under their supervision.</p> <p>Other findings: Chart reviews by this monitor showed that the facility has made progress in correcting the deficiencies in the quality of the admission and integrated psychiatric assessments. The DMH has finalized a new template for the admission psychiatric assessment that includes suicide and violence risk. The new template meets current generally accepted professional standards of care and proper implementation can significantly enhance compliance with EP requirements. In recent weeks, NSH has begun to implement this template. At this time, there continues to be evidence of some deficiencies in the implementation of the admission and integrated assessments and reassessments (see D.1.c.ii, D.1.c.iii and D.1.f) that must be corrected to achieve substantial compliance with this requirement.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Monitor this requirement using the DMH Admission Assessment, Integrated Psychiatric Assessment and Monthly Progress Note
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Section D: Integrated Assessments

		<p>auditing forms based on at least a 20% sample.</p> <p>2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</p>
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 Council for Graduate Medical Education accreditation program, and	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: Continue current practice.</p> <p>Findings: The facility has maintained current practice. All psychiatrists at the facility have successfully completed at least three years of psychiatry residency training in a program approved by the Accreditation Council for Graduate Medical Education.</p> <p>The facility currently has 49.5 staff psychiatrist positions (FTE) filled out of 64.9 allocated positions, for a vacancy rate of 24%. This represents a gain of 1.5 psychiatrist FTEs since last reporting period. The number of board-certified psychiatrists has remained essentially unchanged (30 in December 2007 to 29 in May 2008).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>

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D.1.b.ii	<p>Are verifiably competent (as defined by privileging at initial appointment and thereafter by reprivileging for continued appointment) in performing psychiatric assessments consistent with each State Hospital's standard diagnostic protocols.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: Develop and implement a Quality Profile for staff psychiatrists to include competency in the diagnosis, assessment and reassessment of individuals, and ensure that the reprivileging process incorporates internal monitoring data derived from this process. The facility may share results of the work completed at MSH in this regard.</p> <p>Findings: The facility is in the process of implementing this recommendation.</p> <p>Compliance: Partial.</p> <p>Current recommendation: 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.</p>
D.1.c	<p>Each State hospital shall ensure that:</p>	<p>Please see sub-cells for compliance findings.</p>
D.1.c.i	<p>Within 24 hours of an individual's admission to each State hospital, the individual receives an Admission Medical Assessment that includes:</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1-3, January 2008:</p> <ul style="list-style-type: none"> • Continue to monitor completeness of the admission medical examination within the specified time frame, based on at least a 20% sample. This monitoring must address follow-up regarding incomplete items on the examination. • Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement.

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		<ul style="list-style-type: none"> • Implement corrective actions to improve compliance. <p>Findings: NSH used the current NSH Medical Initial Assessment Auditing Form to assess compliance (January to May 2008). The average sample was 82% of the admissions per month. The following is a summary of the data:</p> <table border="1" data-bbox="991 488 1890 641"> <thead> <tr> <th colspan="3">Initial Medical Assessment</th> </tr> </thead> <tbody> <tr> <td>1.</td> <td><i>Completed within 24 hrs.</i></td> <td>91%</td> </tr> <tr> <td>5.</td> <td><i>Rectal exams refer to Physician & Surgeon/NP if deferred /refused?</i></td> <td>81%</td> </tr> </tbody> </table> <p>The facility's analysis showed that the mean compliance rate for item 1 has increased from the previous review period to this review period (87% to 91%). However, the mean compliance rate for item 5 has decreased from December 2007 to May 2008 (100% to 87%). The facility reported that the new DMH History and Physical form (in preparation) will likely enhance compliance rates for item 5 because it has a specific requirement to document the need to reassess if any aspect of the evaluation is refused or deferred.</p> <p>The mean compliance rates for the requirements in D.1.c.i.1 to D.1.c.i.5 are reported in each corresponding cell below. The sub-indicators and facility's analysis are listed as appropriate.</p> <p>Recommendation 4, January 2008: Finalize the DMH Initial Medical Examination Auditing Form and Instructions for use across facilities.</p> <p>Findings: The DMH is in the process of finalizing this recommendation.</p>	Initial Medical Assessment			1.	<i>Completed within 24 hrs.</i>	91%	5.	<i>Rectal exams refer to Physician & Surgeon/NP if deferred /refused?</i>	81%
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		<p>Other findings: This monitor reviewed the charts of 10 individuals (AWD, CC, CWE, EAB, FCP, FGP, HM, JB, RJT and RR) who were admitted during this reporting period. The review found timely implementation in all cases. However, one chart included a plan to obtain neurological consultation, with no documentation that this plan was either carried out or changed (AWD) and another chart included incomplete examination, with no documentation of follow-up to complete the assessment (RR).</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Finalize the DMH Initial Medical Examination Auditing Form and Instructions for use across facilities. 2. Monitor this requirement using the standardized DMH tool based on at least a 20% sample and ensure that monitoring addresses the quality of the assessments, including the plan of care and follow up regarding incomplete examinations. 3. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).
D.1.c.i.1	a review of systems;	95% (the overall mean rate has increased from 81% reported for the last review period).
D.1.c.i.2	medical history;	95% (the overall mean rate has increased from 83% reported for the last review period).
D.1.c.i.3	physical examination;	95% (the overall mean rate has increased from 78% reported for the last review period).

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D.1.c.i.4	diagnostic impressions; and	95% (no comparative data for this item as data collection began in February 2008).
D.1.c.i.5	management of acute medical conditions	94% (the overall mean rate was 97% during the last review period).
D.1.c.ii	within 24 hours of an individual's admission to each State hospital, the individual receives an Admission Psychiatric Assessment that includes:	<p>Current findings on previous recommendations:</p> <p>Recommendations 1-3 January 2008:</p> <ul style="list-style-type: none"> • Monitor the admission psychiatric assessment for timeliness, completeness and quality and ensure that the compliance rates account for the completeness and quality of each item. • Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement. • Implement corrective actions to improve compliance. <p>Findings: NSH used the DMH Admission Psychiatric Assessment Auditing Form and reviewed an average sample of 82% of the admissions each month (January to May 2008). The mean compliance rate was 99% (this rate was 96% during the last review period).</p> <p>The rates for the requirements in D.1.c.ii.2 through D.1.c.ii.6 are listed for each corresponding cell below. The sub-indicators and data analysis are listed, as appropriate. The plan of improvement is the same as that reported in D.1.a.</p> <p>Recommendation 4, January 2008: Implement the DMH Admission Psychiatric Assessment Auditing Form and Instructions for use across facilities.</p> <p>Findings: NSH has implemented this recommendation.</p>

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		<p>Other findings:</p> <p>This monitor reviewed the charts of the above-mentioned 10 individuals. The review found that in general, the quality of the assessments has improved compared to the last reporting period. In addition, the new DMH template for the admission assessment was properly implemented in one chart (CC). However, the following deficiencies were noted.</p> <ol style="list-style-type: none">1. The assessment did not include any meaningful information in the history of present illness (RJT and RR).2. The assessment indicated that the individual's cognition was impaired, but there was no evidence in the chart that the MMSE was completed at any time (EAB).3. There was no documentation in the section regarding risk assessment (AWD).4. The assessment of thought content did not include specifics regarding the nature of persecutory delusions (RR). <p>These deficiencies must be corrected to achieve substantial compliance. As mentioned earlier, the DMH has finalized a new template for the admission assessment that includes updated suicide and violence risk assessment instruments. Proper implementation of this template should enhance compliance with requirements of the EP and improve the quality of admission risk assessment across the facilities.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none">1. Ensure full implementation of the new DMH template for the admission psychiatric assessment.2. Monitor this requirement using the standardized DMH tool based
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		<p>on at least a 20% sample.</p> <p>3. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</p>																											
D.1.c.ii.1	psychiatric history, including a review of presenting symptoms;	<table border="1"> <tr> <td>2.</td> <td><i>Psychiatric history, including a review of presenting symptoms.</i></td> <td></td> </tr> <tr> <td>2.a</td> <td><i>Identifying data including legal status</i></td> <td>92%</td> </tr> <tr> <td>2.b</td> <td><i>Discharge diagnosis and condition</i></td> <td>80%</td> </tr> <tr> <td>2.c</td> <td><i>Reason for admission and chief complaint</i></td> <td>98%</td> </tr> <tr> <td>2.d</td> <td><i>History of present illness</i></td> <td>90%</td> </tr> <tr> <td>2.e</td> <td><i>Psychiatric history</i></td> <td>91%</td> </tr> <tr> <td>2.f</td> <td><i>Substance abuse history</i></td> <td>97%</td> </tr> <tr> <td>2.g</td> <td><i>Allergies</i></td> <td>99%</td> </tr> <tr> <td>2.h</td> <td><i>Current medications</i></td> <td>94%</td> </tr> </table> <p>No comparative data were available regarding the above sub-indicators.</p>	2.	<i>Psychiatric history, including a review of presenting symptoms.</i>		2.a	<i>Identifying data including legal status</i>	92%	2.b	<i>Discharge diagnosis and condition</i>	80%	2.c	<i>Reason for admission and chief complaint</i>	98%	2.d	<i>History of present illness</i>	90%	2.e	<i>Psychiatric history</i>	91%	2.f	<i>Substance abuse history</i>	97%	2.g	<i>Allergies</i>	99%	2.h	<i>Current medications</i>	94%
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D.1.c.ii.2	complete mental status examination;	89% (mean compliance rate has decreased slightly from December 2007 to May 2008).																											
D.1.c.ii.3	admission diagnoses;	Same as in D.1.a (admission psychiatric assessment).																											
D.1.c.ii.4	completed AIMS;	91% (overall mean compliance rate has increased from 78% reported during the last review period).																											
D.1.c.ii.5	laboratory tests ordered; and	96% (essentially unchanged since the last review period).																											
D.1.c.ii.6	consultations ordered.	75% (mean compliance rate has increased from 43% reported for December 2007 to 75% for May 2008).																											

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	Plan of care	<table border="1" data-bbox="991 228 1890 456"> <tr> <td data-bbox="991 228 1087 269">8.</td> <td data-bbox="1087 228 1793 269"><i>Plan of care</i></td> <td data-bbox="1793 228 1890 269"></td> </tr> <tr> <td data-bbox="991 269 1087 310">8.a</td> <td data-bbox="1087 269 1793 310"><i>Regular psychotropic medications with rationale</i></td> <td data-bbox="1793 269 1890 310">59%</td> </tr> <tr> <td data-bbox="991 310 1087 383">8.b</td> <td data-bbox="1087 310 1793 383"><i>PRN and/or Stat medications as applicable, with specific behavioral indicators</i></td> <td data-bbox="1793 310 1890 383">41%</td> </tr> <tr> <td data-bbox="991 383 1087 456">8.c</td> <td data-bbox="1087 383 1793 456"><i>Special precautions to address risk factors as indicated</i></td> <td data-bbox="1793 383 1890 456">51%</td> </tr> </table> <p data-bbox="991 500 1793 532">Comparative data were not available for all above sub-indicators.</p>	8.	<i>Plan of care</i>		8.a	<i>Regular psychotropic medications with rationale</i>	59%	8.b	<i>PRN and/or Stat medications as applicable, with specific behavioral indicators</i>	41%	8.c	<i>Special precautions to address risk factors as indicated</i>	51%
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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 data-bbox="991 574 1591 607">Current findings on previous recommendations:</p> <p data-bbox="991 651 1486 683">Recommendations 1-3, January 2008:</p> <ul data-bbox="991 688 1835 902" style="list-style-type: none"> • Monitor the integrated psychiatric assessment for timeliness, completeness and quality and ensure that the compliance rates account for the completeness and quality of each item. • Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement. • Implement corrective actions to improve compliance. <p data-bbox="991 946 1104 979">Findings:</p> <p data-bbox="991 984 1885 1198">NSH used the DMH Integrated Assessment Psychiatry Section Auditing Form to assess compliance (January to May 2008). The average sample was 62% of the assessments due each month. The mean compliance rate for this requirement was 68%. The mean compliance rate has increased from 47% (December 2007) to 91% (May 2008).</p> <p data-bbox="991 1242 1885 1382">The mean rates for other requirements in D.1.c.iii are listed in each corresponding cell below. The sub-indicators and analysis are listed, as appropriate. The plan of improvement was the same as that reported in D.1.a.</p>												

		<p>Recommendation 4, January 2008: Implement the DMH Integrated Psychiatric Assessment Auditing Form and Instructions for use across facilities.</p> <p>Findings: NSH has implemented this recommendation.</p> <p>Other findings: The above-mentioned chart reviews by this monitor found the following deficiencies:</p> <ol style="list-style-type: none"> 1. The assessments were missing in three charts (JB, RJP and CWE). 2. The assessment did not include a statement regarding presence of absence of current suicidal ideations, intent or plan (AWD and FGP). 3. The assessment included a plan of care that was not carried out or changed (HM). 4. The pharmacological plan of care included an inappropriate use of one medication (EAB). 5. The assessment of strengths was generic and focused on the individual's desire to leave the facility or general physical health (AWD, FCP and HM). 6. The assessment did not address the individual's strengths (RR). 7. The assessment did not include a diagnostic formulation (RR). 8. Although the individual received a diagnosis that was listed as NOS, the assessment did not include a differential diagnosis (FCP). 9. The assessment of insight and judgment was generic (in most charts). 10. The MMSE was not available in the chart (RR). 11. The mental status examination did not address the individual's attitude or include specifics regarding the nature of persecutory delusions (RR). 12. The assessment included handwritten statements that were not
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		<p>signed/initialed (EAB).</p> <p>These deficiencies must be corrected to achieve substantial compliance.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Monitor this requirement using the standardized DMH tool based on at least a 20% sample. 2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). 																					
<p>D.1.c.iii. 1</p>	<p>psychiatric history, including a review of present and past history;</p>	<table border="1" data-bbox="991 784 1887 1239"> <tr> <td data-bbox="991 784 1087 862">2.</td> <td data-bbox="1087 784 1793 862"><i>Psychiatric history, including a review of present and past history.</i></td> <td data-bbox="1793 784 1887 862"></td> </tr> <tr> <td data-bbox="991 862 1087 899">2.a</td> <td data-bbox="1087 862 1793 899"><i>Identifying data including legal status.</i></td> <td data-bbox="1793 862 1887 899">76%</td> </tr> <tr> <td data-bbox="991 899 1087 977">2.b</td> <td data-bbox="1087 899 1793 977"><i>Statements from the individual are included, if available.</i></td> <td data-bbox="1793 899 1887 977">70%</td> </tr> <tr> <td data-bbox="991 977 1087 1015">2.c</td> <td data-bbox="1087 977 1793 1015"><i>Chief complaint</i></td> <td data-bbox="1793 977 1887 1015">75%</td> </tr> <tr> <td data-bbox="991 1015 1087 1092">2.d</td> <td data-bbox="1087 1015 1793 1092"><i>Diagnosis and medications given at previous facility are included.</i></td> <td data-bbox="1793 1015 1887 1092">58%</td> </tr> <tr> <td data-bbox="991 1092 1087 1162">2.e</td> <td data-bbox="1087 1092 1793 1162"><i>Effectiveness of medications from previous facility is included</i></td> <td data-bbox="1793 1092 1887 1162">53%</td> </tr> <tr> <td data-bbox="991 1162 1087 1239">2.f</td> <td data-bbox="1087 1162 1793 1239"><i>Past psychiatric history is documented including a review of pertinent physical exam status.</i></td> <td data-bbox="1793 1162 1887 1239">51%</td> </tr> </table> <p>No comparative data were available for the above sub-indicators (the overall compliance rate has increased from 47% in December 2007 to 73% in May 2008).</p>	2.	<i>Psychiatric history, including a review of present and past history.</i>		2.a	<i>Identifying data including legal status.</i>	76%	2.b	<i>Statements from the individual are included, if available.</i>	70%	2.c	<i>Chief complaint</i>	75%	2.d	<i>Diagnosis and medications given at previous facility are included.</i>	58%	2.e	<i>Effectiveness of medications from previous facility is included</i>	53%	2.f	<i>Past psychiatric history is documented including a review of pertinent physical exam status.</i>	51%
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<p>D.1.c.iii. 2</p>	<p>psychosocial history;</p>	<table border="1" data-bbox="991 228 1887 574"> <tr> <td>3.</td> <td><i>Psychosocial history is documented.</i></td> <td></td> </tr> <tr> <td>3.a</td> <td><i>Developmental history</i></td> <td>73%</td> </tr> <tr> <td>3.b</td> <td><i>Family history</i></td> <td>76%</td> </tr> <tr> <td>3.c</td> <td><i>Educational history</i></td> <td>75%</td> </tr> <tr> <td>3.d</td> <td><i>Religious and cultural influences</i></td> <td>75%</td> </tr> <tr> <td>3.e</td> <td><i>Occupational history</i></td> <td>75%</td> </tr> <tr> <td>3.f</td> <td><i>Marital status</i></td> <td>76%</td> </tr> <tr> <td>3.g</td> <td><i>Sexual history</i></td> <td>76%</td> </tr> <tr> <td>3.h</td> <td><i>Legal history</i></td> <td>31%</td> </tr> </table> <p data-bbox="991 618 1887 760">No comparative data were available for the above sub-indicators (the overall compliance rate has increased from 47% in December 2007 to 55% in May 2008). The facility acknowledged low compliance with item 3.h but did not provide a clear improvement plan.</p>	3.	<i>Psychosocial history is documented.</i>		3.a	<i>Developmental history</i>	73%	3.b	<i>Family history</i>	76%	3.c	<i>Educational history</i>	75%	3.d	<i>Religious and cultural influences</i>	75%	3.e	<i>Occupational history</i>	75%	3.f	<i>Marital status</i>	76%	3.g	<i>Sexual history</i>	76%	3.h	<i>Legal history</i>	31%												
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		overall compliance rate has increased from 42% in December 2007 to 73% in May 2008).																											
D.1.c.iii. 4	strengths;	64% (the overall compliance rate has increased from 42% in December 2007 to 77% in May 2008).																											
D.1.c.iii. 5	psychiatric risk factors;	<table border="1"> <tr> <td>6.</td> <td><i>Psychiatric risk factors are documented</i></td> <td></td> </tr> <tr> <td>6.a</td> <td><i>Risk for suicide</i></td> <td>73%</td> </tr> <tr> <td>6.b</td> <td><i>Risk for self-injurious behavior</i></td> <td>51%</td> </tr> <tr> <td>6.c</td> <td><i>Risk factors for seclusion (medical and emotional)</i></td> <td>72%</td> </tr> <tr> <td>6.d</td> <td><i>Risk factors for restraint (medical and emotional)</i></td> <td>72%</td> </tr> <tr> <td>6.e</td> <td><i>Risk for aggression</i></td> <td>70%</td> </tr> <tr> <td>6.f</td> <td><i>Risk for fire setting</i></td> <td>58%</td> </tr> <tr> <td>6.g</td> <td><i>Risk for elopement</i></td> <td>58%</td> </tr> <tr> <td>6.h</td> <td><i>Risk for victimization</i></td> <td>18%</td> </tr> </table> <p>No comparative data were available for the above sub-indicators (the overall compliance rate has increased from 42% in December 2007 to 32% in May 2008). The facility acknowledged that the newly developed sub-indicators have increased the rigor of this audit and that several psychiatrists were not complying with items 6.b and 6.h. The facility reported that remediation efforts are underway.</p>	6.	<i>Psychiatric risk factors are documented</i>		6.a	<i>Risk for suicide</i>	73%	6.b	<i>Risk for self-injurious behavior</i>	51%	6.c	<i>Risk factors for seclusion (medical and emotional)</i>	72%	6.d	<i>Risk factors for restraint (medical and emotional)</i>	72%	6.e	<i>Risk for aggression</i>	70%	6.f	<i>Risk for fire setting</i>	58%	6.g	<i>Risk for elopement</i>	58%	6.h	<i>Risk for victimization</i>	18%
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D.1.c.iii. 6	diagnostic formulation;	38% (compliance rate has increased from 42% in December 2007 to 48% in May 2008).																											
D.1.c.iii. 7	differential diagnosis;	42 (compliance rate has increased from 26% in December 2007 to 39% in May 2008).																											
D.1.c.iii. 8	current psychiatric diagnoses;	75% (compliance rate has increased from 53 in December 2007 to 100% in May 2008).																											

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D.1.c.iii. 9	psychopharmacology treatment plan; and	<table border="1" data-bbox="991 267 1887 685"> <tr> <td>10.</td> <td><i>Psychopharmacology treatment plan is documented</i></td> <td></td> </tr> <tr> <td>10.a</td> <td><i>Current target symptoms</i></td> <td>60%</td> </tr> <tr> <td>10.b</td> <td><i>Specific medications to be used</i></td> <td>67%</td> </tr> <tr> <td>10.c</td> <td><i>Dosage titration schedules, if indicated</i></td> <td>58%</td> </tr> <tr> <td>10.d</td> <td><i>Adverse reactions to monitor for</i></td> <td>39%</td> </tr> <tr> <td>10.e</td> <td><i>Rationale for anticholinergics, benzodiazepines, polypharmacy and new generation antipsychotics in at-risk population, if indicated.</i></td> <td>43%</td> </tr> <tr> <td>10.f</td> <td><i>Response to medications since admission, if applicable including PRN and Stat medications.</i></td> <td>38%</td> </tr> <tr> <td>10.g</td> <td><i>Medication consent issues were addressed.</i></td> <td>65%</td> </tr> </table> <p data-bbox="991 727 1887 906">No comparative data were available for the above sub-indicators (the overall compliance rate has increased from 53% in December 2007 to 60% in May 2008). Data analysis showed that several psychiatrists had areas of non-compliance. The facility reported remediation efforts as listed in D.1.a.</p>	10.	<i>Psychopharmacology treatment plan is documented</i>		10.a	<i>Current target symptoms</i>	60%	10.b	<i>Specific medications to be used</i>	67%	10.c	<i>Dosage titration schedules, if indicated</i>	58%	10.d	<i>Adverse reactions to monitor for</i>	39%	10.e	<i>Rationale for anticholinergics, benzodiazepines, polypharmacy and new generation antipsychotics in at-risk population, if indicated.</i>	43%	10.f	<i>Response to medications since admission, if applicable including PRN and Stat medications.</i>	38%	10.g	<i>Medication consent issues were addressed.</i>	65%
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D.1.c.iii. 10	management of identified risks.	62% (compliance rate has increased from 37% in December 2007 to 86% in May 2008).																								
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 data-bbox="991 1141 1591 1170">Current findings on previous recommendations:</p> <p data-bbox="991 1214 1440 1243">Recommendation 1, January 2008:</p> <p data-bbox="991 1252 1887 1393">Provide documentation of CME training of psychiatry staff in the assessment of cognitive and other neuropsychiatric disorders, including dates and titles of courses and names of instructors and their affiliations.</p>																								

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		<p>Findings: During this review period, NSH provided/facilitated the following training activities:</p> <table border="1" data-bbox="991 337 1862 979"> <thead> <tr> <th>Date</th> <th>Title</th> <th>Speaker/affiliations</th> </tr> </thead> <tbody> <tr> <td>2/6/08</td> <td>Treatment of Agitation Associated with Dementia</td> <td>Paul Perry, PhD Touro University</td> </tr> <tr> <td>3/26/08</td> <td>Managing Psychosis and Agitation in Dementia - CATIE AD</td> <td>Paul Perry, PhD Touro University</td> </tr> <tr> <td>4/25/08</td> <td>Differentiating Dementia</td> <td>William Lynch PhD Private Practice</td> </tr> <tr> <td>6/11/08</td> <td>Substance Abuse Overdose and Acute Detox</td> <td>Dennis Hawley MD Napa State Hospital</td> </tr> <tr> <td>6/25/08</td> <td>Use of PRN and Stat Benzodiazepines</td> <td>Paul Perry, PhD Touro University</td> </tr> <tr> <td>7/10/08</td> <td>Evaluation and Management of Dyskinesias</td> <td>Gwendolyn Rothman, MD Napa State Hospital</td> </tr> <tr> <td>7/11/08</td> <td>Suboptimal Effort and Malingering In Neuro-psychological Testing</td> <td>Kyle Boone PhD, ABPP, UCLA School of Medicine</td> </tr> </tbody> </table> <p>Recommendation 2, January 2008: Develop and implement corrective actions to address the deficiencies in finalization of diagnoses listed as R/O and/or NOS.</p> <p>Findings: The plan of improvement was the same as in D.1.a.</p> <p>Other findings: This monitor reviewed the charts of 14 individuals who have received diagnoses listed as NOS continuously for more than two months during this reporting period. The review found general evidence of</p>	Date	Title	Speaker/affiliations	2/6/08	Treatment of Agitation Associated with Dementia	Paul Perry, PhD Touro University	3/26/08	Managing Psychosis and Agitation in Dementia - CATIE AD	Paul Perry, PhD Touro University	4/25/08	Differentiating Dementia	William Lynch PhD Private Practice	6/11/08	Substance Abuse Overdose and Acute Detox	Dennis Hawley MD Napa State Hospital	6/25/08	Use of PRN and Stat Benzodiazepines	Paul Perry, PhD Touro University	7/10/08	Evaluation and Management of Dyskinesias	Gwendolyn Rothman, MD Napa State Hospital	7/11/08	Suboptimal Effort and Malingering In Neuro-psychological Testing	Kyle Boone PhD, ABPP, UCLA School of Medicine
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		<p>deficiencies in the documentation of efforts to finalize the diagnosis, as indicated; the individuals' status regarding cognitive impairments, as indicated; and/or alignment of the diagnostic information in the current WRP with the corresponding psychiatric progress notes. These deficiencies must be corrected to achieve substantial compliance with this requirement. The following table outlines the reviews:</p> <table border="1" data-bbox="991 451 1879 1101"> <thead> <tr> <th>Initials</th> <th>Diagnosis</th> </tr> </thead> <tbody> <tr> <td>BW</td> <td>Mood Disorder, NOS</td> </tr> <tr> <td>CHB</td> <td>Dementia NOS</td> </tr> <tr> <td>CRS</td> <td>Medication-Induced Movement Disorder NOS</td> </tr> <tr> <td>DFH</td> <td>Psychotic Disorder NOS and Pervasive Developmental Disorder NOS</td> </tr> <tr> <td>GWK</td> <td>Psychotic Disorder NOS</td> </tr> <tr> <td>JC</td> <td>Cognitive Disorder, NOS</td> </tr> <tr> <td>KDL</td> <td>Dementia NOS and Cognitive Disorder, NOS</td> </tr> <tr> <td>LGS</td> <td>Depressive Disorder NOS</td> </tr> <tr> <td>MQT</td> <td>Impulse Control Disorder NOS</td> </tr> <tr> <td>QE</td> <td>Dementia NOS</td> </tr> <tr> <td>REA</td> <td>Cognitive Disorder, NOS</td> </tr> <tr> <td>RGW</td> <td>Psychotic Disorder NOS</td> </tr> <tr> <td>RJR</td> <td>Neuroleptic-Induced Movement Disorder NOS</td> </tr> <tr> <td>RS</td> <td>Mood Disorder NOS and Psychotic Disorder NOS</td> </tr> <tr> <td>TJS</td> <td>Psychotic Disorder NOS</td> </tr> </tbody> </table> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Provide documentation of CME training of psychiatry staff in the assessment of cognitive and other neuropsychiatric disorders, including dates and titles of courses and names of instructors and 	Initials	Diagnosis	BW	Mood Disorder, NOS	CHB	Dementia NOS	CRS	Medication-Induced Movement Disorder NOS	DFH	Psychotic Disorder NOS and Pervasive Developmental Disorder NOS	GWK	Psychotic Disorder NOS	JC	Cognitive Disorder, NOS	KDL	Dementia NOS and Cognitive Disorder, NOS	LGS	Depressive Disorder NOS	MQT	Impulse Control Disorder NOS	QE	Dementia NOS	REA	Cognitive Disorder, NOS	RGW	Psychotic Disorder NOS	RJR	Neuroleptic-Induced Movement Disorder NOS	RS	Mood Disorder NOS and Psychotic Disorder NOS	TJS	Psychotic Disorder NOS
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		<p>their affiliations.</p> <p>2. Develop and implement corrective actions to address the deficiencies in finalization of diagnoses listed as R/O and/or NOS.</p>
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 recommendation:</p> <p>Recommendation, January 2008: Same as in D.1.a and D.1.i.</p> <p>Findings: Same as in D.1.a and D.1.i.</p> <p>Compliance: Partial.</p> <p>Current recommendations: Same as in D.1.a and D.1.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 recommendation:</p> <p>Recommendation, January 2008: Same as in D.1.a and D.1.i.</p> <p>Findings: Same as in D.1.a and D.1.i.</p> <p>Compliance: Partial.</p> <p>Current recommendations: Same as in D.1.a and D.1.i.</p>

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D.1.d.iv	"no diagnosis" is clinically justified and documented.	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: Continue current practice.</p> <p>Findings: NSH has continued its current practice. As of May 1, 2008, one individual had "no diagnosis" on Axis I and review found documentation of clinical justification.</p> <p>Compliance: Substantial.</p> <p>Current recommendations: Continue current practice.</p>						
D.1.e	Each State hospital shall ensure that psychiatric reassessments are conducted at a frequency that reflects the individual's clinical needs. At a minimum the reassessments are completed weekly for the first 60 days on the admissions units and monthly on other units.	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: Monitor both elements of this requirement using the DMH Auditing Forms (and Instructions).</p> <p>Findings: NSH used the DMH Weekly Physician Progress Note (PPN) Auditing Form to assess compliance (January to May 2008). The average sample was 41% of the individuals between seven and 60 days of admission. The following is a summary of the data:</p> <table border="1" data-bbox="991 1227 1890 1416"> <tr> <td data-bbox="991 1227 1087 1305">1.</td> <td data-bbox="1087 1227 1793 1305"><i>The reassessments are completed weekly for the first 60 days on the admission units:</i></td> <td data-bbox="1793 1227 1890 1305"></td> </tr> <tr> <td data-bbox="991 1305 1087 1416">1.a</td> <td data-bbox="1087 1305 1793 1416"><i>There is a note present every 7 days from the date of admission, with the understanding that the Integrated Assessment: Psychiatry Section can</i></td> <td data-bbox="1793 1305 1890 1416">62%</td> </tr> </table>	1.	<i>The reassessments are completed weekly for the first 60 days on the admission units:</i>		1.a	<i>There is a note present every 7 days from the date of admission, with the understanding that the Integrated Assessment: Psychiatry Section can</i>	62%
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		<p><i>serve as the first weekly note.</i></p>	
		<p>1.b <i>The note must contain the subjective complaint, objective findings, assessment and plan of care</i></p>	<p>68%</p>
<p>The facility's data analysis showed no change in compliance rate from December 2007 to May 2008. This has been recognized as a performance issue and is being addressed by the facility's Chief of Psychiatry.</p> <p>NSH also used the DMH Monthly PPN Auditing Form to assess compliance (April and May 2008). The average sample was 12% of the individuals who have been hospitalized for 90 days or more. The mean compliance rate for this requirement was 96%. Data analysis showed that the mean compliance rate has increased from 54% in December 2007 to 96% in May 2008.</p> <p>Other findings: This monitor reviewed the charts of 10 individuals (AWD, CC, CWE, EAB, FCP, FGP, HM, JB, RJT and RR) who were admitted during this reporting period. The review focused on the timeliness of the weekly notes. There was partial compliance in all cases.</p> <p>Other chart reviews by this monitor found timely implementation of the monthly notes in most cases. The charts of QE, RA and REA did not include documentation of the monthly reassessments since April 2008.</p> <p>Compliance: Partial.</p> <p>Current recommendations: 1. Monitor this requirement using the DMH Weekly and Monthly PPN Auditing Forms based on at least a 20% sample.</p>			

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		<p>2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</p>
<p>D.1.f</p>	<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, January 2008: Implement a format for psychiatric reassessments that ensures correction of the deficiencies outlined in this monitor's report.</p> <p>Findings: NSH reported that a new format was introduced in March 2008 and acknowledged that some staff psychiatrists are not using it. The facility reported that remediation efforts are pending. The new format adequately addresses requirements of the EP.</p> <p>Recommendations 2 and 3, January 2008:</p> <ul style="list-style-type: none"> • Monitor this requirement based on a 20% sample using the DMH Monthly PPN Auditing Form (and Instructions). • Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement. <p>Findings: NSH used the DMH Monthly PPN Auditing Form to assess compliance (April and May 2008). The average sample was 12% of the individuals who have been hospitalized for 90 or more days. The mean compliance rates for the requirements in D.1.f.i to D.1.f.vii are entered for each corresponding cell below. The sub-indicators and data analysis are listed, as appropriate. Comparative data were not available for some items because monitoring using standardized indicators and sub-indicators began during this review period and some of the items were not included in the older tools.</p>

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		<p>Other findings:</p> <p>Chart reviews by this monitor found general evidence of improved documentation in the monthly progress notes compared to the last review. The improved documentation was noted in those charts that utilized the new format of documentation (e.g. CH, ESJ, JML, LPO, MD, NF, NNM, RS, SB and TA). Overall, however, the facility still falls short of substantial compliance regarding this requirement.</p> <p>Reviewing the charts of six individuals who have experienced the use of seclusion and/or restraint during this review period (AS, AVC, CDC, JJY, KDC and PLB), this monitor assessed the use of PRN/Stat medications prior to seclusion and/or restraints as documented in the orders and progress notes. This review is also relevant to the requirements in D.1.f.vi and F.1.b. The review found that the following pattern of deficiencies still existed:</p> <ol style="list-style-type: none">1. Prescription of PRN medications for generic indications;2. Lack of adequate documentation in the progress notes of the appropriateness and efficacy of the PRN regimen and of timely adjustments of regular treatment following the repeated use of PRN medications;3. Lack of adequate behavioral guidelines for individuals who were refractory to current medication trials; and4. Lack of documentation of a face-to-face assessment by the psychiatrists within 24 hours of the administration of Stat medications. <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none">1. Finalize and implement a format for psychiatric reassessments that ensures correction of the deficiencies outlined in this monitor's
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		<p>report and in the previous report.</p> <ol style="list-style-type: none"> 2. Monitor this requirement based on a review of at least 20% sample. 3. Provide data analysis that evaluates low compliance and delineates areas of relative improvement (during the reporting period and compared to the last period). 																											
D.1.f.i	<p>significant developments in the individual's clinical status and of appropriate psychiatric follow up;</p>	<table border="1"> <tr> <td>2.a</td> <td><i>Subjective complaints are documented.</i></td> <td>92%</td> </tr> <tr> <td>2.b</td> <td><i>Identified target symptoms are documented</i></td> <td>90%</td> </tr> <tr> <td>2.c</td> <td><i>Participation in treatment is documented.</i></td> <td>85%</td> </tr> <tr> <td>2.d</td> <td><i>Progress towards objectives in the WRP.</i></td> <td>79%</td> </tr> <tr> <td>2.e</td> <td><i>The mental status exam is documented</i></td> <td>91%</td> </tr> <tr> <td>2.f</td> <td><i>The individual's legal status and any change in legal status, if applicable.</i></td> <td>82%</td> </tr> <tr> <td>2.g</td> <td><i>Current status of medical problems and treatment are documented</i></td> <td>83%</td> </tr> <tr> <td>2.h.1</td> <td><i>The lab/diagnostic tests and consults for relevant medical conditions are documented and follow up provided as indicated</i></td> <td>87%</td> </tr> <tr> <td>2.h.2</td> <td><i>Current psychotropic medication dosage/laboratory monitoring/diagnostic testing and consultation protocols are followed as indicated (as per DMH Psychotropic Guidelines)</i></td> <td>85%</td> </tr> </table> <p>Comparative data were not available for the above sub-indicators. However, the overall mean compliance rate has decreased from 64% during the last review period to 54% during this review period. The facility reported that mentoring will be provided to improve consistency of utilization of the new progress note format.</p>	2.a	<i>Subjective complaints are documented.</i>	92%	2.b	<i>Identified target symptoms are documented</i>	90%	2.c	<i>Participation in treatment is documented.</i>	85%	2.d	<i>Progress towards objectives in the WRP.</i>	79%	2.e	<i>The mental status exam is documented</i>	91%	2.f	<i>The individual's legal status and any change in legal status, if applicable.</i>	82%	2.g	<i>Current status of medical problems and treatment are documented</i>	83%	2.h.1	<i>The lab/diagnostic tests and consults for relevant medical conditions are documented and follow up provided as indicated</i>	87%	2.h.2	<i>Current psychotropic medication dosage/laboratory monitoring/diagnostic testing and consultation protocols are followed as indicated (as per DMH Psychotropic Guidelines)</i>	85%
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D.1.f.ii	<p>Timely and justifiable updates of diagnosis and treatment, as clinically appropriate;</p>	<table border="1"> <tr> <td>3.a</td> <td><i>The MMSE is completed and documented in the progress note.</i></td> <td>39%</td> </tr> </table>	3.a	<i>The MMSE is completed and documented in the progress note.</i>	39%																								
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<p>Comparative data were not available for the above sub-indicators. However, the overall mean compliance rate has increased from 34% in December 2007 to 44% in May 2008.</p>											
D.1.f.iii	Analyses of risks and benefits of chosen treatment interventions;	<table border="1"> <tr> <td data-bbox="987 451 1081 600">4.a</td> <td data-bbox="1081 451 1795 600"><i>The risks for the current psychopharmacology plan including anticholinergics, benzodiazepines, and polypharmacy are documented.</i></td> <td data-bbox="1795 451 1890 600">59%</td> </tr> <tr> <td data-bbox="987 600 1081 714">4.b</td> <td data-bbox="1081 600 1795 714"><i>The benefits for the current psychopharmacology plan including anticholinergics, benzodiazepines, and polypharmacy are documented.</i></td> <td data-bbox="1795 600 1890 714">79%</td> </tr> <tr> <td data-bbox="987 714 1081 828">4.c</td> <td data-bbox="1081 714 1795 828"><i>Rationale for the current psychopharmacology plan including anticholinergics, benzodiazepines, and polypharmacy are documented</i></td> <td data-bbox="1795 714 1890 828">73%</td> </tr> </table>	4.a	<i>The risks for the current psychopharmacology plan including anticholinergics, benzodiazepines, and polypharmacy are documented.</i>	59%	4.b	<i>The benefits for the current psychopharmacology plan including anticholinergics, benzodiazepines, and polypharmacy are documented.</i>	79%	4.c	<i>Rationale for the current psychopharmacology plan including anticholinergics, benzodiazepines, and polypharmacy are documented</i>	73%
4.a	<i>The risks for the current psychopharmacology plan including anticholinergics, benzodiazepines, and polypharmacy are documented.</i>	59%									
4.b	<i>The benefits for the current psychopharmacology plan including anticholinergics, benzodiazepines, and polypharmacy are documented.</i>	79%									
4.c	<i>Rationale for the current psychopharmacology plan including anticholinergics, benzodiazepines, and polypharmacy are documented</i>	73%									
<p>Comparative data were not available for the above sub-indicators. However, the overall mean compliance rate has increased from 29% in December 2007 to 57% in May 2008.</p>											
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;	<table border="1"> <tr> <td data-bbox="987 1015 1081 1161">5.a</td> <td data-bbox="1081 1015 1795 1161"><i>There is a description of the current risks specific to this individual and the precautions instituted to minimize those risk.</i></td> <td data-bbox="1795 1015 1890 1161">73%</td> </tr> <tr> <td data-bbox="987 1161 1081 1242">5.b</td> <td data-bbox="1081 1161 1795 1242"><i>The monthly note identifies specific risk behaviors including triggers during the interval period.</i></td> <td data-bbox="1795 1161 1890 1242">72%</td> </tr> <tr> <td data-bbox="987 1242 1081 1282">5.c</td> <td data-bbox="1081 1242 1795 1282"><i>If applicable, treatment is modified to minimize risk.</i></td> <td data-bbox="1795 1242 1890 1282">77%</td> </tr> </table>	5.a	<i>There is a description of the current risks specific to this individual and the precautions instituted to minimize those risk.</i>	73%	5.b	<i>The monthly note identifies specific risk behaviors including triggers during the interval period.</i>	72%	5.c	<i>If applicable, treatment is modified to minimize risk.</i>	77%
5.a	<i>There is a description of the current risks specific to this individual and the precautions instituted to minimize those risk.</i>	73%									
5.b	<i>The monthly note identifies specific risk behaviors including triggers during the interval period.</i>	72%									
5.c	<i>If applicable, treatment is modified to minimize risk.</i>	77%									
<p>Comparative data were not available for the above sub-indicators. However, the overall mean compliance rate has increased from 38% in December 2007 to 66% in May 2008.</p>											

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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;	<table border="1" data-bbox="991 267 1885 716"> <tr> <td data-bbox="991 267 1087 342">6.a</td> <td data-bbox="1087 267 1793 342"><i>Rationale for current psychopharmacology plan including analysis of risks and benefits.</i></td> <td data-bbox="1793 267 1885 342">60%</td> </tr> <tr> <td data-bbox="991 342 1087 456">6.b</td> <td data-bbox="1087 342 1793 456"><i>There is a description of any side effects caused by medications, including sedation and cognitive impairment.</i></td> <td data-bbox="1793 342 1885 456">76%</td> </tr> <tr> <td data-bbox="991 456 1087 570">6.c</td> <td data-bbox="1087 456 1793 570"><i>The AIMS was done annually for all individuals and quarterly if there is a positive AIMS or a current diagnosis or history of Tardive Dyskinesia.</i></td> <td data-bbox="1793 456 1885 570">65%</td> </tr> <tr> <td data-bbox="991 570 1087 716">6.d</td> <td data-bbox="1087 570 1793 716"><i>Response to pharmacologic treatment is documented. There is a description of the response to the psychopharmacologic regimen in terms of symptom reduction or other measurable objectives</i></td> <td data-bbox="1793 570 1885 716">84%</td> </tr> </table> <p data-bbox="991 760 1885 862">Comparative data were not available for the above sub-indicators. However, the overall mean compliance rate has increased marginally from 41% in December 2007 to 43% in May 2008.</p>	6.a	<i>Rationale for current psychopharmacology plan including analysis of risks and benefits.</i>	60%	6.b	<i>There is a description of any side effects caused by medications, including sedation and cognitive impairment.</i>	76%	6.c	<i>The AIMS was done annually for all individuals and quarterly if there is a positive AIMS or a current diagnosis or history of Tardive Dyskinesia.</i>	65%	6.d	<i>Response to pharmacologic treatment is documented. There is a description of the response to the psychopharmacologic regimen in terms of symptom reduction or other measurable objectives</i>	84%
6.a	<i>Rationale for current psychopharmacology plan including analysis of risks and benefits.</i>	60%												
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6.d	<i>Response to pharmacologic treatment is documented. There is a description of the response to the psychopharmacologic regimen in terms of symptom reduction or other measurable objectives</i>	84%												
D.1.f.vi	Timely review of the use of "pro re nata" or "as-needed" ("PRN") and "Stat" (i.e., emergency psychoactive) medications and adjustment of regular treatment, as indicated, based on such use; and	<table border="1" data-bbox="991 943 1885 1279"> <tr> <td data-bbox="991 943 1087 1018">7.a</td> <td data-bbox="1087 943 1793 1018"><i>Describes the rationale/specific indications for all PRN orders.</i></td> <td data-bbox="1793 943 1885 1018">62%</td> </tr> <tr> <td data-bbox="991 1018 1087 1092">7.b</td> <td data-bbox="1087 1018 1793 1092"><i>Reviews the PRNs and Stats during the interval period.</i></td> <td data-bbox="1793 1018 1885 1092">53%</td> </tr> <tr> <td data-bbox="991 1092 1087 1167">7.c</td> <td data-bbox="1087 1092 1793 1167"><i>Discusses use of PRN/STAT as indicated to reduce the risk of restrictive interventions.</i></td> <td data-bbox="1793 1092 1885 1167">35%</td> </tr> <tr> <td data-bbox="991 1167 1087 1279">7.d</td> <td data-bbox="1087 1167 1793 1279"><i>Describes modification of regularly scheduled medication regimen based on the use of PRN/STAT medications.</i></td> <td data-bbox="1793 1167 1885 1279">30%</td> </tr> </table> <p data-bbox="991 1323 1885 1424">Comparative data were not available for the above sub-indicators. However, the overall mean compliance rate has increased from 24% in December 2007 to 32% in May 2008.</p>	7.a	<i>Describes the rationale/specific indications for all PRN orders.</i>	62%	7.b	<i>Reviews the PRNs and Stats during the interval period.</i>	53%	7.c	<i>Discusses use of PRN/STAT as indicated to reduce the risk of restrictive interventions.</i>	35%	7.d	<i>Describes modification of regularly scheduled medication regimen based on the use of PRN/STAT medications.</i>	30%
7.a	<i>Describes the rationale/specific indications for all PRN orders.</i>	62%												
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7.d	<i>Describes modification of regularly scheduled medication regimen based on the use of PRN/STAT medications.</i>	30%												

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D.1.f.vii	<p>Verification in a clinically justifiable manner, that psychiatric and behavioral treatments are properly integrated. The psychiatrist shall review the positive behavior support plan prior to implementation to ensure consistency with psychiatric formulation, document evidence of regular exchange of data or information with psychologists regarding differentiation of learned behaviors and behaviors targeted for psychopharmacological treatments, and document evidence of integration of treatments.</p>	<table border="1"> <tr> <td data-bbox="989 267 1087 342">8.a</td> <td data-bbox="1087 267 1793 342"><i>There is a description in the note of the response to non-pharmacologic treatment.</i></td> <td data-bbox="1793 267 1892 342">75%</td> </tr> <tr> <td data-bbox="989 342 1087 492">8.b</td> <td data-bbox="1087 342 1793 492"><i>If applicable, there is documentation to support that the psychiatrist reviewed the PBS plan prior to implementation to ensure consistency with psychiatric formulation.</i></td> <td data-bbox="1793 342 1892 492">67%</td> </tr> <tr> <td data-bbox="989 492 1087 716">8.c</td> <td data-bbox="1087 492 1793 716"><i>There is documentation to support evidence of regular exchange of data or information with psychologists regarding differentiation of learned behaviors and behaviors targeted for psychopharmacologic treatments, and document evidence of integration of treatments.</i></td> <td data-bbox="1793 492 1892 716">49%</td> </tr> <tr> <td data-bbox="989 716 1087 829">8.d</td> <td data-bbox="1087 716 1793 829"><i>There is modification, as clinically appropriate, of diagnosis and/or pharmacological treatment based on above reviews/assessments.</i></td> <td data-bbox="1793 716 1892 829">90%</td> </tr> </table> <p>Comparative data were not available for the above sub-indicators. However, the overall mean compliance rate has increased from 50% in December 2007 to 63% in May 2008.</p>	8.a	<i>There is a description in the note of the response to non-pharmacologic treatment.</i>	75%	8.b	<i>If applicable, there is documentation to support that the psychiatrist reviewed the PBS plan prior to implementation to ensure consistency with psychiatric formulation.</i>	67%	8.c	<i>There is documentation to support evidence of regular exchange of data or information with psychologists regarding differentiation of learned behaviors and behaviors targeted for psychopharmacologic treatments, and document evidence of integration of treatments.</i>	49%	8.d	<i>There is modification, as clinically appropriate, of diagnosis and/or pharmacological treatment based on above reviews/assessments.</i>	90%
8.a	<i>There is a description in the note of the response to non-pharmacologic treatment.</i>	75%												
8.b	<i>If applicable, there is documentation to support that the psychiatrist reviewed the PBS plan prior to implementation to ensure consistency with psychiatric formulation.</i>	67%												
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8.d	<i>There is modification, as clinically appropriate, of diagnosis and/or pharmacological treatment based on above reviews/assessments.</i>	90%												
D.1.g	<p>When individuals are transferred between treatment teams, a psychiatric transfer note shall be completed addressing: review of medical and psychiatric course of hospitalization, including medication trials; current target symptoms; psychiatric risk assessment; current barriers to discharge; and anticipated benefits of transfer.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, January 2008:</p> <ul style="list-style-type: none"> • Monitor this requirement using the DMH Physician Inter-Unit Transfer Note Auditing Form. • Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement. <p>Findings:</p> <p>NSH used the DMH Physician Inter Unit Transfer Note Audit Form to assess compliance (January to may 2008). The average sample was 45%</p>												

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		<p>of the individuals who have experienced inter-unit transfer per month. The following is a summary of the compliance data:</p> <table border="1" data-bbox="991 302 1890 532"> <tr> <td>1.</td> <td><i>Psychiatric course of hospitalization,</i></td> <td>63%</td> </tr> <tr> <td>2.</td> <td><i>Medical course of hospitalization,</i></td> <td>60%</td> </tr> <tr> <td>3.</td> <td><i>Current target symptoms,</i></td> <td>68%</td> </tr> <tr> <td>4.</td> <td><i>Psychiatric risk assessment,</i></td> <td>56%</td> </tr> <tr> <td>5.</td> <td><i>Current barriers to discharge,</i></td> <td>45%</td> </tr> <tr> <td>6.</td> <td><i>Anticipated benefits of transfer.</i></td> <td>50%</td> </tr> </table> <p>Data analysis showed general increases in compliance for the above sub-indicators (December 2007 to May 2008) as follows:</p> <ol style="list-style-type: none"> 1. Item 1: from 45% to 79%; 2. Item 2: from 55% to 59%; 3. Item 3: from 27% to 72%; 4. Item 4: from 63% to 62% (no increase); 5. Item 5: from 36% to 69%; and 6. Item 6: from 63% to 72%. <p>Recommendation 3, January 2008: Implement NSH template for Psychiatry Transfer Note.</p> <p>Findings: NSH reported that the state is in process of finalizing a DMH Psychiatry Transfer Note template to facilitate compliance.</p> <p>Other findings: This monitor reviewed the charts of six individuals who experienced inter-unit transfers during this reporting period. The review found that the notes that were completed contained adequate review of current diagnoses and medications. However, there was a pattern of inconsistent and generally inadequate review of anticipated benefits of</p>	1.	<i>Psychiatric course of hospitalization,</i>	63%	2.	<i>Medical course of hospitalization,</i>	60%	3.	<i>Current target symptoms,</i>	68%	4.	<i>Psychiatric risk assessment,</i>	56%	5.	<i>Current barriers to discharge,</i>	45%	6.	<i>Anticipated benefits of transfer.</i>	50%
1.	<i>Psychiatric course of hospitalization,</i>	63%																		
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6.	<i>Anticipated benefits of transfer.</i>	50%																		

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		<p>transfer, psychiatric and medical course of hospitalization, psychiatric risk assessment and discharge barriers. In addition, no transfer assessment was documented in the chart of TS and the assessment was not signed in the chart of RSR. These deficiencies must be corrected to achieve substantial compliance with this requirement. The following table outlines the reviews:</p> <table border="1" data-bbox="991 451 1476 683"> <thead> <tr> <th>Initials</th> <th>Date of transfer</th> </tr> </thead> <tbody> <tr> <td>HMS</td> <td>05/08/08</td> </tr> <tr> <td>LLS</td> <td>05/14/08</td> </tr> <tr> <td>RJR</td> <td>05/20/08</td> </tr> <tr> <td>SWC</td> <td>05/06/08</td> </tr> <tr> <td>TS</td> <td>05/21/08</td> </tr> </tbody> </table> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Monitor this requirement using the DMH Inter Unit Transfer Note Auditing Form based on at least a 20% sample. 2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). 3. Implement template for Psychiatry Transfer Note. 	Initials	Date of transfer	HMS	05/08/08	LLS	05/14/08	RJR	05/20/08	SWC	05/06/08	TS	05/21/08
Initials	Date of transfer													
HMS	05/08/08													
LLS	05/14/08													
RJR	05/20/08													
SWC	05/06/08													
TS	05/21/08													

2. Psychological Assessments		
		<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Eleven individuals: BW, CD, CP, ER, FK, JC, JW, LG, PD, VB and WW 2. Anne Hoff, PhD, Senior Supervising Psychologist 3. Barry Wagener, RN, Acting PBS Team Leader 4. Carmen Caruso, Clinical Administrator 5. Jim Jones, PhD, Chief of Psychology 6. Julie Winn, PsyD, Senior Supervising Psychologist 7. Kathleen Patterson, PhD, Senior Supervising Psychologist 8. Katie Cooper, PsyD, Enhancement Plan Coordinator 9. Nami Kim, PhD, Senior Supervising Psychologist 10. Pat White, PhD, Senior Psychologist and PBS Team Leader 11. Rachel Bramble, PhD, Senior Supervising Psychologist 12. Richard Lesch, PhD, Senior Supervising Psychologist 13. Stephen Hubert, PhD, Senior Supervising Psychologist 14. Tony Rabin, PhD, Mall Coordinator <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Charts of the following 40 individuals: AA, AGN, AIM, AM, AS, BD, BDS, BS, CD, CE, CG, CH, DBM, DE, DF, DM, EL, FT, GS, HL, HP, HS, IL, IMP, JA, KT, LP, MS, NO, PR, RAL, RF, FG, RY, TL, TM, VC, CH, VL, and WS 2. Completed DMH Psychology Assessment Monitoring Form 3. Focused Psychological Assessments 4. Integrated Assessments: Psychological Section 5. List of Completed Consultations for Educational or Other Psychological Testing 6. List of Completed DSM-IV-TR Checklist 7. List of Individuals with High Triggers 8. List of Individuals Admitted in the Last Six Months

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		<ol style="list-style-type: none"> 9. List of Individuals Admitted Prior to June 1, 2006 10. List of Individuals Evaluated in their Primary/Preferred Language 11. List of Individuals in Needing Neuropsychological Assessments 12. List of Individuals Needing Cognitive and Academic Assessments within 30 Days of Admission 13. List of Individuals Needing PBS Plans 14. List of Individuals Referred for Neuropsychological Assessments/Completed 15. List of Individuals Referred to the BCC 16. List of Individuals Under 23 Years of Age 17. List of Individuals Whose Primary/Preferred Language Is Other Than English 18. List of Individuals with Diagnostic Uncertainties 19. List of Psychologists Undertaking Psychological Evaluations 20. Neuropsychological Focused Assessments 21. NSH's Progress Report (July 2008) 22. Positive Behavioral Support Plans 23. Structural and Functional Assessments <p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. WRPC for GMW 2. WRPC for RAB 3. PSR Mall group: New Start for Mental Health 4. PSR Mall group: Stretching/Relaxation 5. PSR Mall group: Mental Health Through Laughter 6. PSR Mall group: Enhancement Motivation 7. PSR Mall group: Social Skills Through Improvisational Theater 8. PSR Mall group: Suicide Prevention Education Awareness Keys 9. BY CHOICE Redemption Center
D.2.a	Each State hospital shall develop and implement standard psychological assessment protocols, consistent with generally accepted professional	Current findings on previous recommendation:

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	<p>standards of care. These protocols shall address, at a minimum, diagnostic neuropsychological assessments, cognitive assessments, and I.Q./achievement assessments, to guide psychoeducational (e.g., instruction regarding the illness or disorder, and the purpose or objectives of treatments for the same, including medications), educational, rehabilitation, and habilitation interventions, and behavioral assessments (including functional assessment of behavior in schools and other settings), and personality assessments, to inform positive behavior support plans and psychiatric diagnoses.</p>	<p>Recommendation, January 2008: Continue current practice.</p> <p>Findings: NSH continues to use the previously approved DMH psychological assessment protocols.</p> <p>Compliance: Substantial.</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 recommendation:</p> <p>Recommendation, January 2008: Continue current practice.</p> <p>Findings: This monitor's review of documentation found that four of the individuals (FK, HS, JA and MP) below 23 years of age admitted to NSH in the last six months were eligible for the 30-day cognitive and academic assessments. All four individuals were tested in a timely manner. However, the assessment for one of them (JA) could not be completed in a timely manner due to poor participation by JA. According to the Chief of Psychology, the assessments will be completed when JA is able to participate in them.</p> <p>Compliance: Substantial.</p>

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		<p>Current recommendation: Continue current practice.</p>
D.2.c	<p>Each State hospital shall ensure that all clinicians responsible for performing or reviewing psychological assessments and evaluations are verifiably competent in the methodology required to conduct the assessment.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: Continue current practice.</p> <p>Findings: This monitor's documentation review (list of psychologists in the Department of Psychology) found that NSH had 78 psychologists eligible to conduct assessments. All 78 psychologists who were responsible for performing or reviewing psychological assessments and evaluations met the hospital's credentialing and privileging requirements.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
D.2.d	<p>Each State hospital shall ensure that all psychological assessments, consistent with generally accepted professional standards of care, shall:</p>	<p>Please see sub-cells for compliance findings.</p>
D.2.d.i	<p>expressly state the clinical question(s) for the assessment;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: Continue to train psychologists on writing clearly stated referral/clinical questions.</p>

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		<p>Findings: 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>) from the DMH Psychology Assessment Monitoring Form, and audited all 29 (100% of the assessments completed) focused psychological assessments conducted in the last five months (January to May 2008) to address this recommendation, reporting a mean compliance rate of 100%.</p> <p>This monitor reviewed ten psychological assessments (BD, EL, GS, HS, KT, PR, RG, RY, TL and VL). All but one of the psychological assessments (BD) expressly and clearly stated the clinical questions for the assessment.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</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 recommendation:</p> <p>Recommendation, January 2008: Ensure that psychological assessments include all findings relevant to the clinical 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 question(s), but not limited to diagnoses and treatment recommendations</i>) from the DMH Psychology Assessment Monitoring Form, and audited all 29 (100% of</p>

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		<p>the sample) focused psychological assessments conducted in the last five months (January to May 2008) to address this recommendation, reporting a mean compliance rate of 100%.</p> <p>This monitor reviewed ten focused psychological assessments (BD, EL, GS, HS, KT, PR, RG, RY, TL and VL). All but one (RY) of the psychological assessments addressed the clinical questions, and included sufficient information that informed the psychiatric diagnosis, identified the individual's treatment needs, and suggested intervention priorities for consideration by the individual's WRPT.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</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, January 2008: 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 would benefit from individual therapy or group therapy in addition to attendance at mall groups</i>) from the DMH Psychology Assessment Monitoring Form, and audited all 29 (100% of the sample) focused psychological assessments conducted in the last five months (January to May 2008) to address this recommendation, reporting a mean compliance rate of 93%.</p>

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		<p>This monitor reviewed ten focused psychological assessments (BD, EL, GS, HS, KT, PR, RG, RY, TL and VL). All ten assessments had used the findings to make appropriate recommendations that would benefit the individual related to participation in group and/or individual therapy. The recommendations were aligned with the findings.</p> <p>Recommendation 2, January 2008: Provide data and lists of psychologists trained and the number still needing to be trained.</p> <p>Findings: This monitor's documentation review and interview of Anne Hoff, Senior Supervising Psychologist, found that all psychologists at NSH have been trained on matters related to Psychological Assessment methods and procedures both from a clinical perspective and as related to EP requirements. According to Anne Hoff, all psychologists are trained upon recruitment as part of the New Employee Training. In addition, Senior Supervising Psychologists provide ongoing training through regular review of all psychological assessments and corrective feedback to the psychological examiners.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
D.2.d.iv	be based on current, accurate, and complete data;	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: Provide training to psychologists so that assessments include current, accurate and complete data.</p>

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		<p>Findings: NSH used item #6 (<i>All psychological assessments, consistent with generally accepted professional standards of care, shall be based on current, accurate, and complete data</i>) from the DMH Psychology Assessment Monitoring Form, and audited all 29 (100% of the assessments completed) focused psychological assessments conducted in the last five months (January to May 2008) to address this recommendation, reporting a mean compliance rate of 96% (NSH's mean compliance for the previous review period was 63%).</p> <p>This monitor reviewed ten focused psychological assessments (BD, EL, GS, HS, KT, PR, RG, RY, TL and VL). All ten assessments were accurate, current, and complete. The assessments included the required identifying information, the necessary and available sources of information, and the information gathered from direct observation of the individual during the course of the assessment.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
D.2.d.v	<p>determine whether behavioral supports or interventions (e.g., behavior guidelines or mini behavior plans) are warranted or whether a full positive behavior support plan is required;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: 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 used item #7 (<i>All psychological assessments, consistent with</i></p>

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		<p><i>generally accepted professional standards of care, shall determine whether behavioral supports or interventions are warranted or whether a full positive behavior support plan is required</i>) from the DMH Psychology Assessment Monitoring Form, and audited all 29 (100% of the assessments completed) focused psychological assessments conducted in the last five months (January to May 2008) to address this recommendation, reporting a mean compliance rate of 75% (NSHs mean compliance for the previous review period was 43%). NSH's compliance rate for the last month of the previous review period was 67% and is 100% for the last month of this review period.</p> <p>This monitor reviewed ten focused psychological assessments (BL, EL, GS, HS, KT, NO, PR, RG, RY and TL). All but one of the assessments (BD) had used the findings from the assessments to determine whether behavior supports or interventions are required. The recommendations were aligned with the findings.</p> <p>Compliance: Substantial.</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>
D.2.d.vi	include the implications of the findings for interventions;	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: 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>

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		<p>Findings: NSH used item #8 (<i>All psychological assessments, consistent with generally accepted professional standards of care, shall include the implications of the findings for interventions</i>) from the DMH Psychology Assessment Monitoring Form, and audited all 29 (100% of the assessments completed) focused psychological assessments conducted in the last five months (January to May 2008) to address this recommendation, reporting a mean compliance rate of 100%.</p> <p>This monitor reviewed ten focused psychological assessments (BD, EL, GS, HS, KT, PR, RG, RY, TL and VL). All ten assessments included the implications of the findings for the individuals' interventions.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
D.2.d.vii	<p>identify any unresolved issues encompassed by the assessment and, where appropriate, specify further observations, records review, interviews, or re-evaluations that should be performed or considered to resolve such issues; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: Ensure that all focused psychological assessments specify whether there is a need for further observations, record review, interviews, or re-evaluations.</p> <p>Findings: NSH used 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>) from the DMH Psychology Assessment Monitoring Form,</p>

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		<p>and audited all 29 (100% of the assessments completed) focused psychological assessments conducted in the last five months (January to May 2008) to address this recommendation, reporting a mean compliance rate of 82% (NSH's mean compliance rate for the previous reporting period was 69%). NSH's compliance rate for the last month of the previous reporting period was 83% and the compliance rate for the last month of the current review period is 100%.</p> <p>This monitor reviewed ten focused psychological assessments (BD, EL, GS, HS, KT, PR, RG, RY, TL and VL). All but one of the assessments (TL) specified if further observations, record reviews, interviews, or re-evaluations were warranted.</p> <p>Compliance: Substantial.</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>
D.2.d. viii	Use assessment tools and techniques appropriate for the individuals assessed and in accordance with the American Psychological Association Ethical Standards and Guidelines for testing.	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: 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 used 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</i></p>

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		<p><i>Standards and Guidelines for testing</i>) from the DMH Psychology Assessment Monitoring Form, and audited all 29 (100% of the assessments completed) focused psychological assessments conducted in the last five months (January to May 2008) to address this recommendation, reporting a mean compliance rate of 100%.</p> <p>This monitor reviewed ten focused psychological assessments (BD, EL, GS, HS, KT, PR, RG, RY, TL and VL). All ten assessments used tools approved by and included in the Clinical Indicator List. A clear statement of confidentiality was included in the written reports. The assessments were complete and accurate.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</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 § [IV.B.1 and IV.B.2], above.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: Ensure that psychological tests are completed as required.</p> <p>Findings: NSH used item #11 (<i>All psychological assessments of all individuals who were admitted before June 1, 2006 shall be reviewed by qualified clinicians with demonstrated current competency in psychological testing and, as indicated, revised to meet the criteria in § [IV.B.1 and IV.B.2], above</i>) from the DMH Psychology Assessment Monitoring Form, to address this recommendation, reporting a mean compliance rate of 100%.</p> <p>This monitor reviewed nine charts (AA, CG, FT, LP, RF, TM, VC, VH and</p>

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		<p>WS) of individuals admitted to NSH before June 1, 2006. All nine charts had a revised and/or updated integrated psychological assessment.</p> <p>Compliance: Substantial.</p> <p>Current recommendations: Continue current practice.</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 recommendation:</p> <p>Recommendation, January 2008: Ensure that integrated psychological assessments are conducted in a timely manner as required.</p> <p>Findings: Using item #12 (<i>Each State hospital shall ensure that all appropriate psychological assessments shall be provided in a timely manner whenever clinically indicated</i>) from the DMH Psychology Assessment Monitoring Form, NSH assessed its compliance based on an average</p>

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		<p>sample of 47% of the Integrated Psychological Assessments due for the month (January to May 2008), reporting a mean compliance rate of 85% (NSH's mean compliance rate for the previous review period was 39%). NSH's compliance for the last month of the previous review period was 58% and the compliance rate for the last month of the current review period is 72%.</p> <p>According to the Senior Supervising Psychologist, the low compliance rate was due to a dating error by a new psychologist (the examiner had listed the date the assessment was approved by the supervisor rather than the date when the assessment was conducted). The Senior Supervising Psychologist has communicated this discrepancy to the examiner conducting the assessments.</p> <p>This monitor reviewed 11 integrated psychological assessments (AIM, AM, AS, BDS, BS, CH, DE, DM, IL, JA and RAL). Ten of the assessments (AIM, AM, AS, BDS, CH, DE, DM, IL, JA and RAL) were conducted in a timely manner. One of them (BS) was untimely.</p> <p>Current recommendation: Ensure that integrated psychological assessments are conducted in a timely manner as required.</p>
D.2.f.i.1	address the nature of the individual's impairments to inform the psychiatric diagnosis; and	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, January 2008:</p> <ul style="list-style-type: none"> • Continue to provide training to ensure that integrated psychology assessments address the nature of the individual's impairments to inform the psychiatric diagnosis. • Use the DSM-IV-TR Checklist to inform psychiatric diagnoses. <p>Findings: NSH used item #13 (<i>Address the nature of the individual's</i></p>

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		<p><i>impairments to inform the psychiatric diagnosis</i>) from the DMH Psychology Assessment Monitoring Form, and audited a mean sample of 20% of the integrated psychological assessments conducted in the last five months (January to May 2008) to address this recommendation, reporting a mean compliance rate of 78% (NSH's mean compliance for the last review period was 47%). NSH's compliance rate for the last month of the previous review period was 58% and the compliance rate for the last month of the current review period is 100%.</p> <p>According to the Kathleen Patterson, Senior Supervising Psychologist, as of April 2008, all Psychology Integrated Assessments are sent to a Senior Psychologist for review and feedback prior to finalization.</p> <p>This monitor reviewed ten integrated psychological assessments (AM, AS, BDS, BS, CE, CH, DM, IL, JA and RAL). Six of the assessments (AS, BDS, CH, DM, IL and JA) addressed the nature of the individual's signs and symptoms of the psychiatric diagnosis, and the nature of the psychological excesses and deficits. Four of them (AM, BS, CE and RAL) did not document the necessary information. All but one of them (CH) included a completed DSM-IV-TR checklist.</p> <p>Current recommendations:</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	provide an accurate evaluation of the individual's psychological functioning to inform the therapeutic and rehabilitation service planning process;	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: Ensure accurate evaluation of psychological functioning that informs the WRPT of the individual's rehabilitation service needs.</p>

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		<p>Findings: NSH used item #14 (<i>Provide an accurate evaluation of the individual's psychological functioning to inform the therapeutic and rehabilitation service planning process</i>) from the DMH Psychology Assessment Monitoring Form, and audited a mean sample of 20% of the integrated psychological assessments conducted in the last five months (January to May 2008) to address this recommendation, reporting a mean compliance rate of 83% (the mean compliance rate for the previous review period was 87%). NSH's compliance for the last month of the previous review period was 90% and the compliance for the last month of this review period is 95%.</p> <p>This monitor reviewed ten integrated psychological assessments (AM, AS, BDS, BS, CE, CH, DM, IL, JA and RAL). Eight of the assessments (AM, AS, BDS, BS, CH, DM, IL and JA) documented the individual's psychological functioning and used the findings to recommend interventions needed for the individual's rehabilitation. Two of the assessments (CE and RAL) did not provide sufficient information on the individual's psychological functioning and/or appropriate recommendations for rehabilitation services.</p> <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 recommendation:</p> <p>Recommendation, January 2008: Ensure that appropriate structural and functional assessments are undertaken by a qualified psychologist when an individual has learned maladaptive behavior.</p>

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		<p>Findings: NSH used item #5 (<i>PBS assessments include structural and functional assessments, and as necessary, functional analysis</i>) from the DMH Psychology Services Monitoring Form, and audited 100% of the PBS plans developed and implemented in the last five months (January to May 2008) to address this recommendation, reporting a mean compliance rate of 56% (the mean compliance for the last review period was 39%). NSH's compliance for the last month of the previous review period was 32% and the compliance for the last month of this review period is 55%. According to the Chief of Psychology, while evaluators always conduct functional assessments they at times forget to conduct structural assessments. The Chief of Psychology has requested that the Senior Psychologists review assessment drafts and provide feedback to ensure compliance.</p> <p>This monitor reviewed the five PBS plans (DC, GR, JE, JM and MR) NSH had developed and implemented in this review period. In all cases, functional assessments had been conducted as part of the assessments to develop the hypothesis based on the maintaining variables of the target behaviors. However, structural assessments had been conducted only for two of the plans.</p> <p>Current recommendation: Ensure that appropriate structural and functional assessments are undertaken by a qualified psychologist when an individual has learned maladaptive behavior.</p>
D.2.f.iii	<p>additional psychological assessments shall be performed, as appropriate, where clinical information is otherwise insufficient, and to address unresolved clinical or diagnostic questions, including differential diagnosis, "rule-out," "deferred," "no-diagnosis" and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: Ensure that additional psychological assessments are performed, as appropriate, where clinical information is otherwise insufficient, and address unresolved clinical or diagnostic questions.</p>

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	<p>"NOS" diagnoses.</p>	<p>Findings: NSH used items #17-21 from the DMH Psychology Assessment Monitoring Form to determine if additional psychological assessments were performed when there was insufficient clinical information or unresolved clinical or diagnostic questions on psychological assessments conducted in the last five months (January to May 2008). NSH sampled 48% of the assessments with a "Differential Diagnosis" and audited 100% of the assessments for the other diagnostic categories. The table below showing the item numbers and their diagnostic categories with their corresponding mean compliance rate is a summary of the facility's data (modified by this monitor).</p> <table border="1" data-bbox="991 673 1885 865"> <tr> <td>17.</td> <td><i>Differential diagnosis</i></td> <td>86%</td> </tr> <tr> <td>18.</td> <td><i>Rule-out</i></td> <td>75%</td> </tr> <tr> <td>19.</td> <td><i>Deferred</i></td> <td>93%</td> </tr> <tr> <td>20.</td> <td><i>No Diagnosis</i></td> <td>75%</td> </tr> <tr> <td>21.</td> <td><i>NOS</i></td> <td>82%</td> </tr> </table> <p>The mean compliance rates for this review have improved significantly over the mean compliance rates from the previous review (the mean compliance rates for items #17-21 for the previous review period was 51%, 43%, 47%, 43%, and 42% respectively). According to Anne Hoff, Senior Supervising Psychologist, psychologists conducting assessments have been and will continue to be mentored to address follow up assessments for cases requiring diagnostic clarification.</p> <p>This monitor reviewed 12 charts (AGN, AM, AS, BDS, BS, CE, CH, DF, HL, IPM, JA and MS) containing psychological assessments with one or more unresolved clinical and/or diagnostic questions. Additional psychological assessments were conducted on nine of the assessments (AGN, AM, BS, CH, DF, HL, IPM, JA and MS). Additional assessments were not conducted for the remaining three assessments (AS, BDS and</p>	17.	<i>Differential diagnosis</i>	86%	18.	<i>Rule-out</i>	75%	19.	<i>Deferred</i>	93%	20.	<i>No Diagnosis</i>	75%	21.	<i>NOS</i>	82%
17.	<i>Differential diagnosis</i>	86%															
18.	<i>Rule-out</i>	75%															
19.	<i>Deferred</i>	93%															
20.	<i>No Diagnosis</i>	75%															
21.	<i>NOS</i>	82%															

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		<p>CE).</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 recommendation:</p> <p>Recommendation, January 2008: Monitor the use of the procedure for those individuals whose preferred language is not English.</p> <p>Findings: NSH used items #22a-24 from the DMH Psychology Assessment Monitoring Form to audit the procedures used to evaluate the 53 individuals whose primary and/or preferred language is not English. The table below with its indicators and sub-indicators is a summary of the data:</p> <table border="1" data-bbox="991 932 1885 1390"> <tr> <td data-bbox="991 932 1087 1044">21.a</td> <td data-bbox="1087 932 1793 1044"><i>Number of individuals who needed assessment during the evaluation period whose primary language was not English</i></td> <td data-bbox="1793 932 1885 1044">53</td> </tr> <tr> <td data-bbox="991 1044 1087 1122">21.b</td> <td data-bbox="1087 1044 1793 1122"><i>Of those in 21a, number of individuals who were assessed in their primary language</i></td> <td data-bbox="1793 1044 1885 1122">44</td> </tr> <tr> <td data-bbox="991 1122 1087 1232">22.a</td> <td data-bbox="1087 1122 1793 1232"><i>Of those in 21a, number of individuals who could not be assessed because their primary language was not English</i></td> <td data-bbox="1793 1122 1885 1232">9</td> </tr> <tr> <td data-bbox="991 1232 1087 1310">22.b</td> <td data-bbox="1087 1232 1793 1310"><i>Of those in 22a, number of individuals who had plans developed to meet their assessment needs</i></td> <td data-bbox="1793 1232 1885 1310">3</td> </tr> <tr> <td data-bbox="991 1310 1087 1390">23.</td> <td data-bbox="1087 1310 1793 1390"><i>Of those in 22b, number of individuals whose plans for assessment were implemented</i></td> <td data-bbox="1793 1310 1885 1390">0</td> </tr> </table>	21.a	<i>Number of individuals who needed assessment during the evaluation period whose primary language was not English</i>	53	21.b	<i>Of those in 21a, number of individuals who were assessed in their primary language</i>	44	22.a	<i>Of those in 21a, number of individuals who could not be assessed because their primary language was not English</i>	9	22.b	<i>Of those in 22a, number of individuals who had plans developed to meet their assessment needs</i>	3	23.	<i>Of those in 22b, number of individuals whose plans for assessment were implemented</i>	0
21.a	<i>Number of individuals who needed assessment during the evaluation period whose primary language was not English</i>	53															
21.b	<i>Of those in 21a, number of individuals who were assessed in their primary language</i>	44															
22.a	<i>Of those in 21a, number of individuals who could not be assessed because their primary language was not English</i>	9															
22.b	<i>Of those in 22a, number of individuals who had plans developed to meet their assessment needs</i>	3															
23.	<i>Of those in 22b, number of individuals whose plans for assessment were implemented</i>	0															

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		<p>As shown in the table above, NSH had completed assessments in a timely manner using the individuals' preferred/primary language on 44 of the 53 individuals (83%). Nine individuals did not have their evaluations completed. This monitor's documentation review from NSH found that written plans on completing the evaluations were available for three of them, but not for the remaining six. According to the Chief of Psychology, the written plans for the three individuals will be implemented, and a plan will be developed and implemented for the remaining six individuals.</p> <p>This monitor reviewed six charts (CE, DBM, HL, HP, HS and JA) of individuals whose primary/preferred language is not English. The required assessments were conducted in a timely manner for all six individuals.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Monitor the use of the procedure for those individuals whose preferred language is not English.</p>
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3. Nursing Assessments		
		<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Bernadette Ezike, RN, MSN, Nurse Administrator 2. Ed Foulk, RN, MBA, EdD, Executive Director 3. Eve Arcala, RN, Assistant Coordinator of Nursing Services 4. Joellyn Arce, RN, Nurse Coordinator, Headquarters 5. Kuldip Dhaliwal, Assistant Coordinator of Nursing Services 6. Michelle Patterson, RN, HSS 7. Natalie Allen, RN, BSN, Psychiatric Nursing Education Director <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. NSH's progress report and data 2. Calendar for Nursing Assessment training 3. Nursing Assessment course curriculum 4. Training rosters for Admission and Integrated Assessment 5. New hire training validation tracking data 6. NP 101.3 Nursing Assessment draft dated 7/10/08 7. Admission and Integrated Nursing assessments for the following 40 individuals: AHS, AMM, ARM, ATB, AWD, BJ, BMR, BSS, CCR, CDW, CIC, CWE, DEB, DJT, DP, EH, FCP, GPB, HCM, HSS, JA, JEG, JRM, JRQ, KMG, LLS, MEP, PJN, RLW, RR, RS, RTP, SMP, SWS, TBH, TDN, TLB, TOM, VH and WJB <p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. WRPC for RH (Program 4, Unit A2) 2. WRPC for RLM (Program 4, Unit A2)
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:	<p>Compliance:</p> <p>Partial.</p>

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D.3.a.i	a description of presenting conditions;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, January 2008: Continue training regarding Nursing Admission/Integrated Assessments.</p> <p>Findings: NSH's progress report and training rosters indicated that at the time of this review, 16 of the 21 Health Services Specialists were trained on both the Admission and Integrated assessments. As of January 2008, 223 of 371 RNs were given overview training on the new assessment forms. In addition, three Health Services Specialists were trained as trainers in April 2008 and provided in-depth training to 120 of 371 RNs on the Admission assessment and 109 of 371 RNs on the Integrated assessment. NSH indicated that by the next review, all RNs will have received this training.</p> <p>NSH progress report indicated that 31 RNs were identified as needing more mentoring and were provided more focused training and 1:1 mentoring to assist them with developing the skills to complete the Admission/Integrated assessments. Due to the poor compliance rates illustrated by NSH's data, the HSSs will begin to monitor the completion of nursing assessments in August 2008. In addition, new RNs will be observed and mentored regarding admission/integrated assessments.</p> <p>Recommendation 2, January 2008: Continue to monitor this requirement.</p> <p>Findings: NSH assessed its compliance using the DMH Nursing Assessment Monitoring Form for Admission, based on an average sample of 99% of</p>
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		<p>monthly admissions (January to May 2008). Below is a summary of NSH's data:</p> <table border="1"> <tr> <td>1.</td> <td><i>A description of presenting conditions:</i></td> <td></td> </tr> <tr> <td>1.a</td> <td><i>Each section of the Psychiatric and Psychological section of the Nursing Assessment is complete.</i></td> <td>66%</td> </tr> <tr> <td>1.b</td> <td><i>Each box checked is elaborated on in the narrative description in the summary of presenting observations.</i></td> <td>27%</td> </tr> <tr> <td>1.c</td> <td><i>The narrative description of the individual is described in recovery language and when possible from the individual's perspective.</i></td> <td>30%</td> </tr> </table> <p>NSH also assessed its compliance using the DMH Nursing Assessment Monitoring Form for Integrated Assessment, based on an average sample of 90% of integrated assessments due in the review months (January to May 2008). Below is a summary of NSH's data:</p> <table border="1"> <tr> <td>1.</td> <td><i>A description of presenting conditions:</i></td> <td></td> </tr> <tr> <td>1.a</td> <td><i>Each section of the Psychiatric and Psychological section of the Nursing Assessment is complete.</i></td> <td>64%</td> </tr> <tr> <td>1.c</td> <td><i>The narrative description of the individual is described in recovery language and when possible from the individual's perspective.</i></td> <td>17%</td> </tr> </table> <p>The facility did not present an analysis of the data from the previous review period or a review of the barriers to compliance. NSH's plan of correction for D.3.a.i through D.3.a.ix is addressed above under Findings for Recommendation 1.</p> <p>Other findings: This monitor's review of 40 individuals' admission and integrated assessments during the month of December 2007 (AHS, AMM, ARM,</p>	1.	<i>A description of presenting conditions:</i>		1.a	<i>Each section of the Psychiatric and Psychological section of the Nursing Assessment is complete.</i>	66%	1.b	<i>Each box checked is elaborated on in the narrative description in the summary of presenting observations.</i>	27%	1.c	<i>The narrative description of the individual is described in recovery language and when possible from the individual's perspective.</i>	30%	1.	<i>A description of presenting conditions:</i>		1.a	<i>Each section of the Psychiatric and Psychological section of the Nursing Assessment is complete.</i>	64%	1.c	<i>The narrative description of the individual is described in recovery language and when possible from the individual's perspective.</i>	17%
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		<p>ATB, AWD, BJ, BMR, BSS, CCR, CDW, CIC, CWE, DEB, DJT, DP, EH, FCP, GPB, HCM, HSS, JA, JEG, JRM, JRQ, KMG, LLS, MEP, PJN, RLW, RR, RS, RTP, SMP, SWS, TBH, TDN, TLB, TOM, VH and WJB) resulted in findings similar to those of NSH in that the majority of assessments did not contain adequate information regarding the presenting conditions; information was superficial and/or incomplete. Descriptions of presenting conditions upon admission presented the same issues as those observed and described during the previous review despite the implementation of the new admission forms. Although the new assessment forms require additional information to be addressed during the admission process, in many cases several sections of the assessments were either left blank or not fully completed. The areas found to be consistently and adequately addressed in both the admission and integrated assessments included vital signs, allergies, pain, use of assistive devices and activities of daily living; this is consistent with NSH's data.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Complete training for all nurses regarding Admission/Integrated Assessment by the next review period. 2. Implement monitoring and mentoring strategies for nursing assessments. 3. Include comparison data and analysis of barriers in progress report. 4. Continue to monitor this requirement. 													
		Compliance rate for admission assessment		Compliance rate for integrated assessment											
D.3.a.ii	current prescribed medications;	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 5%; text-align: center;">2.</td> <td style="width: 60%;"><i>Current prescribed medications</i></td> <td style="width: 35%;"></td> </tr> <tr> <td style="text-align: center;">2.a</td> <td><i>On the Admission Nursing Assessment all currently pre-</i></td> <td style="text-align: center;">56%</td> </tr> </table>	2.	<i>Current prescribed medications</i>		2.a	<i>On the Admission Nursing Assessment all currently pre-</i>	56%	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 5%; text-align: center;">2.</td> <td style="width: 60%;"><i>Current prescribed medications</i></td> <td style="width: 35%;"></td> </tr> <tr> <td style="text-align: center;">2.b</td> <td><i>On the Integrated Nursing Assessment all sections of the</i></td> <td style="text-align: center;">92%</td> </tr> </table>	2.	<i>Current prescribed medications</i>		2.b	<i>On the Integrated Nursing Assessment all sections of the</i>	92%
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2.a	<i>On the Admission Nursing Assessment all currently pre-</i>	56%													
2.	<i>Current prescribed medications</i>														
2.b	<i>On the Integrated Nursing Assessment all sections of the</i>	92%													

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			<i>scribed medications are documented to include the last time taken, dose, side effects if any, the individuals understanding of the medication and reasons for treatment.</i>			<i>medication management section are completed.</i>		
		2.c	<i>In the additional comments section there is documentation that medication records are not available and the individual is unable to provide any information about past medication history.</i>	56%		2.c	<i>Include when possible the individuals perception of medication regimen or side effects to watch for</i>	90%
D.3.a.iii	vital signs;			99%			97%	
D.3.a.iv	allergies;			90%			92%	
D.3.a.v	pain;			71%			48%	
D.3.a.vi	use of assistive devices;	6.	<i>Use of assistive devices</i>			6.	Use of assistive devices	
		6.a	<i>On Admission nursing assessment each section under vision, sleep, hearing, eating, teeth, and speech are completed</i>	53%		6.c	<i>On the Integrated Nursing Assessment the Assistive Devices section is completed OR</i>	34%
						6.c	<i>the "no problems</i>	82%

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		6.b	<i>On Admission Nursing Assessment, additional assistive devices are completed</i>	74%		noted" box is checked.	
D.3.a.vii	activities of daily living;	7.	<i>Activities of daily living</i>		7.	<i>Activities of daily living</i>	
		7.a	<i>The entire ADL section is complete</i>	91%	7.a	<i>The entire ADL section is complete</i>	84%
		7.b	<i>Any rating of 1 or greater is elaborated on in the comments section</i>	27%	7.b	<i>Any rating of 1 or greater is elaborated on in the comments section</i>	23%
D.3.a.viii	immediate alerts (e.g., escape risk, physical assault, choking risk, suicidal risk, homicide risk, fall risk, sexual assault, self-injurious behavior, arson, or fire setting); and	8.	<i>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.</i>		8.	<i>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.</i>	
		8.a	<i>The None Known box is checked</i>	83%	8.a	<i>The None Known box is checked</i>	82%
		8.b	<i>The alerts section is completed</i>	84%	8.b	<i>The alerts section is completed</i>	70%
D.3.a.ix	conditions needing immediate nursing interventions.			36%			37%

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 recommendation:</p> <p>Recommendation, January 2008: Continue to provide training regarding the Statewide Admission Nursing and Integrated Assessments.</p> <p>Findings: See D.3.a.i.</p> <p>Other findings: NSH has adopted and integrated the Wellness and Recovery Model into the Nursing Department's policies and the Admission and Integrated Assessments have been based on this model.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Complete training for all nurses regarding Admission/Integrated Assessment based on the Wellness and Recovery Model by next review period. 2. Continue to monitor this requirement
<p>D.3.c</p>	<p>Each State hospital shall ensure that all nurses responsible for performing or reviewing nursing assessments are verifiably competent in performing the assessments for which they are responsible. All nurses who are employed at Metropolitan State Hospital shall have graduated from an approved nursing program, shall have passed the NCLEX-RN and shall have a license to practice in the state of California.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: Continue to monitor this requirement.</p> <p>Findings: NSH's progress report indicated that licensure was verified for 100% of newly employed RNs in the January-May period; this was verified by this monitor's review. In addition, NSH indicated that 71% of newly hired RNs completed the clinical competency training for assessment</p>

Section D: Integrated Assessments

		<p>(see D.3.a.i for training data for existing RNs).</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Complete training for all nurses regarding Admission/Integrated Assessment by the next review period. 2. Continue to monitor this requirement. 			
D.3.d	Each State hospital shall ensure that nursing assessments are undertaken on a timely basis, and in particular, that:	Please see sub-cells for compliance findings.			
D.3.d.i	Initial nursing assessments are completed within 24 hours of the individual's admission;	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: Continue to monitor this requirement.</p> <p>Findings: NSH assessed its compliance using the DMH Nursing Assessment Monitoring Form for Admission, based on an average sample of 99% of monthly admissions (January to May 2008). Below is a summary of NSH's data:</p> <table border="1" data-bbox="991 1117 1887 1193"> <tr> <td>12.a</td> <td><i>Initial nursing assessments are completed within 24 hours of the individual's admission.</i></td> <td>95%</td> </tr> </table> <p>The facility did not present a comparison of the overall mean compliance rate from the last review period. The previous NSH report noted that in December 2007 the compliance rate for this requirement was 50%, which demonstrates improvement in the current period.</p>	12.a	<i>Initial nursing assessments are completed within 24 hours of the individual's admission.</i>	95%
12.a	<i>Initial nursing assessments are completed within 24 hours of the individual's admission.</i>	95%			

Section D: Integrated Assessments

		<p>Other findings: This monitor's review of 40 initial nursing assessments found that 15 assessments were left blank in the area identifying what sections were completed, making it impossible to determine timeliness (AHS, ATB, BMR, CDW, DEB, DP, FCP, HSS, JRQ, LLS, RLW, RTP, SMP, TLB and WJB) and two assessments that were not timely completed (CCR and JEG). The lack of completion of the "sections completed" area on the nursing assessment form precludes validation of substantial compliance for this requirement.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that Admission Assessments are adequately completed. 2. Continue to monitor this requirement. 						
D.3.d.ii	Further nursing assessments are completed and integrated into the individual's therapeutic and rehabilitation service plan within seven days of admission; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: Continue to monitor this requirement.</p> <p>Findings: NSH assessed its compliance using the DMH Nursing Assessment Monitoring Form for Integrated Assessment, based on an average sample of 90% of integrated assessments due in the review months (January to May 2008). Below is a summary of NSH's data:</p> <table border="1" data-bbox="991 1227 1890 1416"> <tr> <td data-bbox="991 1227 1087 1377">13.</td> <td data-bbox="1087 1227 1774 1377"><i>Further nursing assessments are completed and integrated into the individual's therapeutic and rehabilitation service plan within seven days of admission.</i></td> <td data-bbox="1774 1227 1890 1377"></td> </tr> <tr> <td data-bbox="991 1377 1087 1416">13.a</td> <td data-bbox="1087 1377 1774 1416"><i>Further nursing assessments are completed and</i></td> <td data-bbox="1774 1377 1890 1416">52%</td> </tr> </table>	13.	<i>Further nursing assessments are completed and integrated into the individual's therapeutic and rehabilitation service plan within seven days of admission.</i>		13.a	<i>Further nursing assessments are completed and</i>	52%
13.	<i>Further nursing assessments are completed and integrated into the individual's therapeutic and rehabilitation service plan within seven days of admission.</i>							
13.a	<i>Further nursing assessments are completed and</i>	52%						

Section D: Integrated Assessments

		<p><i>integrated into the individual's therapeutic and rehabilitation service plan within seven days of admission</i></p>	
		<p>13.b <i>The Integrated Nursing Assessment is completed between 3 to 5 days of admission</i></p>	<p>69%</p>
		<p>No data regarding this requirement was included in the previous NSH progress report for comparison. NSH's progress report indicated that the RNs continue to require additional training due to problems synthesizing and incorporating information into the Integrated Assessments, which resulted in low compliance with this requirement. In addition to the training and mentoring discussed in D.3.a.i, NSH implemented a tracking system in June 2008 to increase compliance with this requirement.</p> <p>Other findings: This monitor's review of 40 Integrated Nursing Assessments found that 16 were not timely completed (AHS, ARM, ATB, CCR, CWE, DP, HSS, JA, JRQ, RR, RS, SWS, TBH, TDN, TLB and TOM); this finding is in alignment with NSH's data.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Implement training, mentoring, and tracking system to increased compliance with this requirement. 2. Continue to monitor this requirement. 	
<p>D.3.d.iii</p>	<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</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, January 2008: Develop and implement a system to facilitate the nurses' knowledge of</p>	

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	<p>a quarterly review and the 12th monthly review shall be the annual review.</p>	<p>the individuals whose WRPCs they attend.</p> <p>Findings: NSH's progress report indicated that in August 2008, the facility developed a procedure that directs the RN who is assigned to the individual but unable to attend the WRPC to review the assessment with the RN who will attend. In addition, the attending RN will meet with the individual prior to the WRPC. Also, a system will be implemented that designates the psychiatric technician or LVN assigned to each individual to meet weekly, review the WRP monthly, complete weekly notes, and communicate information to the RN and WRPT. This system is promising in terms of ensuring that the RNs attending the WRPCs have knowledge of the individual. At the time of this review, there was no written procedure included in the supporting documentation.</p> <p>Recommendation 2, January 2008: Continue to evaluate staffing and scheduling issues to ensure that staff familiar with the individual attends the WRPC.</p> <p>Findings: NSH's progress report indicated that the Unit Supervisors try to ensure that staff familiar with the individual attends the individual's WRPCs. As noted above in Findings for Recommendation 1, the procedure NSH plans to implement should have a positive impact on this requirement.</p> <p>Recommendation 3, January 2008: Continue to monitor this requirement.</p> <p>Findings: NSH assessed its compliance using the DMH WRP Observation Monitoring Form, based on an average sample of 31% of the WRPCs due</p>
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Section D: Integrated Assessments

		<p>in each review month (March to May 2008). Below is a summary of NSH's data:</p> <table border="1" data-bbox="993 305 1887 378"> <tr> <td data-bbox="993 305 1774 378"><i>Did the core Registered Nurse (or an acceptable substitute) attend the WRPC?</i></td> <td data-bbox="1774 305 1887 378">77%</td> </tr> </table> <p>This was the only data presented by NSH. However, NSH's previous progress report included additional data regarding nurses' participation in the WRPCs. Scheduling issues preventing consistent nursing staff from attending the WRPCs have been a major barrier for NSH. The facility indicated that the strategies described under Recommendation 1 and 2 above will be implemented to increase compliance with this requirement.</p> <p>Other findings: This monitor's observations of two WRPCs (Program 4, Units A2 and A4) found that the nurse for one WRPC was familiar with the individual and adequately reviewed the nursing assessments (Unit A4). In the second WRPC (Unit A2), the nurse was unfamiliar with the individual and did not present any clinically relevant information.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Implement the procedure that seeks to ensure that staff familiar with specific individuals attend those individuals' WRPCs. 2. Present complete data addressing this requirement. 3. Continue to monitor this requirement. 	<i>Did the core Registered Nurse (or an acceptable substitute) attend the WRPC?</i>	77%
<i>Did the core Registered Nurse (or an acceptable substitute) attend the WRPC?</i>	77%			

4. Rehabilitation Therapy Assessments		
		<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Beverly Lynn, Acting Senior Rehabilitation Therapist 2. Camille Gentry, Acting Senior Rehabilitation Therapist 3. Phyllis Moore, Acting Senior Rehabilitation Therapist 4. Reggie Ott, Chief of Rehabilitation Services 5. Robert Newman, Acting Senior Rehabilitation Therapist 6. Robert Schaufenbil, Acting Senior Rehabilitation Therapist <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. DMH Rehabilitation Therapy Service Manual final draft 2. Rehabilitation Management Committee procedure (draft) 3. DMH Rehabilitation Therapy Monitoring Form and Instructions (D4 monitoring tool for admission assessments) 4. DMH Rehabilitation Therapy Monitoring Tool and Instructions (IA-RTS audit) 5. DMH Rehabilitation Therapy IA-RTS audit data for January-May 2008 6. Focused assessment (Physical Therapy, Speech Therapy and Comprehensive Integrated Physical Rehabilitation Therapy Assessment) audit data for April-May 2008 7. DMH Vocational Rehabilitation Assessment Tool and Instructions (implemented 3/08) 8. DMH Vocational Rehabilitation Assessment Monitoring Tool and Instructions (implemented 3/08) 9. Draft of Vocational Rehabilitation Screening Tool 10. DMH Occupational Therapy Focused Assessment and Instructions (implemented 3/08) 11. DMH Occupational Therapy Focused Assessment Monitoring Tool and Instructions drafts (implemented 3/08) 12. DMH Speech-Language Focused Assessment and Instructions

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		<p>(implemented 3/08)</p> <ol style="list-style-type: none"> 13. DMH Speech-Language Focused Assessment Monitoring Tool and Instructions (implemented 3/08) 14. DMH Physical Therapy Focused Assessment and Instructions (implemented 3/08) 15. DMH Physical Therapy Focused Assessment Monitoring Tool and Instructions (implemented 3/08) 16. DMH Comprehensive Integrated Physical Rehabilitation Therapy Assessment and Instructions (implemented 3/08) 17. DMH Comprehensive Integrated Physical Rehabilitation Therapy Assessment Monitoring Tool and Instructions (implemented 3/08) 18. List of individuals who had IA-RTS assessments from January- May 2008 19. Records of the following 18 individuals who had IA-RTS assessments from January- April 2008: AB, AMM, AP, CDV, CDW, ELC, FG, FL, FLK, HS, IRS, KLF, KND, LRW, MEP, OB, PCB and SET 20. Record for the following four individuals who had Vocational Rehabilitation Assessments from April-May 2008: DG, MB, PB and RK 21. List of individuals with Physical Therapy assessment in April-May 2008 22. Records for the following five individuals with Physical Therapy assessment in April-May 2008: CH, DC, FAS, JM and LER 23. List of individuals with Speech Therapy assessment/consultation in April-May 2008 24. Records for the following four individuals with Speech Therapy assessment in April-May 2008: AC, HS, RME and SEF 25. List of individuals with Comprehensive Integrated Rehabilitation Assessment in April-May 2008 26. Records for the following six individuals who had a Comprehensive Integrated Rehabilitation Assessments in April-May 2008: AP, GDM, JY, MAM, PFM and RAM 27. List of individuals who had type D.4.d assessments from January-
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		<p>May 2008</p> <p>28. Records of the following 13 individuals who had type D.4.d assessments from January- April 2008: AB, AIR, DM, DR, EY, FM, FP, KDN, LJ, LK, RH, RR and RRT</p> <p>29. Training rosters and competency quizzes for Rehabilitation Therapy admission and focused assessment trainings</p>
D.4.a	<p>Each State hospital shall develop standard rehabilitation therapy assessment protocols, consistent with generally accepted professional standards of care, for satisfying the necessary components of a comprehensive rehabilitation therapy assessment.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, January 2008: Revise and implement the draft DMH Rehabilitation Therapy Service Manual based on changes, new protocols and procedures and system development.</p> <p>Findings: The draft of the statewide Rehabilitation Therapy Manual has been subsequently updated as procedures and processes have evolved. The current draft (final draft) addresses the role of the Rehabilitation Therapist in the WRP, as well as the role of the RIAT team, POST team, Occupational Therapist, Physical Therapist, Speech Therapist, and Vocational Rehabilitation Counselors and Instructors. The manual includes the Rehabilitation Therapist's role in acting as a liaison to report findings of the POST disciplines and Vocational Rehabilitation Services. The final draft is pending statewide implementation. The Manual should continue to be updated as procedures and systems develop.</p> <p>Recommendation 2, January 2008: Revise and implement Rehabilitation Therapy procedure(s) for Assessments to include descriptions of time frames, format and content for all Rehabilitation Therapy Assessments, including Vocational Rehabilitation, Comprehensive Physical Rehabilitation Therapy Assessment, Physical Therapy, Speech Therapy and</p>

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		<p>Occupational Therapy assessments.</p> <p>Findings: The Rehabilitation Therapy Manual has been revised to include information regarding time frames, format and content for all Rehabilitation Therapy Assessments, including Vocational Rehabilitation, Comprehensive Physical Rehabilitation Therapy Assessment, Physical Therapy, Speech Therapy and Occupational Therapy assessments.</p> <p>Recommendation 3, January 2008: Revise and implement focused assessment tools and instructions including Physical, Occupational, Speech, Vocational Rehabilitation and Comprehensive Physical Rehabilitation Therapy assessments and ensure process/format is consistent with that of the other three state hospitals.</p> <p>Findings: The following assessment tools and instructions have been revised, approved, and were implemented on 04/01/08: MH-C 9078 DMH Vocational Rehabilitation Assessment and Instructions; MH-C 9079 DMH Speech-Language Therapy Focused Assessment and Instructions; MH-C 9080 DMH Physical Therapy Focused Assessment and Instructions; MH-C 9081 DMH Occupational Therapy Focused Assessment and Instructions; and MH-C 9082 DMH Comprehensive Integrated Physical Rehabilitation Therapy Assessment and Instructions. This is verified upon review of corresponding procedures and record review of individuals who received IA-RTS assessments in January-May 2008, and focused assessments between April-May 2008.</p> <p>Recommendation 4, January 2008: Develop and implement a plan to ensure that individuals who would benefit from a Comprehensive Physical Rehabilitation Therapy</p>
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		<p>assessment or a Vocational Rehabilitation assessment are referred for this service by the WRPT.</p> <p>Findings: A Vocational Rehabilitation Screen revised draft has been developed and is pending statewide collaboration and implementation.</p> <p>"Recommendations for a Focused Rehabilitation Therapy Services Assessment" training was developed and implemented in April 2008 to train Psychosocial Rehabilitation regarding referrals for Comprehensive Rehabilitation Physical Rehabilitation Therapy and Vocational Rehabilitation assessments. The facility reports that 43/56 Rehabilitation Therapists were trained to competency; this is verified by review of raw data from training rosters and training quizzes.</p> <p>After record review, interview, and observation of a WRP-C on A4 (SNF unit) it does not appear that the current system for referring individuals to the POST team for a Comprehensive Physical Rehabilitation Therapy Assessment or Occupational or Speech Therapy focused assessment when indicated by Dysphagia or Falls risk screening tool, or as clinically indicated on an individual basis is adequate. A draft of the POST referral form listing Occupational, Physical, and Speech Therapy services has been developed and is pending implementation. This tool appears to be comprehensive and may have the ability to generate a referral to the POST team as clinically indicated, if the WRP teams are educated on and oriented to its use.</p> <p>Recommendation 5, January 2008: Develop and implement a D.4 monitoring tool that reports data on Enhancement Plan cells pertaining to all Rehabilitation Therapy assessments (Integrated, Transfer, and Focused) according to DMH format/standards.</p>
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		<p>Findings: The MH-C 9044 Rehabilitation Therapy Assessment Monitoring Form and Instructions was developed and implemented in January 2008 for admission assessments, and in April 2008 for focused assessments.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Implement the Department of Mental Health Rehabilitation Therapy Service Manual draft and revise as needed based on changes, new protocols and procedures, and system development; ensure that all discipline specific service procedures and manuals continue to be consistent with Rehabilitation Therapy practice in relation to Wellness and Recovery model and Enhancement Plan requirements. 2. Develop and implement a plan to ensure that individuals (both new admissions and individuals residing at NSH) who would benefit from a Comprehensive Physical Rehabilitation Therapy assessment, POST focused assessment, and/or Vocational Rehabilitation assessment are referred for this service by the WRPT. 3. Revise and implement Vocational Rehabilitation screening tool to ensure a more comprehensive tool for Vocational Rehabilitation referrals.
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>Findings: Using the DMH Integrated Assessment Rehabilitation Therapy Section Monitoring Tool, NSH assessed its compliance with timeliness based on an average sample of 100% of Integrated Assessment assessments due for each month for the review period of January -May 2008 (total of 176). The following outlines the indicators with corresponding mean compliance rates for January-May 2008:</p>

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		<table border="1"> <tr> <td data-bbox="989 196 1087 337">1.</td> <td data-bbox="1087 196 1789 337"><i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:</i></td> <td data-bbox="1789 196 1885 337"></td> </tr> <tr> <td data-bbox="989 337 1087 414">1.a</td> <td data-bbox="1087 337 1789 414"><i>The assessment was completed within 5 calendar days of the individual's admission, and</i></td> <td data-bbox="1789 337 1885 414">76%</td> </tr> <tr> <td data-bbox="989 414 1087 456">1.b</td> <td data-bbox="1087 414 1789 456"><i>Filed in the medical record</i></td> <td data-bbox="1789 414 1885 456">100%</td> </tr> </table>	1.	<i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:</i>		1.a	<i>The assessment was completed within 5 calendar days of the individual's admission, and</i>	76%	1.b	<i>Filed in the medical record</i>	100%
1.	<i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:</i>										
1.a	<i>The assessment was completed within 5 calendar days of the individual's admission, and</i>	76%									
1.b	<i>Filed in the medical record</i>	100%									
<p>The mean compliance rate has remained stable from the last month of the previous review period, December, to the last month of this review period, May as follows: Item #1 from 84% to 83%; Item #1a from 84% to 83%; Item #1b from 100% to 100%.</p> <p>Using the DMH Vocational Rehabilitation Focused Assessment Monitoring Tool, NSH assessed its compliance with timeliness based on an average sample of 100% of Vocational Rehabilitation focused assessments due for each month for April -May 2008 (total of 9). The following outlines the indicators with corresponding mean compliance rates for April-May 2008:</p>											
<table border="1"> <tr> <td data-bbox="989 938 1087 1079">1.</td> <td data-bbox="1087 938 1789 1079"><i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:</i></td> <td data-bbox="1789 938 1885 1079"></td> </tr> <tr> <td data-bbox="989 1079 1087 1156">1.a</td> <td data-bbox="1087 1079 1789 1156"><i>The assessment was completed within 5 calendar days of the individual's admission, and</i></td> <td data-bbox="1789 1079 1885 1156">44%</td> </tr> <tr> <td data-bbox="989 1156 1087 1198">1.b</td> <td data-bbox="1087 1156 1789 1198"><i>Filed in the medical record</i></td> <td data-bbox="1789 1156 1885 1198">100%</td> </tr> </table>			1.	<i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:</i>		1.a	<i>The assessment was completed within 5 calendar days of the individual's admission, and</i>	44%	1.b	<i>Filed in the medical record</i>	100%
1.	<i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:</i>										
1.a	<i>The assessment was completed within 5 calendar days of the individual's admission, and</i>	44%									
1.b	<i>Filed in the medical record</i>	100%									
<p>No comparable data were available from the last review period as the assessment was implemented April 2008.</p> <p>Using the DMH Speech Therapy Focused Assessment Monitoring Tool, NSH assessed its compliance with timeliness based on an average</p>											

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		<p>sample of 100% of Speech Therapy Focused Assessment assessments due for each month for April-May 2008 (total of 5). The following outlines the indicators with corresponding mean compliance rates for April-May 2008:</p> <table border="1" data-bbox="991 376 1890 641"> <tr> <td data-bbox="991 376 1087 527">1.</td> <td data-bbox="1087 376 1795 527"><i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:</i></td> <td data-bbox="1795 376 1890 527"></td> </tr> <tr> <td data-bbox="991 527 1087 600">1.a</td> <td data-bbox="1087 527 1795 600"><i>The assessment was completed within 5 calendar days of the individual's admission, and</i></td> <td data-bbox="1795 527 1890 600">0%</td> </tr> <tr> <td data-bbox="991 600 1087 641">1.b</td> <td data-bbox="1087 600 1795 641"><i>Filed in the medical record</i></td> <td data-bbox="1795 600 1890 641">100%</td> </tr> </table> <p>No comparable data were available from the last review period as the assessment was implemented April 2008.</p> <p>Using the DMH Physical Therapy Focused Assessment Monitoring Tool, NSH assessed its compliance with timeliness based on an average sample of 100% of Integrated Assessment assessments due for each month for April-May 2008 (total of 12). The following outlines the indicators with corresponding mean compliance rates for April-May 2008:</p> <table border="1" data-bbox="991 1047 1890 1312"> <tr> <td data-bbox="991 1047 1087 1198">1.</td> <td data-bbox="1087 1047 1795 1198"><i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:</i></td> <td data-bbox="1795 1047 1890 1198"></td> </tr> <tr> <td data-bbox="991 1198 1087 1271">1.a</td> <td data-bbox="1087 1198 1795 1271"><i>The assessment was completed within 5 calendar days of the individual's admission, and</i></td> <td data-bbox="1795 1198 1890 1271">58%</td> </tr> <tr> <td data-bbox="991 1271 1087 1312">1.b</td> <td data-bbox="1087 1271 1795 1312"><i>Filed in the medical record</i></td> <td data-bbox="1795 1271 1890 1312">100%</td> </tr> </table> <p>No comparable data were available from the last review period as the assessment was implemented April 2008.</p>	1.	<i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:</i>		1.a	<i>The assessment was completed within 5 calendar days of the individual's admission, and</i>	0%	1.b	<i>Filed in the medical record</i>	100%	1.	<i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:</i>		1.a	<i>The assessment was completed within 5 calendar days of the individual's admission, and</i>	58%	1.b	<i>Filed in the medical record</i>	100%
1.	<i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:</i>																			
1.a	<i>The assessment was completed within 5 calendar days of the individual's admission, and</i>	0%																		
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1.	<i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:</i>																			
1.a	<i>The assessment was completed within 5 calendar days of the individual's admission, and</i>	58%																		
1.b	<i>Filed in the medical record</i>	100%																		

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		<p>Using the DMH Comprehensive Integrated Physical Rehabilitation Therapy Focused Assessment Monitoring Tool, NSH assessed its compliance with timeliness based on an average sample of 100% of Integrated Assessment assessments due for each month for April-May 2008 (total of 8). The following outlines the indicators with corresponding mean compliance rates for April-May 2008:</p> <table border="1" data-bbox="991 483 1881 748"> <tr> <td data-bbox="991 483 1087 634">1.</td> <td data-bbox="1087 483 1793 634"><i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:</i></td> <td data-bbox="1793 483 1881 634"></td> </tr> <tr> <td data-bbox="991 634 1087 711">1.a</td> <td data-bbox="1087 634 1793 711"><i>The assessment was completed within 5 calendar days of the individual's admission, and</i></td> <td data-bbox="1793 634 1881 711">25%</td> </tr> <tr> <td data-bbox="991 711 1087 748">1.b</td> <td data-bbox="1087 711 1793 748"><i>Filed in the medical record</i></td> <td data-bbox="1793 711 1881 748">100%</td> </tr> </table> <p>No comparable data were available from the last review period as the assessment was implemented April 2008.</p> <p>Other findings: Record review of a random sample of Integrated Assessment-Rehabilitation Therapy section from January -May 2008 and focused assessments from April-May 2008 showed that 67% of IA-RTS, 0% of Vocational Rehabilitation, 100% of Physical Therapy, 25% of Speech Therapy, and 17% of Comprehensive Integrated Physical Rehabilitation Therapy assessments were completed in accordance with facility requirements for timeliness.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Ensure that each individual served has a rehabilitation assessment that</p>	1.	<i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:</i>		1.a	<i>The assessment was completed within 5 calendar days of the individual's admission, and</i>	25%	1.b	<i>Filed in the medical record</i>	100%
1.	<i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:</i>										
1.a	<i>The assessment was completed within 5 calendar days of the individual's admission, and</i>	25%									
1.b	<i>Filed in the medical record</i>	100%									

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		<p>is timely and consistent with generally accepted professional standards of care.</p>		
<p>D.4.b.i</p>	<p>Is accurate and comprehensive as to the individual's functional abilities;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, January 2008: Develop and implement audit tools for all focused Rehabilitation Therapy assessments, including Comprehensive Physical Rehabilitation Therapy assessments and Vocational Rehabilitation, Physical, Occupational, and Speech Therapy assessments.</p> <p>Findings: The following audit tools were developed and were implemented for April 2008: MH-C 9044b DMH Comprehensive Integrated Physical Rehabilitation Therapy Assessment Monitoring Form Instructions; MH-C 9044c DMH Occupational Therapy Assessment Monitoring Form Instructions; MH-C 9044d DMH Physical Therapy Assessment Monitoring Form Instructions; MH-C 9044e DMH Speech-Language Pathology Assessment Monitoring Form Instructions; and the MH-C 9044f DMH Vocational Rehabilitation Assessment Monitoring Form Instructions. Data was provided for April and May for all monitoring tools except MH-C 9044c DMH Occupational Therapy Assessment Monitoring Form, as there were no Occupational Therapy assessments due in these months.</p> <p>Using the DMH Integrated Assessment Rehabilitation Therapy Section Monitoring Tool, NSH assessed its compliance with D.4.bi based on an average sample of 100% of Integrated Assessment assessments due for each month for the review period of January -May 2008 (total of 176). The following outlines the indicators with corresponding mean compliance rates for January-May 2008:</p> <table border="1" data-bbox="989 1377 1793 1414"> <tr> <td data-bbox="989 1377 1087 1414">2.</td> <td data-bbox="1087 1377 1793 1414"><i>Is accurate and comprehensive as to the individual's</i></td> </tr> </table>	2.	<i>Is accurate and comprehensive as to the individual's</i>
2.	<i>Is accurate and comprehensive as to the individual's</i>			

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			<i>functional abilities;</i>	
		2.a	<i>Identifying information is fully documented</i>	98%
		2.b	<i>Previous rehabilitation therapy assessments, POST evaluations, vocational evaluations, WRP's and other salient medical records (e.g., 24-hour admission assessments), interview of individual, chart review, observation of structured activities used in the assessment process, and consultations are reviewed and documented</i>	99%
		2.c	<i>Structured assessment activities and pertinent information related to setting/time are listed</i>	94%
		2.d	<i>Leisure and enrichment profile items are completed</i>	100%
		2.e	<i>Functional observation items are completed for [all pertinent sections]</i>	85%
		<p>The compliance rate increased from 91% the last month of the prior review period, December, 2007, to 95% the last month of the current review period, May, 2008. The mean compliance rate for #2 is low due to January outliers.</p> <p>Using the DMH Vocational Rehabilitation Focused Assessment Monitoring Tool, NSH assessed its compliance with D.4.bi based on an average sample of 100% of Vocational Therapy focused assessments due for each month for April -May 2008 (total of 9). The facility reports that 100% of Vocational Rehabilitation assessments audited were accurate and comprehensive as to the individual's functional abilities.</p> <p>Using the DMH Speech Therapy Focused Assessment Monitoring Tool, NSH assessed its compliance with D.4.bi based on an average sample of 100% of Speech Therapy focused assessments due for each month for April -May 2008 (total of 5). The facility reports that 100% of</p>		

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		<p>Speech Therapy assessments audited were accurate and comprehensive as to the individual's functional abilities.</p> <p>Using the DMH Physical Therapy Focused Assessment Monitoring Tool, NSH assessed its compliance with D.4.bi based on an average sample of 100% of Physical Therapy focused assessments due for each month for April -May 2008 (total of 12). The facility reports that 25% of Physical Therapy assessments audited were accurate and comprehensive as to the individual's functional abilities.</p> <p>Using the DMH Comprehensive Integrated Physical Rehabilitation Therapy Focused Assessment Monitoring Tool, NSH assessed its compliance with D.4.bi based on an average sample of 100% of CIPRTA focused assessments due for each month for April -May 2008 (total of 8). The following outlines the indicators with corresponding mean compliance rates for January-May 2008:</p> <table border="1" data-bbox="989 820 1896 1421"> <tr> <td data-bbox="989 820 1087 894">2.</td> <td data-bbox="1087 820 1793 894"><i>Is accurate and comprehensive as to the individual's functional abilities:</i></td> <td data-bbox="1793 820 1896 894"></td> </tr> <tr> <td data-bbox="989 894 1087 932">2.a</td> <td data-bbox="1087 894 1793 932"><i>Identifying information is fully documented</i></td> <td data-bbox="1793 894 1896 932">100%</td> </tr> <tr> <td data-bbox="989 932 1087 1193">2.b</td> <td data-bbox="1087 932 1793 1193"><i>Previous rehabilitation therapy assessments, POST evaluations, vocational evaluations, WRP's and other salient medical records (e.g., 24-hour admission assessments), interview of individual, chart review, observation of structured activities used in the assessment process, and consultations are reviewed and documented</i></td> <td data-bbox="1793 932 1896 1193">100%</td> </tr> <tr> <td data-bbox="989 1193 1087 1268">2.c</td> <td data-bbox="1087 1193 1793 1268"><i>Pertinent medical history completed, including precautions</i></td> <td data-bbox="1793 1193 1896 1268">75%</td> </tr> <tr> <td data-bbox="989 1268 1087 1343">2.d</td> <td data-bbox="1087 1268 1793 1343"><i>Prior level of functioning in all areas is addressed, including adaptive equipment</i></td> <td data-bbox="1793 1268 1896 1343">100%</td> </tr> <tr> <td data-bbox="989 1343 1087 1421">2.e</td> <td data-bbox="1087 1343 1793 1421"><i>Current functional abilities are addressed, as indicated</i></td> <td data-bbox="1793 1343 1896 1421">100%</td> </tr> </table>	2.	<i>Is accurate and comprehensive as to the individual's functional abilities:</i>		2.a	<i>Identifying information is fully documented</i>	100%	2.b	<i>Previous rehabilitation therapy assessments, POST evaluations, vocational evaluations, WRP's and other salient medical records (e.g., 24-hour admission assessments), interview of individual, chart review, observation of structured activities used in the assessment process, and consultations are reviewed and documented</i>	100%	2.c	<i>Pertinent medical history completed, including precautions</i>	75%	2.d	<i>Prior level of functioning in all areas is addressed, including adaptive equipment</i>	100%	2.e	<i>Current functional abilities are addressed, as indicated</i>	100%
2.	<i>Is accurate and comprehensive as to the individual's functional abilities:</i>																			
2.a	<i>Identifying information is fully documented</i>	100%																		
2.b	<i>Previous rehabilitation therapy assessments, POST evaluations, vocational evaluations, WRP's and other salient medical records (e.g., 24-hour admission assessments), interview of individual, chart review, observation of structured activities used in the assessment process, and consultations are reviewed and documented</i>	100%																		
2.c	<i>Pertinent medical history completed, including precautions</i>	75%																		
2.d	<i>Prior level of functioning in all areas is addressed, including adaptive equipment</i>	100%																		
2.e	<i>Current functional abilities are addressed, as indicated</i>	100%																		

		<p>Recommendation 2, January 2008: Provide competency-based training to Rehabilitation Therapy staff regarding all protocol revisions.</p> <p>Findings: Please see D.4.c. for findings regarding this recommendation.</p> <p>Other findings: Record review of a random sample of Integrated Assessment-Rehabilitation Therapy section from January -May 2008 showed that 95% were comprehensive and 95% addressed functional abilities.</p> <p>Record review of Vocational Rehabilitation focused assessments from April-May 2008 showed that 75% were comprehensive and 75% addressed functional abilities.</p> <p>Record review of Speech Therapy focused assessments from April-May 2008 showed that 100% were comprehensive and 100% addressed functional abilities.</p> <p>Record review of Physical Therapy focused assessments from April-May 2008 showed that 80% were comprehensive and 100% addressed functional abilities.</p> <p>Record review of Comprehensive Integrated Physical Rehabilitation Therapy focused assessments from April-May 2008 showed that 67% were comprehensive and 100% addressed functional abilities.</p> <p>Current recommendation: Ensure that all Rehabilitation Services admission and focused assessments are accurate and comprehensive as to the individual's functional abilities.</p>
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D.4.b.ii	Identifies the individual's current functional status and the skills and supports needed to facilitate transfer to the next level of care; and	<p>Current findings on previous recommendation: Ensure that all Integrated Assessments and focused assessments identify the individual's current functional status and the skills and supports needed to facilitate transfer to the next level of care.</p> <p>Findings: Using the DMH Integrated Assessment Rehabilitation Therapy Section Monitoring Tool, NSH assessed its compliance with D.4.b.ii based on an average sample of 100% of Integrated Assessment assessments due for each month for the review period of January -May 2008 (total of 176). The following outlines the indicators with corresponding mean compliance rates for January-May 2008:</p> <table border="1" data-bbox="989 673 1885 1416"> <tr> <td data-bbox="989 673 1087 748">3.</td> <td data-bbox="1087 673 1793 748"><i>Identifies the individual's current functional status, and</i></td> <td data-bbox="1793 673 1885 748"></td> </tr> <tr> <td data-bbox="989 748 1087 971">3.a</td> <td data-bbox="1087 748 1793 971"><i>The functional status is described for Physical Functioning: summarizes the individual's functional status regarding the area of physical functioning in a narrative format, and provides a description of the implications of findings from a rehabilitation services perspective.</i></td> <td data-bbox="1793 748 1885 971">92%</td> </tr> <tr> <td data-bbox="989 971 1087 1193">3.b</td> <td data-bbox="1087 971 1793 1193"><i>The functional status is described for Social Functioning: summarizes the individual's functional status regarding the area of social functioning in a narrative format; and provides a description of the implications of findings from a rehabilitation services perspective.</i></td> <td data-bbox="1793 971 1885 1193">93%</td> </tr> <tr> <td data-bbox="989 1193 1087 1416">3.c</td> <td data-bbox="1087 1193 1793 1416"><i>The functional status is described for Life Skills: summarizes the individual's functional status regarding the area of life skills in a narrative format, and provides a description of the implications of findings from a rehabilitation services perspective.</i></td> <td data-bbox="1793 1193 1885 1416">90%</td> </tr> </table>	3.	<i>Identifies the individual's current functional status, and</i>		3.a	<i>The functional status is described for Physical Functioning: summarizes the individual's functional status regarding the area of physical functioning in a narrative format, and provides a description of the implications of findings from a rehabilitation services perspective.</i>	92%	3.b	<i>The functional status is described for Social Functioning: summarizes the individual's functional status regarding the area of social functioning in a narrative format; and provides a description of the implications of findings from a rehabilitation services perspective.</i>	93%	3.c	<i>The functional status is described for Life Skills: summarizes the individual's functional status regarding the area of life skills in a narrative format, and provides a description of the implications of findings from a rehabilitation services perspective.</i>	90%
3.	<i>Identifies the individual's current functional status, and</i>													
3.a	<i>The functional status is described for Physical Functioning: summarizes the individual's functional status regarding the area of physical functioning in a narrative format, and provides a description of the implications of findings from a rehabilitation services perspective.</i>	92%												
3.b	<i>The functional status is described for Social Functioning: summarizes the individual's functional status regarding the area of social functioning in a narrative format; and provides a description of the implications of findings from a rehabilitation services perspective.</i>	93%												
3.c	<i>The functional status is described for Life Skills: summarizes the individual's functional status regarding the area of life skills in a narrative format, and provides a description of the implications of findings from a rehabilitation services perspective.</i>	90%												

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		<table border="1"> <tr> <td data-bbox="989 191 1087 267">4.</td> <td data-bbox="1087 191 1793 267"><i>The skills and supports needed to facilitate transfer to the next level of care; and</i></td> <td data-bbox="1793 191 1881 267"></td> </tr> <tr> <td data-bbox="989 267 1087 380">4.a</td> <td data-bbox="1087 267 1793 380"><i>The narrative includes a description of the skills and supports necessary to live in the setting in which she/he will be placed, and</i></td> <td data-bbox="1793 267 1881 380">84%</td> </tr> <tr> <td data-bbox="989 380 1087 456">4.b</td> <td data-bbox="1087 380 1793 456"><i>A discussion of possible progression/steps towards this level of independence.</i></td> <td data-bbox="1793 380 1881 456">81%</td> </tr> </table>	4.	<i>The skills and supports needed to facilitate transfer to the next level of care; and</i>		4.a	<i>The narrative includes a description of the skills and supports necessary to live in the setting in which she/he will be placed, and</i>	84%	4.b	<i>A discussion of possible progression/steps towards this level of independence.</i>	81%
4.	<i>The skills and supports needed to facilitate transfer to the next level of care; and</i>										
4.a	<i>The narrative includes a description of the skills and supports necessary to live in the setting in which she/he will be placed, and</i>	84%									
4.b	<i>A discussion of possible progression/steps towards this level of independence.</i>	81%									
<p>The mean compliance rate has increased from the last month of the previous review period, December 2007, to the last month of this review period, May 2008 as follows: Item #3 from 83% to 91%; Item #4 from 71% to 74%. The facility reports that the mean compliance rate for #3 is low due to January outliers, and the mean compliance rate for #4 is due to low compliance with identifying the steps towards next level of care and identifying supports.</p> <p>Using the DMH Vocational Rehabilitation Focused Assessment Monitoring Tool, NSH assessed its compliance with D.4.b.ii based on an average sample of 100% of Vocational Rehabilitation focused assessments due for each month for April -May 2008 (total of 9). The following outlines the indicators with corresponding mean compliance rates for April-May 2008:</p>											
<table border="1"> <tr> <td data-bbox="989 1045 1087 1122">3.</td> <td data-bbox="1087 1045 1772 1122"><i>Identifies the individual's current functional status, and</i></td> <td data-bbox="1772 1045 1881 1122">78%</td> </tr> <tr> <td data-bbox="989 1122 1087 1198">4.</td> <td data-bbox="1087 1122 1772 1198"><i>The skills and supports needed to facilitate transfer to the next level of care</i></td> <td data-bbox="1772 1122 1881 1198">78%</td> </tr> </table>			3.	<i>Identifies the individual's current functional status, and</i>	78%	4.	<i>The skills and supports needed to facilitate transfer to the next level of care</i>	78%			
3.	<i>Identifies the individual's current functional status, and</i>	78%									
4.	<i>The skills and supports needed to facilitate transfer to the next level of care</i>	78%									
<p>Facility analysis concluded that low volume and new tool may have been factors contributing to low compliance.</p> <p>Using the DMH Speech Therapy Focused Assessment Monitoring Tool, NSH assessed its compliance with D.4.b.ii based on an average sample</p>											

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		<p>of 100% of Speech Therapy focused assessments due for each month for April -May 2008 (total of 5). The following outlines the indicators with corresponding mean compliance rates for April-May 2008:</p> <table border="1" data-bbox="991 337 1887 490"> <tr> <td data-bbox="991 337 1066 412">3.</td> <td data-bbox="1066 337 1774 412"><i>Identifies the individual's current functional status, and</i></td> <td data-bbox="1774 337 1887 412">40%</td> </tr> <tr> <td data-bbox="991 412 1066 490">4.</td> <td data-bbox="1066 412 1774 490"><i>The skills and supports needed to facilitate transfer to the next level of care</i></td> <td data-bbox="1774 412 1887 490">80%</td> </tr> </table> <p>Facility analysis concluded that low compliance for #3 is due to information not being included in the appropriate section, and that low volume and new tool may have been factors contributing to low compliance for #3 and #4.</p> <p>Using the DMH Physical Therapy Focused Assessment Monitoring Tool, NSH assessed its compliance with D.4.b.ii based on an average sample of 100% of Physical Therapy focused assessments due for each month for April -May 2008 (total of 12). The following outlines the indicators with corresponding mean compliance rates for April-May 2008:</p> <table border="1" data-bbox="991 971 1887 1123"> <tr> <td data-bbox="991 971 1066 1045">3.</td> <td data-bbox="1066 971 1774 1045"><i>Identifies the individual's current functional status, and</i></td> <td data-bbox="1774 971 1887 1045">67%</td> </tr> <tr> <td data-bbox="991 1045 1066 1123">4.</td> <td data-bbox="1066 1045 1774 1123"><i>The skills and supports needed to facilitate transfer to the next level of care</i></td> <td data-bbox="1774 1045 1887 1123">25%</td> </tr> </table> <p>Facility analysis of low compliance data includes the following: #3- several of the assessments did not thoroughly complete all boxes to identify functional status; #4- staff identified the skills and supports needed but not the possible progression of steps.</p> <p>Using the DMH Comprehensive Integrated Physical Rehabilitation Therapy Focused Assessment Monitoring Tool, NSH assessed its</p>	3.	<i>Identifies the individual's current functional status, and</i>	40%	4.	<i>The skills and supports needed to facilitate transfer to the next level of care</i>	80%	3.	<i>Identifies the individual's current functional status, and</i>	67%	4.	<i>The skills and supports needed to facilitate transfer to the next level of care</i>	25%
3.	<i>Identifies the individual's current functional status, and</i>	40%												
4.	<i>The skills and supports needed to facilitate transfer to the next level of care</i>	80%												
3.	<i>Identifies the individual's current functional status, and</i>	67%												
4.	<i>The skills and supports needed to facilitate transfer to the next level of care</i>	25%												

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		<p>compliance with D.4.b.ii based on an average sample of 100% of Comprehensive Integrated Physical Rehabilitation Therapy focused assessments due for each month for April -May 2008 (total of 5). The following outlines the indicators with corresponding mean compliance rates for April-May 2008:</p> <table border="1" data-bbox="991 414 1885 565"> <tr> <td data-bbox="991 414 1066 488">3.</td> <td data-bbox="1066 414 1774 488"><i>Identifies the individual's current functional status, and</i></td> <td data-bbox="1774 414 1885 488">25%</td> </tr> <tr> <td data-bbox="991 488 1066 565">4.</td> <td data-bbox="1066 488 1774 565"><i>The skills and supports needed to facilitate transfer to the next level of care</i></td> <td data-bbox="1774 488 1885 565">88%</td> </tr> </table> <p>Facility analysis showed that functional status and the skills and supports sections are combined on the CIPRTA assessment. Understanding how to address this complex section will be a focus of mentoring during the next review period.</p> <p>Other findings: Record review of a random sample of Integrated Assessment-Rehabilitation Therapy section from January -May 2008 showed that 95% identified functional status and 78% identified skills and supports needed to transfer to the next level of care.</p> <p>Record review of Vocational Rehabilitation focused assessments from April-May 2008 showed that 75% identified functional status and 75% identified skills and supports needed to transfer to the next level of care.</p> <p>Record review of Speech Therapy focused assessments from April-May 2008 showed that 75% identified functional status and 100% identified skills and supports needed to transfer to the next level of care.</p> <p>Record review of Physical Therapy focused assessments from April-May 2008 showed that 80% identified functional status and 20%</p>	3.	<i>Identifies the individual's current functional status, and</i>	25%	4.	<i>The skills and supports needed to facilitate transfer to the next level of care</i>	88%
3.	<i>Identifies the individual's current functional status, and</i>	25%						
4.	<i>The skills and supports needed to facilitate transfer to the next level of care</i>	88%						

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		<p>identified skills and supports needed to transfer to the next level of care.</p> <p>Record review of Comprehensive Integrated Physical Rehabilitation Therapy focused assessments from April-May 2008 showed that 33% identified functional status and 100% identified skills and supports needed to transfer to the next level of care.</p> <p>Current recommendation: Ensure that all Rehabilitation Services admission and focused assessments identify the individual's current functional status and the skills and supports needed to facilitate transfer to the next level of care.</p>												
D.4.b.iii	Identifies the individual's life goals, strengths, and motivation for engaging in wellness activities.	<p>Current findings on previous recommendation: Ensure that all assessments identify the individual's life goals, strengths, and motivation for engaging in wellness activities.</p> <p>Findings: Using the DMH Integrated Assessment Rehabilitation Therapy Section Monitoring Tool, NSH assessed its compliance with D.4.b.iii based on an average sample of 100% of Integrated Assessment assessments due for each month for the review period of January -May 2008 (total of 176). The following outlines the indicators with corresponding mean compliance rates for January-May 2008:</p> <table border="1" data-bbox="989 1190 1887 1416"> <tr> <td data-bbox="989 1190 1087 1230">5.</td> <td data-bbox="1087 1190 1793 1230"><i>Identifies the individual's life goals,</i></td> <td data-bbox="1793 1190 1887 1230">99%</td> </tr> <tr> <td data-bbox="989 1230 1087 1271">6.</td> <td data-bbox="1087 1230 1793 1271"><i>Strengths, and:</i></td> <td data-bbox="1793 1230 1887 1271"></td> </tr> <tr> <td data-bbox="989 1271 1087 1344">6.a</td> <td data-bbox="1087 1271 1793 1344"><i>The individual's strengths for engaging in wellness activities are identified</i></td> <td data-bbox="1793 1271 1887 1344">93%</td> </tr> <tr> <td data-bbox="989 1344 1087 1416">6.b</td> <td data-bbox="1087 1344 1793 1416"><i>Strengths may include both direct quotes from the individual as well as the therapist's assessment of</i></td> <td data-bbox="1793 1344 1887 1416">89%</td> </tr> </table>	5.	<i>Identifies the individual's life goals,</i>	99%	6.	<i>Strengths, and:</i>		6.a	<i>The individual's strengths for engaging in wellness activities are identified</i>	93%	6.b	<i>Strengths may include both direct quotes from the individual as well as the therapist's assessment of</i>	89%
5.	<i>Identifies the individual's life goals,</i>	99%												
6.	<i>Strengths, and:</i>													
6.a	<i>The individual's strengths for engaging in wellness activities are identified</i>	93%												
6.b	<i>Strengths may include both direct quotes from the individual as well as the therapist's assessment of</i>	89%												

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			<i>the individual's strength</i>	
		7.	<i>Motivation for engaging in wellness activities</i>	
		7.a	<i>Individual's motivation for engaging in wellness activities are identified with individual's response to the following [required] questions</i>	78%
		7.b	<i>The individual's current level of motivation has been identified by considering the individual's stage of change, and:</i>	62%
		7.c	<i>Motivation may include both direct quotes from the individual as well as the therapist's assessment of the individual's motivation</i>	81%
		<p>The mean compliance rate for item # 5 the last review period was 98% compared to 99% in the current review period. The mean compliance rate has increased from the last month of the previous review period, December 2007, to the last month of this review period, May 2008 as follows: Item #6 from 79% to 81%, and Item #7 from 0% to 67%. According to facility analysis, item #6 will meet substantial compliance once staff includes the individual's direct quotes. Analysis of Item #7 showed that staff are identifying which current stage of change the individual is in, but not identifying the level of motivation (low, medium, or high).</p> <p>Using the DMH Vocational Rehabilitation Focused Assessment Tool, NSH assessed its compliance with D.4.biii based on an average sample of 100% of Vocational Rehabilitation Focused Assessments due for each month for the review period of April -May 2008 (total of 9). The following outlines the indicators with corresponding mean compliance rates for April-May 2008:</p>		
		5.	<i>Identifies the individual's life goals,</i>	100%
		6.	<i>Strengths, and:</i>	
		6.a	<i>The individual's strengths for engaging in wellness</i>	100%

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			<i>activities are identified</i>	
		6.b	<i>Strengths may include both direct quotes from the individual as well as the therapist's assessment of the individual's strength</i>	56%
		7.	<i>Motivation for engaging in wellness activities</i>	
		7.a	<i>Individual's motivation for engaging in wellness activities are identified with individual's response to the following [required] questions</i>	33%
		7.b	<i>The individual's current level of motivation has been identified by considering the individual's stage of change, and:</i>	0%
		7.c	<i>Motivation may include both direct quotes from the individual as well as the therapist's assessment of the individual's motivation</i>	33%
		<p>No facility analysis data was provided regarding low compliance rate with items #6 and #7 for Vocational Rehabilitation focused assessments.</p> <p>Using the DMH Speech Therapy Focused Assessment Tool, NSH assessed its compliance with D.4.biii based on an average sample of 100% of Speech Therapy Focused Assessments due for each month for the review period of April -May 2008 (total of 5). The following outlines the indicators with corresponding mean compliance rates for April-May 2008:</p>		
		5.	<i>Identifies the individual's life goals,</i>	
		5.a	<i>The individual's life goals are identified</i>	100%
		5.b	<i>Direct quotes in the individual's own words are used or if quotes are not used as a result of individual's non-verbal status it is stated as such</i>	80%
		6.	<i>Strengths, and:</i>	
		6.a	<i>The individual's strengths for engaging in wellness</i>	100%

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			<i>activities are identified</i>	
		6.b	<i>Strengths may include both direct quotes from the individual as well as the therapist's assessment of the individual's strength</i>	20%
		7.	<i>Motivation for engaging in wellness activities</i>	
		7.a	<i>Individual's motivation for engaging in wellness activities are identified with individual's response to the following [required] questions</i>	20%
		7.b	<i>The individual's current level of motivation has been identified by considering the individual's stage of change, and;</i>	100%
		7.c	<i>Motivation may include both direct quotes from the individual as well as the therapist's assessment of the individual's motivation</i>	80%
		<p>Facility analysis showed that for items #6 and #7 staff did not consistently include the individual's direct quotes.</p> <p>Using the DMH Physical Therapy Focused Assessment Tool, NSH assessed its compliance with D.4.biii based on an average sample of 100% of Physical Therapy Focused Assessments due for each month for the review period of April -May 2008 (total of 12). The following outlines the indicators with corresponding mean compliance rates for April-May 2008:</p>		
		5.	<i>Identifies the individual's life goals,</i>	
		5.a	<i>The individual's life goals are identified</i>	91%
		5.b	<i>Direct quotes in the individual's own words are used or if quotes are not used as a result of individual's non-verbal status it is stated as such</i>	73%
		6.	<i>Strengths, and;</i>	
		6.a	<i>The individual's strengths for engaging in wellness activities are identified</i>	82%

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		6.b	<i>Strengths may include both direct quotes from the individual as well as the therapist's assessment of the individual's strength</i>	0%
		7.	<i>Motivation for engaging in wellness activities</i>	
		7.a	<i>Individual's motivation for engaging in wellness activities are identified with individual's response to the following [required] questions</i>	0%
		7.b	<i>The individual's current level of motivation has been identified by considering the individual's stage of change, and;</i>	0%
		7.c	<i>Motivation may include both direct quotes from the individual as well as the therapist's assessment of the individual's motivation</i>	9%
		<p>Facility analysis showed that for items #5, #6, #7 staff has not included the individual's direct quotes, and minimal training for POST team members in identifying stages of change may have contributed to the low compliance with #7.</p>		
		<p>Using the DMH Comprehensive Integrated Physical Rehabilitation Therapy Focused Assessment Tool, NSH assessed its compliance with D.4.biii based on an average sample of 100% of CIPRTA Focused Assessments due for each month for the review period of April -May 2008 (total of 8). The following outlines the indicators with corresponding mean compliance rates for April-May 2008:</p>		
		5.	<i>Identifies the individual's life goals,</i>	100%
		6.	<i>Strengths, and:</i>	
		6.a	<i>The individual's strengths for engaging in wellness activities are identified</i>	100%
		6.b	<i>Strengths may include both direct quotes from the individual as well as the therapist's assessment of the individual's strength</i>	88%

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		<table border="1"> <tr> <td data-bbox="989 191 1087 228">7.</td> <td data-bbox="1087 191 1793 228"><i>Motivation for engaging in wellness activities</i></td> <td data-bbox="1793 191 1881 228"></td> </tr> <tr> <td data-bbox="989 228 1087 342">7.a</td> <td data-bbox="1087 228 1793 342"><i>Individual's motivation for engaging in wellness activities are identified with individual's response to the following [required] questions</i></td> <td data-bbox="1793 228 1881 342">75%</td> </tr> <tr> <td data-bbox="989 342 1087 456">7.b</td> <td data-bbox="1087 342 1793 456"><i>The individual's current level of motivation has been identified by considering the individual's stage of change, and;</i></td> <td data-bbox="1793 342 1881 456">63%</td> </tr> <tr> <td data-bbox="989 456 1087 565">7.c</td> <td data-bbox="1087 456 1793 565"><i>Motivation may include both direct quotes from the individual as well as the therapist's assessment of the individual's motivation</i></td> <td data-bbox="1793 456 1881 565">75%</td> </tr> </table>	7.	<i>Motivation for engaging in wellness activities</i>		7.a	<i>Individual's motivation for engaging in wellness activities are identified with individual's response to the following [required] questions</i>	75%	7.b	<i>The individual's current level of motivation has been identified by considering the individual's stage of change, and;</i>	63%	7.c	<i>Motivation may include both direct quotes from the individual as well as the therapist's assessment of the individual's motivation</i>	75%	<p>Facility analysis showed that for items #5, #6, #7 staff has not included the individual's direct quotes, and minimal training for POST team members in identifying stages of change may have contributed to the low compliance with #7.</p> <p>Other findings: Record review of a random sample of Integrated Assessment-Rehabilitation Therapy section from January -May 2008 showed that 89% identified strengths, 100% identified life goals, and 33% identified motivation for engaging in wellness activities.</p> <p>Record review of Vocational Rehabilitation focused assessments from April-May 2008 showed that 25% identified strengths, 100% identified life goals, and 25% identified motivation for engaging in wellness activities.</p> <p>Record review of Speech Therapy focused assessments from April-May 2008 showed that 50% identified strengths, 75% identified life goals, and 0% identified motivation for engaging in wellness activities.</p> <p>Record review of Physical Therapy focused assessments from April-May 2008 showed that 40% identified strengths, 60% identified life</p>
7.	<i>Motivation for engaging in wellness activities</i>														
7.a	<i>Individual's motivation for engaging in wellness activities are identified with individual's response to the following [required] questions</i>	75%													
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7.c	<i>Motivation may include both direct quotes from the individual as well as the therapist's assessment of the individual's motivation</i>	75%													

Section D: Integrated Assessments

		<p>goals, and 0% identified motivation for engaging in wellness activities.</p> <p>Record review of Comprehensive Integrated Physical Rehabilitation Therapy focused assessments from April-May 2008 showed that 83% identified strengths, 100% identified life goals, and 67% identified motivation for engaging in wellness activities.</p> <p>Current recommendation: Ensure that all Rehabilitation Services admission and focused assessments identify the individual's life goals, strengths, and motivation for engaging in wellness activities.</p>
D.4.c	<p>Each State hospital shall ensure that all clinicians responsible for performing or reviewing rehabilitation therapy assessments are verifiably competent in performing the assessments for which they are responsible</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, January 2008: Ensure that individuals who are performing assessments have received competency-based training regarding these assessments, and have achieved competency per protocol.</p> <p>Findings: According to facility report, 93% (54/58) of all Wellness and Recovery Plan Team Rehabilitation Therapists have received competency-based training on the Integrated Assessment: Rehabilitation Therapy Section, and 94% (51/54) of staff trained have been trained to competency. This is verified by review of raw data from training rosters and training quizzes.</p> <p>All Vocational Rehabilitation staff members who are performing Vocational Rehabilitation assessments (10/10) received competency-based training on the Vocational Rehabilitation Assessment on 03/26/08 and were trained to competency. This is verified by review of raw data from training rosters and training quizzes.</p>

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		<p>All Physical Therapy staff members who are performing Vocational Rehabilitation assessments (2/2) received competency-based training on the Physical Therapy focused assessment on 4/30/08 and were trained to competency. This is verified by review of raw data from training rosters and training quizzes.</p> <p>All Occupational Therapy staff members who are performing Occupational Therapy assessments (3/3) received competency-based training on the Occupational Therapy focused assessment on 4/30/08 and were trained to competency. This is verified by review of raw data from training rosters and training quizzes.</p> <p>All Speech Therapy staff members who are performing Speech Therapy assessments (3/3) received competency-based training on the Speech Therapy focused assessment on 4/30/08 and were trained to competency. This is verified by review of raw data from training rosters and training quizzes.</p> <p>All POST team members who are performing Comprehensive Integrated Physical Rehabilitation Therapy assessments (6/6) received competency-based training on the Comprehensive Integrated Physical Rehabilitation Therapy focused assessment on 4/30/08 and were trained to competency. This is verified by review of raw data from training rosters and training quizzes.</p> <p>Recommendation 2, January 2008: Establish inter-rater reliability prior to the implementation of Rehabilitation Therapy audit tools.</p> <p>Findings: Inter-rater agreement for MH-C 9044a DMH Integrated Assessment: Rehabilitation Therapy Section Monitoring Form has been established. Overall mean reliability is 92%, with a range of 86%-100%.</p>
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		<p>Inter-rater agreement for MH-C 9044b DMH Comprehensive Integrated Physical Rehabilitation Therapy Assessment Monitoring Form has been established. Overall mean reliability is 91%, with a range of 89%-94%.</p> <p>Inter-rater agreement for MH-C 9044d DMH Physical Therapy Assessment Monitoring Form has been established. Overall mean reliability is 91%, with a range of 86%-95%.</p> <p>Inter-rater agreement for MH-C 9044e DMH Speech-Language Pathology Assessment Monitoring Form has been established. Overall mean reliability is 96%, with a range of 94%-100%.</p> <p>Inter-rater agreement for MH-C 9044f DMH Vocational Rehabilitation Assessment Monitoring Form has been established. Overall mean reliability is 96%, with a range of 89%-100%.</p> <p>Inter-rater agreement for MH-C 9044c DMH Occupational Therapy Assessment Monitoring Form has not been established as there were no assessments completed during this review period. Inter-rater agreement will be established upon the completion of these assessments.</p> <p>Recommendation 3, January 2008: Develop and implement a system by which to analyze audit data for focused assessments (Vocational Rehabilitation, Occupational, Physical, and Speech Therapy assessments and Comprehensive Physical Rehabilitation assessments) and provide feedback to staff regarding performance improvement and recommendations for training/CEU courses based on these findings.</p>
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		<p>Findings: According to facility report, a system to analyze audit data, provide feedback, and recommend further training has been developed and was implemented on 05/01/08. This is verified by review of presented data analysis for all data items related to D.4.bi, D.4.bii, and D.4.biii except the D.4.b.iii section of Vocational Rehabilitation Focused Assessment Monitoring Tool.</p> <p>Recommendation 4, January 2008: Develop and implement a system to recommend training CEU courses based on findings of audit data, and track CEU courses attended by Rehabilitation Therapy staff.</p> <p>Findings: A system to recommend training/CEU courses and track Rehabilitation Therapy staff attendance was developed on 05/01/08 and will be implemented as trends are identified.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
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 recommendation:</p> <p>Recommendation, January 2008: Ensure that all individuals admitted to NSH prior to June 1, 2006 receive an Integrated Assessment-Rehabilitation Therapy Section Assessment within the next twelve months.</p> <p>Findings: The list for individuals admitted prior to 6/01/06 requiring type D4.d</p>

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		<p>assessments is generated by Standards and Compliance. The facility reports the following barriers to tracking these individuals and ensuring that assessments are completed as indicated: when an individual is discharged from the hospital, their name must be removed from the list; and when an individual is transferred from unit to unit, it becomes difficult to track which Rehabilitation Therapist is responsible for completing the assessment. These barriers require that the list is continually updated on a monthly basis.</p> <p>For all individuals who require a type D.4.d assessment, the individual's anniversary date is used as a guideline to schedule the D.4.d Integrated Assessment Rehabilitation Therapy Section assessment. The facility list of completed assessments came from audit data based on admission anniversary dates, and therapist self report.</p> <p>According to facility report, 122 out of 642 type D.4.d assessments were completed during the January-May 2008 review period.</p> <p>Other findings: Upon review of a sample of type D4.d assessments selected from the facility list of completed type D.4.d. assessments, it was noted that only 69% of assessments reported as completed were actually completed.</p> <p>Record review of a sample of completed D.4.d. assessments showed that 100% were comprehensive; 100% addressed functional abilities; 89% identified functional status; 22% identified skills and supports needed to transfer to the next level of care; 100% identified life goals; 33% identified strengths; and 0% identified motivation for engaging in wellness activities.</p> <p>Compliance: Partial.</p>
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Section D: Integrated Assessments

		<p>Current recommendation: Ensure that all individuals admitted to NSH prior to June 1, 2006 receive an Integrated Assessment-Rehabilitation Therapy Section Assessment within the next twelve months.</p>
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Section D: Integrated Assessments

5. Nutrition Assessments		
D.5	<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. Craig Saewong, Acting Assistant Director of Dietetics 2. Heidi Vogelsang, Registered Dietitian 3. Lynn Wurzel, Registered Dietitian 4. Noriko Takenawa, Registered Dietitian 5. Wen Pao, Director of Dietetics <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Nutrition Care Monitoring audit data for January-May 2008 for each assessment type 2. Lists of individuals with Nutrition Care Assessments due from January-May 2008 for each assessment type 3. Record for the following six individuals with type D.5.a assessment from January-May 2008: CH, DDM, DEA, EL, FT and TLN 4. Records for the following three individuals with type D.5.b assessments from January-May 2008: AA, AMW and HCH 5. Records for the following three individuals with type D.5.d assessments from January-May 2008: CO, RG and SM 6. Records for the following five individuals with type D.5.e assessments from January-May 2008: BJ, ELC, JM, MP and VZ 7. Records for the following five individuals with type D.5.f assessments from January-May 2008: AB, DSH, FCP, PMN and RD 8. Records for the following 11 individuals with type D.5.g assessments from January-May 2008: AE, ATB, EE, EPR, JA, JEG, JS, LF, LGB, RTP and SN 9. Records for the following 17 individuals with type D.5.i assessments from January-May 2008: AT, BMC, CH, CH-2, DC, EH, ELH, JD, JVM, KFR, KH, KJN, LG, MO, MS, MWS and RH 10. Records for the following 13 individuals with type D.5.j.i assessments from January-May 2008: AC, AGV, CA, CWP, EL,

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		<p>JWM, LDC, RGW, RH, RM, RZ, SS and TR</p> <p>11. Records for the following 13 individuals with type D.5.j.ii assessments from January-May 2008: ALW, AP, AS, CC, DMP, DP, GH, MD, MDC, MS, RB, RL and THE</p> <p>12. DMH Nutrition Status Type definitions</p>																											
<p>D.5.a</p>	<p>For new admissions with high risk referral (e.g., type I diabetes mellitus, enteral/parenteral feeding, dysphagia/recent choking episode), or upon request by physician, a comprehensive Admission Nutrition Assessment will be completed within 24 hours of notification to the dietitian.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: Continue current practice.</p> <p>Findings: Using the DMH Nutrition Care Monitoring Tool, NSH assessed its compliance based on an average sample of 100% of Nutrition Type D.5.a Assessments due for each month for the review period of January - May 2008 (total of 6). The following outlines the indicators with corresponding mean compliance rates for January-May 2008:</p> <table border="1" data-bbox="991 857 1890 1424"> <tr> <td>1.</td> <td><i>Assessment is completed on time per policy</i></td> <td>50%</td> </tr> <tr> <td>2.</td> <td><i>All required subjective concerns are addressed</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>All pertinent objective nutrition information is accurately addressed</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>Estimated daily needs for nutrients specified are appropriate</i></td> <td>100%</td> </tr> <tr> <td>5.</td> <td><i>Assessment utilizes findings from subjective and objective data</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Nutrition diagnosis is correctly formulated, prioritized and validated</i></td> <td>83%</td> </tr> <tr> <td>7.</td> <td><i>Nutrition education is documented</i></td> <td>75%</td> </tr> <tr> <td>8.</td> <td><i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i></td> <td>50%</td> </tr> <tr> <td>9.</td> <td><i>Progress is monitored, measured, and evaluated</i></td> <td>n/a</td> </tr> </table>	1.	<i>Assessment is completed on time per policy</i>	50%	2.	<i>All required subjective concerns are addressed</i>	100%	3.	<i>All pertinent objective nutrition information is accurately addressed</i>	100%	4.	<i>Estimated daily needs for nutrients specified are appropriate</i>	100%	5.	<i>Assessment utilizes findings from subjective and objective data</i>	100%	6.	<i>Nutrition diagnosis is correctly formulated, prioritized and validated</i>	83%	7.	<i>Nutrition education is documented</i>	75%	8.	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i>	50%	9.	<i>Progress is monitored, measured, and evaluated</i>	n/a
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Section D: Integrated Assessments

		<table border="1"> <tr> <td>10.</td> <td><i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i></td> <td>100%</td> </tr> <tr> <td>11.</td> <td><i>Recommendations are appropriate and complete</i></td> <td>100%</td> </tr> <tr> <td>12.</td> <td><i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i></td> <td>83%</td> </tr> <tr> <td>13.</td> <td><i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i></td> <td>67%</td> </tr> <tr> <td>14.</td> <td><i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i></td> <td>n/a</td> </tr> <tr> <td>15.</td> <td><i>Assessment utilizes approved abbreviations</i></td> <td>100%</td> </tr> <tr> <td>16.</td> <td><i>Assessment is concise</i></td> <td>100%</td> </tr> <tr> <td>17.</td> <td><i>Assessment is legible</i></td> <td>100%</td> </tr> <tr> <td>18.</td> <td><i>Each page of the assessment is signed</i></td> <td>100%</td> </tr> </table>	10.	<i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i>	100%	11.	<i>Recommendations are appropriate and complete</i>	100%	12.	<i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i>	83%	13.	<i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i>	67%	14.	<i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i>	n/a	15.	<i>Assessment utilizes approved abbreviations</i>	100%	16.	<i>Assessment is concise</i>	100%	17.	<i>Assessment is legible</i>	100%	18.	<i>Each page of the assessment is signed</i>	100%	<p>According to facility data analysis, timeliness is below substantial compliance due to delayed referrals by Nursing staff for 24 hour high risk referrals. The Dietetics Department continues to provide training for new nursing staff during orientation on the nutrition high-risk referral procedure, though no additional training has been provided.</p> <p>Other findings: Record review of sample of individuals requiring Nutrition Type D.5.a assessments during the January-May 2008 review period indicated that 33% of assessments were completed on time, 100% had complete subjective findings, 100% had complete pertinent objective findings, 100% had correctly formulated nutrition diagnosis, 100% had individualized and measurable goals, and 100% had appropriate recommendations.</p> <p>Compliance: Partial.</p>
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		<p>Current recommendation: Continue current efforts to achieve compliance.</p>																																	
D.5.b	<p>For new admissions directly into the medical-surgical unit, a comprehensive Admission Nutrition Assessment will be completed within 3 days of admission.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: Continue current practice.</p> <p>Findings: Using the DMH Nutrition Care Monitoring Tool, NSH assessed its compliance based on an average sample of 100% of Nutrition Type D5b. Assessments due for each month for the review period of January - May 2008 (total of 3). The following outlines the indicators with corresponding mean compliance rates for January-May 2008:</p> <table border="1" data-bbox="991 748 1885 1427"> <tr> <td>1.</td> <td><i>Assessment is completed on time per policy</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>All required subjective concerns are addressed</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>All pertinent objective nutrition information is accurately addressed</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>Estimated daily needs for nutrients specified are appropriate</i></td> <td>100%</td> </tr> <tr> <td>5.</td> <td><i>Assessment utilizes findings from subjective and objective data</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Nutrition diagnosis is correctly formulated, prioritized and validated</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Nutrition education is documented</i></td> <td>100%</td> </tr> <tr> <td>8.</td> <td><i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i></td> <td>100%</td> </tr> <tr> <td>9.</td> <td><i>Progress is monitored, measured, and evaluated</i></td> <td>n/a</td> </tr> <tr> <td>10.</td> <td><i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i></td> <td>100%</td> </tr> <tr> <td>11.</td> <td><i>Recommendations are appropriate and complete</i></td> <td>50%</td> </tr> </table>	1.	<i>Assessment is completed on time per policy</i>	100%	2.	<i>All required subjective concerns are addressed</i>	100%	3.	<i>All pertinent objective nutrition information is accurately addressed</i>	100%	4.	<i>Estimated daily needs for nutrients specified are appropriate</i>	100%	5.	<i>Assessment utilizes findings from subjective and objective data</i>	100%	6.	<i>Nutrition diagnosis is correctly formulated, prioritized and validated</i>	100%	7.	<i>Nutrition education is documented</i>	100%	8.	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i>	100%	9.	<i>Progress is monitored, measured, and evaluated</i>	n/a	10.	<i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i>	100%	11.	<i>Recommendations are appropriate and complete</i>	50%
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D.5.c	For new admissions directly into the skilled nursing facility unit, a comprehensive Admission Nutrition Assessment will be completed within 7 days of admission.	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: Continue current practice.</p>																					

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		<p>Findings: No individuals met the criteria to receive a Nutrition Type D5.c assessment during the January-May 2008 review period. There was one individual admitted to the SNF unit in 4/08, but this assessment was classified as a 24 hour high risk assessment (Type D5a).</p> <p>Compliance: Unable to determine compliance.</p> <p>Current recommendation: Continue current efforts to achieve compliance.</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 diarrhea/vomiting more than 24hrs, and MAOI, as clinically indicated), a comprehensive Admission Nutrition Assessment will be completed within 7 days of admission.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: Continue current practice.</p> <p>Findings: Using the DMH Nutrition Care Monitoring Tool, NSH assessed its compliance based on an average sample of 100% of Nutrition Type D5d. Assessments due for each month for the review period of January - May 2008 (total of 5). The following outlines the indicators with corresponding mean compliance rates for January-May 2008:</p> <table border="1" data-bbox="989 1117 1887 1421"> <tr> <td>1.</td> <td><i>Assessment is completed on time per policy</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>All required subjective concerns are addressed</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>All pertinent objective nutrition information is accurately addressed</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>Estimated daily needs for nutrients specified are appropriate</i></td> <td>100%</td> </tr> <tr> <td>5.</td> <td><i>Assessment utilizes findings from subjective and objective data</i></td> <td>100%</td> </tr> </table>	1.	<i>Assessment is completed on time per policy</i>	100%	2.	<i>All required subjective concerns are addressed</i>	100%	3.	<i>All pertinent objective nutrition information is accurately addressed</i>	100%	4.	<i>Estimated daily needs for nutrients specified are appropriate</i>	100%	5.	<i>Assessment utilizes findings from subjective and objective data</i>	100%
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5.	<i>Assessment utilizes findings from subjective and objective data</i>	100%															

Section D: Integrated Assessments

		6.	<i>Nutrition diagnosis is correctly formulated, prioritized and validated</i>	100%
		7.	<i>Nutrition education is documented</i>	100%
		8.	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i>	100%
		9.	<i>Progress is monitored, measured, and evaluated</i>	n/a
		10.	<i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i>	80%
		11.	<i>Recommendations are appropriate and complete</i>	40%
		12.	<i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i>	100%
		13.	<i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i>	100%
		14.	<i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i>	100%
		15.	<i>Assessment utilizes approved abbreviations</i>	100%
		16.	<i>Assessment is concise</i>	100%
		17.	<i>Assessment is legible</i>	100%
		18.	<i>Each page of the assessment is signed</i>	100%
		<p>No facility data analysis was provided regarding type D.5.d Nutrition Assessments.</p> <p>Other findings: Record review of a sample of individuals requiring Nutrition Type D.5.d assessments during the January-May 2008 review period indicated that 100% of assessments were completed on time, 100% had complete subjective findings, 100% had complete pertinent objective findings, 100% had correctly formulated nutrition diagnosis, 100% had individualized and measurable goals, and 100% had appropriate recommendations.</p>		

Section D: Integrated Assessments

		<p>Compliance: Partial.</p> <p>Current recommendation: Continue current efforts to achieve compliance.</p>																											
D.5.e	<p>For new admissions with therapeutic diet orders for medical reasons, a comprehensive Admission Nutrition Assessment will be completed within 7 days of admission.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: Continue current practice.</p> <p>Findings: Using the DMH Nutrition Care Monitoring Tool, NSH assessed its compliance based on an average sample of 100% of Nutrition Type D5e. Assessments due for each month for the review period of January - May 2008 (total of 39). The following outlines the indicators with corresponding mean compliance rates for January-May 2008:</p> <table border="1" data-bbox="991 857 1890 1424"> <tr> <td>1.</td> <td><i>Assessment is completed on time per policy</i></td> <td>80%</td> </tr> <tr> <td>2.</td> <td><i>All required subjective concerns are addressed</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>All pertinent objective nutrition information is accurately addressed</i></td> <td>97%</td> </tr> <tr> <td>4.</td> <td><i>Estimated daily needs for nutrients specified are appropriate</i></td> <td>97%</td> </tr> <tr> <td>5.</td> <td><i>Assessment utilizes findings from subjective and objective data</i></td> <td>97%</td> </tr> <tr> <td>6.</td> <td><i>Nutrition diagnosis is correctly formulated, prioritized and validated</i></td> <td>91%</td> </tr> <tr> <td>7.</td> <td><i>Nutrition education is documented</i></td> <td>100%</td> </tr> <tr> <td>8.</td> <td><i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i></td> <td>100%</td> </tr> <tr> <td>9.</td> <td><i>Progress is monitored, measured, and evaluated</i></td> <td>n/a</td> </tr> </table>	1.	<i>Assessment is completed on time per policy</i>	80%	2.	<i>All required subjective concerns are addressed</i>	100%	3.	<i>All pertinent objective nutrition information is accurately addressed</i>	97%	4.	<i>Estimated daily needs for nutrients specified are appropriate</i>	97%	5.	<i>Assessment utilizes findings from subjective and objective data</i>	97%	6.	<i>Nutrition diagnosis is correctly formulated, prioritized and validated</i>	91%	7.	<i>Nutrition education is documented</i>	100%	8.	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i>	100%	9.	<i>Progress is monitored, measured, and evaluated</i>	n/a
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Section D: Integrated Assessments

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		<p>According to facility analysis, timeliness was below 90% compliance due to misunderstanding of required completion date for D.5.e. Training was provided to ensure future assessments were completed in a timely manner. In addition, the facility reports that quality is inconsistent due to change of staff.</p> <p>Other findings: Record review of a sample of individuals requiring Nutrition Type D.5.e assessments during the January-May 2008 review period indicated that 60% of assessments were completed on time, 100% had complete subjective findings, 100% had complete pertinent objective findings, 100% had correctly formulated nutrition diagnosis, 100% had individualized and measurable goals, and 100% had appropriate recommendations.</p> <p>Compliance: Partial.</p>																												

Section D: Integrated Assessments

		<p>Current recommendation: Continue current efforts to achieve compliance.</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 7 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, January 2008: Continue current practice.</p> <p>Findings: Using the DMH Nutrition Care Monitoring Tool, NSH assessed its compliance based on an average sample of 100% of Nutrition Type D5f. Assessments due for each month for the review period of January - May 2008 (total of 11). The following outlines the indicators with corresponding mean compliance rates for January-May 2008:</p> <table border="1" data-bbox="993 748 1890 1427"> <tr> <td>1.</td> <td><i>Assessment is completed on time per policy</i></td> <td>91%</td> </tr> <tr> <td>2.</td> <td><i>All required subjective concerns are addressed</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>All pertinent objective nutrition information is accurately addressed</i></td> <td>91%</td> </tr> <tr> <td>4.</td> <td><i>Estimated daily needs for nutrients specified are appropriate</i></td> <td>100%</td> </tr> <tr> <td>5.</td> <td><i>Assessment utilizes findings from subjective and objective data</i></td> <td>82%</td> </tr> <tr> <td>6.</td> <td><i>Nutrition diagnosis is correctly formulated, prioritized and validated</i></td> <td>90%</td> </tr> <tr> <td>7.</td> <td><i>Nutrition education is documented</i></td> <td>89%</td> </tr> <tr> <td>8.</td> <td><i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i></td> <td>78%</td> </tr> <tr> <td>9.</td> <td><i>Progress is monitored, measured, and evaluated</i></td> <td>n/a</td> </tr> <tr> <td>10.</td> <td><i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i></td> <td>90%</td> </tr> <tr> <td>11.</td> <td><i>Recommendations are appropriate and complete</i></td> <td>91%</td> </tr> </table>	1.	<i>Assessment is completed on time per policy</i>	91%	2.	<i>All required subjective concerns are addressed</i>	100%	3.	<i>All pertinent objective nutrition information is accurately addressed</i>	91%	4.	<i>Estimated daily needs for nutrients specified are appropriate</i>	100%	5.	<i>Assessment utilizes findings from subjective and objective data</i>	82%	6.	<i>Nutrition diagnosis is correctly formulated, prioritized and validated</i>	90%	7.	<i>Nutrition education is documented</i>	89%	8.	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i>	78%	9.	<i>Progress is monitored, measured, and evaluated</i>	n/a	10.	<i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i>	90%	11.	<i>Recommendations are appropriate and complete</i>	91%
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Section D: Integrated Assessments

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Section D: Integrated Assessments

		<p>Compliance: Partial.</p> <p>Current recommendation: Continue current efforts to achieve compliance.</p>																											
D.5.g	<p>For all other individuals, a comprehensive Admission Nutrition Assessment will be completed within 30 days of admission.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: Continue current practice.</p> <p>Findings: Using the DMH Nutrition Care Monitoring Tool, NSH assessed its compliance based on an average sample of 100% of Nutrition Type D5g. Assessments due for each month for the review period of January - May 2008 (total of 118). The following outlines the indicators with corresponding mean compliance rates for January-May 2008:</p> <table border="1" data-bbox="989 857 1890 1424"> <tr> <td>1.</td> <td><i>Assessment is completed on time per policy</i></td> <td>94%</td> </tr> <tr> <td>2.</td> <td><i>All required subjective concerns are addressed</i></td> <td>96%</td> </tr> <tr> <td>3.</td> <td><i>All pertinent objective nutrition information is accurately addressed</i></td> <td>97%</td> </tr> <tr> <td>4.</td> <td><i>Estimated daily needs for nutrients specified are appropriate</i></td> <td>99%</td> </tr> <tr> <td>5.</td> <td><i>Assessment utilizes findings from subjective and objective data</i></td> <td>96%</td> </tr> <tr> <td>6.</td> <td><i>Nutrition diagnosis is correctly formulated, prioritized and validated</i></td> <td>89%</td> </tr> <tr> <td>7.</td> <td><i>Nutrition education is documented</i></td> <td>98%</td> </tr> <tr> <td>8.</td> <td><i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i></td> <td>96%</td> </tr> <tr> <td>9.</td> <td><i>Progress is monitored, measured, and evaluated</i></td> <td>n/a</td> </tr> </table>	1.	<i>Assessment is completed on time per policy</i>	94%	2.	<i>All required subjective concerns are addressed</i>	96%	3.	<i>All pertinent objective nutrition information is accurately addressed</i>	97%	4.	<i>Estimated daily needs for nutrients specified are appropriate</i>	99%	5.	<i>Assessment utilizes findings from subjective and objective data</i>	96%	6.	<i>Nutrition diagnosis is correctly formulated, prioritized and validated</i>	89%	7.	<i>Nutrition education is documented</i>	98%	8.	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i>	96%	9.	<i>Progress is monitored, measured, and evaluated</i>	n/a
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Section D: Integrated Assessments

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Section D: Integrated Assessments

<p>D.5.h</p>	<p>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>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: Continue current practice.</p> <p>Findings: Using the DMH Nutrition Care Monitoring Tool, NSH assessed its compliance based on an average sample of 16% of Nutrition Assessments (all types) due each month for the review period of January -May 2008 (total of 1849). Based on this data, the facility reports that 94% (weighted mean) of Nutrition assessments had evidence of a correctly assigned NST level.</p> <p>Other findings: Record review of a random sample of completed Nutrition Care assessments across assessment subtypes (out of a total of 62 reviewed) indicated that an average (weighted mean) of 100% of assessments audited had evidence of a correctly assigned NST level.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
<p>D.5.i</p>	<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</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: Continue current practice.</p> <p>Findings: Using the DMH Nutrition Care Monitoring Tool, NSH assessed its compliance based on an average sample of 5% of Nutrition Type D5i.</p>

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	<p>goals/objectives, effectiveness of interventions, changes in goals/plan, recommendations, and follow-up as needed.</p>	<p>Assessments due for each month for the review period of January - May 2008 (total of 1112). The following outlines the indicators with corresponding mean compliance rates for January-May 2008:</p> <table border="1"> <tr> <td>1.</td> <td><i>Assessment is completed on time per policy</i></td> <td>83%</td> </tr> <tr> <td>2.</td> <td><i>All required subjective concerns are addressed</i></td> <td>98%</td> </tr> <tr> <td>3.</td> <td><i>All pertinent objective nutrition information is accurately addressed</i></td> <td>96%</td> </tr> <tr> <td>4.</td> <td><i>Estimated daily needs for nutrients specified are appropriate</i></td> <td>78%</td> </tr> <tr> <td>5.</td> <td><i>Assessment utilizes findings from subjective and objective data</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Nutrition diagnosis is correctly formulated, prioritized and validated</i></td> <td>96%</td> </tr> <tr> <td>7.</td> <td><i>Nutrition education is documented</i></td> <td>82%</td> </tr> <tr> <td>8.</td> <td><i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i></td> <td>100%</td> </tr> <tr> <td>9.</td> <td><i>Progress is monitored, measured, and evaluated</i></td> <td>98%</td> </tr> <tr> <td>10.</td> <td><i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i></td> <td>100%</td> </tr> <tr> <td>11.</td> <td><i>Recommendations are appropriate and complete</i></td> <td>100%</td> </tr> <tr> <td>12.</td> <td><i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i></td> <td>100%</td> </tr> <tr> <td>13.</td> <td><i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i></td> <td>100%</td> </tr> <tr> <td>14.</td> <td><i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i></td> <td>75%</td> </tr> <tr> <td>15.</td> <td><i>Assessment utilizes approved abbreviations</i></td> <td>98%</td> </tr> <tr> <td>16.</td> <td><i>Assessment is concise</i></td> <td>100%</td> </tr> <tr> <td>17.</td> <td><i>Assessment is legible</i></td> <td>100%</td> </tr> <tr> <td>18.</td> <td><i>Each page of the assessment is signed</i></td> <td>100%</td> </tr> </table>	1.	<i>Assessment is completed on time per policy</i>	83%	2.	<i>All required subjective concerns are addressed</i>	98%	3.	<i>All pertinent objective nutrition information is accurately addressed</i>	96%	4.	<i>Estimated daily needs for nutrients specified are appropriate</i>	78%	5.	<i>Assessment utilizes findings from subjective and objective data</i>	100%	6.	<i>Nutrition diagnosis is correctly formulated, prioritized and validated</i>	96%	7.	<i>Nutrition education is documented</i>	82%	8.	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i>	100%	9.	<i>Progress is monitored, measured, and evaluated</i>	98%	10.	<i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i>	100%	11.	<i>Recommendations are appropriate and complete</i>	100%	12.	<i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i>	100%	13.	<i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i>	100%	14.	<i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i>	75%	15.	<i>Assessment utilizes approved abbreviations</i>	98%	16.	<i>Assessment is concise</i>	100%	17.	<i>Assessment is legible</i>	100%	18.	<i>Each page of the assessment is signed</i>	100%
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		<p>According to facility analysis, timeliness is below 90% compliance due to on-going Clinical Dietitian vacancies (57% vacancy rate).</p> <p>Other findings: Record review of sample of individuals requiring Nutrition Type D.5.i assessments during the January-May 2008 review period indicated that 39% of assessments were completed on time, 100% had complete subjective findings, 86% had complete pertinent objective findings, 100% had correctly formulated nutrition diagnosis, 100% had individualized and measurable goals, and 100% had appropriate recommendations.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Continue current efforts to achieve compliance.</p>						
D.5.j.i	Individuals will be reassessed when there is a significant change in condition.	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: Continue current practice.</p> <p>Findings: Using the DMH Nutrition Care Monitoring Tool, NSH assessed its compliance based on an average sample of 8% of Nutrition Type D5j.i. Assessments due for each month for the review period of January - May 2008 (total of 236). The following outlines the indicators with corresponding mean compliance rates for January-May 2008:</p> <table border="1" data-bbox="991 1339 1890 1416"> <tr> <td data-bbox="991 1339 1087 1377">1.</td> <td data-bbox="1087 1339 1793 1377"><i>Assessment is completed on time per policy</i></td> <td data-bbox="1793 1339 1890 1377">90%</td> </tr> <tr> <td data-bbox="991 1377 1087 1416">2.</td> <td data-bbox="1087 1377 1793 1416"><i>All required subjective concerns are addressed</i></td> <td data-bbox="1793 1377 1890 1416">95%</td> </tr> </table>	1.	<i>Assessment is completed on time per policy</i>	90%	2.	<i>All required subjective concerns are addressed</i>	95%
1.	<i>Assessment is completed on time per policy</i>	90%						
2.	<i>All required subjective concerns are addressed</i>	95%						

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		3.	<i>All pertinent objective nutrition information is accurately addressed</i>	100%
		4.	<i>Estimated daily needs for nutrients specified are appropriate</i>	88%
		5.	<i>Assessment utilizes findings from subjective and objective data</i>	100%
		6.	<i>Nutrition diagnosis is correctly formulated, prioritized and validated</i>	100%
		7.	<i>Nutrition education is documented</i>	91%
		8.	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i>	92%
		9.	<i>Progress is monitored, measured, and evaluated</i>	100%
		10.	<i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i>	92%
		11.	<i>Recommendations are appropriate and complete</i>	100%
		12.	<i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i>	100%
		13.	<i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i>	100%
		14.	<i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i>	100%
		15.	<i>Assessment utilizes approved abbreviations</i>	100%
		16.	<i>Assessment is concise</i>	100%
		17.	<i>Assessment is legible</i>	100%
		18.	<i>Each page of the assessment is signed</i>	100%
		<p>No facility data analysis was provided regarding type D.5.j.i Nutrition Assessments.</p> <p>Other findings: Following chart review and interview, it was noted that the data for</p>		

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		<p>total number of type D.5.j.i assessments due each month does not seem to be valid. This is due to the lack of a formal system for logging in referrals and consultations. Currently, the total N is dependent upon Dietitian report of completion of a referral, rather than the total number of referrals received by the department.</p> <p>Record review of sample of individuals requiring Nutrition Type D5.j.i assessments during the January-May 2008 review period indicated that 75% of assessments were completed on time, 100% had complete subjective findings, 100% had complete pertinent objective findings, 100% had correctly formulated nutrition diagnosis, 100% had individualized and measurable goals, and 100% had appropriate recommendations.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue current efforts to achieve compliance. 2. Develop and implement a system to record the number of referrals received and due for each month.
D.5.j.ii	Every individual will be assessed annually.	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: Continue current practice.</p> <p>Findings: Using the DMH Nutrition Care Monitoring Tool, NSH assessed its compliance based on an average sample of 11% of Nutrition Type D.5.j.ii Assessments due for each month for the review period of January - May 2008 (total of 377). The following outlines the indicators with corresponding mean compliance rates for January-May 2008:</p>

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		<p>Other findings: Record review of sample of individuals requiring Nutrition Type D.5.j.ii assessments during the January-May 2008 review period indicated that 86% of assessments were completed on time, 100% had complete subjective findings, 100% had complete pertinent objective findings, 82% had correctly formulated nutrition diagnosis, 100% had individualized and measurable goals, and 82% had appropriate recommendations.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Continue current efforts to achieve compliance.</p>
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Section D: Integrated Assessments

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. Carmen Caruso, Clinical Administrator 2. Cindy Black, Director, Standards and Compliance 3. Donna M. Robeson, LCSW 4. Ed Foulk, RN, MBA, EdD, Executive Director 5. Jane Adams, LCSW, Program 1, Acting Senior Supervisor 6. Katie Cooper, PsyD, Psychologist, Enhancement Plan Coordinator 7. Malia Haas, LCSW, Program 3, Acting Senior Supervisor 8. Michael Comini, LCSW, Section Leader Performance Enhancement 9. Monique Jansma, LCSW, Program 5, Acting Senior Supervisor 10. Rebecca Baumer, LCSW, Program 4, Acting Senior Supervisor <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Charts of the following 24 individuals: AA, ALM, AM, AS, ASM, AZ, CDW, DAM, DB, DBM, DCW, DJT, FCP, JSW, LAS, LCS, LRW, MA, MAS, OB, PLA, REK, RN, and TJ 2. DMH 30-Day Psychosocial Assessment Instructions 3. DMH 30-Day Psychosocial Assessment 4. DMH Social History Assessments Monitoring Form Instructions 5. List of Individuals Assessed to Need Family Therapy 6. NSH Progress Report, July 2008 7. Social History Monitoring Form 8. Training and Development Roster <p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. WRPC for GMW 2. WRPC for RAB 3. PSR Mall group: New Start for Mental Health 4. PSR Mall group: Stretching/Relaxation 5. PSR Mall group: Mental Health Through Laughter

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		<p>6. PSR Mall group: Enhancement Motivation 7. PSR Mall group: Social Skills Through Improvisational Theater 8. PSR Mall group: Suicide Prevention Education Awareness Keys 9. BY CHOICE Redemption Center</p>																		
D.6.a	<p>Is, to the extent reasonably possible, accurate, current and comprehensive;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, January 2008: Ensure that the Integrated Assessment Social Work section is timely, accurate, current and comprehensive.</p> <p>Findings: Using items #1, 2, and 3 from the DMH Social History Integrated Assessments, NSH assessed its compliance based on an average sample of 83% of the Integrated Assessments due for the month (January to May 2008). The table below with its indicators and sub-indicators and corresponding mean compliance is a summary of the data:</p> <table border="1" data-bbox="989 857 1890 1421"> <tr> <td data-bbox="989 857 1087 898">1.</td> <td data-bbox="1087 857 1793 898"><i>Is to the extent reasonably possible, accurate.</i></td> <td data-bbox="1793 857 1890 898"></td> </tr> <tr> <td data-bbox="989 898 1087 938">1.a</td> <td data-bbox="1087 898 1793 938"><i>Identifying information is complete and accurate,</i></td> <td data-bbox="1793 898 1890 938">94%</td> </tr> <tr> <td data-bbox="989 938 1087 1157">1.b</td> <td data-bbox="1087 938 1793 1157"><i>Sources of information include the individual, collateral information sources and specific documents reviewed, or an explanation for not using these sources. Dates of contacts are listed as appropriate. Dates of source documents are listed, and,</i></td> <td data-bbox="1793 938 1890 1157">14%</td> </tr> <tr> <td data-bbox="989 1157 1087 1230">1.c</td> <td data-bbox="1087 1157 1793 1230"><i>The information in the assessment is factually correct and internally consistent.</i></td> <td data-bbox="1793 1157 1890 1230">97%</td> </tr> <tr> <td data-bbox="989 1230 1087 1271">2.</td> <td data-bbox="1087 1230 1793 1271"><i>Current</i></td> <td data-bbox="1793 1230 1890 1271"></td> </tr> <tr> <td data-bbox="989 1271 1087 1421">2.a</td> <td data-bbox="1087 1271 1793 1421"><i>Assessment includes information from current interview, collateral sources, and source documents, or there is sufficient documentation in the assessment to indicate why these sources of</i></td> <td data-bbox="1793 1271 1890 1421">77%</td> </tr> </table>	1.	<i>Is to the extent reasonably possible, accurate.</i>		1.a	<i>Identifying information is complete and accurate,</i>	94%	1.b	<i>Sources of information include the individual, collateral information sources and specific documents reviewed, or an explanation for not using these sources. Dates of contacts are listed as appropriate. Dates of source documents are listed, and,</i>	14%	1.c	<i>The information in the assessment is factually correct and internally consistent.</i>	97%	2.	<i>Current</i>		2.a	<i>Assessment includes information from current interview, collateral sources, and source documents, or there is sufficient documentation in the assessment to indicate why these sources of</i>	77%
1.	<i>Is to the extent reasonably possible, accurate.</i>																			
1.a	<i>Identifying information is complete and accurate,</i>	94%																		
1.b	<i>Sources of information include the individual, collateral information sources and specific documents reviewed, or an explanation for not using these sources. Dates of contacts are listed as appropriate. Dates of source documents are listed, and,</i>	14%																		
1.c	<i>The information in the assessment is factually correct and internally consistent.</i>	97%																		
2.	<i>Current</i>																			
2.a	<i>Assessment includes information from current interview, collateral sources, and source documents, or there is sufficient documentation in the assessment to indicate why these sources of</i>	77%																		

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			<i>information were not utilized, and,</i>	
		2.b	<i>Includes behavioral observations since the time of admission.</i>	19%
		3.	<i>Comprehensive.</i>	
		3.a	<i>All sections are completed with at least the minimum information required in the instructions as applicable or indicates why information is not available.</i>	52%
		<p>NSH's compliance rates for Accurate (97%), Current (77%), and Comprehensive (52%) for the current review period are much higher than the data on the same Accurate (52%), Current (68%), and Comprehensive (26%) from the previous review period. According to the Social Work staff, the low compliance was because the examiners failed to assess all sources of information and direct observation of the individual. NSH has set up Senior Social Work staff to meet bi-weekly to review the Integrated Assessments (Social Work section) and to mentor examiners to ensure that the assessments are thorough and meet compliance.</p> <p>This monitor reviewed ten Integrated Assessments (ALM, AM, AS, CDW, DAM, LCS, MAS, PLA, RN and TJ). None of the ten integrated assessments were accurate with complete identifying information and sources of information. Three of the assessments (AM, PLA and RN) were current with behavioral observation and interview data, and five of the assessments (AM, AS, DBM, LCS and PLA) were comprehensive with all sections completed with at least the minimum information required.</p> <p>Recommendation 2, January 2008: Ensure that the 30-day Social History Assessments are timely, accurate, current and comprehensive.</p>		

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		<p>Findings: Using the DMH Social History 30-Day Psychosocial Assessment Monitoring Form, NSH assessed its compliance based on an average sample of 67% of the 30-Day Psychosocial Assessments due for the month (January to May 2008). The table below with its indicators and sub-indicators and corresponding mean compliance is a summary of the data:</p> <table border="1" data-bbox="989 488 1885 1424"> <tr> <td data-bbox="989 488 1087 526">1.</td> <td data-bbox="1087 488 1793 526"><i>Is, to the extent reasonably possible, accurate</i></td> <td data-bbox="1793 488 1885 526"></td> </tr> <tr> <td data-bbox="989 526 1087 563">1.a</td> <td data-bbox="1087 526 1793 563"><i>Identifying Information is complete and accurate,</i></td> <td data-bbox="1793 526 1885 563">98%</td> </tr> <tr> <td data-bbox="989 563 1087 786">1.b</td> <td data-bbox="1087 563 1793 786"><i>Sources of information include the individual, collateral information sources and specific documents reviewed, or an explanation for not using these sources. Dates of contacts are listed as appropriate. Dates of source documents are listed, and,</i></td> <td data-bbox="1793 563 1885 786">40%</td> </tr> <tr> <td data-bbox="989 786 1087 862">1.c</td> <td data-bbox="1087 786 1793 862"><i>The information in the assessment is factually correct and internally consistent.</i></td> <td data-bbox="1793 786 1885 862">96%</td> </tr> <tr> <td data-bbox="989 862 1087 899">2.</td> <td data-bbox="1087 862 1793 899"><i>Current, and</i></td> <td data-bbox="1793 862 1885 899"></td> </tr> <tr> <td data-bbox="989 899 1087 1084">2.a</td> <td data-bbox="1087 899 1793 1084"><i>Assessment includes information from current interview, collateral sources, and source documents, or there is sufficient documentation in the assessment to indicate why these sources of information were not utilized,</i></td> <td data-bbox="1793 899 1885 1084">95%</td> </tr> <tr> <td data-bbox="989 1084 1087 1161">2.b</td> <td data-bbox="1087 1084 1793 1161"><i>Includes behavioral observations since the time of admission, and</i></td> <td data-bbox="1793 1084 1885 1161">46%</td> </tr> <tr> <td data-bbox="989 1161 1087 1237">2.c</td> <td data-bbox="1087 1161 1793 1237"><i>Provides adequate information regarding the individual's current psychosocial functioning.</i></td> <td data-bbox="1793 1161 1885 1237">53%</td> </tr> <tr> <td data-bbox="989 1237 1087 1274">3.</td> <td data-bbox="1087 1237 1793 1274"><i>Comprehensive</i></td> <td data-bbox="1793 1237 1885 1274"></td> </tr> <tr> <td data-bbox="989 1274 1087 1424">3.a</td> <td data-bbox="1087 1274 1793 1424"><i>All sections are completed with at least the minimum information required in the instructions as applicable or indicate why information is not available.</i></td> <td data-bbox="1793 1274 1885 1424">68%</td> </tr> </table>	1.	<i>Is, to the extent reasonably possible, accurate</i>		1.a	<i>Identifying Information is complete and accurate,</i>	98%	1.b	<i>Sources of information include the individual, collateral information sources and specific documents reviewed, or an explanation for not using these sources. Dates of contacts are listed as appropriate. Dates of source documents are listed, and,</i>	40%	1.c	<i>The information in the assessment is factually correct and internally consistent.</i>	96%	2.	<i>Current, and</i>		2.a	<i>Assessment includes information from current interview, collateral sources, and source documents, or there is sufficient documentation in the assessment to indicate why these sources of information were not utilized,</i>	95%	2.b	<i>Includes behavioral observations since the time of admission, and</i>	46%	2.c	<i>Provides adequate information regarding the individual's current psychosocial functioning.</i>	53%	3.	<i>Comprehensive</i>		3.a	<i>All sections are completed with at least the minimum information required in the instructions as applicable or indicate why information is not available.</i>	68%
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		<p>NSH's compliance rates for Accurate (98%), Current (95%), and Comprehensive (68%) for the current review period are much higher than the compliance rates for Accurate (48%), Current (64%), and Comprehensive (41%) in the previous review period. According to the Social Work staff, the low compliance for the 30-Day Psychosocial Assessments was for the same reasons as were the 5-Day Social History Assessments discussed above, and the plan for improvement is the same for both assessments.</p> <p>This monitor reviewed ten Psychosocial Assessments (ALM, AM, AS, CDW, DAM, LCS, MAS, PLA, RN and TJ). Two of the assessments (AM and MAS) were accurate, current, and comprehensive, meeting all the required elements in this recommendation. The remaining eight (ALM, AS, CDW, DAM, LCS, PLA, RN and TJ) did not include the required elements to meet compliance.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that the Integrated Assessments Social Work section is timely, accurate, current and comprehensive. 2. Ensure that the 30-day Social History Assessments are timely, accurate, current and comprehensive.
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 recommendation:</p> <p>Recommendation, January 2008: Ensure that social workers identify and address the inconsistencies in current assessments.</p>

		<p>Findings: Using items #4-6 from the DMH Social History 30-Day Psychosocial Assessment Monitoring Form, NSH assessed its compliance based on an average sample of 67% of the 30-Day Psychosocial Assessments due for the month (January to May 2008). The table below with its indicators and corresponding mean compliance is a summary of the data:</p> <table border="1" style="margin-left: auto; margin-right: auto;"> <tr> <td style="width: 5%;">4.</td> <td style="width: 80%;"><i>Expressly identifies factual inconsistencies among sources,</i></td> <td style="width: 15%; text-align: center;">65%</td> </tr> <tr> <td>5.</td> <td><i>Resolves or attempts to resolve inconsistencies, and</i></td> <td style="text-align: center;">58%</td> </tr> <tr> <td>6.</td> <td><i>Explains the rationale for the resolution offered.</i></td> <td style="text-align: center;">61%</td> </tr> </table> <p>NSH's data for this review period on identifying (65%), resolving (58%), and rationale (61%) on factual inconsistencies were higher than for the same (identifying, 43%; resolving, 33%; and rationale ,34%) from the previous review period. According to the Social Work staff, the inconsistencies in reporting factual inconsistencies by the examiners will be addressed through a bi-weekly meeting of the examiners with Senior Social Workers to ensure that the elements in reporting on factual inconsistencies are addressed consistently.</p> <p>This monitor reviewed seven charts (AA, AZ, DB, DJT, JSW, LRW and REK). Inconsistencies were addressed and resolutions offered in five of the 30-day Social History assessments in the charts (AA, DB, DJT, JSW and REK). Inconsistencies were not addressed in two (AZ and LRW) of the assessments.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Ensure that social workers identify and address the inconsistencies in current assessments.</p>	4.	<i>Expressly identifies factual inconsistencies among sources,</i>	65%	5.	<i>Resolves or attempts to resolve inconsistencies, and</i>	58%	6.	<i>Explains the rationale for the resolution offered.</i>	61%
4.	<i>Expressly identifies factual inconsistencies among sources,</i>	65%									
5.	<i>Resolves or attempts to resolve inconsistencies, and</i>	58%									
6.	<i>Explains the rationale for the resolution offered.</i>	61%									

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<p>D.6.c</p>	<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>Recommendations 1 and 2, January 2008:</p> <ul style="list-style-type: none"> • Ensure all SW integrated assessments are completed and available to the WRPT before the seven-day WRPC. • Ensure that assessments are not completed too early. <p>Findings:</p> <p>Using item #7 from the DMH Integrated Assessments, NSH assessed its compliance based on an average sample of 67% of the Integrated Assessments due for the month (January to May 2008). The table below with its indicators and sub-indicators and corresponding mean compliance is a summary of the data:</p> <table border="1" data-bbox="991 711 1890 862"> <tr> <td>7.</td> <td><i>Is included in the 7-day integrated assessment.</i></td> <td></td> </tr> <tr> <td>7.a</td> <td><i>The assessment was completed within 5 calendar days of the individual's admission, and</i></td> <td>84%</td> </tr> <tr> <td>7.b</td> <td><i>Filed in the medical record.</i></td> <td>97%</td> </tr> </table> <p>NSH's compliance on timeliness of 84% for this review period was higher than the compliance of 60% for the previous review period. Filing in a timely fashion was not evaluated for the previous period, thus there is no data for comparison. NSH plans to have its Senior Social Workers monitor compliance with this recommendation.</p> <p>This monitor reviewed ten charts (AA, ALM, AM, LAS, PLA, RN AS, DCW, MAS and TJ). Six of the Integrated Assessments in the charts (AA, ALM, AM, LAS, PLA and RN) were completed in a timely manner. The remaining four (AS, DCW, MAS and TJ) were untimely.</p> <p>Using item #8 from the DMH Social History Assessment Monitoring form 30-Day Psychosocial Assessment, NSH assessed its compliance based on an average sample of 67% of the 30-Day Psychosocial</p>	7.	<i>Is included in the 7-day integrated assessment.</i>		7.a	<i>The assessment was completed within 5 calendar days of the individual's admission, and</i>	84%	7.b	<i>Filed in the medical record.</i>	97%
7.	<i>Is included in the 7-day integrated assessment.</i>										
7.a	<i>The assessment was completed within 5 calendar days of the individual's admission, and</i>	84%									
7.b	<i>Filed in the medical record.</i>	97%									

Section D: Integrated Assessments

		<p>Assessments due for the month (January to May 2008). The table below with its indicator and sub-indicators and corresponding mean compliance is a summary of the data:</p> <table border="1" data-bbox="991 337 1885 529"> <tr> <td data-bbox="991 337 1087 378">8.</td> <td data-bbox="1087 337 1793 378"><i>Is fully documented by 30th day</i></td> <td data-bbox="1793 337 1885 378"></td> </tr> <tr> <td data-bbox="991 378 1087 492">8.a</td> <td data-bbox="1087 378 1793 492"><i>Completed no earlier than the first work day after the 7-day WRPC and no later than the 30th calendar day after admission</i></td> <td data-bbox="1793 378 1885 492">72%</td> </tr> <tr> <td data-bbox="991 492 1087 529">8.b</td> <td data-bbox="1087 492 1793 529"><i>Filed in the medical record</i></td> <td data-bbox="1793 492 1885 529">100%</td> </tr> </table> <p>NSH's compliance on timeliness of 84% for this review period was higher than the compliance of 60% for the previous review period. Filing in a timely fashion was not evaluated for the previous period, thus there is no data for comparison. NSH plans to have its Senior Social Workers monitor compliance with this recommendation.</p> <p>This monitor reviewed twelve 30-Day Psychosocial Assessments (AM, AS, ASM, CDW, DBM, FCP, LCS, MAS, OB, PLA, RN and TJ). Four of the Psychosocial Assessments were completed in a timely manner (ASM, AS, OB and TJ), and the remaining eight (AM, CDW, DBM, FCP, LCS, MAS, PLA and RN) were untimely.</p> <p>The 5-Day and 30-Day assessments reviewed by this examiner were not completed too early, as on the day of admission.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Ensure all SW integrated assessments are completed and available to the WRPT before the seven-day WRPC.</p>	8.	<i>Is fully documented by 30th day</i>		8.a	<i>Completed no earlier than the first work day after the 7-day WRPC and no later than the 30th calendar day after admission</i>	72%	8.b	<i>Filed in the medical record</i>	100%
8.	<i>Is fully documented by 30th day</i>										
8.a	<i>Completed no earlier than the first work day after the 7-day WRPC and no later than the 30th calendar day after admission</i>	72%									
8.b	<i>Filed in the medical record</i>	100%									

Section D: Integrated Assessments

<p>D.6.d</p>	<p>Reliably informs the individual's interdisciplinary team about the individual's relevant social factors and educational status.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: Ensure that social histories reliably inform the individual's WRPT about the individual's relevant social factors and educational status.</p> <p>Findings: Using item #10 from the DMH Social History Integrated Assessment Monitoring Form, NSH assessed its compliance based on an average sample of 83% of the Integrated Assessments due for the month (January to May 2008). The table below with its indicator and sub-indicators and corresponding mean compliance is a summary of the data:</p> <table border="1" data-bbox="991 672 1887 862"> <tr> <td data-bbox="991 672 1087 711">10.</td> <td data-bbox="1087 672 1793 711"><i>Educational status.</i></td> <td data-bbox="1793 672 1887 711"></td> </tr> <tr> <td data-bbox="991 711 1087 821">10.a</td> <td data-bbox="1087 711 1793 821"><i>Education includes educational level(s) completed by the individual and subject of any degrees or focus of any vocational training, or</i></td> <td data-bbox="1793 711 1887 821">85%</td> </tr> <tr> <td data-bbox="991 821 1087 862">10.b</td> <td data-bbox="1087 821 1793 862"><i>"Unknown" is checked.</i></td> <td data-bbox="1793 821 1887 862">50%</td> </tr> </table> <p>NSH's compliance data on educational status for this review period is higher than the compliance data (53%) on the same indicator from the previous review period. NSH plans additional training, mentoring and monitoring to improve compliance to this recommendation.</p> <p>This monitor reviewed nine Integrated Assessments (ALM, AM, AS, CDW, DBM, LCS, MAS, RN and TJ). Seven of the assessments (ALM, AM, AS, DBM, LCS, RN and TJ) contained information on the individuals' educational status and social factors. Two of them (CDW and MAS) did not contain the necessary information.</p> <p>Using item #10 from the DMH 30-Day Psychosocial Assessment Form, NSH assessed its compliance based on an average sample of 67% of the Integrated Assessments due for the month (January to May 2008).</p>	10.	<i>Educational status.</i>		10.a	<i>Education includes educational level(s) completed by the individual and subject of any degrees or focus of any vocational training, or</i>	85%	10.b	<i>"Unknown" is checked.</i>	50%
10.	<i>Educational status.</i>										
10.a	<i>Education includes educational level(s) completed by the individual and subject of any degrees or focus of any vocational training, or</i>	85%									
10.b	<i>"Unknown" is checked.</i>	50%									

Section D: Integrated Assessments

		<p>The table below with its indicator and sub-indicators and corresponding mean compliance is a summary of the data:</p> <table border="1" data-bbox="991 305 1890 529"> <tr> <td data-bbox="991 305 1087 342">10.</td> <td data-bbox="1087 305 1793 342"><i>Educational status.</i></td> <td data-bbox="1793 305 1890 342"></td> </tr> <tr> <td data-bbox="991 342 1087 456">10.a</td> <td data-bbox="1087 342 1793 456"><i>Education includes recommendations for learning accommodations and testing, or states if none are needed, and</i></td> <td data-bbox="1793 342 1890 456">19%</td> </tr> <tr> <td data-bbox="991 456 1087 529">10.b</td> <td data-bbox="1087 456 1793 529"><i>Discusses the impact of the individual's education on his/her Wellness and Recovery.</i></td> <td data-bbox="1793 456 1890 529">10%</td> </tr> </table> <p>As shown above, NSH's compliance data on the educational status for the 30-Day Psychosocial Assessment is low. NSH did not audit the educational status for this instrument during the previous review period, thus there is no data for comparison. NSH plans on additional training, mentoring and monitoring to improve compliance to this recommendation.</p> <p>This monitor reviewed ten 30-Day Psychosocial Assessments (ALM, AM, AS, CDW, DBM, LCS, MAS, PLA, RN and TJ). Three of them (ALM, AS and TJ) contained information on the individuals' educational status and social factors. The remaining seven (AM, CDW, DBM, LCS, MAS, PLA and RN) did not.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Ensure that social histories reliably inform the individual's WRPT about the individual's relevant social factors and educational status.</p>	10.	<i>Educational status.</i>		10.a	<i>Education includes recommendations for learning accommodations and testing, or states if none are needed, and</i>	19%	10.b	<i>Discusses the impact of the individual's education on his/her Wellness and Recovery.</i>	10%
10.	<i>Educational status.</i>										
10.a	<i>Education includes recommendations for learning accommodations and testing, or states if none are needed, and</i>	19%									
10.b	<i>Discusses the impact of the individual's education on his/her Wellness and Recovery.</i>	10%									

Section D: Integrated Assessments

7. Court Assessments		
		<p>Methodology:</p> <p><u>Interviewed:</u> Katherine Warburton, DO, Chair, Forensic Review Panel (FRP)</p> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Charts of six individuals (ADT, GC, JT, KR, MPM and SLB) who were admitted under PC 1026 2. Charts of six individuals (BH, BWS, MAS, RA, RAG and SAH) who were admitted under PC 1370 3. Sample of feedback provided by Chair of the FRP to WRPTs via Court Reports tracking records 4. Sample of e-mail feedback notices by the FRP to the WRPTs for January 2008 5. NSH current FRP membership list 6. DMH PC 1026 Report Auditing Form 7. DMH PC 1026 Report Auditing Form Instructions 8. NSH PC 1026 Report Auditing summary data (January to May 2008) 9. DMH PC 1370 Report Auditing Form 10. DMH PC 1370 Report Auditing Form Instructions 11. NSH PC 1370 Report Auditing summary data (January to May 2008) 12. Forensic Review Panel meeting minutes (January to May 2008)
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>

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<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, January 2008: Ensure ongoing training of WRPTs regarding compliance with EP requirements and instructional feedback by the FRP to the teams.</p> <p>Findings: NSH has implemented the following mechanisms in response to this recommendation:</p> <ol style="list-style-type: none"> 1. The FRP has utilized the tracking forms and monitors and personal contact via telephone or e-mail to provide feedback to the WRPTs on 100% of court reports submitted during this reporting period. 2. The Chair of the FRP has provided program-by-program training to ensure that court report training is targeting all members of the WRPTs who are involved with the court letter process. These trainings were completed in May 2008. 3. In April of 2008, the facility established a weekly "Court Report Writing Seminar" for WRPT members who require help with a specific report or with report-writing in general. 4. A two-hour Orientation to Court Reports course has been given to all new psychiatrists throughout the reporting period beginning January 1, 2008. 5. In May 2008, NSH established a shared drive for all court reports. Eventually, each report will be reviewed by senior professionals within the program for compliance prior to submission to the FRP. 6. In early April 2008, the "Court Report of the Week" award was instituted and is announced each week in the hospital bulletin. 7. During May and June, 2008, each non-compliant letter received intensive 1:1 feedback, including extensive written revision suggestions by a second psychiatrist working temporarily in the forensic office.
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		<p>Recommendation 2, January 2008: Ensure that 1026 reports are written in a consistent format.</p> <p>Findings: NSH has disseminated the new DMH manual for the preparation of PC 1026 court reports hospital-wide, and instructed the WRPTs to utilize the template for 1026 letters contained therein.</p> <p>Recommendations 3 and 4, January 2008:</p> <ul style="list-style-type: none"> • Monitor this requirement based on at least a 20% sample using the new standardized tool. • Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement. <p>Findings: NSH used the DMH PC 1026 Court report Auditing Form to assess compliance (January to May 2008). The average sample was 100% of PC 1026 reports. The facility reported a mean compliance rate of 89% with this requirement. The compliance rate has increased from 86% in December 2007 to 95% in May 2008. Training was provided to teach of the WRPTs about the importance of comparing current symptoms with those that led to the instant offense when writing an assessment of restoration to sanity.</p> <p>The mean compliance rate for the requirements in D.7.a.ii to D.7.a.ix and comparative data are provided in each corresponding cell below.</p> <p>Other findings: This monitor reviewed the charts of six individuals who were admitted under PC 1026. Although still short of substantial compliance, the review found general evidence that NSH has made progress in the quality of the reports since the last review period. The main deficiencies were focused on providing specifics in the relapse</p>
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		<p>prevention plan (for mental illness and for substance use disorders) and addressing the precursors/potential for danger. Regarding this requirement, the review found compliance in five charts (ADT, GC, JT, KR and SLB) and partial compliance in one (MPM).</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue training of the WRPTs regarding implementation of all requirements related to PC 1026 reports. 2. Ensure that 1026 reports are written in a consistent format. 3. Monitor this requirement using the DMH PC 1026 Auditing Form based on a 100% sample. 4. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). 									
D.7.a.ii	acts of both verbal and physical aggression and property destruction during the past year of hospitalization and, if relevant, past acts of aggression and dangerous criminal behavior;	<p>NSH reported a mean compliance rate of 87%. The compliance rate has increased from 75% in December 2007 to 100% in May 2008.</p> <p>Chart reviews by this monitor found compliance in all six cases.</p>									
D.7.a.iii	understanding of potential for danger and precursors of dangerous/criminal behavior, including instant offense;	<p>NSH reported a mean compliance rate of 85%. The compliance rate has increased from 60% in December 2007 to 93% in May 2008.</p> <p>Reviews by this monitor found non-compliance in three charts (GC, KR and MPM), compliance in two (JT and ADT) and partial compliance in one (SLB).</p>									
D.7.a.iv	acceptance of mental illness and understanding of the need for treatment, both psychosocial and biological, and the need to adhere to treatment;	<p>NSH reported the following mean compliance rates:</p> <table border="1"> <tr> <td>1.</td> <td><i>Acceptance of mental illness</i></td> <td>92%</td> </tr> <tr> <td>2.</td> <td><i>Understanding of the need for treatment</i></td> <td>89%</td> </tr> <tr> <td>3.</td> <td><i>Understanding of the need to adhere to treatment</i></td> <td>95%</td> </tr> </table>	1.	<i>Acceptance of mental illness</i>	92%	2.	<i>Understanding of the need for treatment</i>	89%	3.	<i>Understanding of the need to adhere to treatment</i>	95%
1.	<i>Acceptance of mental illness</i>	92%									
2.	<i>Understanding of the need for treatment</i>	89%									
3.	<i>Understanding of the need to adhere to treatment</i>	95%									

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		<p>No comparative data were available (this was a composite item in the audit utilized during the previous review).</p> <p>Chart reviews by this monitor found compliance in all six cases.</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>NSH reported the following mean compliance rates:</p> <table border="1"> <tr> <td>1.</td> <td><i>Individual's development of relapse prevention plan for mental illness symptoms</i></td> <td>90%</td> </tr> <tr> <td>2.</td> <td><i>Individual's recognition of precursors and warning signs and symptoms for dangerous acts</i></td> <td>81%</td> </tr> </table> <p>No comparative data were available (this was a composite item in the audit utilized during the previous review).</p> <p>This monitor found compliance in four charts (ADT, GC, MPM and SLB) and partial compliance in two (JT and KR).</p>	1.	<i>Individual's development of relapse prevention plan for mental illness symptoms</i>	90%	2.	<i>Individual's recognition of precursors and warning signs and symptoms for dangerous acts</i>	81%
1.	<i>Individual's development of relapse prevention plan for mental illness symptoms</i>	90%						
2.	<i>Individual's recognition of precursors and warning signs and symptoms for dangerous acts</i>	81%						
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 88%. The compliance rate was 79% in December 2007 and in May 2008.</p> <p>Chart reviews by this monitor found compliance in two cases (ADT and SLB) and partial compliance in one (KR). The requirement was not applicable in the remaining three charts.</p>						
D.7.a.vii	<p>previous community releases, if the individual has had previous CONREP revocations;</p>	<p>NSH reported a mean compliance rate of 79%. The compliance rate has increased from 96% in December 2007 to 98% in May 2008.</p> <p>This monitor found compliance in two charts (KR and MPM) and non-compliance in one (ADT). The requirement was not applicable in the remaining three charts.</p>						
D.7.a.	<p>social support, financial resources, family</p>	<p>NSH reported a mean compliance rate of 75%. The compliance rate</p>						

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viii	conflicts, cultural marginalization, and history of sexual and emotional abuse, if applicable; and	has increased from 79% in December 2007 to 98% in May 2008. This monitor found compliance in four charts (ADT, GC, JT and SLB) and partial compliance in two (KR and MPM).
D.7.a.ix	relevant medical issues, all self-harm behaviors, risks for self harm and risk of harm to others, to inform the courts and the facility where the individual will be housed after discharge.	NSH reported a mean compliance rate of 70%. The mean compliance rate has remained at 95% (December 2007 to May 2008). This monitor found compliance in four charts (GC, JT, MPM and SLB), partial compliance in one (ADT) and non-compliance in one (KRT).
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.
D.7.b.i	relevant clinical description of initial presentation, if available, which caused the individual to be deemed incompetent to stand trial by the court;	Current findings on previous recommendations: Recommendations 1 and 2, January 2008: <ul style="list-style-type: none"> • Same as D.7.a.i (as applicable to PC 1370). • Address the reason(s) for any significant discrepancy between the monitor's findings and the facility's data.

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		<p>Findings: Using the DMH PC 1370 Court Report Auditing Form (average sample of 100%), NSH reported a mean compliance rate of 97% with this requirement (January to May 2008). The mean compliance rate has increased from 87% during the last review period to 97% for this period.</p> <p>Other findings: This monitor reviewed the charts of six individuals (BH, BWS, MAS, RA, RAG and SAH) who were admitted under PC 1370. Although still short of substantial compliance, the review found general evidence that NSH has made progress in the quality of the reports since the last review period. The main deficiency was focused on the course of hospitalization and setting within which the symptoms occur. Regarding this requirement, the monitor found compliance in all six cases.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue training of the WRPTs regarding implementation of all requirements related to PC 1370 reports. 2. Monitor this requirement using the DMH PC 1026 Auditing Form based on a 100% sample. 3. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).
D.7.b.ii	clinical description of the individual at the time of admission to the hospital;	<p>NSH reported a mean compliance rate of 95% (this rate is comparable to that reported during the last review period).</p> <p>This monitor found compliance in all six charts reviewed.</p>
D.7.b.iii	course of hospital stay, describing any progress or lack of progress, response to	<p>NSH reported the following mean compliance rates:</p>

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	<p>treatment, current relevant mental status, and reasoning to support the recommendation; and</p>	<table border="1" data-bbox="993 191 1885 347"> <tr> <td data-bbox="993 191 1087 228">1.</td> <td data-bbox="1087 191 1793 228"><i>Description of any progress or lack of progress</i></td> <td data-bbox="1793 191 1885 228">98%</td> </tr> <tr> <td data-bbox="993 228 1087 266">2.</td> <td data-bbox="1087 228 1793 266"><i>Individual's response to treatment</i></td> <td data-bbox="1793 228 1885 266">96%</td> </tr> <tr> <td data-bbox="993 266 1087 303">3.</td> <td data-bbox="1087 266 1793 303"><i>Current relevant mental status</i></td> <td data-bbox="1793 266 1885 303">93%</td> </tr> <tr> <td data-bbox="993 303 1087 347">4.</td> <td data-bbox="1087 303 1793 347"><i>Reasoning to support the recommendations</i></td> <td data-bbox="1793 303 1885 347">94%</td> </tr> </table> <p data-bbox="993 386 1808 456">These rates are comparable to the rates reported during the last review period.</p> <p data-bbox="993 500 1850 602">This monitor found compliance in two charts (BH and SAH), partial compliance in two (BWS and RA) and non-compliance in two (MAS and RAG).</p>	1.	<i>Description of any progress or lack of progress</i>	98%	2.	<i>Individual's response to treatment</i>	96%	3.	<i>Current relevant mental status</i>	93%	4.	<i>Reasoning to support the recommendations</i>	94%
1.	<i>Description of any progress or lack of progress</i>	98%												
2.	<i>Individual's response to treatment</i>	96%												
3.	<i>Current relevant mental status</i>	93%												
4.	<i>Reasoning to support the recommendations</i>	94%												
D.7.b.iv	<p>all self-harm behaviors and relevant medical issues, to inform the courts and the facility where the individual will be housed after discharge.</p>	<p data-bbox="993 646 1850 716">NSH reported a mean compliance rate of 82%. The mean compliance rate has increased from 83% in December 2007 to 91% in May 2008.</p> <p data-bbox="993 760 1850 829">This monitor found compliance in five charts (BH, BWS, RA, RAG and SAH) and partial compliance in one (MAS).</p>												
D.7.c	<p data-bbox="317 873 953 1344">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 data-bbox="993 873 1577 906">Current findings on previous recommendation:</p> <p data-bbox="993 946 1409 979">Recommendation, January 2008: Continue current practice.</p> <p data-bbox="993 1057 1104 1089">Findings: NSH has maintained a FRP that provides adequate oversight, including review of 100% of PC 1026 and 1370 reports. As of April 17, 2008, all senior clinicians have been asked to join the forensic review panel. Senior psychiatrists and psychologists have demonstrated consistent attendance and now review letters from their respective programs and provide "local" feedback to the treatment teams (within the context of the FRP). At present, three forensic psychiatrists are members of the FRP.</p>												

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		<p>Compliance: Substantial.</p> <p>Current recommendations: Continue current practice.</p>
D.7.c.i	<p>The membership of the FRP shall include Director of Forensic Psychiatry, Facility Director or designee, Medical Director or designee, Chief of Psychology or designee, Chief of Social Services or designee, Chief of Nursing Services or designee, and Chief of Rehabilitation Services or designee. The Director of Forensic Psychiatry shall serve as the chair and shall be a board certified forensic psychiatrist. A quorum shall consist of a minimum of four FRP members or their designee.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: Continue current practice.</p> <p>Findings: NSH has continued its practice. The attendance at the FRP has reportedly improved substantially with the addition of senior psychiatrists and psychologists.</p> <p>Other findings: At the request of this monitor, NSH has provided information regarding formal and informal training that was provided to members of the FRP. The following is a summary:</p> <ol style="list-style-type: none"> 1. FRP members have received "formal" training" as follows: <ol style="list-style-type: none"> a. Scheduled didactic sessions were given by the acting Chief of Forensic Psychiatry. b. The curriculum included an explanation of constitutional rights including due process and the fundamental right to liberty; the relevant sections of the California Penal Code; and how this information ties in the with EP requirements. c. Landmark court decisions for 1370s (Dusky and Jackson) and 1026s (Durham and M'Naghten) were covered. d. The gravity of 1026 extensions and 2972 renewals was addressed by highlighting the differences in the language for each statute. The double jeopardy clause was discussed

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		<p>briefly.</p> <ul style="list-style-type: none">e. The training contained a review of the DMH manual and an item by item discussion of each enhancement plan requirement.f. The "formal training" was mandatory for all staff deemed by program management to be involved in the court report process. All psychiatrists, including new psychiatrists, also received this training at least once (the training was given twice during the court report workshop time). <p>2. FRP member also receive ongoing "informal training" on a one-on-one basis by the Chief of Forensic Psychiatry within the context of the FRP. This includes elements of the curriculum above and weekly review of monitors to ensure that members demonstrate competence in reviewing court reports.</p> <p>Compliance: Substantial.</p> <p>Current recommendations: Continue current practice.</p>
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Section E: Discharge Planning and Community Integration

E. Discharge Planning and Community Integration		
		<p>Summary of Progress: NSH has implemented the Family Therapy Needs services by conducting a needs assessment and following it up with announcement of the service through various mediums and events. NSH has also identified Spanish-speaking individuals for services when consent is received. NSH has also printed out family education information in both Spanish and English.</p>
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. Carmen Caruso, Clinical Administrator 2. Cindy Black, Director, Standards and Compliance 3. Ed Foulk, RN, MBA, EdD, Executive Director 4. Jane Adams, LCSW, Senior Supervising Social Worker 5. Katie Cooper, PsyD, Psychologist, Enhancement Plan Coordinator 6. Malia Haas, LCSW, Program 3, Acting Senior Supervisor 7. Michael Comini, LCSW, Section Leader 8. Monique Jansma, LCSW, Program 5, Acting Senior Supervisor 9. Rebecca Baumer, LCSW, Program 4, Acting Senior Supervisor <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Charts of the following 28 individuals: AL, ALV, BC, BDB, BN, BS, CDB, CH, EH, GS, JA, JDT, JLI, JLM, JM, JS, KMG, MAA, MSB, PJN, PVW, RAC, RJT, RR, SN, TLB, TLN, and VBH 2. Copy of NSH's Family Education and Services Handouts 3. NSH's Family Support Group Brochure (Spanish and English Versions) 4. NSH's Family Education and Outreach Group Brochure 5. DMH's Rights for Individuals in Mental Health Facilities Handbook (Spanish and English Versions)

Section E: Discharge Planning and Community Integration

		<ol style="list-style-type: none"> 6. Discharge Planning and Community Integration Tracking Sheet 7. Discharge Planning and Community Integration Training Module 8. List of Individuals Who Have Met Discharge Criteria 9. Staff Training and Development Roster 10. NSH's WRP Class Roster Trainings (January - May 2008) <p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. WRPC for GMW 2. WRPC for RAB 3. PSR Mall group: New Start for Mental Health 4. PSR Mall group: Stretching/Relaxation 5. PSR Mall group: Mental Health Through Laughter 6. PSR Mall group: Enhancement Motivation 7. PSR Mall group: Social Skills Through Improvisational Theater 8. PSR Mall group: Suicide Prevention Education Awareness Keys 9. BY CHOICE Redemption Center
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, January 2008: Ensure that social workers review discharge status on each discharge criterion with the WRPT and the individual at all scheduled WRPCs involving the individual.</p> <p>Findings: NSH did not audit this recommendation.</p> <p>This monitor interviewed the Senior Social Work staff. According to the staff, the Chief of Social Work has emphasized the importance of considering an individual's discharge plan from the day of admission, and of discussing discharge criteria at all WRPCs. In addition, the Social Work Department has assigned Senior Supervising Psychiatric Social Workers to train staff, mentor and provide feedback, and audit</p>

		<p>compliance with EP requirements.</p> <p>This monitor observed two WRPCs (GMW and RAB). The WRPTs reviewed the individual's discharge status and updated the information. The WRPTs also reviewed the discharge status with the individual.</p> <p>This monitor reviewed five charts (EH, JA, RAC, TLB and VBH). The WRP in one chart (TLB) had a fairly good writeup on the individual's discharge status, current functioning, and participation in activities dealing with his discharge matters. A minimal mention of discharge matters was found for VBH. However, there was no indication that there was any input by the Social Work staff for either of them. Documentation on discharge status of the individuals in the remaining three WRPs (EH, JA, and RAC) was unsatisfactory. For example, there was no discussion of discharge status for JA, and the documentation for RAC read "No barriers to discharge at this time;" however this individual is a new admission and there is no referral for discharge, for there to be no barriers to discharge.</p> <p>Recommendation 2, January 2008: Ensure that the Present Status section of the quarterly WRP is updated to reflect the status of each discharge criterion.</p> <p>Findings: NSH did not audit this recommendation.</p> <p>This monitor reviewed 11 charts (BDB, BS, JM, JS, KMG, MAA, PJN, RJT, RR, SN and TLN). Six of the WRPs in the charts (BDB, JM, MAA, PJN, SN and TLN) had documentation to show that the discharge criteria were updated in the present status sections. The remaining five (BS, JS, KMG, RJT and RR) did not update the status of each discharge criterion. .</p>
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		<p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that social workers review discharge status on each discharge criterion with the WRPT and the individual at all scheduled WRPCs involving the individual. 2. Ensure that the Present Status section of the quarterly WRP is updated to reflect the status of each discharge criterion.
E.1.a	those factors that likely would foster successful discharge, including the individual's strengths, preferences, and personal life goals;	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: Link the individual's life goals to one or more focus/foci of hospitalization, with associated objectives and interventions.</p> <p>Findings: Using item #1 from the DMH Discharge Planning and Community Integration Audit Form, NSH assessed its compliance based on an average sample of 19% of WRPs due for the month (January to May 2008), reporting a mean compliance rate of 66% (NSH's mean compliance for the previous review period was 35%). NSH's compliance rate for the last month of the previous review period was 41% and the compliance rate for this review period is 68%. According to the Social Work staff, Senior Social Work staff is to mentor and monitor to ensure compliance to this recommendation.</p> <p>This monitor reviewed 11 charts (BS, CDB, JM, JS, KMG, MAA, PJN, RJT, RR, SN and TLN). Six of the WRPs in the charts (JM, JS, PJN, RJT, RR and SN) had linked the individual's life goals to one or more of the focus/foci of hospitalization, with associated objectives and interventions. The remaining five (BS, CDB, KMG, MAA and TLN) did not link the individual's life goals to any focus or developed associated</p>

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		<p>objectives and interventions.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Link the individual's life goals to one or more focus/foci of hospitalization, with associated objectives and interventions.</p>
E.1.b	the individual's level of psychosocial functioning;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, January 2008: Ensure that the level of psychosocial functioning (functional status) is included in the individual's Present Status section of the case formulation section of the WRP.</p> <p>Findings: Using item #2 (<i>The individual's level of psychosocial functioning</i>) from the DMH Discharge Planning and Community Integration Audit Form, NSH assessed its compliance based on an average sample of 19% of WRPs due for the month (January to May 2008), reporting a compliance rate of 93% (the compliance rate for the previous review period was 61%). NSH's compliance for the last month of the previous period was 63% and the compliance for the last month of this review period is 96%.</p> <p>This monitor reviewed 11 charts (BS, CDB, JM, JS, KMG, MAA, PJN, RJT, RR, SN and TLN). The individual's level of psychosocial functioning was included in the present status sections of all 11 WRPs in the charts.</p> <p>Recommendation 2, January 2008: Implement the DMH WRP Manual in developing and updating the case</p>

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		<p>formulation.</p> <p>Findings: This monitor's documentation review (WRP Training Content and Roster) and interview of the Senior Social Work Staff found that WRPT members and Social Work staff have received training on WRP writeups (January 3 and 24, 2008, and May 28, 2008) following the DMH WRP Manual. According to NSH's progress report, this recommendation has been "implemented." However, NSH did not audit this recommendation to assess if the "implementation" is being applied correctly.</p> <p>This monitor reviewed five charts (EH, JA, RAC, TLB and VBH). Except for VBH, the contents in the case formulation sections in many of the WRPs in the charts were insufficient, incorrect, or in conflict within and between other assessments conducted. For example, the entry in the Present Status section for RAC stated "No barriers to discharge at this time" when in fact this individual is a new admission, has not been referred for discharge, and a number of criteria RAC has to meet was listed under the "Discharge Criteria for Anticipated Placement" section. In JA's case, statements in one paragraph under the Present Status section of the WRP listed a number of inappropriate behaviors including teasing peers, throwing chairs, and knocking over peers in the hallways, yet in another paragraph under the section "Behavioral Guidelines/PBS Plan" it was stated that "Neither Behavioral Guidelines or a PBS Plan have been necessitated, as there has been no evidence of emergent behavior problems at this time." The WRPs did not always include information from the Social Work Integrated and Psychosocial Assessments especially information regarding the individual's next placement and the skills the individual lacks and the supports the individual needs.</p>
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		<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 1, January 2008: Ensure that discharge barriers, especially difficulties in previously unsuccessful placements, are discussed with the individual at scheduled WRPCs.</p> <p>Findings: <i>Using item #3 (Any barriers preventing the individual from transitioning to a more integrated environment, especially difficulties raised in previously unsuccessful placements) from the DMH Discharge Planning and Community Integration Audit Form, NSH assessed its compliance based on an average sample of 19% of WRPs due for the month (January to May 2008), reporting a mean compliance rate of 44% (the mean compliance for the previous review period was 10%). NSH's compliance rate for the last month of the previous period was 8% and compliance for the current review period is 46%. NSH has assigned Senior Social Work staff to monitor and mentor to improve compliance.</i></p> <p>This monitor reviewed 11 charts (CDB, DS, JM, JS, KMG, MAA, PJN, RJT, RR, SN and TN). Three of the WRPs in the charts (CDB, JM and TN) had documentation indicating that discharge barriers were</p>

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		<p>discussed with the individual. Such was not the case for the remaining eight WRPs (DS, JS, KMG, MAA, PJN, RJT, RR and SN) in the charts.</p> <p>Recommendation 2, January 2008: Include skill training and supports in the WRP so that the individual can overcome the stated barriers.</p> <p>Findings: NSH did not audit this recommendation.</p> <p>This monitor reviewed 11 charts (BS, CDB, JM, JS, KMG, MAA, PJN, RJT, RN, SN and TLN). Two of the WRPs in the charts (CDB and JM) included the skills and supports needed by the individual to overcome discharge barriers. The remaining nine WRPs (BS, JS, KMG, MAA, PJN, RJT, RN, SN and TLN) did not address these elements.</p> <p>Recommendation 3, January 2008: Report to the WRPT, on a monthly basis, the individual's progress made in overcoming the barriers to discharge.</p> <p>Findings: NSH did not audit this recommendation.</p> <p>This monitor observed two WRPT conferences (GMW and RAB). In both cases, the WRPTs discussed the individuals' progress with regards to their discharge 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
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		<p>scheduled WRPCs.</p> <ol style="list-style-type: none"> 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	<p>the skills and supports necessary to live in the setting in which the individual will be placed.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: Ensure that the skills and supports necessary for the individual to live in the setting in which he/she will be placed are documented in the Present Status section of the individual's WRP.</p> <p>Findings: Using item #4 (<i>The skills and supports necessary to live in the setting in which the individual will be placed</i>) from the DMH Discharge Planning and Community Integration Audit Form, NSH assessed its compliance based on an average sample of 19% of the WRPs due for the month (January to May 2008), reporting a mean compliance rate of 24% (the mean compliance for the previous review period was 18%). NSH's compliance for the last month of the previous review was 25% and the compliance for the last month of this review period is 40%. NSH plans on enhanced mentoring and supervision to increase compliance with this requirement.</p> <p>This monitor reviewed five charts (EH, JA, RAC, TLB and VBH). None of the WRPs in the charts addressed many of the skills and supports the individuals need to live in the settings in which they will be placed. For example, vocational and housing supports for EH as identified in the 30-Day Psychosocial Assessment were not included in the Present Status section of his WRP. The skills and supports listed in VBH's Integrated Assessment: Social Work section includes assistance to access SSI benefits and WRAP around services was not included in the</p>

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		<p>Present Status section of his WRP.</p> <p>Compliance: Partial.</p> <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>Recommendations 1 and 2, January 2008:</p> <ul style="list-style-type: none"> • Continue to train the Social Work Department on engaging the individual as an active participant in the discharge planning process. • Implement the requirement outlined in the DMH WRP Manual on discharge process. <p>Findings: NSH has distributed the DMH WRP Manual to all Social Work staff and provided training on implementing the requirements as outlined in the Manual. NSH intends to continue to provide further mentoring and monitoring to ensure that all staff are familiar with and follow the requirements outlined in the Manual.</p> <p>Using item #12 from the DMH WRP Observation Monitoring Form, NSH assessed its compliance based on an average sample of 22% of WRPs due for the month (January to May 2008). The table below with its indicator and sub-indicators and corresponding mean compliance is a summary of the data:</p> <table border="1" data-bbox="989 1339 1793 1412"> <tr> <td data-bbox="989 1339 1087 1412">12.</td> <td data-bbox="1087 1339 1793 1412"><i>Each State hospital shall ensure that, beginning at the time of admission and continuously throughout the</i></td> <td data-bbox="1793 1339 1892 1412"></td> </tr> </table>	12.	<i>Each State hospital shall ensure that, beginning at the time of admission and continuously throughout the</i>	
12.	<i>Each State hospital shall ensure that, beginning at the time of admission and continuously throughout the</i>				

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		<p><i>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.</i></p>	
		<p>12.a <i>The WRPT asks the individual for his or her input into the evaluation of progress on each objective related to discharge.</i></p>	<p>15%</p>
		<p>12.b <i>The WRPT asks the individual if he or she is able to easily understand the materials presented in the PSR Mall groups or individual therapy that are related to the discharge criteria.</i></p>	<p>8%</p>
<p>NSH's mean compliance for the previous review period was 0% and the mean compliance for this review period is 12%. The mean compliance for the last month of the previous review period was 0% and the mean compliance for the last month of this review period is 17%.</p> <p>This monitor observed two WRPCs (GMW and RAB). Both WRPTs discussed with the individuals their progress and understanding of their discharge matters. However, review of charts found that this information is not documented properly. WRPTs should document their discussion with the individual and the individuals' response to the discussion on his/her discharge matters. If the individual's level of functioning, mental status, or legal status impacts the individual's ability to provide input, then that should be documented in the Present Status section.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Continue to train the Social Work Department on engaging the</p>			

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		individual as an active participant in the discharge planning process.
E.3	Each State hospital shall ensure that, consistent with generally accepted professional standards of care, each individual has a professionally developed discharge plan that is integrated within the individual's therapeutic and rehabilitation service plan, that addresses his or her particular discharge considerations, and that includes:	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: Continue to use the monitoring instrument and monitor to ensure that the individual has a professionally developed discharge plan.</p> <p>Findings: NSH has completed and implemented the monitoring instrument "DMH WRP Discharge Planning and Community Integration Audit Form". NSH now is using the instrument to monitor the quality of the individual's discharge plans.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Continue current monitoring practice.</p>
E.3.a	measurable interventions regarding these discharge considerations:	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: Ensure that all discharge criteria and their related intervention(s) are measurable.</p> <p>Findings: Using item #6 from the DMH Discharge Planning and Community Integration auditing form, NSH assessed its compliance based on an average sample of 19% of WRPs due for the month (January to May 2008), reporting a mean compliance rate of 38% (the mean compliance for the previous review period was 43%). NSH's compliance for the last month of the previous period was 29% and compliance for the last</p>

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		<p>month for this review period is 39%.</p> <p>This monitor reviewed 11 charts (BS, CDB, JM, JS, KMG, MAA, PJN, RJT, RR, SN and TLN). Three of the WRPs in the charts (BS, MAA and RJT) had developed their discharge criteria and measurable interventions in measurable terms. The remaining eight (CDB, JM, JS, KMG, PJN, RR, SN and TLN) had one or more of the discharge criteria and or interventions that were unobservable/measurable.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Ensure that all discharge criteria and their related intervention(s) are measurable.</p>
E.3.b	the staff responsible for implement the interventions; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: For those active treatment interventions where a discipline is specified rather than the staff member's name and discipline, clearly state the name of the staff member responsible.</p> <p>Findings: Using item #7 (<i>The staff responsible for implementing the interventions</i>) from the DMH Discharge Planning and Community Integration auditing form, NSH assessed its compliance based on an average sample of 19% of WRPs due for the month (January to May 2008), reporting a mean compliance rate of 73% (the mean compliance for the previous review period was 37%). NSH's compliance for the last month of the previous review period was 43% and the compliance for the last month of this review period is 74%.</p>

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		<p>This monitor reviewed 11 charts (BS, CDB, JM, JS, KMG, MAA, PJN, RJT, RR, SN and TN). Five of the WRPs in the charts (BS, JM, KMG, PJN and RJT) had identified the staff members responsible for implementing the active treatment interventions. The remaining six (CBD, JS, MAA, RR, SN and TN) did not.</p> <p>Compliance: Partial.</p> <p>Current recommendation: For those active treatment interventions where a discipline is specified rather than the staff member's name and discipline, clearly state the name of the staff member responsible.</p>
E.3.c	The time frames for completion of the interventions.	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: Ensure that interventions are reviewed at least monthly.</p> <p>Findings: Using item #8 (<i>The time frames for completion of the interventions</i>) from the DMH Discharge Planning and Community Integration Audit Form, NSH assessed its compliance based on an average sample of 19% of WRPs due for the month (January to May 2008), reporting a mean compliance rate of 67% (the mean compliance from the previous review period was 30%). NSH's compliance for the last month of the previous review period was 30% and the compliance for the last month of this review period is 66%.</p> <p>This monitor reviewed 11 charts (BN, BS, CDB, JM, JS, KMG, MAA, PJN, RJP, RR and TLN). Three of the WRPs in the charts (BS, PJN and RJP) had listed the appropriate time frames for reviewing the interventions. The remaining eight (BN, CDB, JM, JS, KMG, MAA, RR</p>

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		<p>and TLN) did not have dates for review of the interventions or the given dates were not aligned with the next scheduled conference.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Ensure that interventions are reviewed at least monthly.</p>
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:	<p>Compliance: Partial.</p>
E.4.a	individuals who have met discharge criteria are discharged expeditiously, subject to the availability of suitable placements; and	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, January 2008:</p> <ul style="list-style-type: none"> • Continue to reduce the overall number of individuals still hospitalized after referral for discharge has been made. • Identify and resolve system factors that act as barriers to timely discharge. <p>Findings: This monitor's documentation review (number of individuals referred for discharge, number of individuals still in hospital after referral for discharge) found that 153 individuals were referred for discharge during this review period (January to May 2008). Fifty-one of the 153 individuals (33%) referred for discharge still are in hospital.</p> <p>According to the Social Work staff, NSH has taken numerous steps to address this requirement. NSH had outside professionals train NSH staff on matters related to discharge, including preparation of court letters, placement resources, determination of individuals appropriate for developmental disability services, and skilled staffing needs. NSH</p>

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		<p>also obtained the involvement of Social Services on engaging family members in the discharge planning process and education of patient's rights. NSH has established a committee to assist Program V to address discharge-related issues in a timely manner. CONREP representatives are to work with Social Services to address discharge criteria. NSH has reviewed and revised the COT packet to streamline paperwork. NSH has also assigned Senior Supervising Social Work staff to collect monthly data on individuals referred for discharge. According to the Senior Social Work staff, finding conservatorships and acceptance by regional centers are two major external factors that act as barriers. The social work staff are working with external agencies to minimize the impact of these external factors on timely discharge of individuals referred for discharge.</p> <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, January 2008:</p> <ul style="list-style-type: none"> • Develop and implement a monitoring and tracking system to address this requirement. • Develop and implement documentation guidelines to ensure that individuals receive adequate assistance when they transition to the new setting. <p>Findings: This monitor's documentation review (WRP Discharge Planning and Community Integration Audit Form) and interview of Social Work staff found that NSH continues to use item #10 (<i>Individuals receive</i></p>

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		<p><i>adequate assistance in transitioning to the new setting</i>) from the WRP Discharge Planning and Community Integration Audit Form to review and audit individuals' transitional needs.</p> <p>Using item #10 (<i>Individuals receive adequate assistance in transitioning to the new setting</i>) from the DMH Discharge Planning and Community Integration Audit Form, NSH assessed its compliance by analyzing all individuals (100%) who met discharge criteria for this review period (January to May 2008), reporting a mean compliance rate of 60% (the mean compliance for the previous review period was at 18%).</p> <p>This monitor reviewed ten charts (AL, ALV, BC, CH, GS, JDT, JLI, JLM, MSB and PVW). Four of the WRPs in the charts (AL, GS, JLI and JLM) had identified and/or provided individuals with the necessary assistance to transition to the new setting. The remaining six (ALV, BC, CH, JDT, MSB and PVW) did not indicate if the individuals received any assistance.</p> <p>Current recommendation: Develop and implement documentation guidelines to ensure that individuals receive adequate assistance when they transition to the new setting.</p>
E.5	For all children and adolescents it serves, each State hospital shall:	<p>The requirements of Section E.5 are not applicable to NSH because it does not serve children or adolescents.</p>
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	

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	adolescent that addresses the obstacles to successful discharge to the most integrated, appropriate placement as clinically and legally indicated.	
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F. Specific Therapeutic and Rehabilitation Services	
	<p>Summary of Progress on Psychiatric Services:</p> <ol style="list-style-type: none">1. The DMH has implemented several adequate updates of the individualized medication guidelines.2. NSH appears to have reduced the unjustified use of anticholinergic medications.3. NSH improved the timeliness of AIMS testing for individuals diagnosed with tardive dyskinesia (TD).4. NSH has increased reporting of adverse drug reactions (ADRs) using updated data collection tools and instructions.5. NSH has improved the process of Intensive Case Analysis (ICA) of ADRs that met severity thresholds.6. NSH has improved the process of Drug Utilization Evaluation (DUE).7. NSH has updated its data collection tools and instructions in this area. <p>Summary of Progress on Psychological Services:</p> <ol style="list-style-type: none">1. NSH has implemented the system-wide PBS plan.2. NSH has established and implemented the Psychology Specialty Services Committee.3. The DCAT team is functioning as outlined in the DMH WRP Manual.4. NSH has increased the number of behavior guidelines written and implemented, and the behavior guidelines are based on a Positive Support Model without any aversive procedures.5. The PBS teams now consistently consult other relevant disciplines and integrate other treatment modalities as part of their PBS plan assessment and intervention methodology. <p>Summary of Progress on Nursing Services:</p> <ol style="list-style-type: none">1. The Nursing Department has achieved substantial compliance regarding nursing staff following the appropriate medication

	<p>administration protocol.</p> <ol style="list-style-type: none">2. NSH has implemented a number of strategies to ensure that immobile individuals are not rendered bed-bound due to lack of equipment or staff. <p>Summary of Progress on Rehabilitation Therapy Services:</p> <ol style="list-style-type: none">1. Course outlines have been developed for many Rehabilitation Therapy PSR Mall groups, but few 12 week lesson plans have been developed as indicated by PSR manual and EP requirements.2. An F.4 Monitoring tool has been developed and is pending implementation. <p>Summary of Progress on Nutrition Services:</p> <ol style="list-style-type: none">1. The Meal accuracy report has been implemented and review of data shows substantial compliance with tray accuracy.2. Lesson plans and curricula for Dietitian facilitated PSR Mall groups have been developed but are not currently being implemented secondary to staff shortage. <p>Summary of Progress on Pharmacy Services:</p> <p>NSH has improved the process of review and recommendations made by pharmacists upon the prescription of new medication orders.</p> <p>Summary of Progress on General Medical Services:</p> <ol style="list-style-type: none">1. NSH has revised its AD/Policies and Procedures. The revisions adequately addressed most of the process deficiencies cited by this monitor.2. DMH has initiated the development of medical and nursing protocols and a new template for nursing documentation. If properly implemented, these tools can facilitate communication between medical and nursing staff in the assessment and management of medical conditions.
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Section F: Specific Therapeutic and Rehabilitation Services

	<p>Summary of Progress on Infection Control:</p> <ol style="list-style-type: none">1. NSH's Infection Control Department has achieved substantial compliance in the areas of assessing data for trends; initiating inquiries regarding problematic trends, and identifying necessary corrective action.2. In an effort to increase compliance in certain areas, the Infection Control Department has hired an additional nurse to assist the unit staff with Infection Control issues. <p>Summary of Progress on Dental Services:</p> <ol style="list-style-type: none">1. The Dental Department at NSH has hired a number of staff to provide more timely and comprehensive dental services.2. As of May 27, 2008, the Dental Department has resumed performing Level 1 priority dentistry for preventative and restorative treatments. Up to this time, the department was only able to see individuals for admission and annual exams and emergencies.3. NSH has achieved substantial compliance in the areas of documentation of dental services, including but not limited to findings, descriptions of any treatment provided, and plans of care; and justification for tooth extractions as a treatment of last resort.
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Section F: Specific Therapeutic and Rehabilitation Services

1. Psychiatric Services		
		<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. John Banducci, Pharmacy Director 2. Patricia Tyler, MD, Acting Medical Director 3. Richard Forde, MD, Acting Chief of Psychiatry <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. The charts of the following 40 individuals: AJM, AKS, BB, CAD, CAG, CDC, CRS, DRZ, FHT, GBO, GDS, GLH, GMW, JDN, JHM, JMC, JPJ, JRD, JTS, KJM, KT, LDC, LG, MAS, MAW, MJF, PSR, RCW, REA, RLH, RMP, RS, RVG, SAR, SLH, TEH, VH, VLC, WCF and WJM 2. California Department of Mental Health (DMH) Psychotropic Medication Policies and Guidelines (January 2008) 3. Memorandum to CM from Michael Cummings, MD regarding Psychotropic Medication policy (June 23, 2008) 4. NSH Staff Psychiatrist Manual 5. NSH List of Individuals with Psychotropic Medications, Diagnoses and Attending Physicians 6. NSH database regarding intra-class and inter-class polypharmacy 7. DMH Admission Psychiatric Assessment Auditing Form 8. NSH Admission Psychiatric Assessment summary data (January to May 2008) 9. DMH Integrated Assessment: Psychiatry Section Auditing Form 10. NSH Integrated Psychiatric Assessment Auditing summary data (January to May 2008) 11. DMH Monthly Physician Progress Note (PPN) Auditing Form 12. NSH Physician PPN Auditing summary data (April and May 2008) 13. DMH Nursing Services Monitoring Form (PRN medications) 14. NSH Nursing PRN medications auditing summary data (February to May 2008)

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		<ol style="list-style-type: none"> 15. DMH Nursing Services Monitoring Form (Stat medications) 16. NSH Nursing Stat medications auditing summary data (February to May 2008) 17. DMH Benzodiazepine Auditing Form 18. NSH Benzodiazepine Auditing summary data (January to May 2008) 19. DMH Anticholinergic Auditing Form 20. NSH Anticholinergic Auditing summary data (January to May 2008) 21. DMH Polypharmacy Auditing Form 22. NSH Polypharmacy Auditing summary data (January to May 2008) 23. NSH Medication Monitoring New generation Antipsychotics (NGA) Auditing Form 24. NSH NGA Auditing summary data (January to May 2008) 25. NSH database regarding individuals suffering from tardive dyskinesia 26. DMH Tardive Dyskinesia (TD) Auditing Form 27. NSH TD Auditing summary data (January to May 2008) 28. NSH Adverse Drug Reaction Reports (January to May 2007 to April 2008) 29. NSH summary reports regarding DUEs conducted from January to May 2008 30. NSH Administrative Directive (AD) #554, Adverse Drug Reactions, June 2008 31. NSH ADR Reporting Form Instructions 32. NSH ADR (Data Collection) Form 33. NSH AD #567, Drug Utilization Evaluation (DUE), June 2008 34. NSH Intensive Case Analyses regarding ADRs and MVRs January to May 2008 35. DMH Medication Variance Reporting (MVR) Form Instructions 36. Medication Variance Reporting & Monitoring (Data Collection) Form 37. Nursing Policy and Procedure Manual, Section MED: 1102.1, Medication Variance: Reporting and Monitoring, January 2008 38. Minutes of the meetings of the Pharmacy and Therapeutics (P&T) Committee (January 25, February 13, March 12, April 16 and May
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		28, 2008)
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, January 2008: Ensure that the Medical Staff manual includes the same individualized DUE instruments that accompany the guidelines.</p> <p>Findings: NSH has implemented this recommendation. In addition, the latest update of the individualized medication guidelines has been placed on the facility's internal website (INET).</p> <p>Recommendation 2, January 2008: Monitor these requirements using standardized indicators across state facilities.</p> <p>Findings: NSH has implemented this recommendation.</p> <p>Recommendation 3, January 2008: Finalize the DMH New Generation Antipsychotics and the PRN Audit Forms and accompanying instructions for use across facilities.</p> <p>Findings: The DMH is in the process of finalizing the DMH New Generation Antipsychotics Auditing Form. The new DMH Monthly PPN will be used for monitoring of the physicians' prescription and review of PRN medications.</p> <p>Recommendations 4 and 5, January 2008:</p> <ul style="list-style-type: none"> • Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement.

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		<ul style="list-style-type: none"> • Implement planned corrective actions to improve compliance. <p>Findings: NSH used the previously mentioned processes of self-assessment using the DMH Admission Psychiatric Assessment, Integrated Assessment: Psychiatry Section and Monthly PPN Auditing Forms. The compliance data, with corresponding indicators and sub-indicators and data analysis are summarized in each cell below. Comparative data were not available for some items because monitoring using standardized indicators and sub-indicators began during this review period and some of the items were not included in the older tools.</p> <p>Other findings: Earlier this year, the DMH updated the individualized medication guidelines. The updates included several process improvements, but have yet to include the following:</p> <ol style="list-style-type: none"> 1. Guidelines regarding the use of lithium and carbamazepine and the antidepressants venlafaxine, bupropion and mirtazapine. 2. Guidelines to improve monitoring of serum lipase and amylase for individuals receiving high risk medications. <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Finalize individualized guidelines for all psychotropic and anticonvulsant medications listed in the formulary. 2. Ensure that the individualized medication guidelines are continually revised, as appropriate, to reflect current literature, relevant clinical experience and professional practice guidelines. 3. Finalize the DMH auditing form regarding the use of new generation antipsychotic medications.
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		<p>4. Monitor these requirements using the standardized DMH tools based on at least a 20% sample.</p> <p>5. Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period).</p>																																										
F.1.a.i	specifically matched to current, clinically justified diagnoses or clinical symptoms;	<table border="1" data-bbox="993 451 1887 716"> <thead> <tr> <th colspan="3">Admission Psychiatric Assessment</th> </tr> </thead> <tbody> <tr> <td>8.</td> <td><i>Plan of care includes:</i></td> <td></td> </tr> <tr> <td>8.a</td> <td><i>Regular psychotropic medications, with rationale.</i></td> <td>59%</td> </tr> <tr> <td>8.b</td> <td><i>PRN and/or Stat medication as applicable, with specific behavioral indications</i></td> <td>41%</td> </tr> <tr> <td>8.c</td> <td><i>Special precautions to address risk factors, as indicated.</i></td> <td>51%</td> </tr> </tbody> </table> <p data-bbox="993 760 1860 976">Comparative data were not available for the above sub-indicators. However, the overall mean compliance rate has increased from 36% in December 2007 to 58% in May 2008. The facility attributed low compliance to the current template of the admission psychiatric assessment and reported that implementation of the new template should improve compliance.</p> <table border="1" data-bbox="993 1015 1887 1393"> <thead> <tr> <th colspan="3">Integrated Psychiatric Assessment</th> </tr> </thead> <tbody> <tr> <td>7.</td> <td><i>Diagnostic formulation is documented</i></td> <td>38%</td> </tr> <tr> <td>10.</td> <td><i>Psychopharmacology treatment plan includes:</i></td> <td>30%</td> </tr> <tr> <td>10.a</td> <td><i>Current target symptoms</i></td> <td>60%</td> </tr> <tr> <td>10.b</td> <td><i>Specific medication to be used</i></td> <td>67%</td> </tr> <tr> <td>10.c</td> <td><i>Dosage titration schedules, if indicated.</i></td> <td>58%</td> </tr> <tr> <td>10.d</td> <td><i>Adverse reactions to monitor for</i></td> <td>39%</td> </tr> <tr> <td>10.e</td> <td><i>Rationale for anticholinergics, benzodiazepines, polypharmacy and new generation</i></td> <td>43%</td> </tr> <tr> <td>10.f</td> <td><i>Response to medication since admission, if</i></td> <td>38%</td> </tr> </tbody> </table>	Admission Psychiatric Assessment			8.	<i>Plan of care includes:</i>		8.a	<i>Regular psychotropic medications, with rationale.</i>	59%	8.b	<i>PRN and/or Stat medication as applicable, with specific behavioral indications</i>	41%	8.c	<i>Special precautions to address risk factors, as indicated.</i>	51%	Integrated Psychiatric Assessment			7.	<i>Diagnostic formulation is documented</i>	38%	10.	<i>Psychopharmacology treatment plan includes:</i>	30%	10.a	<i>Current target symptoms</i>	60%	10.b	<i>Specific medication to be used</i>	67%	10.c	<i>Dosage titration schedules, if indicated.</i>	58%	10.d	<i>Adverse reactions to monitor for</i>	39%	10.e	<i>Rationale for anticholinergics, benzodiazepines, polypharmacy and new generation</i>	43%	10.f	<i>Response to medication since admission, if</i>	38%
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			<i>applicable, including PRN and Stat medications.</i>																	
		10.g	<i>Medication consent issues were addressed</i>	65%																
		<p>The data showed that the mean compliance rate has increased from December 2007 to May 2008 as follows:</p> <ol style="list-style-type: none"> 1. Item 7: 47% to 48%; and 2. Item 10: 53% to 60% (no comparative data were available for the sub-indicators). <p>NSH's plan of improvement is the same as that reported in D.1.a. In addition, the facility reported that its Standards Compliance Department has instituted mechanisms of communications with the Chief of Psychiatry and authors of the assessments to enhance compliance.</p>																		
		<table border="1"> <tr> <td colspan="4">Monthly PPN</td> </tr> <tr> <td>2.b</td> <td><i>The current target symptoms which are the focus of treatment are identified in the progress note.</i></td> <td></td> <td>90%</td> </tr> <tr> <td>6.a.1</td> <td><i>The risks, benefits and rationale for the current psychopharmacology plan including anticholinergics, benzodiazepines, and polypharmacy are documented.</i></td> <td></td> <td>62%</td> </tr> <tr> <td>6.a.2</td> <td><i>There is a clear description of the reasoning for continuing the current medication regiment and the proposed future plans, such as augmentation, dose tapering, change in medication, etc.</i></td> <td></td> <td>76%</td> </tr> </table>			Monthly PPN				2.b	<i>The current target symptoms which are the focus of treatment are identified in the progress note.</i>		90%	6.a.1	<i>The risks, benefits and rationale for the current psychopharmacology plan including anticholinergics, benzodiazepines, and polypharmacy are documented.</i>		62%	6.a.2	<i>There is a clear description of the reasoning for continuing the current medication regiment and the proposed future plans, such as augmentation, dose tapering, change in medication, etc.</i>		76%
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		<p>The mean compliance rate for item 2.b has increased from 56% in December 2007 to 91% in May 2008. No comparative data were available for 6.a.1 and 6.a.2. The facility acknowledged the low sample size in this audit.</p>																		

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F.1.a.ii	prescribed in therapeutic amounts, as dictated by the needs of the individual served;	<table border="1" data-bbox="991 228 1885 418"> <tr> <th colspan="3">Monthly PPN</th> </tr> <tr> <td data-bbox="991 272 1087 418">2.h.2</td> <td data-bbox="1087 272 1793 418"><i>Current psychotropic medication dosage/laboratory monitoring/diagnostic testing and consultation protocols are followed as indicated (as per DMH Psychotropic guidelines.)</i></td> <td data-bbox="1793 272 1885 418">85%</td> </tr> </table> <p data-bbox="991 459 1885 492">No comparative data were available for this item.</p>	Monthly PPN			2.h.2	<i>Current psychotropic medication dosage/laboratory monitoring/diagnostic testing and consultation protocols are followed as indicated (as per DMH Psychotropic guidelines.)</i>	85%						
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F.1.a.iii	tailored to each individual's symptoms;	Same as F.1.a.i.												
F.1.a.iv	monitored for effectiveness against clearly identified target variables and time frames;	<table border="1" data-bbox="991 643 1885 833"> <tr> <th colspan="3">Monthly PPN</th> </tr> <tr> <td data-bbox="991 686 1087 719">2.b</td> <td data-bbox="1087 686 1793 719"><i>Identified target symptoms are documented.</i></td> <td data-bbox="1793 686 1885 719">90%</td> </tr> <tr> <td data-bbox="991 719 1087 751">2.c</td> <td data-bbox="1087 719 1793 751"><i>Participation in treatment is documented.</i></td> <td data-bbox="1793 719 1885 751">85%</td> </tr> <tr> <td data-bbox="991 751 1087 833">2.d</td> <td data-bbox="1087 751 1793 833"><i>Progress towards objective in the Wellness and Recovery Plan (is documented).</i></td> <td data-bbox="1793 751 1885 833">79%</td> </tr> </table> <p data-bbox="991 873 1885 906">No comparative data were available for this item.</p>	Monthly PPN			2.b	<i>Identified target symptoms are documented.</i>	90%	2.c	<i>Participation in treatment is documented.</i>	85%	2.d	<i>Progress towards objective in the Wellness and Recovery Plan (is documented).</i>	79%
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F.1.a.v	monitored appropriately for side effects;	<table border="1" data-bbox="991 984 1885 1097"> <tr> <th colspan="3">Monthly PPN</th> </tr> <tr> <td data-bbox="991 1027 1087 1060">6.b</td> <td data-bbox="1087 1027 1793 1060"><i>Monitoring of side effects (is documented.)</i></td> <td data-bbox="1793 1027 1885 1060">76%</td> </tr> <tr> <td data-bbox="991 1060 1087 1097">6.c</td> <td data-bbox="1087 1060 1793 1097"><i>AIMS is completed.</i></td> <td data-bbox="1793 1060 1885 1097">65%</td> </tr> </table> <p data-bbox="991 1138 1885 1170">No comparative data were available for this item.</p>	Monthly PPN			6.b	<i>Monitoring of side effects (is documented.)</i>	76%	6.c	<i>AIMS is completed.</i>	65%			
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6.c	<i>AIMS is completed.</i>	65%												
F.1.a.vi	modified based on clinical rationales;	<table border="1" data-bbox="991 1248 1885 1396"> <tr> <th colspan="3">Monthly PPN</th> </tr> <tr> <td data-bbox="991 1292 1087 1325">6.a.1</td> <td data-bbox="1087 1292 1793 1396"><i>The risks, benefits and rationale for the current psychopharmacology plan including anticholinergics, benzodiazepines, and polypharmacy are documented.</i></td> <td data-bbox="1793 1292 1885 1396">62%</td> </tr> </table>	Monthly PPN			6.a.1	<i>The risks, benefits and rationale for the current psychopharmacology plan including anticholinergics, benzodiazepines, and polypharmacy are documented.</i>	62%						
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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	<table border="1"> <tr> <td colspan="3">Monthly PPN</td> </tr> <tr> <td>2.c</td> <td><i>Participation in treatment is documented.</i></td> <td>85%</td> </tr> <tr> <td>6.b</td> <td><i>Monitoring of side effects (is documented.)</i></td> <td>76%</td> </tr> <tr> <td>6.c</td> <td><i>AIMS is completed.</i></td> <td>64%</td> </tr> </table> <p>No comparative data for available for this item</p>	Monthly PPN			2.c	<i>Participation in treatment is documented.</i>	85%	6.b	<i>Monitoring of side effects (is documented.)</i>	76%	6.c	<i>AIMS is completed.</i>	64%
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F.1.a.viii	Properly documented.	<p>The facility provided the following weighted means for all items above:</p> <table border="1"> <tr> <td>Admission Psychiatric Assessment</td> <td>48%</td> </tr> <tr> <td>Integrated Assessment (Psychiatry)</td> <td>33%</td> </tr> <tr> <td>Monthly PPN</td> <td>77%</td> </tr> </table>	Admission Psychiatric Assessment	48%	Integrated Assessment (Psychiatry)	33%	Monthly PPN	77%						
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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, January 2008: Ensure that all PRN orders for psychotropic medications are limited to no more than 15 days of use before the orders are reviewed and rewritten as necessary. This time limit should be gradually shortened to three days of use.</p> <p>Findings: As of May 2008, NSH had not implemented this recommendation. The facility reported that in August 2008, its Pharmacy and Therapeutics</p>												

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		<p>(P&T) Committee approved a time limit of 14 days.</p> <p>Recommendation 2, January 2008: Finalize a PRN Audit Form and accompanying instructions for use across DMH facilities.</p> <p>Findings: The DMH Monthly PPN Auditing Form is sufficient to monitor this requirement.</p> <p>Recommendation 3, January 2008: Monitor the use of PRN and Stat medications based on at least a 20% sample and provide data analysis regarding low compliance and delineation of areas of relative improvement.</p> <p>Findings: NSH used the above-mentioned process of DMH Monthly PPN Auditing. The following is a summary of the compliance data:</p> <table border="1" data-bbox="991 894 1887 1081"> <thead> <tr> <th colspan="3">Monthly PPN</th> </tr> </thead> <tbody> <tr> <td data-bbox="991 935 1087 1081">7.</td> <td data-bbox="1087 935 1793 1081"><i>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:</i></td> <td data-bbox="1793 935 1887 1081">40%</td> </tr> </tbody> </table> <p>Comparative data showed that the mean compliance rate has increased from 42% in December 2007 to 47% in May 2008. The facility did not present data on the sub-indicators that are needed to better assess compliance with the requirement.</p> <p>The facility reported that beginning in July, 2008, Stat orders began to be reviewed weekly and greater emphasis was placed on utilizing the NSH PPN template in order to improve compliance. As mentioned</p>	Monthly PPN			7.	<i>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:</i>	40%
Monthly PPN								
7.	<i>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:</i>	40%						

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		<p>above, the P&T Committee approved a time limit of 14 days as a maximum length of PRN orders (August 2008).</p> <p>NSH also used the DMH Nursing Services Monitoring Auditing forms (PRN and Stat) to assess compliance (February to May 2008). The average samples were 33% and 34% of the number of PRN and Stat medications administered each month, respectively. However, the data are not presented in this report because of inconsistencies in the information provided. In addition, the facility's data analysis included incomprehensible/incomplete information regarding nursing practices.</p> <p>Other findings: See other findings in D.1.f.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Provide documentation of procedure/instruction to ensure that all PRN orders for psychotropic medications are limited to no more than 15 days of use before the orders are reviewed and rewritten as necessary. This time limit should be gradually shortened to three days of use. 2. Monitor this requirement using the DMH Monthly PPN Auditing Form based on at least a 20% sample and present data for the relevant sub-indicators. 3. Present data based on the Nursing Services Monitoring Auditing Forms for PRN and Stat medications that clearly delineates compliance with the following: <ol style="list-style-type: none"> a. Safe administration of PRN medication; b. Documentation of circumstances requiring PRN medication; c. Documentation of the individual's response to PRN medication; d. Safe administration of Stat medications;
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		<p>e. Documentation of the circumstances requiring Stat administration of medications;</p> <p>f. Documentation of the individual's response to Stat medication.</p> <p>4. Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period).</p>															
F.1.c	<p>Each State hospital shall monitor the psychiatric use of benzodiazepines, anticholinergics, and polypharmacy to ensure clinical justification and attention to associated risks.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1, 2 and 3, January 2008:</p> <ul style="list-style-type: none"> • Continue to monitor the use of benzodiazepines, anticholinergics and polypharmacy based on at least a 20% sample size using the standardized DMH instruments. • Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement. • Identify patterns and trends regarding high-risk medication uses and implement corrective and educational actions. <p>Findings: NSH used the DMH Benzodiazepine, Anticholinergics and Polypharmacy Audit Forms to assess compliance (February to April 2008). The following is a summary outline of the monitoring indicators and corresponding mean compliance rates:</p> <table border="1" data-bbox="991 1079 1887 1421"> <tr> <td colspan="3">Benzodiazepines (average S=26% of all individuals receiving regularly scheduled benzodiazepines):</td> </tr> <tr> <td>1.</td> <td><i>Indication for regularly scheduled use of benzodiazepine clearly documented in medical record</i></td> <td>65%</td> </tr> <tr> <td>2.</td> <td><i>Benzodiazepine used for individuals with alcohol / drug use problems justified in PPN</i></td> <td>32%</td> </tr> <tr> <td>3.</td> <td><i>Benzodiazepine used for individuals with cognitive disorders justified in PPN</i></td> <td>45%</td> </tr> <tr> <td></td> <td><i>Routine Benzodiazepine use for more than 2 months,</i></td> <td></td> </tr> </table>	Benzodiazepines (average S=26% of all individuals receiving regularly scheduled benzodiazepines):			1.	<i>Indication for regularly scheduled use of benzodiazepine clearly documented in medical record</i>	65%	2.	<i>Benzodiazepine used for individuals with alcohol / drug use problems justified in PPN</i>	32%	3.	<i>Benzodiazepine used for individuals with cognitive disorders justified in PPN</i>	45%		<i>Routine Benzodiazepine use for more than 2 months,</i>	
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			<i>PPN clearly documents the risks of:</i>																							
		4.	<i>Drug dependence</i>	22%																						
		5.	<i>Cognitive decline</i>	22%																						
		6.	<i>Sedation</i>	25%																						
		7.	<i>Gait unsteadiness / falls if indicated</i>	28%																						
		8.	<i>Respiratory depression (for those with underlying respiratory problems e.g. COPD)</i>	25%																						
		9.	<i>Toxicity if used in individuals with liver impairment (if using long acting agents)</i>	50%																						
		10.	<i>Treatment modified in an appropriate and timely manner to ensure proper indications and to minimize risk.</i>	56%																						
		<p>The mean compliance rates have increased from December 2007 to May 2008 as follows:</p> <table border="1"> <thead> <tr> <th>Item</th> <th>Change in compliance rate</th> </tr> </thead> <tbody> <tr> <td>1.</td> <td>44% to 56%</td> </tr> <tr> <td>2.</td> <td>13% to 82%</td> </tr> <tr> <td>3.</td> <td>0% to 96%</td> </tr> <tr> <td>4.</td> <td>11 to 59%</td> </tr> <tr> <td>5.</td> <td>3% to 38%</td> </tr> <tr> <td>6.</td> <td>3% to 47%</td> </tr> <tr> <td>7.</td> <td>4% to 66%</td> </tr> <tr> <td>8.</td> <td>0% to 96%</td> </tr> <tr> <td>9.</td> <td>0% to 88%</td> </tr> <tr> <td>10.</td> <td>41% to 80%</td> </tr> </tbody> </table>			Item	Change in compliance rate	1.	44% to 56%	2.	13% to 82%	3.	0% to 96%	4.	11 to 59%	5.	3% to 38%	6.	3% to 47%	7.	4% to 66%	8.	0% to 96%	9.	0% to 88%	10.	41% to 80%
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		restrictions on the unjustified use of these medications by the P&T Committee, full implementation of the NSH PPN template and other actions reported in D.1.a.
		Anticholinergics (average S=17%, with N varying depending on the indicator)
1.	Indication for use of anticholinergic clearly documented in PPN (N = All individuals on any of the the four anticholinergics)	71%
	Regularly scheduled anticholinergics for more than two months clearly documented in the PPN risks of: (N= All individuals over age 60 and with cognitive impairment of any type for #2-6.)	
2.	Cognitive impairment	27%
3.	Sedation	22%
4.	Gait unsteadiness/falls	32%
5.a	Blurred vision	18%
5.b	Constipation	15%
5.c	Urinary retention	15%
6.	Worsening narrow angle glaucoma	48%
	Regularly scheduled anticholinergics use for more than 2 months clearly document in PPN risks of: (N= all individuals on anticholinergics for more than two months regardless of age or cognitive status for #7-13.)	
7.	Cognitive impairment	20%
8.	Sedation as indicated	14%
9.	Gait unsteadiness / falls (as indicated)	19%
10.a	Blurred vision	13%
10.b	Constipation	13%
10.c	Urinary retention	11%
11.	Worsening narrow angle glaucoma, if present	24%

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		12.	Substance abuse/dependence if listed on Axis I	14%																																					
		13.	Worsening TD if present	37%																																					
		14.	Dosage is within DMH psychotropic medication policy (unless TRC/MRC consult was obtained. N= all individuals on the four anticholinergics for #14.	94%																																					
		15.	Treatment modified in an appropriate and timely manner to ensure proper indications and minimize risk. N= all individuals on anticholinergics for more than two months regardless of age or cognitive status for #15.	50%																																					
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		<p>the facility's psychiatrists are not following the Therapeutic Review Committee (TRC) recommendations and/or not documenting the reason for ignoring these recommendations. In May 2008, NSH's MEC started utilizing Senior Psychiatrist reviews of polypharmacy and TRC recommendations and conducting focused reviews of cases for which there is no documented justification for polypharmacy.</p> <p>Other findings: This monitor reviewed the charts of individuals receiving long-term treatment with the following types of medication use:</p> <ol style="list-style-type: none"> 1. Benzodiazepines in presence of diagnoses of substance use disorders and/or cognitive disorders (#10); 2. Anticholinergic medications for individuals diagnosed with cognitive disorders (#5); and 3. Various forms of polypharmacy (#5). <p>The review was based on the medications received as of May 1, 2008.</p> <p>The reviews found evidence of apparent decrease in the overall use of anticholinergic medications for individuals with cognitive disorders. However, the reviews found that too many individuals are still receiving long-term regular treatment with benzodiazepines (lorazepam and/or clonazepam) and/or anticholinergic medications (benztropine and/or diphenhydramine) without documented justification.</p> <p>Regarding polypharmacy, the review found that too many individuals were receiving various combinations of intra-class polypharmacy including up to four antipsychotic medications as well as inter-class polypharmacy without documentation of the rationale for polypharmacy, associated risks, including drug-drug interactions and/or attempts to simplify/optimize the regimen. This was noted</p>
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		<p>The following tables outline the reviews:</p> <table border="1"> <thead> <tr> <th colspan="3">Benzodiazepine use</th> </tr> <tr> <th>Individual</th> <th>Medication(s)</th> <th>Diagnosis</th> </tr> </thead> <tbody> <tr> <td>CAD</td> <td>Lorazepam</td> <td>Polysubstance Dependence</td> </tr> <tr> <td>CRS</td> <td>Clonazepam</td> <td>Polysubstance Dependence</td> </tr> <tr> <td>GBO</td> <td>Lorazepam</td> <td>Polysubstance Dependence</td> </tr> <tr> <td>KT</td> <td>Clonazepam</td> <td>Mild Mental Retardation</td> </tr> <tr> <td>LG</td> <td>Lorazepam</td> <td>Alcohol Dependence</td> </tr> <tr> <td>MAW</td> <td>Lorazepam</td> <td>Dementia Due to General Medical Condition With Behavioral Disturbance</td> </tr> <tr> <td>REA</td> <td>Lorazepam</td> <td>Polysubstance Dependence and Cognitive Disorder NOS</td> </tr> <tr> <td>RLH</td> <td>Lorazepam</td> <td>Mild Mental Retardation</td> </tr> <tr> <td>RVG</td> <td>Lorazepam</td> <td>Dementia Due to General Medical Condition With Behavioral Disturbance</td> </tr> <tr> <td>VLC</td> <td>Lorazepam</td> <td>Mild Mental Retardation</td> </tr> </tbody> </table> <table border="1"> <thead> <tr> <th colspan="3">Anticholinergic use</th> </tr> <tr> <th>Individual</th> <th>Medication(s)</th> <th>Diagnosis</th> </tr> </thead> <tbody> <tr> <td>BB</td> <td>Benztropine</td> <td>Cognitive Disorder NOS</td> </tr> <tr> <td>DRZ</td> <td>Trihexyphenidyl</td> <td>Mild Mental Retardation</td> </tr> <tr> <td>JDN</td> <td>Benztropine</td> <td>Dementia Due to General Medical Condition With Behavioral Disturbance</td> </tr> <tr> <td>JTS</td> <td>Diphenhydramine</td> <td>Borderline Intellectual Functioning</td> </tr> <tr> <td>LG</td> <td>Benztropine</td> <td>Mild Mental Retardation</td> </tr> <tr> <td>RLH</td> <td>Benztropine</td> <td>Mild Mental Retardation</td> </tr> </tbody> </table>	Benzodiazepine use			Individual	Medication(s)	Diagnosis	CAD	Lorazepam	Polysubstance Dependence	CRS	Clonazepam	Polysubstance Dependence	GBO	Lorazepam	Polysubstance Dependence	KT	Clonazepam	Mild Mental Retardation	LG	Lorazepam	Alcohol Dependence	MAW	Lorazepam	Dementia Due to General Medical Condition With Behavioral Disturbance	REA	Lorazepam	Polysubstance Dependence and Cognitive Disorder NOS	RLH	Lorazepam	Mild Mental Retardation	RVG	Lorazepam	Dementia Due to General Medical Condition With Behavioral Disturbance	VLC	Lorazepam	Mild Mental Retardation	Anticholinergic use			Individual	Medication(s)	Diagnosis	BB	Benztropine	Cognitive Disorder NOS	DRZ	Trihexyphenidyl	Mild Mental Retardation	JDN	Benztropine	Dementia Due to General Medical Condition With Behavioral Disturbance	JTS	Diphenhydramine	Borderline Intellectual Functioning	LG	Benztropine	Mild Mental Retardation	RLH	Benztropine	Mild Mental Retardation
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Polypharmacy use		
Individual	Medication(s)	Diagnosis
AJM	Quetiapine, chlorpromazine, divalproex and lorazepam.	
AKS	Risperidone, olanzapine, ziprasidone, lorazepam, divalproex, and benztropine	Polysubstance Dependence
CDC	Olanzapine (PRN), risperidone, risperidone microspheres, fluphenazine decanoate, lorazepam and temazepam	
JPJ	Clozapine, haloperidol, olanzapine, aripiprazole, lithium, lamotrigine and lorazepam.	
LDC	Risperidone microspheres, ziprasidone, carbamazepine and trihexyphenidyl,	
PSR	Olanzapine, risperidone, divalproex, clonazepam, buspirone, duloxetine and hydroxyzine	Polysubstance Dependence
RCW	Clozapine, quetiapine, clorimipramine, divalproex and lorazepam.	
RS	Trifluoperazine, ziprasidone, olanzapine, fluoxetine, lorazepam and temazepam (PRN).	Other Substance Abuse

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		SLH	Chlorpromazine, quetiapine, aripiprazole, divalproex, trazadone, lorazepam and diphenhydramine.	
		WJB	Thiothexine, haloperidol, olanzapine, clonazepam, benztropine, trihexyphenidyl, lamotrigine and citalopram.	Polysubstance Dependence
		<p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Monitor these requirements using the standardized DMH tools based on at least a 20% sample. 2. Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period). 		
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, January 2008: Finalize the DMH tool regarding the monitoring of new generation antipsychotics for use across facilities.</p> <p>Findings: DMH is in the process of implementing this recommendation.</p> <p>Recommendations 2,3 and 4 January 2008:</p> <ul style="list-style-type: none"> • Monitor this item based on at least a 20% sample and present data separately by drug. • Provide data analysis that evaluates low compliance and delineates areas of relative improvement. 		

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		<ul style="list-style-type: none"> Implement corrective actions to improve compliance with this requirement. <p>Findings: NSH used the current NSH New Generation Antipsychotic (NGA) Medication Auditing Form to assess compliance (January to May 2008). The facility reviewed an average sample of 69% of the individuals receiving any one or combination of the following medications: aripiprazole, clozapine, olanzapine, risperidone, quetiapine and ziprasidone. The following is a summary of the compliance data:</p> <table border="1" data-bbox="991 597 1873 1395"> <tr> <td>2.</td> <td><i>Family/personal risk factors addressed in PPN (if medication started within last 90 days)</i></td> <td>87%</td> </tr> <tr> <td>2.a</td> <td><i>Dose initiation meets requirements</i></td> <td>89%</td> </tr> <tr> <td>2.b</td> <td><i>Dose titration meets requirements</i></td> <td>87%</td> </tr> <tr> <td>3.</td> <td><i>Justification documented in PPN for individuals with diagnosis of:</i></td> <td>37%</td> </tr> <tr> <td>3.a</td> <td><i>Dyslipidemia</i></td> <td>42%</td> </tr> <tr> <td>3.b</td> <td><i>Diabetes</i></td> <td>39%</td> </tr> <tr> <td>3.c</td> <td><i>Obesity</i></td> <td>41%</td> </tr> <tr> <td>4.</td> <td><i>Justification for use documented in PPN for individuals on risperdone with hyperprolactinemia.</i></td> <td>15%</td> </tr> <tr> <td>5.</td> <td><i>Appropriate monitoring for postural hypotension for individual >60 y/o with BP <90/60 on quetiapine, clozapine</i></td> <td>No data</td> </tr> <tr> <td>6.</td> <td><i>ECG within previous 12 months if on Clozaril</i></td> <td>33%</td> </tr> <tr> <td>7.</td> <td><i>Appropriate baseline and regular monitoring of:</i></td> <td>85%</td> </tr> <tr> <td>7.a</td> <td><i>Body Mass Index</i></td> <td>89%</td> </tr> <tr> <td>7.b</td> <td><i>Waist circumference</i></td> <td>87%</td> </tr> <tr> <td>8.</td> <td><i>Appropriate Labs:</i></td> <td>53%</td> </tr> <tr> <td>8.a</td> <td><i>Lipid Panel</i></td> <td>80%</td> </tr> <tr> <td>8.a</td> <td><i>HgbA1C</i></td> <td>55%</td> </tr> </table>	2.	<i>Family/personal risk factors addressed in PPN (if medication started within last 90 days)</i>	87%	2.a	<i>Dose initiation meets requirements</i>	89%	2.b	<i>Dose titration meets requirements</i>	87%	3.	<i>Justification documented in PPN for individuals with diagnosis of:</i>	37%	3.a	<i>Dyslipidemia</i>	42%	3.b	<i>Diabetes</i>	39%	3.c	<i>Obesity</i>	41%	4.	<i>Justification for use documented in PPN for individuals on risperdone with hyperprolactinemia.</i>	15%	5.	<i>Appropriate monitoring for postural hypotension for individual >60 y/o with BP <90/60 on quetiapine, clozapine</i>	No data	6.	<i>ECG within previous 12 months if on Clozaril</i>	33%	7.	<i>Appropriate baseline and regular monitoring of:</i>	85%	7.a	<i>Body Mass Index</i>	89%	7.b	<i>Waist circumference</i>	87%	8.	<i>Appropriate Labs:</i>	53%	8.a	<i>Lipid Panel</i>	80%	8.a	<i>HgbA1C</i>	55%
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		8.c	<i>Prolactin level if on risperidone</i>	49%																								
		9.	<i>If individual is female, annual breast exam</i>	55%																								
		<p>NSH did not provide comparative data (December 2007 to May 2008) as requested. The facility reported that it is in the process of developing an alert, in the Physician Order System Database, to facilitate compliance with the monitoring requirements regarding the use of NGA medications. The facility also reported that the P&T Committee is instituting corrective actions to limit the unjustified use of NGA polypharmacy.</p> <p>Other findings: This monitor reviewed the charts of 11 individuals who were receiving NGAs and suffering from a variety of metabolic disorders. The following table outlines the initials of the individuals, the medication(s) used and the metabolic disorder(s):</p>																										
		<table border="1"> <thead> <tr> <th data-bbox="989 824 1142 863">Individual</th> <th data-bbox="1142 824 1478 863">Medication(s)</th> <th data-bbox="1478 824 1862 863">Diagnosis</th> </tr> </thead> <tbody> <tr> <td data-bbox="989 863 1142 938">CAG</td> <td data-bbox="1142 863 1478 938">Olanzapine, risperidone and paliperidone</td> <td data-bbox="1478 863 1862 938">Diabetes Mellitus</td> </tr> <tr> <td data-bbox="989 938 1142 1013">DRZ</td> <td data-bbox="1142 938 1478 1013">Risperidone</td> <td data-bbox="1478 938 1862 1013">Diabetes Mellitus, Hyperlipidemia and Obesity</td> </tr> <tr> <td data-bbox="989 1013 1142 1088">GDS</td> <td data-bbox="1142 1013 1478 1088">Clozapine and risperidone</td> <td data-bbox="1478 1013 1862 1088">Diabetes Mellitus, Hyperlipidemia and Obesity</td> </tr> <tr> <td data-bbox="989 1088 1142 1162">GLH</td> <td data-bbox="1142 1088 1478 1162">Olanzapine</td> <td data-bbox="1478 1088 1862 1162">Diabetes Mellitus and Obesity</td> </tr> <tr> <td data-bbox="989 1162 1142 1237">GMW</td> <td data-bbox="1142 1162 1478 1237">Quetiapine</td> <td data-bbox="1478 1162 1862 1237">Diabetes Mellitus, Hyperlipidemia and Obesity</td> </tr> <tr> <td data-bbox="989 1237 1142 1312">JMC</td> <td data-bbox="1142 1237 1478 1312">Olanzapine and clozapine</td> <td data-bbox="1478 1237 1862 1312">Hyperlipidemia</td> </tr> <tr> <td data-bbox="989 1312 1142 1424">KJM</td> <td data-bbox="1142 1312 1478 1424">Clozapine</td> <td data-bbox="1478 1312 1862 1424">Diabetes Mellitus, Hyperlipidemia, Obesity and Polydipsia/Hyponatremia</td> </tr> </tbody> </table>			Individual	Medication(s)	Diagnosis	CAG	Olanzapine, risperidone and paliperidone	Diabetes Mellitus	DRZ	Risperidone	Diabetes Mellitus, Hyperlipidemia and Obesity	GDS	Clozapine and risperidone	Diabetes Mellitus, Hyperlipidemia and Obesity	GLH	Olanzapine	Diabetes Mellitus and Obesity	GMW	Quetiapine	Diabetes Mellitus, Hyperlipidemia and Obesity	JMC	Olanzapine and clozapine	Hyperlipidemia	KJM	Clozapine	Diabetes Mellitus, Hyperlipidemia, Obesity and Polydipsia/Hyponatremia
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		RMP	Olanzapine and risperidone	Diabetes Mellitus and Hyperlipidemia
		SAR	Risperidone and ziprasidone	Diabetes Mellitus
		TEH	Quetiapine	Diabetes Mellitus, Hyperlipidemia and Morbid Obesity
		VH	Risperidone and clozapine	Obesity
<p>This review showed that in general, the facility provided adequate laboratory monitoring of the metabolic indicators, blood counts and vital signs in individuals at risk. However, a pattern of deficiencies was noted. This pattern must be corrected in order to achieve substantial compliance. The following is an outline of the deficiencies:</p> <ol style="list-style-type: none"> 1. There was inadequate laboratory monitoring of serum lipase and amylase in individuals currently receiving high-risk treatment with olanzapine and risperidone (CAG), risperidone (SAR), risperidone and clozapine (VH) and quetiapine (GMW and TEH). 2. There was inadequate laboratory monitoring of serum lipids in individuals diagnosed with Diabetes Mellitus and receiving high-risk treatment with olanzapine (CAG) and risperidone (SAR). 3. The WRPs and corresponding psychiatric progress notes did not address significant weight gain in an individual who suffered from Diabetes Mellitus and Hyperlipidemia who received high-risk treatment with olanzapine and risperidone (RMP). 4. The WRP and corresponding psychiatric progress notes did not address worsening status of hyperlipidemia in two individuals diagnosed with Diabetes Mellitus, Hyperlipidemia and Obesity who had significant elevation of serum lipids since January/February 2008 and were receiving high-risk treatment with risperidone (DRZ) and clozapine (KJM). 5. There was inadequate laboratory and clinical monitoring of 				

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		<p>endocrine status in female individuals who were receiving high-risk treatment with risperidone (e.g. SAR).</p> <p>6. There was no documentation of timely attempts to utilize safer treatment alternatives for individuals diagnosed with Diabetes Mellitus, Hyperlipidemia and Obesity, and receiving high-risk treatment with risperidone (DRZ) and quetiapine (TEH). There was no documentation of timely psychiatric reassessment since April 2008 for DRZ.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Finalize the DMH tool regarding the monitoring of new generation antipsychotics for use across facilities. 2. Monitor these requirements using the standardized DMH tools based on at least a 20% sample. 3. Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period).
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 while he/she is receiving antipsychotic medication, and every 3 months if the test is positive, TD is present, or the individual has a history of TD.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, January 2008:</p> <ul style="list-style-type: none"> • Develop and implement systems to ensure accurate identification of all individuals with current diagnosis or history of TD. • Ensure consistent implementation of recommendations made by the TD clinic. • Ensure that the TD statement/policy/procedure addresses management strategies. <p>Findings: NSH is in the process of implementing these recommendations. The</p>

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		<p>facility reported that training (regarding TD management strategies) was provided to 50% of the psychiatrists on July 10, 2008 and will be provided to the remaining psychiatrists in August 2008.</p> <p>Recommendation 4, January 2008: Monitor this requirement based on a 100% sample and provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement.</p> <p>Findings: NSH used the DMH TD Auditing Form to assess compliance (January to may 2008). The average sample and target population varied depending on the indicator, but were not identified for some indicators. The following is a summary of the compliance data:</p> <table border="1" data-bbox="991 743 1894 1421"> <tr> <td data-bbox="991 743 1087 821">1.</td> <td data-bbox="1087 743 1793 821"><i>A baseline assessment shall be performed for each individual at admission.</i></td> <td data-bbox="1793 743 1894 821">91%</td> </tr> <tr> <td data-bbox="991 821 1087 932">2.</td> <td data-bbox="1087 821 1793 932"><i>Subsequent monitoring of the individual every 12 months while he/she is receiving antipsychotic medication</i></td> <td data-bbox="1793 821 1894 932">78%</td> </tr> <tr> <td data-bbox="991 932 1087 1042">3.</td> <td data-bbox="1087 932 1793 1042"><i>Monitoring of the individual is conducted every 3 months if the test (AIMS or DISCUS) is positive, TD is present, or the individual has a history of TD.</i></td> <td data-bbox="1793 932 1894 1042">44%</td> </tr> <tr> <td data-bbox="991 1042 1087 1153">4.</td> <td data-bbox="1087 1042 1793 1153"><i>If an older generation antipsychotic is used there is evidence in monthly physician progress note of justification of using the older generation medication.</i></td> <td data-bbox="1793 1042 1894 1153">60%</td> </tr> <tr> <td data-bbox="991 1153 1087 1230">5.</td> <td data-bbox="1087 1153 1793 1230"><i>A neurology consultation / TD Clinic evaluation was completed as indicated.</i></td> <td data-bbox="1793 1153 1894 1230">59%</td> </tr> <tr> <td data-bbox="991 1230 1087 1383">6.</td> <td data-bbox="1087 1230 1793 1383"><i>Monthly progress notes for the past 3 months indicate that antipsychotic treatment has been modified to reduce risk or there is documentation of rationale for continuation.</i></td> <td data-bbox="1793 1230 1894 1383">60%</td> </tr> <tr> <td data-bbox="991 1383 1087 1421">7.</td> <td data-bbox="1087 1383 1793 1421"><i>Tardive Dyskinesia is included in Focus 6 of the WRP.</i></td> <td data-bbox="1793 1383 1894 1421">65%</td> </tr> </table>	1.	<i>A baseline assessment shall be performed for each individual at admission.</i>	91%	2.	<i>Subsequent monitoring of the individual every 12 months while he/she is receiving antipsychotic medication</i>	78%	3.	<i>Monitoring of the individual is conducted every 3 months if the test (AIMS or DISCUS) is positive, TD is present, or the individual has a history of TD.</i>	44%	4.	<i>If an older generation antipsychotic is used there is evidence in monthly physician progress note of justification of using the older generation medication.</i>	60%	5.	<i>A neurology consultation / TD Clinic evaluation was completed as indicated.</i>	59%	6.	<i>Monthly progress notes for the past 3 months indicate that antipsychotic treatment has been modified to reduce risk or there is documentation of rationale for continuation.</i>	60%	7.	<i>Tardive Dyskinesia is included in Focus 6 of the WRP.</i>	65%
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<p>Other findings:</p>																						
<p>This monitor reviewed the charts of six individuals (FHT, JHM, JRD, MAS, MJF and WCF) who were diagnosed with tardive dyskinesia as per the WRPs and/or the psychiatric assessments. The facility has a database that identified 11 individuals with this diagnosis. This review found that NSH has made progress as follows:</p>																						
<ol style="list-style-type: none"> 1. The WRPs included diagnosis, focus and corresponding objectives and interventions related to tardive dyskinesia in most of the charts reviewed. 2. The objectives and interventions related to tardive dyskinesia utilized appropriate leaning outcomes in a few charts (e.g. RAS). 3. The admission AIMS tests were completed in most of the charts reviewed. The test was not available for review in an individual who 																						

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		<p>was admitted in 1994 (JHM).</p> <ol style="list-style-type: none"> 4. The quarterly AIMS tests were completed in all the charts reviewed, except one (FHT). 5. Two charts (JHM and WCF) documented attempts to utilize and/or optimize safer antipsychotic treatment alternatives. 6. None of the charts reviewed included evidence of unjustified long-term use of anticholinergic medications. <p>However, the review also showed a pattern of deficiencies as follows:</p> <ol style="list-style-type: none"> 1. The facility's database appeared to underestimate the number of individuals suffering from involuntary abnormal movements compared to other facilities with similar populations of individuals receiving long-term antipsychotic medications. 2. Several individuals were diagnosed with tardive dyskinesia as per the WRPs and/or psychiatric assessments but were not included in the facility's database (JHM, MAS and MJF). 3. The facility's database did not identify individuals with history of tardive dyskinesia and positive AIMS who do not currently carry a diagnosis of tardive dyskinesia. 4. The WRP included an inappropriate focus statement regarding the involuntary movement disorder (JHM). 5. The WRP identified TD as a diagnosis but did not include corresponding focus, objectives or interventions (JRD and WCF). 6. Admission AIMS was not completed in the chart of JRD due to the individual's refusal, with no documentation of subsequent attempts to obtain the required data when the individual was agreeable. <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement systems to ensure accurate identification of
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		<p>all individuals with current diagnosis or history of TD.</p> <ol style="list-style-type: none"> 2. Ensure consistent implementation of recommendations made by the TD clinic. 3. Ensure that the TD statement/policy/procedure addresses management strategies. 4. Monitor this requirement based on a 100% sample and identify the target population for all indicators. 5. Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period).
F.1.f	<p>Each State hospital shall ensure timely identification, reporting, data analyses, and follow up remedial action regarding all adverse drug reactions ("ADR").</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, January 2008: Ensure that the current ADR policy and procedure, instructions and data collection tool correct all of the deficiencies listed in the July 2007 monitor's report.</p> <p>Findings: NSH has implemented this recommendation. The facility revised its AD#554, ADRs (June 2008). The revised AD contains a policy and procedure and data collection tool that corrects the process deficiencies outlined by this monitor. Training on the revised procedure was provided to the psychiatry staff in May 2008.</p> <p>Recommendation 2, January 2008: Present summary data to address the following:</p> <ol style="list-style-type: none"> a. Number of ADRs reported during the review period compared with the number during the previous period; b. Classification of ADRs by outcome category; c. Clinical information regarding each ADR that was classified as severe and the outcome to the individual involved; d. Information regarding any intensive case analysis done for each

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		<p>reaction that was classified as severe and for any other reaction.</p> <p>e. Ensure that all intensive case analysis include, as appropriate, conclusions and corrective action recommendations.</p> <p>Findings: NSH has improved the processes of reporting and analysis of ADRs during this review period. The facility's data showed an increase in the reports of ADRs from 495 during the previous six month period (July to December 2008) to 520 during this five-month period (January to May 2008). The classification by outcome and probability showed that eight ADRs (2% of total) met criteria for severe reactions and 30 ADRs (5% of total) were rated as definite reactions using the probability scale.</p> <p>NSH conducted adequate intensive case analyses (ICAs) on all severe ADRs. The ICAs included appropriate recommendations and corrective actions. The ADRs involved the following:</p> <ol style="list-style-type: none"> 1. Hypotension on clozapine resulting in ER evaluation; 2. Hypotension while on Peg-Interferon with ziprasidone resulting in hospitalization and discontinuation of medication 3. Elevated CPK on Entacapone and Carbidopa/Levodopa; 4. Sub-therapeutic dosing of clindamycin resulting in hospitalization; 5. Shortness of breath and cardiomyopathy while on clozapine resulting in hospitalization and medication discontinuation; 6. Severe agranulocytosis on clozapine resulting in hospitalization and medication discontinuation; and 7. Elevated Liver Function Tests and Acute Hepatitis on Ribavirin/Interferon resulting in hospitalization and medication discontinuation. <p>Compliance: Partial.</p>
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		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Present summary data to address the following: <ol style="list-style-type: none"> a. Number of ADRs reported during the review period compared with the number during the previous period; b. Classification of ADRs by outcome category compared with the number during the previous period; c. Clinical information regarding each ADR that was classified as severe and the outcome to the individual involved; d. Information regarding any intensive case analysis done for each reaction that was classified as severe and for any other reaction. e. Outline of intensive case analysis including description of ADR, recommendations and actions taken. 2. Provide analysis of patterns and trends, with corrective/educational actions related to ADRs.
F.1.g	<p>Each State hospital shall ensure drug utilization evaluation ("DUE") occurs in accord with established, up-to-date medication guidelines that shall specify indications, contraindications, and screening and monitoring requirements for all psychotropic medications; the guidelines shall be in accord with current professional literature.</p> <p>A verifiably competent psychopharmacology consultant shall approve the guidelines and ensure adherence to the guidelines.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, January 2008: Implement DUEs, with priority to high-risk and high-volume medications.</p> <p>Findings: During this review period, NSH conducted eight DUEs. These DUEs involved a review of four medications (lamotrigine, benzodiazepines, aripiprazole and alendronate) and four system issues (Therapeutic Review Committee process, use of stimulants in forensic population, use of opiates and use of Lipitor vs. generic equivalent). The DUEs included appropriate recommendations and corrective actions.</p> <p>Recommendation 2, January 2008: Ensure proper aggregation and analysis of DUE data to determine</p>

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		<p>practitioner and group patterns and trends.</p> <p>Findings: NSH's data that were derived from the DMH auditing instruments of benzodiazepines, anticholinergics and polypharmacy, the NSH tool regarding use of NGA medications and the facility's DUE are appropriate steps in this venue (see F.1.c and F.1.e). The facility plans to continue to utilize these tools to complete this analysis, including corrective/educational actions to improve performance.</p> <p>Recommendation 3, January 2008: Ensure that the individualized medication guidelines are continually updated to reflect current literature, relevant clinical experience and current professional practice guidelines.</p> <p>Findings: Same as other findings in F.1.a</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Provide summary data on DUEs conducted during the review period, including topic, findings, recommendations and actions taken. 2. Same as in F.1.a
F.1.h	Each State hospital shall ensure documentation, reporting, data analyses, and follow up remedial action regarding actual and potential medication variances ("MVR") consistent with generally accepted professional standards of care.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, January 2008: Implement the new data collection policy and procedure, tool and instructions regarding reporting of variances.</p>

		<p>Findings: NSH revised its policy and procedure regarding Medication Variance: Reporting and Monitoring in January 2008 and implemented the new MVR data collection tool and instruction in May 2008. The facility provided training on the new process to psychiatry staff (April 16 and July 9, 2008) as well as ongoing training of the nursing staff. Effective July 2008, NSH began to report aggregated MVR data to its P&T Committee.</p> <p>Recommendations 2 and 3 January 2008:</p> <ul style="list-style-type: none"> • Present summary data to address the following: <ul style="list-style-type: none"> ○ Number of variances reported during the review period compared with the number during the previous period; ○ Classification of variance by actual vs. potential; ○ Classification of critical breakdown points; ○ Classification of variances by outcome category; ○ Clinical information regarding each variance that was classified as severe and the outcome to the individual involved; ○ Information regarding any intensive case analysis done for each variance classified that was rated as severe and for any other variance. • Ensure that all intensive case analysis include, as appropriate, conclusions and recommendations for corrective action. <p>Findings: NSH has presented data to address the recommendation. However, the data were based on the older data collection process that was found to be inadequate (new process was implemented during May 2008). The data showed that no reaction reached a severity level requiring ICA (the facility reviewed 12 variances and presented the results of the review using an ICA format).</p>
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		<p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Implement the new data collection policy and procedure, tool and instructions regarding reporting of variances. 2. Present data to address the following: <ol style="list-style-type: none"> a. Total number of actual and potential variances during the review period compared with numbers reported during the previous period; b. Number of variances by category (e.g. prescription, administration, documentation, etc) and by potential vs. actual; c. Clinical information regarding each variance (category E or above) and the outcome to the individual involved; d. Information regarding any intensive case analysis done for each reaction that was classified as category E or above and for any other reaction e. Outline of ICAs, including description of variance, recommendations and actions taken 3. Provide analysis of patterns and trends, with corrective/ educational actions related to ADRs.
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 recommendation:</p> <p>Recommendation, January 2008: Same as in F.1.a through F.1.h.</p> <p>Findings: Same as in F.1.a through F.1.h.</p> <p>Compliance: Partial.</p>

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		<p>Current recommendations: Same as in F.1.a through F.1.h.</p>
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 recommendation:</p> <p>Recommendation, January 2008: 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, Therapeutics Review, and Mortality and Morbidity Committees consistent with generally accepted professional standards of care.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: Same as above.</p> <p>Findings: Same as above.</p> <p>Compliance: Partial.</p> <p>Current recommendations: Same as above.</p>
F.1.l	<p>Each State hospital shall ensure that all physicians and clinicians are verifiably competent, consistent</p>	<p>Current findings on previous recommendations:</p>

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	<p>with generally accepted professional standards of care, in appropriate medication management, interdisciplinary team functioning, and the integration of behavioral and pharmacological treatments.</p>	<p>Recommendation 1, January 2008: 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, January 2008: Ensure appointment and utilization of a full complement of senior psychiatrists to assist in the mentoring and monitoring activities required for implementation of the EP.</p> <p>Findings: NSH has appointed Senior Psychiatrists in all five programs (see D.1.a for utilization of these positions relevant to the recommendation). In addition, the facility has appointed Chiefs of Psychiatry, Forensic Psychiatry and the Substance Recovery program.</p> <p>Compliance: Partial.</p> <p>Current recommendations: Same as in D.1.b, D.1.c, D.1.f.viii and F.1.a through F.1.h.</p>
F.1.m	<p>Each State hospital shall review and ensure the appropriateness and safety of the medication treatment, consistent with generally accepted professional standards of care, for:</p>	<p>Compliance: Partial.</p>
F.1.m.i	<p>all individuals prescribed continuous anticholinergic treatment for more than two months;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: Same as in F.1.c.</p>

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		<p>Findings: Same as in F.1.c.</p> <p>Current recommendations: Same as in F.1.c.</p>
F.1.m.ii	all elderly individuals and individuals with cognitive disorders who are prescribed continuous anticholinergic treatment regardless of duration of treatment;	Same as in F.1.c.
F.1.m.iii	all individuals prescribed benzodiazepines as a scheduled modality for more than two months;	Same as in F.1.c.
F.1.m.iv	all individuals prescribed benzodiazepines with diagnoses of substance abuse or cognitive impairments, regardless of duration of treatment; and	Same as in F.1.c.
F.1.m.v	all individuals with a diagnosis or evidencing symptoms of tardive dyskinesia.	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: Same as F.1.e.</p> <p>Findings: Same as F.1.e.</p> <p>Current recommendations: Same as F.1.e.</p>
F.1.m.vi	all individuals diagnosed with dyslipidemia, and/or obesity, and/or diabetes mellitus who are prescribed new generation antipsychotic medications	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: Same as in F.1.d. and F.1.g.</p>

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		<p>Findings: Same as in F.1.d. and F.1.g.</p> <p>Current recommendations: Same as in F.1.d. and F.1.g.</p>
F.1.n	Each State hospital shall ensure that the medication management of individuals with substance abuse disorders is provided consistent with generally accepted professional standards of care.	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: Same as in C.2.o and F.1.c.</p> <p>Findings: Same as in C.2.o and F.1.c.</p> <p>Compliance: Partial.</p> <p>Current recommendations: Same as in C.2.o and F.1.c.</p>
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.	

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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. Eleven individuals: BW, CD, CP, ER, FK, JC, JW, LG, PD, VB and WW 2. Alex Kettner, PsyD, PBS team Leader 3. Anne Hoff, PhD, Senior Supervising Psychologist 4. Barry Wagener, RN, PBS Team Member 5. Carmen Caruso, Clinical Administrator 6. Edna Mulgrew, PhD, Senior Supervising Psychologist, BCC Coordinator 7. Jim Jones, PhD, Chief of Psychology 8. Julie Winn, PsyD, Senior Supervising Psychologist 9. Kathleen Patterson, PhD, Senior Supervising Psychologist 10. Katie Cooper, PsyD, Enhancement Plan Coordinator 11. Kobita Rikhye, PsyD, PBS Team Leader 12. Nami Kim, PhD, Senior Supervising Psychologist 13. Pat White, PhD, Senior Psychologist and PBS Team Leader 14. Patricia Spivey, PsyD, PBS Team Leader 15. Rachel Bramble, PhD, Senior Supervising Psychologist 16. Richard Lesch, PhD, Senior Supervising Psychologist 17. Stephen Hubert, PhD, Senior Supervising Psychologist 18. Tony Rabin, PhD, Mall Coordinator 19. Wendy Hatcher, PsyD, PBS Team Leader <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Charts of the following 47 individuals: AA, AC, AL, AR, AVC, BF, BM, BR, CK, CO, CRR, DC, DH, DN, EC, EEF, EFP, GR, HDW, ID, JM, JN, JW, KC, KT, LG, LW, MC, ME, MP, MR, MVB, MW, OB, PM, RCH, RL, RN, RS, RTP, RW, SS, TLN, TOM, TR, VH, and WB 2. Behavior Guidelines 3. Behavioral Consultation Committee (BCC) Meeting Attendance

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		<p>Roster</p> <ol style="list-style-type: none"> 4. Behavioral Consultation Committee (BCC) Meeting Minutes 5. BY CHOICE Satisfaction Survey Results 6. BY CHOICE Training Attendance Roster 7. BY CHOICE Training Documentation 8. Completed PBS-BCC Checklists 9. List of DCAT Caseload 10. List of DCAT Mall Service 11. Functional Assessments 12. General Management Meeting Minutes 13. List of Completed DSM-IV Checklists 14. List of Individuals Referred for Neuropsychological Assessment and Completed 15. List of Individuals Referred for Neuropsychological Assessment 16. PBS Plans 17. Psychology Specialist Services Meeting Minutes 18. Staff Certification and Fidelity Checks 19. Structural Assessments 20. Summary list of PBS Consultations with Other Disciplines <p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. WRPC for GMW 2. WRPC for RAB 3. PSR Mall group: New Start for Mental Health 4. PSR Mall group: Stretching/Relaxation 5. PSR Mall group: Mental Health Through Laughter 6. PSR Mall group: Enhancement Motivation 7. PSR Mall group: Social Skills Through Improvisational Theater 8. PSR Mall group: Suicide Prevention Education Awareness Keys 9. BY CHOICE Redemption Center
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<p>F.2.a</p>	<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, January 2008: Continue to recruit additional PBS team members until all PBS teams are fully staffed.</p> <p>Findings: This monitor's interview of the Chief of Psychology and the PBS team members found that NSH does not have the necessary number of PBS teams to meet the 1:300 ratio. NSH has two fully staffed PBS teams. The remaining two teams are short of Psychiatric Technician team members. According to the Chief of Psychology, Jim Jones, NSH has actively advertised and interviewed a number of candidates. However, none of the candidates passed the "Qualifying Appraisal Panel Examination."</p> <p>Recommendation 2, January 2008: Continue to train the RNs, PTs and data analysts in data collection methods and on the reliable use of evidence-based tools until they achieve competency.</p> <p>Findings: This monitor's documentation review (training roster and sign-in sheets) found that NSH has conducted numerous training sessions for its PBS team members between March and May 2008.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to recruit additional PBS team members until all PBS teams are fully staffed. 2. Continue to train all PBS team members until they achieve
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		competency.
F.2.a.i	the development and use of positive behavior support plans, including methods of monitoring program interventions and the effectiveness of the interventions, providing staff training regarding program implementation, and, as appropriate, revising or terminating the program; and	<p>Current findings on previous recommendations:</p> <p>Recommendations 1-3, January 2008:</p> <ul style="list-style-type: none"> • Continue with training and certification of staff responsible for implementing the PBS plans. • Provide documentation that staff in all treatment settings have been trained to competency on all PBS plans. • Continue to conduct fidelity checks prior to implementation of PBS plans. <p>Findings: This monitor's documentation review (PBS plans, staff training documentation) found that NSH has developed and implemented five PBS plans (AL, DC, GR, JM and MR), and staff training has been conducted for those responsible for implementing these five PBS plans. Training has been conducted across settings including the Mall and the school. In all cases, fidelity checks had been conducted prior to implementation of the PBS plans.</p> <p>Recommendation 4, January 2008: Ensure that outcome data is updated in the Present Status section of the case formulation and the PBS plan is identified in the intervention section of the WRP.</p> <p>Findings: This monitor reviewed the charts of five individuals with PBS plans (AL, DC, GR, JM and MR). In all cases, the plans were documented in the Present Status section of the individual's WRP. However, the plans were developed and implemented fairly recently and did not have any outcome data for reporting.</p>

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		<p>While NSH has improved in the areas of assessment to implementation of PBS plans and fidelity checks and progress monitoring after implementation of the PBS plans, NSH should review its process and procedures to ensure that individuals who are not making sufficient progress through the behavior guidelines are referred to the PBS teams. The number of individuals in the facility with significant problems is much higher than the number of individuals with intervention plans (including individual therapies, behavior guidelines, and PBS plans). It is this monitor's hope that with the Psychology Specialty Services meetings, issues regarding those who are not making sufficient progress will be addressed.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue with training and certification of staff responsible for implementing the PBS plans. 2. Provide documentation that staff in all treatment settings have been trained to competency on all PBS plans. Continue to conduct fidelity checks prior to implementation of PBS plans. 3. Ensure that outcome data is updated in the Present Status section of the case formulation and the PBS plan is identified in the intervention section of the 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>Recommendation 1, January 2008: Continue to monitor the implementation of the BY CHOICE program to ensure that the program is being implemented as required by the DMH WRP Manual.</p>

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		<p>Findings: This monitor's interview of the BY CHOICE Coordinator and the Chief of Psychology found that NSH has implemented the BY CHOICE program in line with the DMH WRP Manual. NSH monitors the implementation of the BY CHOICE program on a monthly basis with fidelity checks on both staff and individuals. This monitor's visit to the BY CHOICE incentive store, observation of Mall services, and interview of individuals found that the BY CHOICE program is fully implemented with continued training for both staff and individuals.</p> <p>Recommendation 2, January 2008: Ensure that the program has additional resources, including computers and software necessary for the program to function efficiently.</p> <p>Findings: This monitor's interview of the BY CHOICE coordinator found that the BY CHOICE program lacked resources to be fully functional. The program lacked a system for on-line inventory control, a scanner, computers, store counters, and staffing.</p> <p>Recommendation 3, January 2008: BY CHOICE point allocation should be determined by the individual at the individual's WRPC, with facilitation by the staff, and documented in the Present Status section of the individual's WRP.</p> <p>Findings: This monitor's interview of the BY CHOICE Program Coordinator found that NSH has continued to train its staff in properly implementing the BY CHOICE point allocation. The table below shows the number of staff trained in each program.</p>
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Program	1	2	3	4	5	Non-unit	New hire
# Trained	66	71	72	93	72	49	180

According to the BY CHOICE Program Coordinator, staff training on BY CHOICE point allocation will continue until all staff is trained.

NSH conducted an individual satisfaction survey in March of 2008; question #7 of this survey asked *Do you discuss how you want your points allocated when you meeting with your team during your conferences.* Fifty-eight percent of respondents replied yes.

NSH also conducted fidelity checks on BY CHOICE implementation for level of care staff, BY CHOICE staff, and individuals, reporting mean compliance rates of 58%, 85%, and 60% respectively.

This monitor reviewed 14 charts (AVD, BF, BM, CK, CRR, DH, EC, HDW, ID, JW, RN, RS, TOM and WB). Three of the WRPs in the charts (CRR, HDW and WB) showed that point allocation was conducted with the individual's participation. The remaining 11 (AVD, BF, BM, CK, DH, EC, ID, JW, RN, RS and TOM) did not update the BY CHOICE point allocation and/or the documentation did not show that the individual was the one who made the point allocation with support from the team. None of them had proper BY CHOICE point allocation as required by the DMH WRP Manual. Documentation in many of the WRPs was brief and did not include the various elements to satisfy proper documentation. Documentation on HDW, for example, simply stated that the individual "chose not to participate at this time;" "no point allocation needed at this time" (RN); "did not want to talk about BY CHOICE" (WB); and "does not take BY CHOICE card" (BM). There is no discussion on the status of the individual's performance/participation in

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		<p>areas where the points were allocated and/or what the team intends to do to improve the individual's participation in the BY CHOICE program.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to monitor the implementation of the BY CHOICE program to ensure that the program is being implemented as required by the DMH WRP Manual. 2. Ensure that the program has additional resources, including computers and software necessary for the program to function efficiently. 3. BY CHOICE point allocation should be determined by the individual at the individual's WRPC, with facilitation by the staff, and documented in the Present Status section of the individual's WRP.
F.2.b	<p>Each State Hospital shall ensure that the Chief of Psychology has the clinical and administrative responsibility for the Positive Behavior Supports Team and the By CHOICE incentive program.</p>	<p>Findings: This monitor's interview of the Chief of Psychology found that the Chief of Psychology continues to have the clinical and administrative responsibility for the Positive Behavior Supports Team and the BY CHOICE incentive program. However, the Chief of Psychology has delegated some of the duties to the Coordinator of Psychology Specialist Services.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
F.2.c	<p>Each State Hospital shall ensure that:</p>	<p>Please see sub-cells for compliance findings.</p>

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<p>F.2.c.i</p>	<p>behavioral assessments include structural and functional assessments and, as necessary, functional analysis;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: Implement the Automated WaRMSS and Trigger Tracking systems to track individuals in need of behavioral interventions.</p> <p>Findings: This monitor's interview of the Chief of Psychology and the Director of Standards Compliance found that NSH is using the WaRMSS and EIOR reports and HSS logs to track individuals in need of behavioral interventions. According to the Chief of Psychology, PBS staff visits units to work with staff on developing and implementing behavioral interventions. The PBS staff activities with the unit staff are documented in the IDN and a summary report sent to the Chief of Psychology. Furthermore, the Psychology Specialty Services Committee (PSSC) meets regularly to review individuals who meet trigger thresholds.</p> <p>Using item #5 from the DMH Psychology Services Monitoring form, NSH assessed its compliance based on 100% of the PBS plans developed and implemented during this review period (January to May 2008). The table below with its indicator and sub-indicators and corresponding mean compliance is a summary of the data:</p> <table border="1" data-bbox="989 1078 1894 1414"> <tr> <td data-bbox="989 1078 1087 1154">5.</td> <td data-bbox="1087 1078 1795 1154"><i>PBS assessments include structural and functional assessments, and as necessary, functional analysis</i></td> <td data-bbox="1795 1078 1894 1154">56%</td> </tr> <tr> <td data-bbox="989 1154 1087 1268">5.a</td> <td data-bbox="1087 1154 1795 1268"><i>Pertinent records were reviewed (e.g., individual's chart/record, meeting notes, anecdotal records, evaluations, previous interventions),</i></td> <td data-bbox="1795 1154 1894 1268">100%</td> </tr> <tr> <td data-bbox="989 1268 1087 1414">5.b</td> <td data-bbox="1087 1268 1795 1414"><i>Structural assessments (e.g., ecological, sleep, medication effects, mall attendance) were conducted, as needed, to determine broader variables affecting the individual's behavior,</i></td> <td data-bbox="1795 1268 1894 1414">40%</td> </tr> </table>	5.	<i>PBS assessments include structural and functional assessments, and as necessary, functional analysis</i>	56%	5.a	<i>Pertinent records were reviewed (e.g., individual's chart/record, meeting notes, anecdotal records, evaluations, previous interventions),</i>	100%	5.b	<i>Structural assessments (e.g., ecological, sleep, medication effects, mall attendance) were conducted, as needed, to determine broader variables affecting the individual's behavior,</i>	40%
5.	<i>PBS assessments include structural and functional assessments, and as necessary, functional analysis</i>	56%									
5.a	<i>Pertinent records were reviewed (e.g., individual's chart/record, meeting notes, anecdotal records, evaluations, previous interventions),</i>	100%									
5.b	<i>Structural assessments (e.g., ecological, sleep, medication effects, mall attendance) were conducted, as needed, to determine broader variables affecting the individual's behavior,</i>	40%									

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		5.c	<i>Functional assessment interviews were conducted with people (e.g., individual, parents and family members, therapists and care staff, teachers) who often interact with the individual within different settings and activities, as needed.</i>	100%
		5.d	<i>Direct observations were conducted across relevant circumstances (e.g., multiple settings, over time) and by more than one observer, as appropriate,</i>	0%
		5.e	<i>Other assessment tools (e.g., rating scales, checklists) were used to produce objective information regarding events preceding and following the behavior of concern, as well as ecological and motivational variables that may be affecting the individual's behavior, as needed, and</i>	40%
		5.f	<i>If necessary, suspected maintaining variables were manipulated to assess the motivation(s) for the individual's behavior.</i>	NA
		<p>According to the Chief of Psychology, Senior Psychologists, and PBS team members, NSH plans on further mentoring and supervision to improve performance in the various phases of the development and implementation of PBS plans including monitoring triggers, conducting assessments, developing and implementing the plans, staff training across settings, and continued monitoring of fidelity of treatment implementation. Senior Psychologists are to review drafts and provide feedback to ensure that the plans meet compliance criteria.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Continue to use the WaRMSS, EIOR, and HSS logs, and PSSC to track</p>		

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		and monitor individuals in need of behavioral interventions.
F.2.c.ii	hypotheses of the maladaptive behavior are based on structural and functional assessments;	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: Ensure that hypotheses of maladaptive behavior are based on reliable data.</p> <p>Findings: Using item #6 (<i>The hypotheses of the maladaptive behavior are based on structural and functional assessments</i>) from the DMH Psychology Services Monitoring Form, NSH assessed its compliance by analyzing all (100%) of the PBS plans developed and implemented during this review period (January to May 2008), reporting a mean compliance rate of 60% (the mean compliance from the previous period was 43%). NSH's compliance for the last month of the previous review period was 50% and the compliance from this review period is 75%.</p> <p>This monitor's findings from review of PBS plans (DC, GR, JE, JM and MR) and associated assessments is in agreement with the facility's data. A number of the PBS plans were missing the structural assessments and direct observations. Hypotheses derived without these assessment components would be non-specific and prone to error.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Ensure that hypotheses of maladaptive behavior are based on reliable data.</p>
F.2.c.iii	There is documentation of previous behavioral interventions and their effects;	Current findings on previous recommendation:

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		<p>Recommendation, January 2008: Document previous behavioral interventions and their effects.</p> <p>Findings: Using item #7 (<i>There is documentation of previous behavioral interventions and their effects</i>) from the DMH Psychology Services Monitoring Form, NSH assessed its compliance by analyzing all (100%) of the PBS plans developed and implemented during this review period (January to May 2008), reporting a mean compliance rate of 80% (the mean compliance for the previous review period was 71%). NSH's mean compliance for the last month of the previous review period was 100% and the compliance for the last month of this review period is 75%. This monitor's review of the five PBS plans developed and implemented during this review period (DC, GR, JE, JM and MR) is in agreement with the facility's data.</p> <p>According to the PBS team members, they have been receiving training and feedback from their consultant (Angela Adkins, March 20 and May 22, 2008, with continued consultation via e-mail and phone calls); NSH plans on continuing with training and mentoring to improve compliance to this recommendation.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Document previous behavioral interventions and their effects.</p>
F.2.c.iv	behavioral interventions, which shall include positive behavior support plans, are based on a positive behavior supports model and do not include the use of aversive or punishment contingencies;	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: Ensure that all behavioral interventions are based on a positive behavior supports model and do not include the use of aversive or</p>

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		<p>punishment contingencies.</p> <p>Findings: <i>Using item #8 (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> from the DMH Psychology Services Monitoring Form, NSH assessed its compliance by analyzing all (100%) of the PBS plans developed and implemented during this review period (January to May 2008), reporting a mean compliance rate of 100% (the mean compliance for the previous review period was 86%). NSH's compliance for the last month of the previous review period was 100% and the compliance for the last month of this review period is 100%.</p> <p>This monitor reviewed 16 PBS plans and behavioral interventions (AA, CO, DN, EFP, ID, JN, KC, KT, LG, LW, MVB, MW, RL, SS, TR and VH) developed and implemented during this review period. All 16 intervention plans (100%) were based on a positive behavior supports model and did not include the use of aversive or punishment contingencies.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to conduct all behavioral interventions based on a positive behavior supports model without the use of aversive or punishment contingencies.</p>
F.2.c.v	behavioral interventions are consistently implemented across all settings, including school settings;	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: Continue to implement all behavioral interventions consistently across</p>

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		<p>all settings, including Mall, vocational and education settings.</p> <p>Findings: Using item #9 (<i>Behavioral interventions are consistently implemented across all settings, including school settings</i>) from the DMH Psychology Services Monitoring Form, NSH assessed its compliance by analyzing all (100%) of the PBS plans developed and implemented during this review period (January to May 2008), reporting a mean compliance rate of 100% (the mean compliance for the previous review period was 100%). NSH's compliance for the last month of the previous review period was 100% and the compliance for this review period is 100%.</p> <p>This monitor's review of the fidelity checks, staff certification, and integrity assessments (for example GR and JM) is in agreement with the facility's data.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to implement all behavioral interventions consistently across all settings, including Mall, vocational and education settings.</p>
F.2.c.vi	triggers for instituting individualized behavioral interventions are specified and utilized, and that these triggers include excessive use of seclusion, restraint, or psychiatric PRN and Stat medication for behavior control;	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: Document and present data to show that the system of using trigger data to initiate a Behavior Guideline or obtain PBS consultation is functioning as intended.</p> <p>Findings: This monitor's interview of PBS team members, the Chief of Psychology, and the Senior Supervising Psychologists found that NSH</p>

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has developed multiple systems and procedures to capture individuals who need behavioral interventions. NSH uses the WaRMSS, EIOR reports, and HSS logs to identify and determine individuals in need of behavioral interventions. In addition, Psychology Specialty Services regularly reviews the identified cases and triages to the appropriate level of intervention.

NSH reviewed the number of behavior guidelines/PBS plans developed and/or implemented in response to the number of individuals triggering during this review period (January to May 2008). The table below showing the number of individuals with triggers (N), the number of individuals with behavior guidelines/PBS plans (n), and the types of triggers and the number of individuals under each trigger for the month is a summary of the facility's data.

	Jan	Feb	Mar	Apr	May	Mean
N	566	488	494	478	514	508
n	24	12	16	12	25	18
Restraint	18	16	23	14	21	18
Seclusion	7	5	2	2	2	4
PRN	528	457	453	456	472	473
Stat	13	10	16	6	20	13

As the table above shows, NSH has developed and/or implemented 89 intervention plans for the 110 restraint and seclusion triggers across the five months.

This monitor reviewed 14 charts (AC, AR, CK, CRR, DH, EC, EEF, HDW, ID, JW, PM, RN, RS and WB) of individuals with multiple triggers. All 14 cases had been brought to the attention of the PBS team members. Seven of the 14 cases (CK, DH, EC, EEF, ID, JW and RN) had resulted in the development and/or implementation of intervention plans. The remaining cases failed to meet the PBS team criteria for any kind of

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		<p>interventions. NSH should refine their criteria to ensure that individuals with triggers receive timely and appropriate intervention plans. For individuals displaying maladaptive behaviors but not meeting threshold, staff (unit staff, PBS staff, and PSSC staff) may want to consider behavior guidelines/PBS plans to teach, strengthen, and or improve positive behaviors, incompatible behaviors, social skills etc.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Document and present data to show that the system of using trigger data to initiate a Behavior Guideline or obtain PBS consultation is functioning as intended.</p>
F.2.c.vii	<p>positive behavior support teams and team psychologists integrate their therapies with other treatment modalities, including drug therapy;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: Continue efforts to integrate all behavioral interventions with other treatment modalities, including drug therapy.</p> <p>Findings: Using item #11 (<i>Positive Behavior Support Teams and team psychologists integrate their therapies with other treatment modalities, including drug therapy</i>) from the DMH Psychology Services Monitoring Form, NSH assessed its compliance by analyzing all (100%) of the PBS plans developed and implemented during this review period (January to May 2008), reporting a mean compliance rate of 100% (the mean compliance for the previous review period was 100%).</p> <p>This monitor's documentation review (progress notes, meeting notes, and PBS assessment documentation) on AL, GR, JM and MR was in agreement with the facility's data. This monitor noted that there was</p>

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		<p>increased inter-discipline collaboration at NSH.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue with current efforts to integrate all behavioral interventions with other treatment modalities, including drug therapy.</p>
F.2.c.viii	<p>all positive behavior support plans are specified in the objectives and interventions sections of the individual's Wellness and Recovery Plan;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: 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: This monitor's documentation review (PBS Plans and WRPs) found that PBS plans that were already developed and implemented were specified in the objectives and interventions sections of the individual's WRP plans. In a number of cases (for example, DC, MR, and JM) the plans were at the pre-implementation or conference level and were yet to be specified in the objectives and interventions section of the WRPs.</p> <p>Compliance: Substantial.</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>
F.2.c.ix	<p>all positive behavior support plans are updated as indicated by outcome data and reported at least quarterly in the Present Status section</p>	<p>Current findings on previous recommendation:</p>

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	<p>of the case formulation in the individual's Wellness and Recovery Plan</p>	<p>Recommendation, January 2008: Update all PBS plans as indicated by outcome data and document it at every scheduled WRPC in the Present Status section of the individual's case formulation.</p> <p>Findings: Using item #13 (<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>) from the DMH Psychology Services Monitoring Form, NSH assessed its compliance by analyzing all (100%) of the PBS plans developed and implemented during this review period (January to May 2008), reporting a mean compliance rate of 100% (the mean compliance for the previous review period was 62%).</p> <p>This monitor's documentation review (PBS plans date of implementation and available data) found that only two plans were in effect since January and February 2008. Both these plans had undergone multiple revisions based on progress/lack of progress and were documented in the individuals' WRPs. The other five plans are fairly recent, developed in May 2008, and do not have sufficient data to determine the need for revision.</p> <p>Other findings: NSH took the initiative to track and monitor documentation of all behavior guidelines developed and implemented during this review period. Using item #13 (<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>) from the DMH WRP Clinical Chart Audit Form, NSH assessed its compliance by analyzing a 2% sample of the behavioral guidelines developed and implemented during this review period (January to May 2008) reporting a mean compliance rate of</p>
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		<p>67%.</p> <p>Compliance: Substantial.</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	<p>all staff has received competency-based training on implementing the specific behavioral interventions for which they are responsible, and performance improvement measures are in place for monitoring the implementation of such interventions.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: 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> <p>Findings: Using item #14 (<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>) from the DMH Psychology Services Monitoring Form, NSH assessed its compliance by analyzing all (100%) of the PBS plans developed and implemented during this review period (January to May 2008), reporting 100% compliance. This monitor's review of the documented PBS plans is in agreement with the facility's data.</p> <p>Compliance: Substantial.</p>

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		<p>Current recommendation: Continue current practice.</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 recommendation:</p> <p>Recommendation, January 2008: Maintain current service provision.</p> <p>Findings: This monitor's interview of the Chief of Psychology and the PBS team members found that the PBS team members at NSH have as their primary responsibility the provision of behavioral services, including behavioral interventions and one hour/week of PSR Mall services.</p> <p>Compliance: Substantial.</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 recommendation:</p> <p>Recommendation, January 2008: Ensure that BY CHOICE point allocation is updated monthly in the individual's WRP.</p> <p>Findings: Using item #16 (<i>The BY CHOICE point allocation is updated monthly in the individual's Wellness and Recovery Plan</i>) from the DMH WRP Clinical Chart Audit Form, NSH assessed its compliance by analyzing a mean sample of 2% of the charts of individuals admitted during this review period (January to May 2008), reporting a mean compliance rate of 40% (the mean compliance for the previous review period was 30%).</p>

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		<p>NSH's compliance for the last month of the previous review period was 22% and the compliance for the last month of this review period is 52%.</p> <p>This monitor reviewed ten charts (BR, LG, MC, ME, MP, OB, RCH, RTP, RW and TLN). Five of the WRPs in the charts (BR, ME, MP, RCH and TLN) had updated the individual's BY CHOICE point allocation in the Present Status section of the individual's WRP. The remaining five (LG, MC, OB, RTP and RW) did not fulfill this requirement. In some cases the same statements were documented across WRPs (for example MC, RTP and RW).</p> <p>Compliance: Partial.</p> <p>Current recommendation: Ensure that BY CHOICE point allocation is updated monthly in the individual's WRP.</p>
F.2.d	<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) 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</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: 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 documentation review (training data, DCAT Mall services list, DCAT database, progress notes) and interview of the Chief of Psychology and PBS team members found the DCAT has been attending training sessions conducted by their consultant, as well as peer presentations. The DCAT has been consulting with unit psychologists, WRPTs, and PSR Mall service facilitators. The DCAT has been</p>

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	<p>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>providing Mall services (Mall groups include DCAT Coping Skills and Social Skills groups). The DCAT is working with a list of 250 cases for cognitive screening.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
<p>F.2.e</p>	<p>Each State Hospital shall develop and implement a Behavioral Consultation Committee (BCC), chaired by the Chief of Psychology, and co-chaired by the Chief of Psychiatry, to review the Wellness and Recovery Plan and maladaptive behavior(s) of the individuals who have not made timely progress on positive behavior support plans. The Chief of Psychology is responsible for the functions of this committee, together with members of the positive behavior support team (in functions of the committee that relate to individuals under the care of those team members). The committee membership shall include all clinical discipline heads, including the medical director, as well as the clinical administrator of the facility.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, January 2008: Continue to use the PBS-BCC checklist to define the sequence of steps for referrals to the BCC.</p> <p>Findings: This monitor's documentation review (progress report, PBS-BCC meeting minutes, PBS-BCC checklists, and case referrals) and interview with the Chief of Psychology found that the PBS-BCC checklist continues to be the process used to refer cases to the BCC.</p> <p>Recommendation 2, January 2008: Ensure that all standing members of the BCC attend every meeting.</p> <p>Findings: This monitor's documentation review (BCC Meeting schedule, meeting minutes, and attendance rosters) and interview of the Chief of Psychology found that NSH has conducted regularly scheduled meetings over the last six months. This monitor's review of the attendance roster found that attendance at these meetings has improved and is consistent. Many of the members who could not attend meetings had sought excuse with reasons for the absence.</p>

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		<p>It is this monitor's opinion that NSH, as well as the other facilities, should consider merging the BCC group with the PSSC. This will reduce the number of meetings as a large number of staff is required to attend both meetings. Besides, attendance of the medical staff at the PSSC meetings would be immensely beneficial to the PSSC in case review, medical input, integration of medical therapies with the PBS plans and behavior guidelines, and to provide a platform for teaching and training.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
F.2.f	<p>Each State Hospital shall ensure that it has sufficient neuropsychological services for the provision of adequate neuropsychological assessment of individuals with persistent mental illness.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, January 2008:</p> <ul style="list-style-type: none"> • Ensure that neuropsychologists provide cognitive remediation and cognitive retraining groups in the PSR Mall. • Increase the number of neuropsychologists to meet the demand for neuropsychological services. <p>Findings: This monitor's documentation review (List of Individuals Referred for Neuropsychological Assessment and Completed) and interview with the Chief of Psychology and the Senior Psychologists at NSH found that currently NSH has one of the four required neuropsychologists. Given the severe staffing shortage, the one neuropsychologist is unable to provide cognitive remediation and cognitive retraining groups in the PSR Mall. Furthermore, referral for neuropsychological evaluations has increased and the one neuropsychologist is unable to conduct the</p>

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		<p>evaluations in a timely fashion. NSH received a total of 29 referrals for neuropsychological evaluation during this reporting period (January to May 2008), and only six of them were completed at the time of this review. NSH's documentation showed that it took, on average, three months and 18 days to complete a referral.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that neuropsychologists provide cognitive remediation and cognitive retraining groups in the PSR Mall. 2. Increase the number of neuropsychologists to meet the demand for neuropsychological services.
F.2.g	<p>All clinical psychologists with privileges at any State Hospital shall have the authority to write orders for the implementation of positive behavior support plans, consultation for educational or other testing, and positive behavior support plan updates.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: Continue current practice.</p> <p>Findings: This monitor's interview of the Chief of Psychology found that the clinical psychologists with privileges at NSH continue to have the authority to write orders for the implementation of positive behavior support plans, consultation for educational or other testing, and positive behavior support plan updates.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>

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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. Bernadette Ezike, RN, MSN, Nurse Administrator 2. Ed Foulk, RN, MBA, EdD, Executive Director 3. Eve Arcala, RN, Assistant Coordinator of Nursing Services 4. Joellyn Arce, RN, Nurse Coordinator, Headquarters 5. Kuldip Dhaliwal, Assistant Coordinator of Nursing Services 6. Michelle Patterson, RN, HSS 7. Natalie Allen, RN, BSN, Psychiatric Nursing Education Director <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. NSH's progress report and data 2. NSH's rater reliability tracking form data 3. Nursing Policy and Procedure 1131, PRN or Stat Medication Use for Physical and Psychiatric Symptom Management 4. Nursing Policy and Procedure 1101, Medication Administration: General Information 5. Nursing Policy and Procedure 1102, Medication Administration Documentation 6. Nursing Policy and Procedure 1102.1, Medication Variance: Reporting and Monitoring 7. Nursing Policy and Procedure 102, Provision of Nursing Care to Individuals with Medical Conditions 8. Nursing Policy and Procedure 113, Care of the Individual In Bed-Bound Status 9. Nursing monthly newsletter 10. Spot Check Instructions for review of Medication Administration Records and Controlled Drug Shift Count Log 11. Training roster for Spot Checks, RN Assessment, Weekly Nursing Note, Therapeutic Milieu, PBS training, Psych Nursing 101, and Medication Administration Skills

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		<p>12. Change of Condition monitoring form 13. Special Order 136; Provision of Medical Care to Individuals 14. Course curriculum for Complete Physical Assessment training 15. Training roster for Physical Assessment training 16. Positioning and Activity Flow Sheets 17. Training roster for Medication and Therapeutic Communication training 18. DMH Nursing Services Monitoring form and instructions 19. Random unit's MARS 20. Adaptive & Durable Medical Equipment Tracking List for Units A3 and A4 21. Medical records for the following 64 individuals: AHS, AMM, ARM, AS, ATB, AWD, BJ, BMR, BSS, CCR, CDC, CDW, CIC, CMK, CWE, DEB, DH, DIB, DJC, DJM, DJT, DMH, DP, DPN, EH, FCP, GPB, HCM, HSS, JA, JAG, JCR, JEG, JRM, JRQ, KH, KMG, LLS, LRW, MEP, MLW, PJN, PLB, RG, RLW, RN, RR, RRW, RS, RTP, SMP, SWH, SWS, TAB, TBH, TDN, TLB, TOM, TR, TT, VH, VH, WGH and WJB</p> <p><u>Observed:</u> 1. Medication pass on Units Q1 and 2, Q3 and 4 2. Shift report on Unit T3</p>
F.3.a	Each State hospital shall develop and implement policies and protocols regarding the administration of medication, including pro re nata ("PRN") and "Stat" medication (i.e., emergency use of psychoactive medication), consistent with generally accepted professional standards of care, to ensure:	Please see sub-cells for compliance findings.
F.3.a.i	safe administration of PRN medications and Stat medications;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, January 2008: Provide inter-rater reliability data for the Medication Administration</p>

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		<p>Monitoring Form.</p> <p>Findings: NSH reported that inter-rater agreement for the Medication Administration Monitoring form was 97%.</p> <p>Recommendation 2, January 2008: Increase audited sample size.</p> <p>Findings: The data provided by NSH indicated that the mean sample size for this requirement was 33%, which is a significant increase from 7% during the last review period.</p> <p>Recommendation 3, January 2008: Continue to monitor this requirement.</p> <p>Findings: The facility reported data based on the DMH Nursing Services Monitoring Form for PRN/Stat, based on average samples of 33% of PRN medications and 34% of Stat medications given each month (February to May 2008). The tables below summarize NSH's data:</p> <table border="1" data-bbox="991 1040 1890 1421"> <thead> <tr> <th colspan="3">PRN Medications</th> </tr> </thead> <tbody> <tr> <td>1.a</td> <td><i>If PRN was administered, it was administered based on a complete physician's order</i></td> <td>43%</td> </tr> <tr> <td>c.i</td> <td><i>The nursing staff administered the correct medication</i></td> <td>98%</td> </tr> <tr> <td>c.ii</td> <td><i>The nursing staff administered the correct dose</i></td> <td>97%</td> </tr> <tr> <td>c.iii</td> <td><i>The nursing staff administered the correct form</i></td> <td>88%</td> </tr> <tr> <td>c.iv</td> <td><i>The nursing staff administered the correct route</i></td> <td>89%</td> </tr> <tr> <td>c.v</td> <td><i>The nursing staff administered at the correct time</i></td> <td>98%</td> </tr> <tr> <td>c.vi</td> <td><i>The nursing staff administered on the correct date</i></td> <td>99%</td> </tr> </tbody> </table>	PRN Medications			1.a	<i>If PRN was administered, it was administered based on a complete physician's order</i>	43%	c.i	<i>The nursing staff administered the correct medication</i>	98%	c.ii	<i>The nursing staff administered the correct dose</i>	97%	c.iii	<i>The nursing staff administered the correct form</i>	88%	c.iv	<i>The nursing staff administered the correct route</i>	89%	c.v	<i>The nursing staff administered at the correct time</i>	98%	c.vi	<i>The nursing staff administered on the correct date</i>	99%
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c.vii	<i>The nursing staff administered for the correct indication</i>	93%						
c.viii	<i>The nursing staff administered to the correct individual</i>	99%						
Stat Medications								
1.b.i	<i>The Stat medication was administered based on a complete physician's order</i>	55%						
b.ii	<i>The Stat medication was administered within one hour of the order</i>	87%						
c.i	<i>The nursing staff administered the correct medication</i>	98%						
c.ii	<i>The nursing staff administered the correct dose</i>	98%						
c.iii	<i>The nursing staff administered the correct form</i>	94%						
c.iv	<i>The nursing staff administered the correct route</i>	93%						
c.v	<i>The nursing staff administered at the correct time</i>	94%						
c.vi	<i>The nursing staff administered on the correct date</i>	99%						
c.vii	<i>The nursing staff administered for the correct indication</i>	93%						
c.viii	<i>The nursing staff administered to the correct individual</i>	99%						
<p>Since there was no data from the last review, no comparison was possible. The facility indicated the following issues related to the low compliance for the related items:</p> <ul style="list-style-type: none"> • Items 1.a. (PRN) and 1.b.i (Stat): incomplete physician's order regarding specific behavior description • Item 1.bii. (Stat): Stat administration within one hour of the order was not clearly documented <p>The facility reported that physicians' orders will be monitored and</p>								

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		<p>findings reported at the Psychiatry Key Indicator meeting to increase compliance. In addition, the Nursing Coordinators will review data bi-monthly and the Professional Nursing Education Director will update training based on these reviews.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
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, January 2008: Evaluate the current medication administration system.</p> <p>Findings: NSH adequately revised Nursing Policy and Procedure 1131, PRN/Stat Medication Use for Physical and Psychiatric Symptom Management, to include specific direction regarding who is responsible for the documentation and what documentation is required for PRN and Stat medications.</p> <p>Recommendation 2, January 2008: Continue to monitor this requirement.</p> <p>Findings: The following data is from the DMH Nursing Services Monitoring Form (PRN and Stat), based on average samples of 32% of PRN medications and 33% of Stat medications given each month (February to May 2008):</p>

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		<table border="1" data-bbox="993 228 1890 380"> <tr> <td data-bbox="993 228 1087 269"></td> <td data-bbox="1087 228 1703 269"></td> <td data-bbox="1703 228 1797 269">PRN</td> <td data-bbox="1797 228 1890 269">Stat</td> </tr> <tr> <td data-bbox="993 269 1087 380">2.b</td> <td data-bbox="1087 269 1703 380"><i>In the IDN, there is a comprehensive assessment of the individual prior to the PRN medication</i></td> <td data-bbox="1703 269 1797 380">27%</td> <td data-bbox="1797 269 1890 380">37%</td> </tr> </table> <p data-bbox="993 423 1881 602">NSH did not provide comparison data or barriers to compliance for these items. The facility indicated that strategies for addressing the low compliance included alerting nursing staff through a newsletter that there had been a change in medication administration procedure. NSH indicated that training on the revised policy will continue.</p> <p data-bbox="993 646 1881 784">This monitor's review of 50 incidents of PRN medications for eight individuals (DMH, JCR, LRW, PLB, RN, RRW, SWH and VH) found that a comprehensive assessment was documented prior to the administration of the PRN in four incidents.</p> <p data-bbox="993 828 1881 966">This monitor's review of 50 incidents of Stat medications for 13 individuals (AS, CDC, CMK, DJM, DMH, JAG, PLB, RG, RRW, RS, SWH, VH and WGH) found that a comprehensive assessment was documented prior to the administration of the Stat in seven incidents.</p> <p data-bbox="993 1010 1142 1078">Compliance: Partial.</p> <p data-bbox="993 1122 1640 1230">Current recommendations: 1. Provide required information in progress report. 2. Continue to monitor this requirement.</p>			PRN	Stat	2.b	<i>In the IDN, there is a comprehensive assessment of the individual prior to the PRN medication</i>	27%	37%
		PRN	Stat							
2.b	<i>In the IDN, there is a comprehensive assessment of the individual prior to the PRN medication</i>	27%	37%							
F.3.a.iii	documentation of the individual's response to PRN and Stat medication.	<p data-bbox="993 1276 1581 1305">Current findings on previous recommendation:</p> <p data-bbox="993 1349 1461 1414">Recommendation, January 2008: Continue to monitor this requirement.</p>								

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		<p>Findings: The following data is from the DMH Nursing Services Monitoring Form (PRN and Stat), based on average samples of 32% of PRN medications and 33% of Stat medication given each month (February to May 2008):</p> <table border="1" data-bbox="993 414 1892 712"> <tr> <td data-bbox="993 414 1087 488">3.</td> <td data-bbox="1087 414 1703 488"><i>Documentation of the individual's response to (PRN/Stat) medication.</i></td> <td data-bbox="1703 414 1797 488">PRN</td> <td data-bbox="1797 414 1892 488">Stat</td> </tr> <tr> <td data-bbox="993 488 1087 602">3.b.i</td> <td data-bbox="1087 488 1703 602"><i>In the IDN, there is a comprehensive assessment of the individual's response to the administered (PRN/Stat)</i></td> <td data-bbox="1703 488 1797 602">34%</td> <td data-bbox="1797 488 1892 602">40%</td> </tr> <tr> <td data-bbox="993 602 1087 712">3.b.ii</td> <td data-bbox="1087 602 1703 712"><i>The comprehensive assessment was completed within one hour of administration</i></td> <td data-bbox="1703 602 1797 712">88%</td> <td data-bbox="1797 602 1892 712">72%</td> </tr> </table> <p>NSH did not provide comparison data or barriers to compliance regarding these items. NSH indicated that the plan of correction was the same as noted in F.3.a.ii.</p> <p>This monitor's review of 50 incidents of PRN medications for eight individuals (DMH, JCR, LRW, PLB, RN, RRW, SWH and VH) found that 11 incidents included a comprehensive assessment of the individual's response and 38 were assessed within one hour.</p> <p>This monitor's review of 50 incidents of Stat medications for 13 individuals (AS, CDC, CMK, DJM, DMH, JAG, PLB, RG, RRW, RS, SWH, VH and WGH) found that 14 incidents included a comprehensive assessment of the individual's response and 32 were assessed within one hour.</p> <p>Compliance: Partial.</p>	3.	<i>Documentation of the individual's response to (PRN/Stat) medication.</i>	PRN	Stat	3.b.i	<i>In the IDN, there is a comprehensive assessment of the individual's response to the administered (PRN/Stat)</i>	34%	40%	3.b.ii	<i>The comprehensive assessment was completed within one hour of administration</i>	88%	72%
3.	<i>Documentation of the individual's response to (PRN/Stat) medication.</i>	PRN	Stat											
3.b.i	<i>In the IDN, there is a comprehensive assessment of the individual's response to the administered (PRN/Stat)</i>	34%	40%											
3.b.ii	<i>The comprehensive assessment was completed within one hour of administration</i>	88%	72%											

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		<p>Current recommendation: See F.3.a.ii.</p>			
<p>F.3.b</p>	<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, January 2008: Revise the system addressing this requirement to ensure compliance.</p> <p>Findings: See below.</p> <p>Recommendation 2, January 2008: Continue to monitor this requirement.</p> <p>Findings: The following data is from the NSH Nursing Services Spot Check Audit, based on a 100% sample of initials found to be missing during spot checks each month (January to May 2008):</p> <table border="1" data-bbox="995 894 1885 971"> <tr> <td data-bbox="995 894 1066 971">1.</td> <td data-bbox="1066 894 1776 971"><i>MVR received by Nursing Services for missing initials found on spot checks</i></td> <td data-bbox="1776 894 1885 971">41%</td> </tr> </table> <p>No comparison data were provided regarding this item. NSH indicated that barriers to compliance with this item included inconsistent spot checks conducted by the HSSs and the lack of a tracking system regarding the Medication Variance Reports (MVRs). The facility indicated that the spot check process was revised in April 2008 and HSS were trained on the process. In addition, a tracking system for the MVRs was implemented in June 2008 and the HSSs are now providing quarterly in-services regarding Medication Variance Reporting and analysis.</p> <p>This monitor's review of a number of MARs found 15 individuals' MARs</p>	1.	<i>MVR received by Nursing Services for missing initials found on spot checks</i>	41%
1.	<i>MVR received by Nursing Services for missing initials found on spot checks</i>	41%			

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		<p>that contained blanks. Only four MVRs were found.</p> <p>Compliance: Partial.</p> <p>Current recommendations: See F.3.a.ii.</p>						
F.3.c	<p>Each State hospital shall ensure that all nursing interventions are fully integrated into the therapeutic and rehabilitation service plan and that nursing interventions are written in a manner aligned with the rest of the interventions in the therapeutic and rehabilitation service plan, in particular, in observable, behavioral, and/or measurable terms. No nursing care plans other than the nursing interventions integrated in the therapeutic and rehabilitation service plan are required. No nursing diagnoses other than as specified in the therapeutic and rehabilitation service plan, in terms of the current DSM criteria, are required.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, January 2008: Provide data for the next review regarding this requirement.</p> <p>Findings: NSH implemented the DMH Nursing Services Monitoring-Nursing Intervention monitoring tool in February 2008 to collect data regarding this requirement, addressing this recommendation.</p> <p>Recommendation 2, January 2008: Continue to monitor this requirement.</p> <p>Findings: The following data is from the DMH Nursing Services Monitoring Nursing Interventions audit, based on an average sample of 20% of WRPs (February to May 2008):</p> <table border="1" data-bbox="993 1154 1887 1414"> <tr> <td data-bbox="993 1154 1068 1265">4.</td> <td data-bbox="1068 1154 1776 1265"><i>The nursing interventions include specific strategies to assist the individual in meeting his or her objectives.</i></td> <td data-bbox="1776 1154 1887 1265">19%</td> </tr> <tr> <td data-bbox="993 1265 1068 1414">5.</td> <td data-bbox="1068 1265 1776 1414"><i>The nursing interventions aligned and complement other interventions (including interventions in the therapeutic milieu) in the WRP to assist the individual 24 hours a day.</i></td> <td data-bbox="1776 1265 1887 1414">22%</td> </tr> </table>	4.	<i>The nursing interventions include specific strategies to assist the individual in meeting his or her objectives.</i>	19%	5.	<i>The nursing interventions aligned and complement other interventions (including interventions in the therapeutic milieu) in the WRP to assist the individual 24 hours a day.</i>	22%
4.	<i>The nursing interventions include specific strategies to assist the individual in meeting his or her objectives.</i>	19%						
5.	<i>The nursing interventions aligned and complement other interventions (including interventions in the therapeutic milieu) in the WRP to assist the individual 24 hours a day.</i>	22%						

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		<table border="1"> <tr> <td data-bbox="989 190 1068 266">6.</td> <td data-bbox="1068 190 1774 266"><i>The nursing interventions are written in observable, behavioral, and/or measurable terms.</i></td> <td data-bbox="1774 190 1892 266">14%</td> </tr> <tr> <td data-bbox="989 266 1068 342">8.</td> <td data-bbox="1068 266 1774 342"><i>There is no nursing diagnosis (NANDA) statements in the WRP.</i></td> <td data-bbox="1774 266 1892 342">67%</td> </tr> </table>	6.	<i>The nursing interventions are written in observable, behavioral, and/or measurable terms.</i>	14%	8.	<i>There is no nursing diagnosis (NANDA) statements in the WRP.</i>	67%	<p>NSH's progress report indicated that the nursing staff was having difficulty writing interventions in observable, behavioral, and/or measurable terms that are aligned with the rest of the interventions in the therapeutic and rehabilitation service plans. To address this low compliance, NSH indicated that a system will be implemented in August 2008 that includes the assignment of individuals to a Psychiatric Technician (PT) or Licensed Vocational Nurse (LVN) as the primary on the WRPT. The responsibilities of the designated PT/LVN will include a weekly meeting with each individual, a monthly review of the WRPs with the individual, documentation in weekly notes, and timely communication of information to the RN case manager and WRPT of individual specific information. NSH also revised training for WRPs to include all requirements of writing a WRP.</p> <p>This monitor's review of 40 individuals' WRPs (AHS, AMM, ARM, ATB, AWD, BJ, BMR, BSS, CCR, CDW, CIC, CWE, DEB, DJT, DP, EH, FCP, GPB, HCM, HSS, JA, JEG, JRM, JRQ, KMG, LLS, MEP, PJN, RLW, RR, RS, RTP, SMP, SWS, TBH, TDN, TLB, TOM, VH and WJB) found little improvement from the last review regarding appropriate and meaningful objectives and interventions.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Implement strategies addressing low compliance rates with this requirement. 2. Continue to monitor this requirement.
6.	<i>The nursing interventions are written in observable, behavioral, and/or measurable terms.</i>	14%							
8.	<i>There is no nursing diagnosis (NANDA) statements in the WRP.</i>	67%							

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<p>F.3.d</p>	<p>All nursing staff working with an individual shall be familiar with the goals, objectives and interventions for that individual.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, January 2008: Implement the DMH Nursing Services Monitoring form.</p> <p>Findings: NSH has implemented the DMH Nursing Services Monitoring audit in February 2008.</p> <p>Recommendation 2, January 2008: Continue to monitor this requirement.</p> <p>Findings: NSH's data from the DMH Nursing Services Monitoring Nursing Staff Familiarity audit, based on an average sample of 25% of licensed nursing staff on AM/PM shift (February to May 2008), is summarized below:</p> <table border="1" data-bbox="993 894 1894 1123"> <tr> <td data-bbox="993 894 1066 1008">6.</td> <td data-bbox="1066 894 1776 1008"><i>Nursing Staff working with an individual shall be familiar with the goals, objectives and interventions for that individual.</i></td> <td data-bbox="1776 894 1894 1008"></td> </tr> <tr> <td data-bbox="993 1008 1066 1049">6.a</td> <td data-bbox="1066 1008 1776 1049"><i>goals</i></td> <td data-bbox="1776 1008 1894 1049">54%</td> </tr> <tr> <td data-bbox="993 1049 1066 1089">6.b</td> <td data-bbox="1066 1049 1776 1089"><i>objectives</i></td> <td data-bbox="1776 1049 1894 1089">43%</td> </tr> <tr> <td data-bbox="993 1089 1066 1123">6.c</td> <td data-bbox="1066 1089 1776 1123"><i>interventions in the therapeutic milieu</i></td> <td data-bbox="1776 1089 1894 1123">46%</td> </tr> </table> <p>See F.3.c for NSH's plan of correction regarding these items.</p> <p>Compliance: Partial.</p> <p>Current recommendations: See F.3.c.</p>	6.	<i>Nursing Staff working with an individual shall be familiar with the goals, objectives and interventions for that individual.</i>		6.a	<i>goals</i>	54%	6.b	<i>objectives</i>	43%	6.c	<i>interventions in the therapeutic milieu</i>	46%
6.	<i>Nursing Staff working with an individual shall be familiar with the goals, objectives and interventions for that individual.</i>													
6.a	<i>goals</i>	54%												
6.b	<i>objectives</i>	43%												
6.c	<i>interventions in the therapeutic milieu</i>	46%												

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<p>F.3.e</p>	<p>Each State hospital shall ensure that nursing staff timely monitor, document and report the status of symptoms, target variables, health, and mental health status, of individuals in a manner that enables interdisciplinary teams to assess each individual's status, and response to interventions, and to modify, as appropriate, individuals' therapeutic and rehabilitation service plans. Each State Hospital shall ensure that all nursing shift changes include a review of changes in status of individuals on the unit.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, January 2008: Implement a monitoring system addressing the elements of this requirement.</p> <p>Findings: The statewide Nursing Administrator group is in the process of developing a statewide monitoring tool addressing this requirement. However, NSH has drafted a policy and monitoring tool regarding Change of Condition and will finalize these after the statewide policy is developed. NSH's Change of Condition monitoring tool was implemented in April 2008 and generated the data presented below under findings for Recommendation 3.</p> <p>Recommendation 2, January 2008: Develop and implement a template for shift reports.</p> <p>Findings: NSH developed a shift report template that was piloted on an admission unit in Program 2 in July 2008. A statewide Nursing policy and protocol is in development to meet the elements of this requirement.</p> <p>Recommendation 3, January 2008: Provide monitoring data for this requirement during the next review.</p> <p>Findings: NSH assessed its compliance using the NSH Change of Condition Monitoring tool, based on an average sample of 91% of admissions to acute facility for the month (March to May 2008). The following is a summary of the data:</p>
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		1.	<i>There is an appropriate documentation of the change of health status of the individual</i>	
		1.a	<i>Accurately describe the symptoms observed and/or reported</i>	49%
		1.b	<i>Document the time and date of onset of symptoms</i>	84%
		2.	<i>There is a comprehensive RN assessment documented on the significant change in condition assessment including: (AS APPROPRIATE)</i>	
		2.a	<i>Allergies</i>	56%
		2.b	<i>Vital signs</i>	76%
		2.c	<i>O2 Sat</i>	74%
		2.d	<i>Lung sounds</i>	32%
		2.e	<i>Neuro checks</i>	47%
		2.f	<i>Abdominal pain</i>	31%
		3.	<i>Time and date of RN Assessment completed</i>	56%
		4.	<i>There is documentation of interventions completed</i>	
		4.a	<i>There is documentation of any additional interventions /monitoring implemented</i>	55%
		4.b	<i>Individual's response to interventions is documented</i>	22%
		5.	<i>There is documentation of physician notification</i>	
		5.a	<i>Documentation includes name of the physician</i>	48%
		5.b	<i>Date/Time physician was notified</i>	45%
		5.c	<i>Documentation includes time physician called back/responded</i>	45%
		5.d	<i>Documentation includes any instructions to monitor the individual and/or orders given</i>	66%
		6.	<i>Once individual is returned from outside facility WRP was modified appropriately</i>	
		6.a	<i>Individual's plan of care, in Focus 6, updated as needed</i>	30%

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		<p>NSH's data analysis demonstrated an overall lack of progress in monitoring, reporting and documenting changes in health and mental health conditions. The facility implemented training, including theory and skill demonstrations, regarding physical assessment for the unit RNs in July 2008 to increase compliance.</p> <p>This monitor reviewed the charts of 11 individuals (DH, DIB, DJC, DMH, DPN, KH, MLW, RS, TAB, TR and TT) who required emergency medical care. Below is a summary of findings regarding the nursing documentation found in the progress notes:</p> <ol style="list-style-type: none"> 1. An individual was admitted to the community hospital for anemia and hypotension on 5/1/08. Issues included: <ol style="list-style-type: none"> a. Complaints of stomach pains not adequately assessed beginning on 4/25/08. b. No documentation that physician was notified of change in vital signs on 4/29/08. c. Progress notes indicated that there was confusion regarding which physician was available and on-call to address the individual's status. d. No vital signs documented 3.5 hours after initial vital signs obtained. e. No documentation of status or vital signs prior to transfer to hospital. f. No documentation of updates while in hospital. g. Was given Risperdal 1 mg Stat upon return from hospital. No justification found in progress notes. 2. An individual was admitted to the community hospital for a bowel obstruction on 5/11/08. Issues included: <ol style="list-style-type: none"> a. Progress notes indicated that on 5/4/08, the individual complained of "LBM" (loose bowel movements) and was given a PRN for diarrhea. No physical assessment was documented in response to this complaint.
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		<ul style="list-style-type: none"> b. Progress notes indicated when nursing called the MOD regarding the individual being in pain but refusing an assessment, the individual was told "No assessment, no order." In addition, the notes indicated that the MOD deemed the individual medically cleared and told nursing to call the psychiatrist. c. No follow-up regarding PRN for diarrhea found in progress notes. d. No documentation of updates while the individual was in the hospital 5/11-5/21. e. No indication of an assessment of the individual's abdominal incision upon return to facility (5/21/08) until 5/23/08. f. Progress notes on 5/22/08 indicated that the individual received Vistaril Stat. However, no note was found regarding justification from staff that gave medication. g. Progress notes out of order. <p>3. An individual was admitted to the community hospital on 1/10/08. Issues included:</p> <ul style="list-style-type: none"> a. No nursing assessment prior to transfer to hospital. There was no progress note found describing the reason he was sent to the hospital. b. No documentation of updates while the individual was in the hospital from 1/10/08-1/16/08. c. No description regarding the reason the individual was sent to the hospital was found in the progress notes on 1/16/08, the day he returned to NSH. d. Progress notes out of order. e. This monitor was unable to determine from review of the progress notes why the individual was sent to the hospital. <p>4. An individual was admitted to the community hospital for status epilepticus on 4/11/08. Issues included:</p> <ul style="list-style-type: none"> a. Progress note on 4/11/08 indicated an increase in the individual's mental confusion but did not include any type of
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		<p>description of mental status assessment.</p> <ul style="list-style-type: none"> b. No documentation of updates while the individual was in the hospital 4/11-4/13/08. c. Progress notes out of order. d. Good progress note was entered upon his return to NSH. <p>5. An individual was seen at the community hospital for altered mental status on 2/1/08. Issues included:</p> <ul style="list-style-type: none"> a. Notes indicated that on 1/30/08, the individual was hit by a peer and sustained a cut above his left eye. Nurse's note indicated that he just stared at staff when asked what happened. No vital signs or neuro checks were documented. b. Notes on 1/30/08 indicated "PERL." However, the correct acronym is PERRLA (pupils equal, round, reactive to light and accommodation). c. Progress note on 1/31/08 indicated that the individual has trouble expressing himself. However, there was no indication if this was indicated a change in his mental status. d. No indication in progress notes what was done while the individual was at the hospital. e. Progress note on 2/2/08 was unclear regarding medications given to the individual and noted, "Staff felt it was important to get regular meds in him (unsure if true but unlicensed staff report only getting Ativan @QVH [Queen of the Valley Hospital]." f. No indication in progress notes that Depakote level was elevated on 2/2/08. <p>6. An individual was admitted to the community hospital on 2/13/08 for pneumonia. Issues included:</p> <ul style="list-style-type: none"> a. Notes for 2/11/08 indicated that the individual had an increase in pulse, temperature of 102.4 and wheezing on expiration and coughing. No assessment of lung sounds. No indication that the physician was notified. b. Notes for 2/12/08 indicated temperature of 101.5 with
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		<p>continued wheezing and coughing. No assessment of lung sounds or blood pressure or respirations documented.</p> <ul style="list-style-type: none"> c. Good summary of symptoms documented on 2/13/08. However, no status or assessment of the individual at the time of transfer to the hospital was documented. d. No documentation of updates while the individual was in the hospital 2/13/-2/20. e. No progress note indicating his return to NSH. <p>7. An individual was admitted to the community hospital on 3/10/08 for bowel obstruction. Issues included:</p> <ul style="list-style-type: none"> a. No documentation found regarding status or assessment at the time the individual was transferred to the hospital. b. A late-entry on 3/11/08 indicted that the individual was vomiting, had abdominal and chest x-ray and labs the day prior. No documentation found regarding this information on 3/10/08. c. No summary of hospital treatment or assessment documented upon return to NSH. d. No documentation of the individual's status from 3/13/08 to 3/16/08 after hospitalization. <p>8. An individual was admitted to the community hospital on 2/6/08 for cardiac catheterization. Issues included:</p> <ul style="list-style-type: none"> a. Notes indicated that the individual had a pulse rate of 225 on 2/5/08. No other vital signs or assessment documented. b. No assessment or status documented at the time of transfer to hospital. c. No summary of hospital treatment documented upon return to NSH. <p>9. An individual was admitted to the community hospital on 3/9/08 for acute appendicitis. Issues included:</p> <ul style="list-style-type: none"> a. Incomplete assessment documented in response to complaints of abdominal cramping and constipation on 3/8/08. b. Notes on 3/9/08 indicated same complaints. No assessment of
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		<p>the individual was found.</p> <ul style="list-style-type: none"> c. No assessment or status documented at the time of transfer to hospital. d. No documentation of updates while the individual was in hospital. <p>10. An individual was admitted to the community hospital on 2/17/08 for pneumonia/hypoxia. Issues included:</p> <ul style="list-style-type: none"> a. No assessment of lung sounds documented for decreased oxygen saturation on 2/16/08. b. No assessment or status documented at the time of transfer to hospital. c. No documentation of updates while the individual was in the hospital 2/17-2/20/08. d. No summary of hospital treatment or assessment documented upon the individual's return to NSH. <p>11. An individual was admitted to the community hospital on 2/22/08 for seizures. Issues included:</p> <ul style="list-style-type: none"> a. Progress note upon transfer to hospital difficult to read. b. Good updates found in progress notes regarding updates on the individual's status while in hospital. <p>Overall, these findings were similar to those of NSH regarding change in conditions.</p> <p><u>Shift Report</u></p> <p>NSH's progress report indicated that a template for shift report was being developed by the Statewide Nursing Administrators workgroup and the State's Nursing consultant. The facility recently piloted a shift report template on Program 2, Unit T3.</p> <p>At the shift report observed by this monitor on Unit T3, the team had the template on a screen for all team members to see. It included the Axis diagnoses and other pertinent information from the WRPs. The</p>
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		<p>shift report included slightly more clinical information than observed at previous shift reports. The template is promising, although there continues to be a significant disconnect between clinical issues such as signs and symptoms of Axis I, II, and III diagnoses and the information that is passed to the oncoming shift. The template had only been implemented in the previous two weeks. Thus, the shift report was more focused on tasks rather than on clinical issues. When asked, the team members stated that they liked the new format and recognized that it was still a very new system and needed to be further developed.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
F.3.f	Each State hospital shall develop and implement a system to monitor nursing staff while administering medication to ensure that:	Please see sub-cells for compliance findings.
F.3.f.i	nursing staff are knowledgeable regarding each individual's prescribed medications;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, January 2008: Ensure that 20% of nurses per program per quarter are observed during Medication Pass and Treatment Administration.</p> <p>Findings: No data was provided by NSH addressing this recommendation.</p> <p>Recommendation 2, January 2008: Continue to monitor this requirement.</p>

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		<p>Findings: NSH's compliance data from the DMH Nursing Services Monitoring audit for Medication Administration, based on an average sample of 18% of medication-certified staff (February-May 2008), indicated the following:</p> <table border="1" data-bbox="993 412 1881 862"> <tr> <td data-bbox="993 412 1066 488">8.</td> <td data-bbox="1066 412 1776 488"><i>Nursing staff are knowledgeable regarding each individual's prescribed medications</i></td> <td data-bbox="1776 412 1881 488"></td> </tr> <tr> <td data-bbox="993 488 1066 599">8.a</td> <td data-bbox="1066 488 1776 599"><i>If a medication requires vital signs assessment prior to administration; the nursing staff is observed reviewing this reading</i></td> <td data-bbox="1776 488 1881 599">98%</td> </tr> <tr> <td data-bbox="993 599 1066 709">8.b</td> <td data-bbox="1066 599 1776 709"><i>If a medication requires a blood glucose level prior to administration; the nursing staff is observed reviewing this reading</i></td> <td data-bbox="1776 599 1881 709">94%</td> </tr> <tr> <td data-bbox="993 709 1066 862">8.c</td> <td data-bbox="1066 709 1776 862"><i>The nursing staff is able to answer questions about one medication that is administered to the individual. (The questions include purpose of medication, common side effects, etc.)</i></td> <td data-bbox="1776 709 1881 862">79%</td> </tr> </table> <p>NSH had fewer qualified auditors due to issues regarding inter-rater agreement and consequently observed a small number of medication administrations. NSH indicated that the increase in the inter-rater reliability was related to the decrease in compliance for item c. Beginning in April 2008, the Nursing Coordinators receive the compliance data to identify nursing staff that need mentoring by the HSS.</p> <p>Other findings: This monitor observed medication pass on Units Q 1 and 2, Q 3 and 4 and noted that very little medication teaching was provided to the individuals. The use of a "pill line" prevented confidential conversations regarding medication issues. For example, one individual was asked why he was taking a particular medication. He indicated that he had become</p>	8.	<i>Nursing staff are knowledgeable regarding each individual's prescribed medications</i>		8.a	<i>If a medication requires vital signs assessment prior to administration; the nursing staff is observed reviewing this reading</i>	98%	8.b	<i>If a medication requires a blood glucose level prior to administration; the nursing staff is observed reviewing this reading</i>	94%	8.c	<i>The nursing staff is able to answer questions about one medication that is administered to the individual. (The questions include purpose of medication, common side effects, etc.)</i>	79%
8.	<i>Nursing staff are knowledgeable regarding each individual's prescribed medications</i>													
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8.c	<i>The nursing staff is able to answer questions about one medication that is administered to the individual. (The questions include purpose of medication, common side effects, etc.)</i>	79%												

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		<p>constipated. However, this conversation was held with 7-10 other individuals standing closely behind him. In addition, this monitor noted that one staff member who had given his morning medications was filling out the MARs after all medications had been administered, not at the time the medications were given as required. When asked about this practice, he noted that he had been "caught" doing this a couple of weeks earlier. From this monitor's observation, it was clear that medication administration is rushed and chaotic in order to give all individuals their medications within the appropriate time frames and activities of the groups.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>									
F.3.f.ii	education is provided to individuals during medication administration;	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: Continue to monitor this requirement.</p> <p>Findings: NSH's compliance data from the DMH Nursing Services Monitoring audit for Medication Administration, based on an average sample of 18% of medication-certified staff (February-May 2008), indicated the following:</p> <table border="1" data-bbox="991 1227 1894 1414"> <tr> <td data-bbox="991 1227 1066 1304">9.</td> <td data-bbox="1066 1227 1776 1304"><i>Education is provided to individuals during medication administration.</i></td> <td data-bbox="1776 1227 1894 1304"></td> </tr> <tr> <td data-bbox="991 1304 1066 1378">9.a</td> <td data-bbox="1066 1304 1776 1378"><i>If an individual ask a question, the nursing staff is able to competently answer the question.</i></td> <td data-bbox="1776 1304 1894 1378">92%</td> </tr> <tr> <td data-bbox="991 1378 1066 1414">9.b</td> <td data-bbox="1066 1378 1776 1414"><i>When an individual has been prescribed a new</i></td> <td data-bbox="1776 1378 1894 1414">66%</td> </tr> </table>	9.	<i>Education is provided to individuals during medication administration.</i>		9.a	<i>If an individual ask a question, the nursing staff is able to competently answer the question.</i>	92%	9.b	<i>When an individual has been prescribed a new</i>	66%
9.	<i>Education is provided to individuals during medication administration.</i>										
9.a	<i>If an individual ask a question, the nursing staff is able to competently answer the question.</i>	92%									
9.b	<i>When an individual has been prescribed a new</i>	66%									

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			<i>medication, the nursing staff provides education about that medication.</i>				
		9.c	<i>Nursing staff makes at least one inquiry or comment to the individual about his or her medications at each medication administration</i>	69%			
F.3.f.iii	nursing staff are following the appropriate medication administration protocol; and	<p>See also F.3.f.i.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Continue to monitor this requirement.</p> <p>Current findings on previous recommendations:</p> <p>Recommendation 1, January 2008: Increase audited sample size.</p> <p>Findings: NSH increased the sample size in March, April and May 2008.</p> <p>Recommendation 2, January 2008: Continue to monitor this requirement.</p> <p>Findings: NSH's compliance data from the DMH Nursing Services Monitoring audit for Medication Administration, based on an average sample of 18% of medication-certified staff (February-May 2008), indicated the following:</p> <table border="1" data-bbox="993 1344 1797 1416"> <tr> <td data-bbox="993 1344 1087 1416">10.</td> <td data-bbox="1087 1344 1797 1416"> <i>Nursing staff are following the appropriate medication administration protocol.</i> </td> <td data-bbox="1797 1344 1896 1416"></td> </tr> </table>			10.	<i>Nursing staff are following the appropriate medication administration protocol.</i>	
10.	<i>Nursing staff are following the appropriate medication administration protocol.</i>						

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		10.a	<i>The correct medications are administered</i>	100%
		10.b	<i>The medications are administered to the correct individual</i>	100%
		10.c	<i>The medications are administered in the ordered form</i>	100%
		10.d	<i>The medications are administered by the correct route</i>	100%
		10.e	<i>The medications are administered at the correct time</i>	100%
		10.f	<i>The medications are administered on the date</i>	100%
		10.g	<i>The medications are administered for the right indication</i>	100%
		<p>This monitor's observations of medication pass found that the correct individual received the correct medication at the correct time.</p> <p>Compliance: Substantial..</p> <p>Current recommendation: Continue current practice.</p>		
F.3.f.iv	medication administration is documented in accordance with the appropriate medication administration protocol.	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: See F.3.f.iii.</p> <p>Findings: NSH's compliance data from the DMH Nursing Services Monitoring audit for Medication Administration, based on an average sample of 18% of medication-certified staff (February-May 2008), indicated the following:</p>		

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		<table border="1"> <tr> <td data-bbox="989 190 1089 305">11.</td> <td data-bbox="1089 190 1797 305"><i>Medication administration is documented in accordance with the appropriate medication administration protocol</i></td> <td data-bbox="1797 190 1892 305"></td> </tr> <tr> <td data-bbox="989 305 1089 420">11.a</td> <td data-bbox="1089 305 1797 420"><i>Medications are documented upon administration, prior to the administering medications to the next individuals</i></td> <td data-bbox="1797 305 1892 420">96%</td> </tr> <tr> <td data-bbox="989 420 1089 493">11.b</td> <td data-bbox="1089 420 1797 493"><i>Nursing staff correctly documents the MTR to reflect what actually occurred.</i></td> <td data-bbox="1797 420 1892 493">97%</td> </tr> </table>	11.	<i>Medication administration is documented in accordance with the appropriate medication administration protocol</i>		11.a	<i>Medications are documented upon administration, prior to the administering medications to the next individuals</i>	96%	11.b	<i>Nursing staff correctly documents the MTR to reflect what actually occurred.</i>	97%
11.	<i>Medication administration is documented in accordance with the appropriate medication administration protocol</i>										
11.a	<i>Medications are documented upon administration, prior to the administering medications to the next individuals</i>	96%									
11.b	<i>Nursing staff correctly documents the MTR to reflect what actually occurred.</i>	97%									
F.3.g	Each State hospital shall ensure that individuals remain in a "bed-bound" status only for clinically justified reasons.	<p>This monitor's observations of medication pass did not support NSH's data regarding this requirement. See F.3.f.i.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that auditors are accurately reporting data regarding the documentation of medication administration. 2. Continue to monitor this requirement. <p>Current findings on previous recommendations:</p> <p>Recommendation 1, January 2008: Develop and implement a system to ensure individuals on the Skilled Nursing Unit are not rendered bed-bound due to lack of equipment or staff.</p> <p>Findings: NSH has revised Nursing Policy and Procedure Basic 113, Care of the Individuals in Bed-Bound Status ,to include directions regarding issues related to adaptive equipment and staffing shortages to ensure that individuals would not become bed-bound due to these issues. NSH is reviewing Activity Log Forms and Medical Restraints Observation</p>									

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		<p>Records to ensure that immobile individuals are not rendered bed-bound due to lack of equipment or staff.</p> <p>Recommendation 2, January 2008: Provide data regarding the above.</p> <p>Findings: Training rosters provided by NSH indicated that the staff on Units A3 and A4 received training in May 2008 and will receive training regarding revised Nursing Policy and Procedure 113 during August 2008.</p> <p>Recommendation 3, January 2008: Continue to monitor this requirement.</p> <p>Findings: NSH's data indicated that for three individuals who were bed-bound during February and March 2008, there was a physician's order justifying the clinical reason for the bed-bound status. There were no bed-bound individuals in January, April and May 2008.</p> <p>Other findings: This monitor's review of Safety Restraint Observation Records for individuals on Unit A4 and observations on the unit found no indication that individuals were rendered bed-bound due to lack of equipment or staff.</p> <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Implement training as planned. 2. Continue to monitor this requirement.
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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, January 2008: Provide data regarding annual training.</p> <p>Findings: NSH's compliance data from the Education Orientation Training Report: Psych Nursing 101 DMH Nursing Services Monitoring audit indicated 80% compliance with the requirement that new hires complete competency-based training (January-May 2008).</p> <p>Recommendation 2, January 2008: Continue to monitor this requirement.</p> <p>Findings: Regarding existing NSH staff, the facility demonstrated via training rosters that in May 2008, 160 out of 1103 nursing staff completed the required training. NSH has mandated training on Therapeutic Milieu, which is conducted four times a month, to increase compliance with this requirement. .</p> <p>Compliance: Partial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>

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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 recommendation:</p> <p>Recommendation, January 2008: See F.3.h.i.</p> <p>Findings: NSH's Therapeutic Milieu training includes requirements of F.3.h.i and F.3.h.i. (See F.3.h.i.)</p> <p>Compliance: Partial. (See F.3.h.i.)</p> <p>Current recommendation: Continue to monitor this requirement.</p>
F.3.h.iii	positive behavior support principles.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, January 2008: Implement eight-hour PBS training.</p> <p>Findings: Training rosters demonstrated that NSH is providing the content of the approved statewide PBS training in a four-hour session addressing this recommendation.</p> <p>Recommendation 2, January 2008: Continue to provide unit-based PBS training.</p> <p>Findings: Training rosters verified that in May 2008, 112 nursing staff (out of 1103) received Focused PBS trainings on their units. Training for this recommendation is ongoing.</p>

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		<p>Recommendation 3, January 2008: Continue to monitor this requirement.</p> <p>Findings: Training rosters verified that in May 2008, 116 out of 1103 total nursing staff have attended PBS training. Training for this requirement is ongoing to increase compliance.</p> <p>Compliance: Partial.</p> <p>Current recommendations: Continue to monitor 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 recommendation:</p> <p>Recommendation, January 2008: Continue to monitor this requirement.</p> <p>Findings: Review of NSH's data regarding training for January-May 2008 found that 98% (64 new hires) of licensed nursing staff completed Medication Administration Skills and 80% (262 existing staff) of licensed nursing staff completed Medication Administration Skills. To increase compliance, the class size for training was increased in June 2008 and trained licensed registered nurses were used to assist with skills competency check-offs.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>

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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. Beverly Lynn, Acting Senior Rehabilitation Therapist 2. Camille Gentry, Acting Senior Rehabilitation Therapist 3. Kathleen Elbert, Art Therapist 4. Phyllis Moore, Acting Senior Rehabilitation Therapist 5. Reggie Ott, Chief of Rehabilitation Services 6. Robert Newman, Acting Senior Rehabilitation Therapist 7. Robert Schaufenbil, Acting Senior Rehabilitation Therapist <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. DMH Rehabilitation Therapy Service Manual 2. DMH Rehabilitation Therapy F4 Audit Tool and instructions 3. POST monthly progress note draft 4. Audit data related to WRP integration of Physical, Occupational and Speech Therapy services for April 2008 5. 24 Hour Rehabilitation Support Plan (draft) 6. Criteria for 24 Hour Support Plan (draft) 7. NSH Mall Course Schedule for Rehabilitation Therapy PSR Mall groups 8. List of individuals with adaptive equipment 9. Records for the following 21 individuals participating or enrolled in observed Mall groups: AAC, ALR, AM, AMS, ATM, DKRH, EAG, EM, HSS, JA, JDT, LC, LFC, LLS, PEM, RC, SLC, TCG, TDF, THE and TLJ 10. Records for the following 18 individuals to compare Integrated Assessments-Rehabilitation Therapy Section with WRP documents: AB, AMM, AP, CDV, CDW, ELC, FG, FL, FLK, HS, IRS, KLF, KND, LRW, MEP, OB, PCB and SET 11. Records for the following four individuals with Vocational Rehabilitation Focused assessments to compare assessments and

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		<p>corresponding WRP's: DG, MB, PB and RK</p> <ol style="list-style-type: none"> 12. List of individuals who received direct Physical Therapy services from January-May 2008 13. Records for the following five individuals with Physical Therapy assessment from April-May 2008 to compare assessments and corresponding WRP's: CH, DC, FAS, JM and LER 14. Records for the following nine individuals who received direct Physical Therapy services between January-May 2008: DHS, JAG, JCT, JDS, JWS, PA, PAM, SSP and WZ 15. List of individuals who received direct Speech Therapy services from January- May 2008 16. Records for the following four individuals with Speech Therapy assessment from April-May 2008 to compare assessments and corresponding WRP's: AC, HS, RME and SEF 17. Records for the following five individuals who received direct Speech Therapy services from January-May 2008: HH, JED, JKD, RAM and WCF 18. List of individuals who received direct Occupational Therapy services from January-May 2008 19. Records for the following seven individuals who received direct Occupational Therapy services from January-May 2008: CHH, ERC, ETR, JH, PWB, SSP and ZEK 20. Records for the following six individuals who had a Comprehensive Integrated Rehabilitation Assessments to compare assessments with corresponding WRP's: AP, GDM, JY, MAM, PFM and RAM 21. Records of the following 13 individuals who had type D.4.d assessments to compare assessment findings with corresponding WRP's: AB, AIR, DM, DR, EY, FM, FP, KDN, LJ, LK, RH, RR and RRT <p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. Adaptive Equipment database demonstration 2. Leisure Exploration PSR Mall Group 3. Communication through Art PSR Mall Group
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		<p>4. Communication Skills through Drumming PSR Mall Group</p> <p>5. Vocational Rehabilitation PSR Mall Group</p> <p>6. Relaxation PSR Mall Group</p> <p>7. Communication Skills through Drama PSR Mall Group</p> <p>8. Mural Painting PSR Mall Group</p>
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:	<p>Compliance: Partial.</p>
F.4.a.i	the provision of direct services by rehabilitation therapy services staff; and	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, January 2008: Develop and implement a procedure that specifies criteria for the need and implementation (including training and monitoring) of a 24-hour support plan (Integrated Restorative Care Plan) related to physical and nutritional rehabilitation supports that is consistent with procedures at other state hospitals.</p> <p>Findings: Drafts of guidelines and a template for a 24 Hour Rehabilitation Support Plan have been developed, and are pending statewide approval and implementation. The guidelines address criteria for a 24 hour Rehabilitation Support Plan, implementation time frames, and review and re-assessment. However, the guidelines specify that the plans should be monitored rather than re-assessed by the Rehabilitation Therapy department, and that the plans are re-assessed and reviewed by the WRPT. It is recommended that the plans be re-assessed and reviewed by the therapists who created them to ensure that the plans are being implemented and are clinically appropriate. The data from the review or re-assessment would then be reviewed by the WRPT as</p>

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		<p>part of the present status section of the Case Formulation. The format of the 24 hour plan appears to be comprehensive, and addresses dining, positioning, mobility, activities of daily living, and communication. The drafts should be reviewed by all four hospitals to ensure consistency between hospitals and to ensure that the drafts are in line with the Wellness and Recovery Model and the Enhancement Plan requirements prior to implementation.</p> <p>Recommendation 2, January 2008: Develop and implement formats for progress notes for Vocational Rehabilitation, and Occupational, Physical and Speech Therapy direct treatment that are consistent with those at the other state hospitals as well as with individual discipline practice requirements.</p> <p>Findings: Drafts for progress notes for Physical, Occupational and Speech Therapy direct treatment and Vocational Rehabilitation (for services other than PSR Mall groups) have been developed and are pending implementation. These are state-wide drafts.</p> <p>Recommendation 3, January 2008: Ensure that all Rehabilitation Therapy staff is provided competency-based training on all procedures related to the Enhancement Plan, Wellness and Recovery model, and Psychosocial Rehabilitation Mall, including Mall Facilitator Monthly Progress Notes and writing of lesson plans/curricula.</p> <p>Findings: According to facility report, 7/10 Physical Occupational Speech Therapy Team staff members were trained to competency on "Strength-Based Objectives & Interventions" on 5/23/08. On 3/19/08, 62% (37/60) of Rehabilitation Therapists received training on "Lesson Plan and Curriculum Development". This is verified by review</p>
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		<p>of training rosters and training quizzes. The facility plan is to train all remaining Rehabilitation Therapists and Physical Occupational Speech Therapy team members by August 2008.</p> <p>Recommendation 4, January 2008: Develop and implement an F.4 audit tool to ensure the adequate and timely provision and implementation of Rehabilitation Services, including direct treatment (1:1 and group) and indirect supports (e.g. Integrated Restorative Care Plan, adaptive equipment). Implementation findings should also include recommendations regarding foci, objectives and interventions made by Rehabilitation Therapy Services, quality of these objectives with regard to Wellness and Recovery criteria, documentation of progress towards objectives, modification of objectives/ interventions as needed and WRP inclusion.</p> <p>Findings: The F4 audit tool was developed and approved in June 2008. Data collected from the F.4 monitoring tool will be presented during the next review.</p> <p>Recommendation 5, January 2008: Establish inter-rater reliability among staff performing audits prior to implementation.</p> <p>Findings: The facility reports that inter-rater agreement for the F.4 monitoring tool (DMH Rehabilitation Therapy Services Audit Form MH-C9085) will be established in August 2008.</p> <p>Other findings: The data below presents the number of scheduled vs. actual hours of direct services provided by Occupational, Physical, and Speech Therapy between 07/07/08 and 07/11/08:</p>
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		<table border="1" data-bbox="991 228 1614 383"> <thead> <tr> <th></th> <th>Scheduled</th> <th>Provided</th> </tr> </thead> <tbody> <tr> <td>PT</td> <td>139</td> <td>81</td> </tr> <tr> <td>OT</td> <td>14</td> <td>12</td> </tr> <tr> <td>SLP</td> <td>13</td> <td>12</td> </tr> </tbody> </table> <p data-bbox="991 427 1871 678">Record review of individuals receiving direct Physical Therapy treatment revealed that 78% of records had assessment findings aligned with treatment plans, 89% contained evidence of change as needed, 78% contained IDN documentation of progress, 11% contained documentation of progress in the present status section of the WRP, 13% had documentation of focus, 0% had documentation of adequate objectives, and 0% contained evidence of appropriate interventions.</p> <p data-bbox="991 722 1858 1008">Record review of individuals receiving direct Speech Therapy treatment revealed that 100% of records had assessment findings aligned with treatment plans, 0% contained evidence of change as needed, 0% of records contained IDN documentation of progress, 0% contained documentation of progress in the present status section of the WRP, 20% had documentation of focus, 0% had documentation of adequate objectives, and 40% contained evidence of appropriate interventions.</p> <p data-bbox="991 1052 1879 1305">Record review of individuals receiving Occupational Therapy treatment revealed that 100% of records had assessment findings aligned with treatment plans, 86% contained evidence of change as needed, 100% of records contained IDN documentation of progress, 0% contained documentation of progress in the present status section of the WRP, 57% had documentation of focus, 29% had documentation of adequate objectives, and 0% contained evidence of appropriate interventions.</p> <p data-bbox="991 1349 1325 1377">Current recommendations:</p> <ol data-bbox="991 1386 1850 1417" style="list-style-type: none"> 1. Implement formats for progress notes for Occupational, Physical 		Scheduled	Provided	PT	139	81	OT	14	12	SLP	13	12
	Scheduled	Provided												
PT	139	81												
OT	14	12												
SLP	13	12												

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		<p>and Speech Therapy direct treatment that are consistent with those at the other state hospitals as well as with individual discipline practice act requirements.</p> <ol style="list-style-type: none"> 2. Ensure that all Rehabilitation Therapists and Vocational Rehabilitation staff is trained to competency regarding "lesson Plan and Curriculum Development", and that all POST team members are trained to competency on writing "Strength-Based Objectives & Interventions". 3. Implement the F.4 audit tool, and establish inter-rater agreement.
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 recommendation:</p> <p>Recommendation, January 2008: Develop and implement a plan to ensure that in vivo monitoring of Physical Therapy programs implemented by nursing staff or individuals themselves occurs as needed.</p> <p>Findings: A process for provision of Physical and Occupational therapy treatment activities by nursing staff on unit A4 has been implemented. However, no plan has been developed to ensure that individuals on other units who require this service are provided with it. Also, current programs on A4 implemented by nursing staff are general (e.g., "range of motion"), rather than specific and individualized treatment programs. There is not currently a database to track individuals who require indirect Physical or Occupational therapy programs, which lists when staff has received competency based training/return demonstration, and how often the individual should be re-assessed by the Physical or Occupational Therapist to determine the continued appropriateness of the program. No formal system is in place (facility-wide) to provide oversight to program implementation.</p>

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		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a procedure for nursing staff provision of indirect Physical and Occupational Therapy programs. 2. Develop and implement a database to track individuals receiving these services, as well as when staff has received competency based training/return demonstration, and how often the individual should be re-assessed by the Physical or Occupational Therapist to determine the continued appropriateness of the program.
F.4.b	<p>Each State hospital shall provide competency-based training to nursing staff, as appropriate, on the use and care of adaptive equipment, transferring, and positioning, as well as the need to promote individuals' independence.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: Develop and implement a plan to ensure that competency-based training on the use and care of adaptive equipment, transferring and positioning, as well as the need to promote individuals' independence, occurs as needed.</p> <p>Findings: Competency based training has been provided by the Physical Occupational Speech Therapy Team to nursing staff assigned to the skilled nursing unit (A-4) and the Acute Psychiatric Unit (A-9). Nine out of nine staff were trained to competency on "Rehabilitation Nursing Documentation" on 5/30/08; 7/7 staff were trained to competency on "Positioning" on 5/30/08; 7/7 staff were trained to competency on "Mobility and Transfers" on 5/27/08; 8/8 staff were trained to competency on "Range of Motion" on 5/23/08; 17/17 staff were trained to competency on "Body Mechanics" on 5/21/08; 4/4 staff were trained to competency on "Roho Cushions and Equipment Overview" on 5/16/08; and 16/16 staff were trained to competency on "Range of Motion" on 3/4/08. All trainings were verified by review of training rosters and competency quizzes. However, it is unclear how many staff who required competency based training on other units received this service.</p>

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		<p>Compliance: Partial.</p> <p>Current recommendation: Ensure that competency based training on the use and care of adaptive equipment, transferring, and positioning, as well as the need to promote individuals' independence occurs as needed.</p>
F.4.c	Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, January 2008: Ensure that all Mall groups facilitated by Rehabilitation Therapists have requisite course outlines, lesson plans and curricula per PSR Mall standards.</p> <p>Findings: According to facility report, 24 lesson plans, 358 course outlines, and 18 curricula have been developed for PSR Mall groups. According to facility report, the PSR Group Facilitator Consultation form was implemented by Senior Rehabilitation Therapists to enable them to provide mentoring and direction to assist with the completion of lesson plans, course outlines and curricula for all groups facilitated by Rehabilitation Therapy Services clinicians.</p> <p>Recommendation 2, January 2008: Ensure that for all individuals receiving direct treatment by Rehabilitation Therapists, progress towards objectives is documented in the WRP and focus, objectives and interventions are modified as needed.</p> <p>Findings: See F.4.a and F.4.c "Other Findings" for findings regarding this</p>

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		<p>recommendation.</p> <p>Recommendation 3, January 2008: Ensure that all Integrated Restorative Care Plans are implemented for individuals requiring indirect Rehabilitation Therapy Services.</p> <p>Findings: The guidelines and format for 24 hour Rehabilitation Support plans is pending implementation. Currently, no individuals have a plan in the new format, but according to facility report, 78 individuals have plans developed in the old format. Upon interview, it is noted that some individuals with plans in the old format may not meet criteria for plans in the new system.</p> <p>Other findings: In regards to PSR Mall Services provision, the following outlines the average number of hours scheduled versus provided for one week in May 2008:</p> <table border="1" data-bbox="991 894 1852 1084"> <thead> <tr> <th>As of May 2008</th> <th>Number of Therapists</th> <th>Hours Scheduled</th> <th>Hours Provided</th> </tr> </thead> <tbody> <tr> <td>RT - Long Term</td> <td>48</td> <td>10.3</td> <td>7.7</td> </tr> <tr> <td>RT - Admissions</td> <td>7</td> <td>6.3</td> <td>4.9</td> </tr> <tr> <td>Voc</td> <td>21</td> <td>18.2</td> <td>11.4</td> </tr> </tbody> </table> <p>Upon observation of PSR Mall groups led by Rehabilitation Therapists, it was noted that two out of seven observed had lesson plans in place, and being used.</p> <p>According to record review of individuals participating in Rehabilitation Therapist led PSR Mall groups, 19% showed WRP inclusion of focus, 0% had WRP inclusion of adequate objectives, and 24% of WRP documentation of interventions. From the same record sample, 10%</p>	As of May 2008	Number of Therapists	Hours Scheduled	Hours Provided	RT - Long Term	48	10.3	7.7	RT - Admissions	7	6.3	4.9	Voc	21	18.2	11.4
As of May 2008	Number of Therapists	Hours Scheduled	Hours Provided															
RT - Long Term	48	10.3	7.7															
RT - Admissions	7	6.3	4.9															
Voc	21	18.2	11.4															

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		<p>had evidence of Monthly Facilitator Mall Progress Notes, and 0% contained documentation of progress in the present status section of the WRP.</p> <p>Upon review of sample of IA-RTS assessments and type D.4.d. assessments completed from January-May 2008, it was noted that 74% of assessments included recommendations for focus, 0% contained adequate objectives, and 62% included interventions. In addition, 85% of records reviewed showed documentation of Rehabilitation Therapist attendance at WRP conference following the assessment.</p> <p>Upon review of IA-RTS assessments and type D.4.d assessments, it was noted that foci, objectives and interventions are not consistently aligned. In addition, Focus 10 objectives and interventions do not consistently address Focus 10 needs.</p> <p>Upon review of sample of Comprehensive Integrated Physical Rehabilitation Assessments completed from January-May 2008, it was noted that 100% of assessments included recommendations for focus, 67% contained adequate objectives, and 50% included appropriate interventions.</p> <p>No 24-hour Rehabilitation Support plans were reviewed as none were developed during the January-May 2008 review period.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that for all individuals receiving treatment by Rehabilitation Therapists in PSR Mall groups, progress towards objectives is documented in the WRP and focus, objectives, and interventions are modified as needed.
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		<ol style="list-style-type: none"> 2. Ensure that for all Rehabilitation Therapist led PSR Mall groups, foci, objectives and interventions are aligned. 3. Develop and implement a database to track individuals with 24 hour plans, as well as when staff has received competency based training/return demonstration, and how often the individual should be re-assessed by the POST team member(s) to determine the continued appropriateness of the plan. 4. Ensure that all individuals with current Integrated Restorative Care Plans are reviewed to ensure that they meet the criteria for the new 24 hour Rehabilitation Support plans, with conversion to the new format as clinically indicated.
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, January 2008: Develop and implement a plan to ensure that in vivo monitoring of adaptive equipment occurs as needed on an individualized basis by a professional with clinical expertise to determine compliance with both implementation and continued appropriateness of supports.</p> <p>Findings: There is currently no plan in place to ensure that review and re-assessment by appropriate team members occurs as needed to ensure that adaptive equipment is clinically appropriate and implemented as indicated.</p> <p>Recommendation 2, January 2008: Develop and implement an adaptive equipment database to track when a piece of equipment is ordered, the date of implementation, level of assistance to individual with device, whether training/monitoring is necessary and when training/monitoring is provided if appropriate.</p>

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		<p>Findings: An adaptive equipment database has been developed that meets the requirements of this recommendation, and the facility reports that this database will be populated in July 2008.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Ensure that each individual who requires adaptive equipment is provided with equipment that meets his/her assessed needs and promotes his/her independence, and provide individuals with training and support to use such equipment.</p>
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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. Craig Saewong, Acting Assistant Director of Dietetics 2. Heidi Vogelsang, Registered Dietitian 3. Lynn Wurzel, Registered Dietitian 4. Noriko Takenawa, Registered Dietitian 5. Wen Pao, Director of Dietetics <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Lists of individuals with Nutrition Care Assessments due from January-May 2008 for each assessment type 2. Records for the following 73 individuals with type a-j.ii. assessment from January-May 2008: AA, AB, AC, AE, AGV, ALW, AMW, AP, AS, AT, ATB, BJ, BMC, CA, CC, CH, CH, CH-2, CO, CWP, DC, DDM, DEA, DMP, DP, DSH, EE, EH, EL, ELC, ELH, EPR, FCP, FT, GH, HCH, JA, JD, JEG, JM, JS, JVM, JWM, KFR, KH, KJN, LDC, LF, LG, LGB, MD, MDC, MO, MP, MS, MWS, PMN, RB, RD, RG, RGW, RH, RL, RM, RTP, RZ, SM, SN, SS, THE, TLN, TR and VZ 3. Meal Accuracy Report audit data from January-May 2008 4. Nutrition Care Monitoring Tool audit data from January-May 2008 regarding Nutrition Education Training and response to MNT (weighted mean across assessment sub-types) 5. Audit data for January-May 2008 regarding WRP integration of Nutrition Services recommendations 6. DMH Nutrition Care Monitoring Instructions (revised and approved 11/07) 7. Facility training data and competency scores for RN's and Dietitians, as well as raw data binders
F.5.a	Each State hospital shall modify policies and procedures to require that the therapeutic and	Current findings on previous recommendations:

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	<p>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>Recommendations 1 and 2, January 2008:</p> <ul style="list-style-type: none"> • Implement PSR Nutrition Mall groups for Weight Management and Diabetes Management. • Begin to track facilitator hours for PSR Mall Nutrition groups. <p>Findings: The facility reports that Dietitian-led PSR Mall classes are not currently being provided due to staffing shortage. However, upon request by the PSR Mall Director, Dietitians have re-developed the Weight Management lesson plan to better meet the needs of individuals, and adapted the lesson plan so that other professionals could facilitate this group.</p> <p>Recommendation 3, January 2008: Continue current practice.</p> <p>Findings: Current procedures for Nutrition services appear to meet generally accepted standards of practice.</p> <p>Nutrition Education and documentation of Medical Nutrition Training response are direct services provided by Dietitians at NSH. Using the DMH Nutrition Care Monitoring Tool, NSH assessed its compliance with these indicators based on an average sample of 16% of Nutrition Assessments (all types) due each month for the review period of January -May 2008 (total of 1849). The following presents these indicators with corresponding mean compliance rates for January-May 2008:</p> <table border="1" data-bbox="989 1263 1887 1411"> <tr> <td data-bbox="989 1263 1087 1300">7.</td> <td data-bbox="1087 1263 1793 1300"><i>Nutrition education is documented</i></td> <td data-bbox="1793 1263 1887 1300">95%</td> </tr> <tr> <td data-bbox="989 1300 1087 1411">8.</td> <td data-bbox="1087 1300 1793 1411"><i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i></td> <td data-bbox="1793 1300 1887 1411">96%</td> </tr> </table>	7.	<i>Nutrition education is documented</i>	95%	8.	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i>	96%
7.	<i>Nutrition education is documented</i>	95%						
8.	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i>	96%						

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		<p>According to review of Meal Accuracy Report data, trays (regular and modified diets) audited from January-May 2008 (total of 4452 out of 8995, for a 49% sample) were 98% accurate.</p> <p>Other findings: According to record review of sample of D.5 Nutrition assessments across assessment sub-types, a weighted mean of 98% of Nutrition Care Assessments had evidence of Nutrition Training/Education if clinically indicated, and 98% of Nutrition Care Assessments had evidence of individual response to MNT (Medical Nutrition Training).</p> <p>Compliance: Partial.</p> <p>Current recommendation: Continue current efforts to achieve compliance.</p>
F.5.b	Each State hospital shall ensure that one or more treatment team members demonstrate competence in the dietary and nutritional issues affecting the individuals they serve and the development and implementation of strategies and methodologies to address such issues.	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, January 2008:</p> <ul style="list-style-type: none"> • Continue current practice. • Provide and implement training to Dietitians to write Nutrition recommendations in WRP format (focus, objective, intervention) for report by nurse to the WRP. <p>Findings: WaRMSS Training in the WRP module was provided for Clinical Dietitians on 4/15/08. Clinical Dietitians were trained to write nutrition recommendations in WRP format and communicate with RN to report in WRP.</p> <p>Using the DMH Nutrition Care Monitoring Tool, NSH assessed its</p>

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		<p>compliance with WRP integration based on an average sample of 16% of Nutrition Assessments (all types) due each month for the review period of January -May 2008 (total of 1849). The following presents these indicators with corresponding mean compliance rates for January-May 2008:</p> <table border="1" data-bbox="991 414 1881 600"> <tr> <td data-bbox="991 414 1087 488">19.</td> <td data-bbox="1087 414 1793 488"><i>The WRP has at least ONE Focus that pertains to nutrition recommendations as clinically indicated</i></td> <td data-bbox="1793 414 1881 488">45%</td> </tr> <tr> <td data-bbox="991 488 1087 600">20.</td> <td data-bbox="1087 488 1793 600"><i>The WRP has at least one objective and interventions linked to the Focus that pertains to the nutrition recommendation as clinically indicated</i></td> <td data-bbox="1793 488 1881 600">45%</td> </tr> </table> <p>The mean % compliance has increased from 25% in the previous review period, to 45% in this review period.</p> <p>According to facility analysis, there is a systemic issue with communication from the dietitians to nursing staff consistently including recommendations in the WRP. The issue will be brought to the attention to the Nurse Administrator for corrective action.</p> <p>Other findings: Upon record review of sample of Nutrition Care assessments completed across assessment sub-types, it was noted that 69% of corresponding WRP documents contained Nutrition Care focus, and 49% contained evidence of at least one objective and intervention linked to the focus.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Continue current efforts to achieve compliance.</p>	19.	<i>The WRP has at least ONE Focus that pertains to nutrition recommendations as clinically indicated</i>	45%	20.	<i>The WRP has at least one objective and interventions linked to the Focus that pertains to the nutrition recommendation as clinically indicated</i>	45%
19.	<i>The WRP has at least ONE Focus that pertains to nutrition recommendations as clinically indicated</i>	45%						
20.	<i>The WRP has at least one objective and interventions linked to the Focus that pertains to the nutrition recommendation as clinically indicated</i>	45%						

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<p>F.5.c</p>	<p>Each State hospital shall develop and implement policies and procedures to address the needs of individuals who are at risk for aspiration or dysphagia, including but not limited to, the development and implementation of assessments and interventions for mealtimes and other activities involving swallowing.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: Continue current practice.</p> <p>Findings: The DMH Statewide Dietetics Department Policy: Dysphagia and Aspiration Management addresses the dietitian's role in the team process regarding dysphagia and aspiration prevention and management and appears to meet generally accepted standards of practice.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
<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 recommendation:</p> <p>Recommendation, January 2008: Continue current practice.</p> <p>Findings: According to facility report, one new employee was hired in 3/08, and has been trained to competency (at least 90%) regarding Dysphagia course content. At the time of the last review, it was noted that 100% of dietitians had received Dysphagia Training to competency.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>

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<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 recommendation:</p> <p>Recommendation, January 2008: Continue current practice.</p> <p>Findings: The DMH Statewide Dietetics Department Policy for Tube Feeding appears to meet accepted standards of practice.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
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6. Pharmacy Services		
	<p>Each State hospital shall provide adequate and appropriate pharmacy services consistent with generally accepted professional standards of care. Each State hospital shall develop and implement policies and procedures that require:</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Dolly Matteucci, Hospital Administrator 2. John Banducci, Pharmacy Director <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. The charts of the following three individuals: AKS, ARM and YAQ 2. NSH data regarding recommendations made by the pharmacists and physicians response (January to May 2008) 3. Summary description of each of the pharmacists' recommendations that were not responded to or acted upon by physicians during this reporting period
F.6.a	<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, January 2008: The state must address issues related to recruitment and retention of pharmacy staff needed to execute the EP.</p> <p>Findings: NSH has maintained the same number of Pharmacist I positions (and gained one FTE Pharmacist II) since the last review. As of May 31, 2008, NSH had five FTE Pharmacist I positions filled (there were 13.5 positions allocated) and one FTE Pharmacist II position (out of two allocations).</p> <p>In order to meet the Pharmacy workload, NSH has been augmenting regular full-time staff with several contract Pharmacists (between 2 and 3.5 FTE). Although significant vacancies of staff Pharmacists still exist, the Pharmacy Director stated that the facility currently has sufficient staffing levels to implement EP requirements.</p>

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		<p>Recommendation 2, January 2008: Implement the newly revised Pharmacy Policy #704.</p> <p>Findings: NSH has implemented this recommendation effective February 13, 2008.</p> <p>Recommendation 3, January 2008: Continue to monitor this requirement and provide data analysis that addresses trends/patterns requiring corrective action.</p> <p>Findings: NSH reviewed a 100% sample of the recommendations made by pharmacists (January to May 2008). The following is a summary of the data:</p> <table border="1" data-bbox="991 820 1675 1393"> <thead> <tr> <th>Area of recommendation(s)</th> <th>Total #</th> </tr> </thead> <tbody> <tr> <td>Drug-to-drug interactions</td> <td>14</td> </tr> <tr> <td>Side-effects</td> <td>20</td> </tr> <tr> <td>Need for lab work and testing</td> <td>64</td> </tr> <tr> <td>Contra-indications</td> <td>2</td> </tr> <tr> <td>Drug allergy</td> <td>7</td> </tr> <tr> <td>Dose range</td> <td>42</td> </tr> <tr> <td>Indication for medication</td> <td>9</td> </tr> <tr> <td>Polypharmacy</td> <td>0</td> </tr> <tr> <td>Drug-to-food interactions</td> <td>6</td> </tr> <tr> <td>Incomplete orders</td> <td>7</td> </tr> <tr> <td>Confusing orders needing clarification</td> <td>18</td> </tr> <tr> <td>Duplicate orders</td> <td>15</td> </tr> </tbody> </table>	Area of recommendation(s)	Total #	Drug-to-drug interactions	14	Side-effects	20	Need for lab work and testing	64	Contra-indications	2	Drug allergy	7	Dose range	42	Indication for medication	9	Polypharmacy	0	Drug-to-food interactions	6	Incomplete orders	7	Confusing orders needing clarification	18	Duplicate orders	15
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		Others	12
		Total number of recommendations	216
		<p>The total number of recommendations increased from 66 during the last review period to 216 during this review period. The facility reported that the number of recommendations made by Pharmacists concerning drug-drug and drug-food interactions and allergies was low, as these issues are part of the alert system of the current Physicians Order System (POS). The large number of recommendations involving the need for laboratory work reflects the need to improve compliance with the baseline laboratory monitoring required as per the DMH Psychotropic Medication Polices.</p> <p>Other findings: This monitor reviewed the charts of three individuals who were involved in situations in which the physicians did not act in response to the pharmacist's recommendation. In the chart of YAQ, there was no documentation of the rationale for not conducting an EKG study prior to the initiation of ziprasidone treatment, as recommended by the pharmacist. There have been no documented adverse effects to the individual. The chart of ARM included adequate documentation of the physician's rationale for not following the pharmacist's recommendation. In the chart of AKS, there was no documentation by the physician of the rationale for continuation of treatment with ziprasidone despite a recommendation to the contrary by the facility's pharmacist. However, the medication was discontinued shortly thereafter following a cardiology consultation.</p> <p>Compliance: Partial.</p> <p>Current recommendations: 1. Monitor this requirement based on a 100% sample.</p>	

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		<p>2. Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period).</p>						
<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 recommendation:</p> <p>Recommendation, January 2008: Same as in F.6.a.</p> <p>Findings: The facility monitored this requirement based on a 100% sample. The data are summarized as follows:</p> <table border="1" data-bbox="991 672 1848 824"> <tr> <td>Recommendations followed</td> <td>168</td> </tr> <tr> <td>Recommendations not followed, but rationale documented</td> <td>9</td> </tr> <tr> <td>Recommendations not followed and rationale/response not documented</td> <td>39</td> </tr> </table> <p>The facility reported that efforts to improve physicians' response the recommendations have included the following:</p> <ol style="list-style-type: none"> 1. If the recommendation is not responded to and poses a significant risk potential (in the judgment of the pharmacist), the Chief of Psychiatry is immediately notified by the Pharmacy Director and requested to investigate. 2. Beginning May 2008, the Pharmacy Director and Chief of Psychiatry began bi-weekly meetings to review patterns/trends and discuss plans for correction. 3. In May 2008, the Chief of Psychiatry began sending e-mails to individual physicians requesting that they respond to the pharmacist's recommendations. 4. As of May 31, 2008, all recommendations that were not responded to have been promptly attended to by the Chief of Psychiatry and 	Recommendations followed	168	Recommendations not followed, but rationale documented	9	Recommendations not followed and rationale/response not documented	39
Recommendations followed	168							
Recommendations not followed, but rationale documented	9							
Recommendations not followed and rationale/response not documented	39							

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		<p>WRPT Psychiatrist</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none">1. Monitor this requirement based on a 100% sample.2. Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period).
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7. General Medical Services		
		<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Abishai Rumano, MD, Acting Chief Physician and Surgeon 2. Dennis Hawley, MD, Physician and Surgeon 3. Emmanuel Cepe, MD, Physician and Surgeon 4. Lane Melgarejo, MD, Physician and Surgeon 5. Marlene Salvador, MD, Physician and Surgeon 6. Mu Chou, MD, Physician and Surgeon 7. Rajeev Sachdev, MD, Physician and Surgeon 8. Rodolfo Pineda, MD, Physician and Surgeon 9. William Kocsis, MD, Physician and Surgeon <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. The charts of the following 11 individuals who were transferred to an outside medical facility during this reporting period: BMN, DC, DH, DIB, DMH, DPN, KFH, MLW, RS, TR and TT 2. AD #600, Medical Services, revised 3. DMH Special Order #136, Provision of Medical Care to Individuals 4. RN Significant Change in Condition Assessment Note template 5. DMH Medical Surgical Progress Notes Auditing Form 6. DMH Medical Surgical Progress Notes Auditing Form Instructions 7. NSH Medical Surgical Progress Notes Auditing summary data (March to May 2008) 8. DMH Integration of Medical Conditions into the WRP Auditing Form 9. DMH Integration of Medical Conditions into the WRP Auditing Form Instructions 10. NSH Integration of Medical Conditions into the WRP Auditing summary data (March to May 2008) 11. DMH Medical Transfer Auditing Form 12. DMH Medical Transfer Auditing Form Instructions

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		<ol style="list-style-type: none"> 13. NSH Medical Transfer Auditing summary data (January to May 2008) 14. NSH data regarding timeliness of consultations off-site (January to May 2008) 15. NSH medical and psychiatric night/weekend and holiday coverage schedule (January to May 2008) 16. DMH Diabetes Mellitus Auditing Form 17. DMH Diabetes Mellitus Auditing Form Instructions 18. NSH Diabetes Mellitus Auditing summary data (January to May 2008) 19. DMH Hypertension Auditing Form 20. DMH Hypertension Auditing Form Instructions 21. NSH Hypertension Auditing summary data (January to May 2008) 22. DMH Dyslipidemia Auditing Form 23. DMH Dyslipidemia Auditing Form Instructions 24. NSH Dyslipidemia Auditing summary data (January to May 2008) 25. DMH Asthma/COPD Auditing Form 26. DMH Asthma/COPD Auditing Form Instructions 27. NSH Asthma/COPD Auditing summary data (January to May 2008) 28. NSH Cardiac Disease Monitoring Form 29. NSH Cardiac Disease Monitoring summary data (January to May 2008) 30. NSH Preventive Care Monitoring Form 31. NSH Preventive Care Monitoring summary data (January to May 2008)
F.7.a	<p>Each State hospital shall provide adequate, appropriate, and timely preventive, routine, specialized, and emergency medical care to all individuals in need of such services, consistent with generally accepted professional standards of care. Each State hospital shall ensure that individuals with medical problems are promptly identified,</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, January 2008: Finalize and implement the newly drafted ADs (Medical and Psychiatric Services, Medical Ancillary Services and Medical Emergencies) and ensure correction of the ten process deficiencies identified in the previous reports.</p>

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	<p>assessed, diagnosed, treated, monitored and, as monitoring indicates is necessary, reassessed, diagnosed, and treated, consistent with generally accepted professional standards of care.</p>	<p>Findings: NSH has yet to finalize and implement the revisions of its AD/Policies and procedures regarding this recommendation. The draft revisions adequately addressed the deficiencies except that further refinements are needed in the areas of communication of needed data to consultants, timely review and filing of consultation and laboratory reports and follow-up on consultation recommendations. The facility has yet to develop AD/Policy/Procedure to address the deficiency in the area of medical emergency response, including drill practice. DMH is in the process of finalizing a revised version of its Special Order#136, Provision of Medical Care to Individuals. The revisions provide adequate instruction to the facilities regarding a system of care that meets generally accepted standards.</p> <p>Recommendation 2, January 2008: Implement corrective actions to address the monitor's findings of deficiencies in this report.</p> <p>Findings: NSH implemented the following actions:</p> <ol style="list-style-type: none"> 1. The Chief of Medical Ancillary Services (MAS) is reviewing audit results and providing individualized teaching, mentoring, and supervision. 2. Education is provided in MAS meetings (no specifics were given). 3. The facility has reassigned four FTE Primary Care Physicians from general medical clinics to the programs. 4. The DMH is in the process of developing medical and nursing care protocols and procedures to improve the communication of changes in medical conditions between physicians and nurses. If properly implemented, the new template for RN Significant Change in Condition Assessment Note can facilitate needed correction.
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		<p>Other findings: This monitor reviewed the charts of 11 individuals who were transferred to an outside medical facility during this reporting period. The following table outlines the individuals' initials, date/time of physician evaluation at the time of transfer and the reason for the transfer:</p> <table border="1" data-bbox="991 485 1808 1057"> <thead> <tr> <th>Individual</th> <th>Date and time of MD evaluation</th> <th>Reason for transfer</th> </tr> </thead> <tbody> <tr> <td>BMN</td> <td>2/09/08 22:00</td> <td>Abdominal pain</td> </tr> <tr> <td>DC</td> <td>1/10/08 17:00</td> <td>Altered mental status</td> </tr> <tr> <td>DH</td> <td>2/01/08 13:00</td> <td>Decreased level of consciousness</td> </tr> <tr> <td>DIB</td> <td>5/01/08 12:23</td> <td>Gastrointestinal bleeding</td> </tr> <tr> <td>DMH</td> <td>2/05/08 23:00</td> <td>Pneumonia</td> </tr> <tr> <td>DPN</td> <td>4/11/08 17:35</td> <td>Seizure activity</td> </tr> <tr> <td>KFH</td> <td>3/10/08 15:25</td> <td>Bowel obstruction</td> </tr> <tr> <td>MLW</td> <td>3/09/08 09:20</td> <td>Ruptured appendix</td> </tr> <tr> <td>RS</td> <td>2/22/08 18:45</td> <td>Seizure activity</td> </tr> <tr> <td>TR</td> <td>2/17/08 01:00</td> <td>Pneumonia</td> </tr> <tr> <td>TT</td> <td>5/11/08 (No time documented)</td> <td>Bowel obstruction</td> </tr> </tbody> </table> <p>The review found evidence of timely and appropriate care in most charts. However, a persisting pattern of deficiencies was found as follows:</p> <ol style="list-style-type: none"> 1. There was evidence of inappropriate initial medical intervention for an individual who was suffering from insomnia due to breathing difficulties and was later diagnosed with pneumonia. 2. There was no documentation of a formulation of the factors that contributed to the occurrence of divalproex toxicity in an 	Individual	Date and time of MD evaluation	Reason for transfer	BMN	2/09/08 22:00	Abdominal pain	DC	1/10/08 17:00	Altered mental status	DH	2/01/08 13:00	Decreased level of consciousness	DIB	5/01/08 12:23	Gastrointestinal bleeding	DMH	2/05/08 23:00	Pneumonia	DPN	4/11/08 17:35	Seizure activity	KFH	3/10/08 15:25	Bowel obstruction	MLW	3/09/08 09:20	Ruptured appendix	RS	2/22/08 18:45	Seizure activity	TR	2/17/08 01:00	Pneumonia	TT	5/11/08 (No time documented)	Bowel obstruction
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		<p>individual.</p> <ol style="list-style-type: none">3. The nurse's assessment of an individual who complained of abdominal pain and was later diagnosed with perforated appendix did not address the timeframes of the change in the physical status.4. The nurse's assessment of an individual who was diagnosed with possible bowel obstruction did not address the timeframes of the change in the individual's status.5. There was no evidence that a physician's order for monitoring of blood pressure was carried out in an individual who complained of dizziness and was later diagnosed with gastrointestinal bleeding.6. There was no documentation of a nurse's assessment of the change in the physical status of an individual who was transferred for treatment of pneumonia.7. There was no documentation by the receiving or the attending physician of the status of metabolic factors that may have contributed to the occurrence of a recurrent delirium in an individual who suffered from a dementia and a psychotic illness. The chart did not include physician documentation of precautions to decrease future risk.8. There was no documentation of a medical formulation of factors that may have contributed to the occurrence of small bowel obstruction secondary to adhesions in an individual. The chart did not include physician documentation of precautions to decrease future risk. <p>These deficiencies must be corrected to achieve substantial compliance with this section.</p> <p>Compliance: Partial.</p>
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		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Finalize and implement DMH Special Order#136, Provision of Medical Care to Individuals. 2. Develop and implement revised AD/Policies and Procedures that adequately address all the areas of deficiencies listed above and provide supporting documentation with specific references. 3. Implement corrective actions to address the monitor's findings of deficiencies in this report, including the new medical and nursing care protocols and the RN Significant Change in Condition Assessment Note template.
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, January 2008: Finalize a DMH tool for initial medical assessments for use across facilities.</p> <p>Findings: DMH is in the process of finalizing this tool.</p> <p>Recommendation 2, January 2008: Implement the DMH Medical Surgical Progress Notes Audit Form.</p> <p>Findings: NSH has implemented this recommendation.</p> <p>Recommendations 3-5, January 2008:</p> <ul style="list-style-type: none"> • Provide monitoring data regarding initial medical and quarterly reassessments based on at least a 20% sample.

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		<ul style="list-style-type: none"> • Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement. • Implement plans of correction regarding the initial medical assessments and ongoing reassessments. <p>Findings: NSH's data regarding the initial medical assessment were presented in D.1.c.i.</p> <p>NSH began implementation of the quarterly note in March 2008. The facility used the DMH Medical Surgical Progress Notes Auditing Form to assess compliance (March to May 2008). The average sample was 10% of all individuals with at least one diagnosis on Axis III. The following is a summary of the data:</p> <table border="1" data-bbox="991 743 1885 1084"> <tr> <td data-bbox="991 743 1087 821">1.</td> <td data-bbox="1087 743 1793 821"><i>There is a quarterly note that documents reassessment of the individual medical status.</i></td> <td data-bbox="1793 743 1885 821">61%</td> </tr> <tr> <td data-bbox="991 821 1087 899">2.</td> <td data-bbox="1087 821 1793 899"><i>Significant conditions for which the individual is at risk for complications are identified.</i></td> <td data-bbox="1793 821 1885 899">58%</td> </tr> <tr> <td data-bbox="991 899 1087 1084">3.</td> <td data-bbox="1087 899 1793 1084"><i>If applicable, the on call (after hours) physician documents in the PPN necessary communication between the regular medical physician and the on-call (after hours) physician regarding changes in the individual's physical condition.</i></td> <td data-bbox="1793 899 1885 1084">N/A</td> </tr> </table> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Monitor quarterly medical reassessments based on a 100% sample and identify the target population for all indicators. 2. Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting 	1.	<i>There is a quarterly note that documents reassessment of the individual medical status.</i>	61%	2.	<i>Significant conditions for which the individual is at risk for complications are identified.</i>	58%	3.	<i>If applicable, the on call (after hours) physician documents in the PPN necessary communication between the regular medical physician and the on-call (after hours) physician regarding changes in the individual's physical condition.</i>	N/A
1.	<i>There is a quarterly note that documents reassessment of the individual medical status.</i>	61%									
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		period and compared to the previous period).																					
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 1, January 2008: Present monitoring data using the DMH Integration of Medical Conditions into the WRP and Medical Transfer Audit Forms, based on at least a 20% sample.</p> <p>Findings: The facility used the DMH Integration of Medical Conditions into the WRP Auditing Form to assess compliance (March to May 2008). The average sample was 17% of all individuals with at least one diagnosis on Axis III. The following is a summary of the data:</p> <table border="1" data-bbox="991 748 1887 1161"> <tr> <td>1.</td> <td><i>All medical conditions listed in Axis III are included on the Medical Conditions form</i></td> <td>71%</td> </tr> <tr> <td>2.</td> <td><i>The WRP includes a focus statement, objective and intervention for each medical condition listed on the Medical Conditions form</i></td> <td>59%</td> </tr> <tr> <td>3.</td> <td><i>There is an appropriate focus statement for each medical condition or diagnosis</i></td> <td>63%</td> </tr> <tr> <td>4.</td> <td><i>There is an appropriate objective for each medical condition or diagnosis</i></td> <td>73%</td> </tr> <tr> <td>5.</td> <td><i>There are appropriate intervention(s) for each objective</i></td> <td>73%</td> </tr> </table> <p>The mean compliance rates have increased December 2007 to May 2008 as follows:</p> <table border="1" data-bbox="991 1310 1371 1424"> <thead> <tr> <th>Item</th> <th>Compliance rate</th> </tr> </thead> <tbody> <tr> <td>1.</td> <td>26 to 89%</td> </tr> <tr> <td>2.</td> <td>28 to 89%</td> </tr> </tbody> </table>	1.	<i>All medical conditions listed in Axis III are included on the Medical Conditions form</i>	71%	2.	<i>The WRP includes a focus statement, objective and intervention for each medical condition listed on the Medical Conditions form</i>	59%	3.	<i>There is an appropriate focus statement for each medical condition or diagnosis</i>	63%	4.	<i>There is an appropriate objective for each medical condition or diagnosis</i>	73%	5.	<i>There are appropriate intervention(s) for each objective</i>	73%	Item	Compliance rate	1.	26 to 89%	2.	28 to 89%
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		<table border="1"> <tr> <td>3.</td> <td>34 to 92%</td> </tr> <tr> <td>4.</td> <td>34 to 92%</td> </tr> <tr> <td>5.</td> <td>33 to 92%</td> </tr> </table>	3.	34 to 92%	4.	34 to 92%	5.	33 to 92%	<p>NSH reported that WRP trainers provided focused mentoring on identification of foci beginning in March 2008. This included the need to open a Focus 6 for appropriate medical conditions.</p> <p>Recommendations 2 and 3, January 2008:</p> <ul style="list-style-type: none"> • Present monitoring data regarding the timeliness and quality of on- and off-site consultation referrals. • Present data analysis that evaluates low compliance and delineates areas of relative improvement. <p>Findings:</p> <p>NSH used the DMH Medical Transfer Auditing form to assess compliance (January to May 2008). The average sample was 100% of the transfers. The following is a summary of the data:</p> <table border="1"> <tr> <td>1.</td> <td><i>There is appropriate documentation by the nurse that identifies the symptoms of concern and notification of the physician.</i></td> <td>93%</td> </tr> <tr> <td>2.</td> <td><i>There is appropriate and timely response and documentation from the transferring physician meeting the standards of care for the condition being transferred.</i></td> <td>89%</td> </tr> <tr> <td>3.</td> <td><i>Sufficient information is provided to the accepting facility in order to ensure continuity of care.</i></td> <td>73%</td> </tr> <tr> <td>4.</td> <td><i>Sufficient information is provided by the external facility (acute medical care facility/emergency department) at the time of discharge in order to ensure the continuity of care.</i></td> <td>92%</td> </tr> <tr> <td>5.</td> <td><i>Upon return from acute medical treatment, the</i></td> <td>98%</td> </tr> </table>	1.	<i>There is appropriate documentation by the nurse that identifies the symptoms of concern and notification of the physician.</i>	93%	2.	<i>There is appropriate and timely response and documentation from the transferring physician meeting the standards of care for the condition being transferred.</i>	89%	3.	<i>Sufficient information is provided to the accepting facility in order to ensure continuity of care.</i>	73%	4.	<i>Sufficient information is provided by the external facility (acute medical care facility/emergency department) at the time of discharge in order to ensure the continuity of care.</i>	92%	5.	<i>Upon return from acute medical treatment, the</i>	98%
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		<p><i>accepting physician provides an appropriate note describe the course of treatment provided at the acute medical facility.</i></p>															
		<p>6. <i>Timely written progress notes by the regular medial physician shall address the treatment provided at the acute medical facility and follow-up treatment provided at the DMH hospital.</i></p>	79%														
		<p>7. <i>The WRP was updated to reflect the individual's current status following hospitalization or emergency room treatment.</i></p>	40%														
		<p>Comparative data showed an increase in mean compliance rates from November 2007 (monitoring was done in December 2007) to May 2008 as follows (no data were available for item 7):</p>															
		<table border="1"> <thead> <tr> <th>Item</th> <th>Compliance rate</th> </tr> </thead> <tbody> <tr> <td>1.</td> <td>50 to 93%</td> </tr> <tr> <td>2.</td> <td>43 to 100%</td> </tr> <tr> <td>3.</td> <td>0 to 94%</td> </tr> <tr> <td>4.</td> <td>63 to 100%</td> </tr> <tr> <td>5.</td> <td>88 to 100%</td> </tr> <tr> <td>6.</td> <td>29 to 93%</td> </tr> </tbody> </table>		Item	Compliance rate	1.	50 to 93%	2.	43 to 100%	3.	0 to 94%	4.	63 to 100%	5.	88 to 100%	6.	29 to 93%
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5.	88 to 100%																
6.	29 to 93%																
		<p>NSH presented data regarding the timeliness of consultation referrals. The facility reviewed an average sample of 20% of the referrals to off-site consultants/services during the months of November and December 2007. The following is an outline of the indicators and corresponding mean compliance rates:</p>															
		<p>1. <i>Scheduled within two weeks</i></p>	34%														
		<p>2. <i>Average number of days to scheduled appointment</i></p>	21														

Section F: Specific Therapeutic and Rehabilitation Services

		<p>The data showed an increase in compliance rate from 4% to 44% (item 1) and a decrease in the average number of days from 34 to 17 days (November 2007 to May 2008). The facility assessed that refusal by the individuals was the main barrier and presented a plan of correction, including review by the chief of the service of any case involving a delay of more than 14 days, education of the individuals and further work with local facilities.</p> <p>Recommendation 4, January 2008: Implement plans of correction regarding the processes of integration of medical conditions into the WRP and medical transfers.</p> <p>Findings: Same as in F.7.b.i.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Monitor this requirement using the DMH Medical Transfer Auditing Form and the facility's audit regarding timeliness of consultations off-site based on at least a 20% sample. 2. Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period).
F.7.b.iii	define the duties and responsibilities of primary care (non-psychiatric) physicians;	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: Same as in F.7.a.</p> <p>Findings: Same as in F.7.a.</p>

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		<p>Compliance: Partial.</p> <p>Current recommendations: Same as in F.7.a.</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 recommendation:</p> <p>Recommendation, January 2008: Continue current practice.</p> <p>Findings: NSH has continued its practice. At the present time, the facility utilizes three psychiatrists whose sole assignment is providing psychiatric coverage from 4:30 PM to 8:30 AM Monday through Friday. NSH also have two medical consultants whose sole duties are to provide medical coverage after-hours during the week while the other medical consultants share the remaining medical coverage. On the weekends and holidays, this service is rotated on a voluntary basis among the relevant physicians.</p> <p>NSH is evaluating the need for daytime MOD coverage and the need for additional psychiatric training for primary care physician.</p> <p>Compliance: Substantial.</p> <p>Current recommendations: 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</p>	<p>Current findings on previous recommendations:</p>

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	<p>individual is treated in another medical facility.</p>	<p>Recommendations 1 and 2, January 2008:</p> <ul style="list-style-type: none"> • Monitor the timeliness and completeness of needed records. • Present data analysis and plan to improve compliance. <p>Findings: Same as in F.7.b.ii (medical transfer auditing data).</p> <p>Compliance: Partial.</p> <p>Current recommendations: Same as in F.7.b.ii.</p>
<p>F.7.c</p>	<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, January 2008: Monitor specific medical conditions including Diabetes Mellitus, Hypertension, Dyslipidemia and Asthma/COPD using the standardized tools based on at least a 20% sample.</p> <p>Findings: NSH used the DMH standardized tools to assess compliance regarding the management of Diabetes Mellitus, Hypertension, Dyslipidemia and Asthma/COPD (January to May 2008). The average sample was 20% of individuals diagnosed with these disorders. The following is a summary of the data and data analysis. The facility reported that beginning in June 2008, an audit-driven corrective action plan (ADCAP) was implemented wherein monthly audit results were provided to the physicians and surgeons and focused CME recommendations were made based on low-compliance items.</p>

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Diabetes Mellitus		
1.	<i>The individual has been evaluated and supporting documentation is completed at least quarterly.</i>	64%
2.	<i>HgbA1C was ordered quarterly.</i>	77%
3.	<i>The HgbA1C is equal to or less than 7%.</i>	70%
4.	<i>Blood sugar is monitored regularly.</i>	99%
5.	<i>Urinary micro albumin is monitored annually.</i>	24%
6.	<i>If the urine micro albumin level is greater than 30, ACE or ARP is prescribed, if not otherwise contraindicated.</i>	30%
7.	<i>The lipid profile is monitored on admission or time of diagnosis and at least annually.</i>	95%
8.	<i>LDL is less than 100mg/dl or there is a plan of care in place to appropriate treat the LDL.</i>	87%
9.	<i>Blood pressure is monitored weekly.</i>	47%
10.	<i>If blood pressure is greater than 130/80, there is a plan of care in place to appropriately lower the blood pressure.</i>	58%
11.	<i>An eye exam by an ophthalmologist/optometrist was completed at least annually.</i>	72%
12.	<i>Podiatry care was provided by a podiatrist at least annually.</i>	69%
13.	<i>A dietary consultation was considered and the recommendation followed, as applicable.</i>	92%
14.	<i>Diabetes is addressed in Focus 6 of the WRP.</i>	91%
15.	<i>Focus 6 for Diabetes has appropriate objectives and interventions for this condition.</i>	90%

With few exceptions, the mean compliance rates have increased from November 2007 to May 2008 (no monitoring was done in December 2007 for some items) as follows:

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		<table border="1"> <thead> <tr> <th>Item</th> <th>Compliance rate</th> </tr> </thead> <tbody> <tr> <td>1.</td> <td>61 to 77%</td> </tr> <tr> <td>2.</td> <td>81 to 82%</td> </tr> <tr> <td>4.</td> <td>54 to 100%</td> </tr> <tr> <td>5.</td> <td>34 to 30%</td> </tr> <tr> <td>7.</td> <td>68 to 100%</td> </tr> <tr> <td>9.</td> <td>10 to 57%</td> </tr> <tr> <td>11.</td> <td>66 to 72%</td> </tr> <tr> <td>12.</td> <td>56 to 75%</td> </tr> <tr> <td>13.</td> <td>42 to 87%</td> </tr> <tr> <td>14.</td> <td>85 to 90%</td> </tr> <tr> <td>15.</td> <td>81 to 87%</td> </tr> </tbody> </table> <p>No comparative data were available for items 3, 6, 8 and 10.</p> <p>The facility plans to conduct a DUE focusing on the use of new generation antipsychotic medications for individuals with diagnosis of Diabetes Mellitus/metabolic syndrome</p> <table border="1"> <thead> <tr> <th colspan="3">Hypertension</th> </tr> </thead> <tbody> <tr> <td>1.</td> <td><i>The individual has been evaluated and supporting documentation completed at least quarterly.</i></td> <td>53%</td> </tr> <tr> <td>2.</td> <td><i>Blood pressure is monitored weekly.</i></td> <td>75%</td> </tr> <tr> <td>3.</td> <td><i>Blood pressure is less than 140/90 or there is an appropriate plan of care in place to reduce blood pressure.</i></td> <td>88%</td> </tr> <tr> <td>4.</td> <td><i>If the individual is 40 or older, aspirin has been ordered unless contraindicated.</i></td> <td>40%</td> </tr> <tr> <td>5.</td> <td><i>Hypertension is addressed in Focus 6 of the WRP.</i></td> <td>78%</td> </tr> <tr> <td>6.</td> <td><i>Focus 6 for Hypertension has appropriate objectives and interventions.</i></td> <td>75%</td> </tr> </tbody> </table>	Item	Compliance rate	1.	61 to 77%	2.	81 to 82%	4.	54 to 100%	5.	34 to 30%	7.	68 to 100%	9.	10 to 57%	11.	66 to 72%	12.	56 to 75%	13.	42 to 87%	14.	85 to 90%	15.	81 to 87%	Hypertension			1.	<i>The individual has been evaluated and supporting documentation completed at least quarterly.</i>	53%	2.	<i>Blood pressure is monitored weekly.</i>	75%	3.	<i>Blood pressure is less than 140/90 or there is an appropriate plan of care in place to reduce blood pressure.</i>	88%	4.	<i>If the individual is 40 or older, aspirin has been ordered unless contraindicated.</i>	40%	5.	<i>Hypertension is addressed in Focus 6 of the WRP.</i>	78%	6.	<i>Focus 6 for Hypertension has appropriate objectives and interventions.</i>	75%
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	4.	<i>The LDL level is \leq or a plan of care is in place.</i>	89%																						
	5.	<i>The Triglyceride level is \leq 200 of a plan of care is in place.</i>	87%																						
	6.	<i>Dyslipidemia is addressed in focus 6 of the WRP.</i>	86%																						
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	9.	<i>BMI is less than or equal to 25 and the waist circumference is less than 40 (males) and less than 35 (females) or a weight management program has been initiated.</i>	87%																						
	10.	<i>An exercise program has been initiated.</i>	78%																						
	11.	<i>If non-pharmacological interventions have been ineffective to control Dyslipidemia, medications have been considered or initiated.</i>	98%																						
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		11.	62 to 100%															
Asthma/COPD																		
1. <i>The individual has been evaluated and supporting documentation completed at least quarterly.</i> 45%																		
2. <i>For individuals with a diagnosis of COPD, a baseline chest x-ray has been completed.</i> 74%																		
3. <i>If a rescue inhaler is being used more than 2 days a week, the individual has been assessed and an appropriate plan of care has been developed.</i> 53%																		
4. <i>If the individual is currently a smoker, a smoking cessation program has been discussed and included in the WRP.</i> 33%																		
5. <i>Asthma or COPD is addressed in focus 6 of the WRP.</i> 65%																		
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7. <i>The individual has been assessed for a flu vaccination.</i> 59%																		
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Preventive Care		
1.	<i>If the individual indicated that he/she is a smoker on the Admission Medical H&P, has Smoking Cessation Medical Assistance been initiated, as documented in a psychiatric Progress Note within the previous 6 months and/or on the WRP, including documentation of each of the following: advising the patient to quit smoking, discussion of cessation medication and discussion of smoking cessation strategies?</i>	37%
2.	<i>If the patient has a BMI >27, has weight loss prevention assistance been initiated, as documented in a psychiatric Progress note within the previous 6 months and/or on the most recent WRP, including each of the following: a dietary consult, restricted caloric diet, discussion of physical activity and advising physical activity?</i>	78%
3.	<i>If the individual is 50 or older or is medically debilitated, has the individual been offered a flu shot in the past year as documented on the Preventive Care Tracking Form?</i>	42%
4.	<i>If the individual is 65 or older, has a pneumococcal vaccine by ordered in the previous two years as documented on the Preventive Care Tracking Form?</i>	0%
5.	<i>If the individual is 50 or older, has the individual been offered an influenza immunization during the previous September through February, if they were at NSH during that period, as documented on the Preventive Care Tracking Form?</i>	30%
6.	<i>If the individual is 65 or older, has a Pneumonia vaccination been offered if they haven't ever had one previously or is there documentation that they have previously had one as documented on the Preventive</i>	0%

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			<i>Care Tracking Form?</i>	
		7.	<i>If the individual is a women age 50 or older or has a family history of breast cancer as indicated on the Admission H&P, has a mammogram been ordered within the past year as documented on the Preventive Care Tracking Form?</i>	50%
		8.	<i>If the individual is age 51 or older, has colorectal cancer screening been done as evidenced by documentation on the Preventive Care Tracking Form of one of the following four items having been done or ordered: (1) fecal occult blood test during the past year, (2) flexible sigmoidoscopy during the past four years, (3) double contrast barium enema during the past four years or (4) colonoscopy during the past nine years?</i>	55%
		9.	<i>If the individual is a woman age 21 or older, has a pap smear been done within the previous two years as documented on the Preventive Care Tracking Form?</i>	75%
		10.	<i>If the individual is a woman age 16 or older, has one Chlamydia tests been done/ordered within the previous year as documented on the Preventive Care Tracking Form?</i>	60%
		11.	<i>If the individual is a woman 65 or older, has osteoporosis testing been done as evidenced by a bone density test during the previous year as evidenced on the Preventive Care Tracking Form?</i>	0%
		NSH reported that Nurse Practitioners were credentialed in July 2008 to work under practice protocols to order these items on a consistent basis for all individuals.		

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		<p>Recommendation 3, January 2008: Provide data analysis that evaluates low compliance and delineates areas of relative improvement.</p> <p>Findings: This was addressed under Recommendation 1 above.</p> <p>Recommendation 4, January 2008: Implement the draft NSH Medical Services Checklist.</p> <p>Findings: NSH provided medical staff with the Draft NSH Medical Services Checklist (not finalized, due to pending approval of nurse practitioner guidelines). The checklist outlines what items must be done for each medical condition being audited, when the item is due and who is responsible for ordering or providing the item. This checklist will be formalized and included in the revised Medical Staff manual.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Monitor specific medical conditions including Diabetes Mellitus, Hypertension, Dyslipidemia and Asthma/COPD using the standardized tools based on at least a 20% sample. 2. Monitor cardiac disease and preventive care using the NSH new tools. 3. Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period).
F.7.d	Each State Hospital shall monitor, on a continuous basis, outcome indicators to identify trends and	Current findings on previous recommendations:

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	<p>patterns in the individual's health status, assess the performance of medical systems, and provide corrective follow-up measures to improve outcomes.</p>	<p>Recommendations 1-3, January 2008:</p> <ul style="list-style-type: none"> • Develop and implement a formalized physician peer review system that utilizes indicators aligned with the standards and expectations outlined in F.7.a. • Identify trends and patterns based on clinical and process outcomes. • Provide corrective actions to address problematic trends and patterns. <p>Findings: As mentioned in F.7.a, NSH has a peer review system that utilizes information from specific indicators as identified on monthly audits and provides feedback to practitioners regarding individualized deficiencies, with follow-up for correction and education. The facility reported that deficiencies in specific medical topics were addressed through CME activities, including a Cardiology Lecture on April 30, 2008 and a COPD/Asthma Lecture Scheduled for late July 2008. In addition, NSH has taken the initiative in the development and implementation of new peer review monitors regarding preventative care and care of individuals diagnosed with cardiac disease.</p> <p>NSH has yet to implement a physician performance profile for the physicians and surgeons and provide more information regarding trends and patterns in the health status of individuals based on clinical and process outcomes, with corrective actions, as indicated.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Implement a Physician Performance profile for physicians and surgeons and utilize the data in the processes of reappointment and reprivileging.
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		<ol style="list-style-type: none">2. Continue to update practice guidelines guided by current literature and relevant clinical experience.3. Provide peer review data analysis regarding practitioner and group trends, with corrective actions, as indicated.4. Identify trends and patterns in the health status of individuals based on clinical and process outcomes, with corrective actions, as indicated.5. Finalize efforts to automate data systems to facilitate data collection and analysis.
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8. Infection Control		
	<p>Each State hospital shall develop and implement infection control policies and procedures to prevent the spread of infections or communicable diseases, consistent with generally accepted professional standards of care.</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Gordon Wells, RN, PHN I 2. Maj Yazidi, RN, PHN I, HSS 3. Robert Kolker, RN, PHN II <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. NSH's progress report and data 2. Infection Control (IC) training rosters 3. NSH's IC Committee meeting minutes dated 12/18/07, 3/18/08, and 6/17/08 4. NSH's Infectious Disease meeting minutes dated 3/26/08 and 6/17/08 5. NSH's Medical Executive Committee meeting minutes dated 3/11/08 6. NSH's HIV Sub-Committee meeting minutes dated 11/20/07, 1/15/08, 2/19/08, 3/18/08 and 5/20/08 7. NSH Infection Control Manual 8. NSH's Nursing Coordinator Meeting minutes dated 2/4/08, 2/11/08, 5/12/08 and 5/19/08 9. NSH's Nursing Policy and Procedure Committee meeting minutes dated 2/14/08, 5/22/08 and 7/3/08 10. NSH's Risk Reduction Oversight Committee meeting minutes dated 4/15/08 11. NSH AD 555, Medical Procedures on Admission and Annually (draft with proposed changes) 12. Example of Plato analysis data 13. Hepatitis Tracking sheets 14. Charts of the following 86 individuals: ALR, AM, AMM, AMP, ARM, ATB, BAM, BJ, BKD, BSS, BTM, CCR, CHM, CIC, CJH, CR, CWE, DB, DCH, DJM, DJT, DKB, DKN, DLP, DMP, DN, EAH, EH, ERM, FAG, FBT, FCP, FEG, FG, FMS, FW, GBB, GMW, GVC, HCM, HJM, HSS, JA, JAC,

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		JC, JHM, JRM, JRQ, JRV, JSW, KMG, LRW, MAB, MCA, MDD, MEP, MET, MHJ, MLM, MPH, PJN, PSR, RAC, RCB, RH, RJT, RLF, RLW, RM, RME, RR, RW, RZ, SMP, SWS, TAC, TBH, TLB, TN, TOM, VVH, VZ, WJB, WJT, WL and WRQ			
F.8.a	Each State hospital shall establish an effective infection control program that:	Please see sub-cells for compliance findings.			
F.8.a.i	actively collects data regarding infections and communicable diseases;	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, January 2008:</p> <ul style="list-style-type: none"> Continue implementation of monitoring system for the Infection Control Department (IC). Reconcile inconsistencies between current Infection Control policies/procedures and indicators for monitoring. <p>Findings: In an interview, the Infection Control Department staff indicated that the statewide Infection Control monitoring tools have been revised in alignment with NSH's IC policies and procedures since the last review.</p> <p>Recommendation 3, January 2008: Continue to monitor this requirement.</p> <p>Findings: <u>Admission PPD</u> Using the DMH IC Admission PPD Auditing Form, NSH assessed its compliance based on an average sample of 94% of individuals admitted to the hospital with a negative PPD in the review month (January through May 2008). The following is a summary of NSH's data:</p> <table border="1"> <tr> <td>1.</td> <td><i>Notification by the unit via a PPD form is sent to the Infection Control Department for all PPD readings.</i></td> <td>84%</td> </tr> </table>	1.	<i>Notification by the unit via a PPD form is sent to the Infection Control Department for all PPD readings.</i>	84%
1.	<i>Notification by the unit via a PPD form is sent to the Infection Control Department for all PPD readings.</i>	84%			

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		2.	<i>PPDs were ordered by the physician during the admission procedure.</i>	88%
		3.	<i>PPDs were administered by the nurse within 24 hours of the physicians order.</i>	82%
		4.	<i>1st step PPDs were read by the nurse within 7 days of administration.</i>	92%
		5.	<i>2nd step PPDs were read by the nurse within 48-72 hours of administration.</i>	59%
<p>There was no comparison to the data provided by NSH at the last review for all of the following items:</p>				
	F.8.a.ii	Assesses these data for trends	NSH's data analysis demonstrated that reading first-step PPDs and notification by the units, physician PPD orders, and PPD administration by the RN within 24 hours is close to substantial compliance. The second-step process compliance rate (item 5) had improved from 3% in January to 89% in May.	
	F.8.a.iii	Initiates inquiries regarding problematic trends	NSH indicated that there were no problematic trends for these items.	
	F.8.a.iv	Identifies necessary corrective action	The facility provided training rosters, minutes of the IC Committee meetings and Nursing Coordinator meeting minutes verifying that they provided training to the admission unit physicians and nursing staff on the new PPD procedure (two-step) to increase compliance.	
	F.8.a.v	Monitors to	Training rosters indicated that the	

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			<p>ensure that appropriate remedies are achieved</p>	<p>Infection Control staff received training in February 2008 regarding accessing their data in Plato. They now review the data for any areas that are out of compliance. In addition, Standards Compliance staff attend the IC Committee and monthly Infectious Disease Key Indicator Committee meetings to review the IC data. Any recommendations that are made are reviewed by the IC staff and prioritized for implementation.</p>												
<p>This monitor's review of the charts of 20 individuals admitted during the review period (AMM, ARM, ATB, BJ, BSS, CWE, DJT, EH, FCP, HCM, HSS, JRM, KMG, MEP, PJN, RLW, RR, TBH, TOM and WJB) found that 17 had a physician's order for PPD upon admission and that the PPD was administered within 24 hours. Also, 18 of the first-step PPDs and 15 of the second-step PPDs were timely read.</p> <p><u>Annual PPD</u></p> <p>Using the DMH IC Annual PPD Auditing Form, NSH assessed its compliance based on an average sample of 53% of individuals needing an annual PPD each month (January through May 2008). The following is a summary of NSH's data:</p> <table border="1" data-bbox="955 1079 1858 1388"> <tr> <td data-bbox="955 1079 1050 1153">1.</td> <td data-bbox="1050 1079 1753 1153"><i>Notification by the unit via a PPD form sent to the Infection Control Department for all PPD readings.</i></td> <td data-bbox="1753 1079 1858 1153">75%</td> </tr> <tr> <td data-bbox="955 1153 1050 1226">2.</td> <td data-bbox="1050 1153 1753 1226"><i>PPDs were ordered by the physician during the annual review procedure.</i></td> <td data-bbox="1753 1153 1858 1226">77%</td> </tr> <tr> <td data-bbox="955 1226 1050 1299">3.</td> <td data-bbox="1050 1226 1753 1299"><i>PPDs were administered by the nurse within 24 hours of the order.</i></td> <td data-bbox="1753 1226 1858 1299">74%</td> </tr> <tr> <td data-bbox="955 1299 1050 1388">4.</td> <td data-bbox="1050 1299 1753 1388"><i>PPDs were read by the nurse within 48-72 hours of administration.</i></td> <td data-bbox="1753 1299 1858 1388">82%</td> </tr> </table>					1.	<i>Notification by the unit via a PPD form sent to the Infection Control Department for all PPD readings.</i>	75%	2.	<i>PPDs were ordered by the physician during the annual review procedure.</i>	77%	3.	<i>PPDs were administered by the nurse within 24 hours of the order.</i>	74%	4.	<i>PPDs were read by the nurse within 48-72 hours of administration.</i>	82%
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		F.8.a.ii	Assesses these data for trends	NSH's analysis of the data indicated that annual PPD data showed a gradual increase during the current review period. During the next review, the facility expects to achieve substantial compliance with these items.
		F.8.a.iii	Initiates inquiries regarding problematic trends	Although NSH reported that based on its analysis of the data, the only area demonstrating a problematic trend was the physicians's order for annual PPDs, the other items listed above indicated problematic trends as well not addressed by NSH.
		F.8.a.iv	Identifies necessary corrective action	The facility indicated that starting in May 2008; the IC department began notifying the physicians when annual PPDs were due each month to increase compliance. Other items were not addressed by NSH.
		F.8.a.v	Monitors to ensure that appropriate remedies are achieved	NSH will continue to monitor these items for compliance.
		<p>This monitor's review of the charts of 20 individuals who needed an annual PPD (ALR, BAM, CHM, DJM, DN, EAH, ERM, FMS, GMW, GVC, JEK, JHM, JLW, JRV, KSW, MCA, MDD, MFN, MHJ and PSR) found that 17 had timely orders for the PPD, which were administered and read within the required timeframes.</p> <p><u>Positive PPD</u> Using the DMH IC Positive PPD Auditing Form, NSH assessed its compliance based on an average sample of 89% of individuals who had a positive PPD test for the month (January through May 2008). The</p>		

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		<p>following table is a summary of NSH's data:</p> <table border="1" data-bbox="955 267 1858 868"> <tr> <td>1.</td> <td><i>Notification by the unit via a PPD form is sent to Public Health Office for all PPD readings.</i></td> <td>97%</td> </tr> <tr> <td>2.</td> <td><i>All positive PPDs received PA and lateral chest x-ray.</i></td> <td>80%</td> </tr> <tr> <td>3.</td> <td><i>All positive PPDs received an evaluation by the Med-Surg Physician.</i></td> <td>54%</td> </tr> <tr> <td>4.</td> <td><i>Active disease is identified, then individual is transferred to medical isolation and appropriate treatment is provided.</i></td> <td>NA</td> </tr> <tr> <td>5.</td> <td><i>If LTBI (latent TB infection) is present, there is a Focus 6 opened.</i></td> <td>NA</td> </tr> <tr> <td>6.</td> <td><i>If LTBI (latent TB infection) is present, there are appropriate objectives written to provide treatment and to prevent spread of the disease.</i></td> <td>NA</td> </tr> <tr> <td>7.</td> <td><i>If LTBI (latent TB infection) is present, there are appropriate interventions written to prevent the progression of the disease.</i></td> <td>NA</td> </tr> </table> <table border="1" data-bbox="955 901 1879 1421"> <tr> <td data-bbox="955 901 1092 1234">F.8.a.ii</td> <td data-bbox="1092 901 1302 1234">Assesses these data for trends</td> <td data-bbox="1302 901 1879 1234">NSH indicated that Item 1, Notification by the units is in substantial compliance and that Item 2, All positive PPDs received PA and lateral chest x-ray is close to substantial compliance. The facility did not have any individuals with active disease. They also indicated that Items #5-7 are from the revised auditing tool and that no data were available for this review.</td> </tr> <tr> <td data-bbox="955 1234 1092 1421">F.8.a.iii</td> <td data-bbox="1092 1234 1302 1421">Initiates inquiries regarding problematic trends</td> <td data-bbox="1302 1234 1879 1421">NSH indicated that their analysis of the data for this review period showed that individuals with positive PPDs were not being consistently being evaluated by the physician and x-rays were not consistently</td> </tr> </table>	1.	<i>Notification by the unit via a PPD form is sent to Public Health Office for all PPD readings.</i>	97%	2.	<i>All positive PPDs received PA and lateral chest x-ray.</i>	80%	3.	<i>All positive PPDs received an evaluation by the Med-Surg Physician.</i>	54%	4.	<i>Active disease is identified, then individual is transferred to medical isolation and appropriate treatment is provided.</i>	NA	5.	<i>If LTBI (latent TB infection) is present, there is a Focus 6 opened.</i>	NA	6.	<i>If LTBI (latent TB infection) is present, there are appropriate objectives written to provide treatment and to prevent spread of the disease.</i>	NA	7.	<i>If LTBI (latent TB infection) is present, there are appropriate interventions written to prevent the progression of the disease.</i>	NA	F.8.a.ii	Assesses these data for trends	NSH indicated that Item 1, Notification by the units is in substantial compliance and that Item 2, All positive PPDs received PA and lateral chest x-ray is close to substantial compliance. The facility did not have any individuals with active disease. They also indicated that Items #5-7 are from the revised auditing tool and that no data were available for this review.	F.8.a.iii	Initiates inquiries regarding problematic trends	NSH indicated that their analysis of the data for this review period showed that individuals with positive PPDs were not being consistently being evaluated by the physician and x-rays were not consistently
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			being ordered.									
	F.8.a.iv	Identifies necessary corrective action	NSH decided in June 2008 to assign the nurse practitioners to see the individuals with a positive PPD and complete the documentation and as appropriate, order the x-rays.									
	F.8.a.v	Monitors to ensure that appropriate remedies are achieved	NSH indicated that it will continue to monitor this requirement.									
<p>This monitor's review of the charts of 14 individuals who had a positive PPD (AMM, AMP, CIC, EH, FG, FW, JA, JC, MET, MPH, RCB, TN, VVH and WL) found one chart that did not contain the chest x-ray in the chart (AMP), seven that did not have an evaluation documented from the physician, and five that did not have an open Focus 6, objectives, or interventions.</p> <p><u>Hepatitis C</u> Using the DMH IC Hepatitis C Auditing Form, NSH assessed its compliance based on an average sample of 90% of individuals admitted to the hospital who are Hepatitis C positive for the month (January through May 2008). The following is a summary of NSH's data:</p> <table border="1"> <tr> <td>1.</td> <td><i>Notification by the lab was made to the Infection Control Department identifying the individual with a positive Hepatitis C Antibody.</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>Notification by the lab was made to the unit housing the individual that he/she has a positive Hepatitis C Antibody test.</i></td> <td>98%</td> </tr> <tr> <td>3.</td> <td><i>Hepatitis C Tracking sheet was initiated or the Public Health database was updated for each individual</i></td> <td>60%</td> </tr> </table>				1.	<i>Notification by the lab was made to the Infection Control Department identifying the individual with a positive Hepatitis C Antibody.</i>	100%	2.	<i>Notification by the lab was made to the unit housing the individual that he/she has a positive Hepatitis C Antibody test.</i>	98%	3.	<i>Hepatitis C Tracking sheet was initiated or the Public Health database was updated for each individual</i>	60%
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			<i>testing positive for Hepatitis C Antibody.</i>	
		4.	<i>The individual's medication plan was evaluated and immunizations for Hepatitis A and B were considered.</i>	56%
		5.	<i>A Focus 6 is opened for Hepatitis C.</i>	80%
		6.	<i>Appropriate objective is written to include treatment as required by the Hepatitis C Tracking Sheet</i>	30%
		7.	<i>Appropriate interventions are written to include treatment as required by the Hepatitis C Tracking Sheet, or as required by the WRP Manual.</i>	35%
		F.8.a.ii	Assesses these data for trends	NSH's analysis indicated that notification by the lab to the IC department and to the units is in substantial compliance. Improvement in opening the Focus 6 for Hepatitis C has been made. Issues regarding documentation of Hepatitis C on the tracking sheets, reviewing the medication plan, and inclusion of appropriate objectives and interventions in the WRPs continue. NSH's Infectious Disease Key Indicator Review Committee minutes and the IC Committee minutes address this on-going low compliance
		F.8.a.iii	Initiates inquiries regarding problematic trends	NSH's progress report stated that the reason why Focus 6 is not opened for Hepatitis C is because of internal facility practices. No specifics regarding the meaning of this were provided by the facility.
		F.8.a.iv	Identifies necessary corrective action	NSH indicated that the Medical Director and Chief of Medical Ancillary Services (MAS) is investigating the issue and will implement a solution. However, no specific

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		F.8.a.v	Monitors to ensure that appropriate remedies are achieved	<p>interventions were provided by NSH.</p> <p>NSH will continue to monitor these items.</p>															
<p>This monitor's review of the charts of 15 individuals who had Hepatitis C (AM, BKD, DJT, DKN, GBB, JRQ, MET, MLM, RBC, RM, RME, SMP, TAC, VVH and WRQ) found that 10 had a blank Hepatitis C tracking sheet, two did not have documentation that the medication plan and immunizations were evaluated, one did not have a Focus 6 opened, and four did not have appropriate objectives and interventions in the WRPs.</p> <p><u>HIV Positive</u></p> <p>Using the DMH IC HIV Positive Auditing Form, NSH assessed its compliance based on 100% of individuals who are positive for HIV antibody for the month (January through May 2008). The following is a summary of NSH's data:</p>																			
<table border="1"> <tr> <td data-bbox="955 938 1033 1047">1.</td> <td data-bbox="1033 938 1738 1047"><i>Notification by the lab was made to the infection control department identifying the individual with a positive HIV Antibody</i></td> <td data-bbox="1738 938 1858 1047">100%</td> </tr> <tr> <td data-bbox="955 1047 1033 1156">2.</td> <td data-bbox="1033 1047 1738 1156"><i>Notification was made to the unit housing the individual that he/she has a positive HIV Antibody test.</i></td> <td data-bbox="1738 1047 1858 1156">100%</td> </tr> <tr> <td data-bbox="955 1156 1033 1265">3.</td> <td data-bbox="1033 1156 1738 1265"><i>If the individual was admitted with a diagnosis of HIV positive, a referral was made to the appropriate clinic during the admission process.</i></td> <td data-bbox="1738 1156 1858 1265">100%</td> </tr> <tr> <td data-bbox="955 1265 1033 1373">4.</td> <td data-bbox="1033 1265 1738 1373"><i>If the individual was diagnosed with HIV during hospitalization, a referral was made to the appropriate clinic.</i></td> <td data-bbox="1738 1265 1858 1373">NA</td> </tr> <tr> <td data-bbox="955 1373 1033 1421">5.</td> <td data-bbox="1033 1373 1738 1421"><i>The individual is seen initially and followed up, as</i></td> <td data-bbox="1738 1373 1858 1421">100%</td> </tr> </table>					1.	<i>Notification by the lab was made to the infection control department identifying the individual with a positive HIV Antibody</i>	100%	2.	<i>Notification was made to the unit housing the individual that he/she has a positive HIV Antibody test.</i>	100%	3.	<i>If the individual was admitted with a diagnosis of HIV positive, a referral was made to the appropriate clinic during the admission process.</i>	100%	4.	<i>If the individual was diagnosed with HIV during hospitalization, a referral was made to the appropriate clinic.</i>	NA	5.	<i>The individual is seen initially and followed up, as</i>	100%
1.	<i>Notification by the lab was made to the infection control department identifying the individual with a positive HIV Antibody</i>	100%																	
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5.	<i>The individual is seen initially and followed up, as</i>	100%																	

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			<i>clinically indicated, by the appropriate clinic every three months for ongoing care and treatment, unless another timeframe is ordered by the physician.</i>	
		6.	<i>A Focus 6 is opened for HIV (unspecified viral illness)</i>	75%
		7.	<i>Appropriate objective is written to address the progression of the disease.</i>	75%
		8.	<i>Appropriate interventions are written.</i>	75%
		F.8.a.ii	Assesses these data for trends	NSH indicated on their progress report that all items are in substantial compliance. However, their data does not support this analysis.
		F.8.a.iii	Initiates inquiries regarding problematic trends	The facility did not identify any problematic trends; however, items addressing opening a Focus 6 and objectives and interventions in the WRP demonstrate problematic issues.
		F.8.a.iv	Identifies necessary corrective action	None were identified by NSH.
		F.8.a.v	Monitors to ensure that appropriate remedies are achieved	NSH will continue to monitor these items
		<p>This monitor's review of the charts of four individuals with HIV (AB, CA, FG and RLF) found that all were in compliance with the items listed above but did note that although the WRPs addressed HIV, they were not individualized.</p>		

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		<p><u>Immunizations</u> Using the DMH IC Immunization Auditing Form, NSH assessed its compliance based on an average sample of 83% of individuals admitted to the facility each month (January through May 2008). The following summarizes NSH's data:</p> <table border="1" data-bbox="955 414 1858 755"> <tr> <td data-bbox="955 414 1050 487">1.</td> <td data-bbox="1050 414 1753 487"><i>Notification by the lab was made to the Infection Control Department of an individual's immunity status.</i></td> <td data-bbox="1753 414 1858 487">88%</td> </tr> <tr> <td data-bbox="955 487 1050 560">2.</td> <td data-bbox="1050 487 1753 560"><i>Notification by the lab was made to the unit housing the individual of his/her immunity status.</i></td> <td data-bbox="1753 487 1858 560">92%</td> </tr> <tr> <td data-bbox="955 560 1050 633">3.</td> <td data-bbox="1050 560 1753 633"><i>Immunizations were ordered by the physician within 30 days of receiving notification by the lab</i></td> <td data-bbox="1753 560 1858 633">37%</td> </tr> <tr> <td data-bbox="955 633 1050 755">4.</td> <td data-bbox="1050 633 1753 755"><i>Immunizations were administered by the nurse within 24 hours of the physician order and completed within timeframes.</i></td> <td data-bbox="1753 633 1858 755">18%</td> </tr> </table> <table border="1" data-bbox="955 787 1879 1421"> <tr> <td data-bbox="955 787 1092 933">F.8.a.ii</td> <td data-bbox="1092 787 1291 933">Assesses these data for trends</td> <td data-bbox="1291 787 1879 933">NSH's analysis indicated that the notification by the laboratory to the Infection Control Department and to the Units is close to substantial compliance.</td> </tr> <tr> <td data-bbox="955 933 1092 1234">F.8.a.iii</td> <td data-bbox="1092 933 1291 1234">Initiates inquiries regarding problematic trends</td> <td data-bbox="1291 933 1879 1234">NSH's data indicated that orders for and administration of immunizations had low compliance because of an artifact in the original auditing tool which required the orders to be completed within five days. NSH reported that they were not able to meet this timeframe due to their centralized referral system.</td> </tr> <tr> <td data-bbox="955 1234 1092 1421">F.8.a.iv</td> <td data-bbox="1092 1234 1291 1421">Identifies necessary corrective action</td> <td data-bbox="1291 1234 1879 1421">The facility reported that the monitoring tool was revised in alignment with the centralized referral system, which should accurately reflect compliance with these items 3 & 4.</td> </tr> </table>	1.	<i>Notification by the lab was made to the Infection Control Department of an individual's immunity status.</i>	88%	2.	<i>Notification by the lab was made to the unit housing the individual of his/her immunity status.</i>	92%	3.	<i>Immunizations were ordered by the physician within 30 days of receiving notification by the lab</i>	37%	4.	<i>Immunizations were administered by the nurse within 24 hours of the physician order and completed within timeframes.</i>	18%	F.8.a.ii	Assesses these data for trends	NSH's analysis indicated that the notification by the laboratory to the Infection Control Department and to the Units is close to substantial compliance.	F.8.a.iii	Initiates inquiries regarding problematic trends	NSH's data indicated that orders for and administration of immunizations had low compliance because of an artifact in the original auditing tool which required the orders to be completed within five days. NSH reported that they were not able to meet this timeframe due to their centralized referral system.	F.8.a.iv	Identifies necessary corrective action	The facility reported that the monitoring tool was revised in alignment with the centralized referral system, which should accurately reflect compliance with these items 3 & 4.
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		F.8.a.v	Monitors to ensure that appropriate remedies are achieved	NSH will continue to monitor the items addressing this issue.															
<p><u>Immunization Refusals</u> Using the DMH IC Immunization Refusal Auditing Form, NSH assessed its compliance based on 100% of individuals who refused their immunization during the month (January through May 2008). The following is a summary of NSH's data:</p> <table border="1" data-bbox="957 638 1856 1125"> <tr> <td data-bbox="957 638 1052 748">1.</td> <td data-bbox="1052 638 1761 748"><i>Notification by the unit was made to the Infection Control Department of the individual's refusal of the immunization(s).</i></td> <td data-bbox="1761 638 1856 748">100%</td> </tr> <tr> <td data-bbox="957 748 1052 824">2.</td> <td data-bbox="1052 748 1761 824"><i>There is a Focus 6 opened for the refusal of the immunization</i></td> <td data-bbox="1761 748 1856 824">0%</td> </tr> <tr> <td data-bbox="957 824 1052 901">3.</td> <td data-bbox="1052 824 1761 901"><i>There are appropriate objective(s) developed for the refusal of immunization(s).</i></td> <td data-bbox="1761 824 1856 901">0%</td> </tr> <tr> <td data-bbox="957 901 1052 1011">4.</td> <td data-bbox="1052 901 1761 1011"><i>There are appropriate interventions written for the objective(s) developed for the refusal of immunization(s).</i></td> <td data-bbox="1761 901 1856 1011">0%</td> </tr> <tr> <td data-bbox="957 1011 1052 1125">5.</td> <td data-bbox="1052 1011 1761 1125"><i>The unit notified the Infection Control Department when the individual consented and received the immunization(s).</i></td> <td data-bbox="1761 1011 1856 1125">37%</td> </tr> </table>					1.	<i>Notification by the unit was made to the Infection Control Department of the individual's refusal of the immunization(s).</i>	100%	2.	<i>There is a Focus 6 opened for the refusal of the immunization</i>	0%	3.	<i>There are appropriate objective(s) developed for the refusal of immunization(s).</i>	0%	4.	<i>There are appropriate interventions written for the objective(s) developed for the refusal of immunization(s).</i>	0%	5.	<i>The unit notified the Infection Control Department when the individual consented and received the immunization(s).</i>	37%
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5.	<i>The unit notified the Infection Control Department when the individual consented and received the immunization(s).</i>	37%																	
		F.8.a.ii	Assesses these data for trends	NSH indicated that Item 1, notification by the unit, is in substantial compliance. However, no improvement has been made regarding the documentation of the immunization refusals on the Medical Condition form and the WRP. No analysis was provided for item 5 regarding unit															

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				notification to the IC department.
		F.8.a.iii	Initiates inquiries regarding problematic trends	NSH's progress report indicated that the lack of compliance regarding the opening of a Focus 6 was due to internal facility practices. No other information was provided. In addition, NSH's progress report indicated that immunizations are a personal choice rather than a treatment refusal issue. However, no other information was provided.
		F.8.a.iv	Identifies necessary corrective action	NSH's progress report indicated that they would request the CM to reconsider the necessity of including items F.8.a.ii - v in this audit form. However, a Refusal Workgroup has been initiated to address issues of low compliance regarding treatment refusals.
		F.8.a.v	Monitors to ensure that appropriate remedies are achieved	No specific information was provided by NSH addressing this requirement.
		<p>This monitor's review of the charts of eight individuals who refused immunizations (ATB, CR, FEG, JRQ, JSW, LRW, RAC and RJT) found that only one addressed the issue in the WRP. In addition, the following was found noted in a number of Focus Descriptions: "Needs Focus and care plan for refusal. If you have questions or want an example, please call the WRP trainers at Ext.....". However, no actual objectives and interventions were developed.</p> <p><u>MRSA</u> Using the DMH IC MRSA Auditing Form, NSH assessed its compliance</p>		

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		<p>based on an average sample of 76% of individuals who tested positive for MRSA for the month (January through May 2008). The following is a summary of NSH's data:</p> <table border="1" data-bbox="955 337 1858 1015"> <tr> <td>1.</td> <td><i>Notification by the lab was made to the Infection Control Department when an individual has a positive culture for MRSA.</i></td> <td>80%</td> </tr> <tr> <td>2.</td> <td><i>Notification by the lab was made to the unit housing the individual that a positive culture for MRSA was obtained.</i></td> <td>76%</td> </tr> <tr> <td>3.</td> <td><i>The individual is placed on contact precaution per MRSA policy.</i></td> <td>92%</td> </tr> <tr> <td>4.</td> <td><i>The appropriate antibiotic was ordered for treatment of the infection(s).</i></td> <td>100%</td> </tr> <tr> <td>5.</td> <td><i>The public health office contacts the unit RN and provides MRSA protocol and guidance for the care of the individual.</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>A Focus 6 is opened for MRSA.</i></td> <td>82%</td> </tr> <tr> <td>7.</td> <td><i>Appropriate objective is written to include prevention of spread of infection.</i></td> <td>50%</td> </tr> <tr> <td>8.</td> <td><i>Appropriate interventions are written to include contact precautions.</i></td> <td>50%</td> </tr> </table> <table border="1" data-bbox="955 1052 1881 1424"> <tr> <td data-bbox="955 1052 1094 1349">F.8.a.ii</td> <td data-bbox="1094 1052 1304 1349">Assesses these data for trends</td> <td data-bbox="1304 1052 1881 1349">NSH indicated in its progress report that it has generally been in substantial compliance on all items except those regarding documentation in the individual's WRP. However, there own data suggests items 1, 2, 6, 7 and 8 are not in substantial compliance.</td> </tr> <tr> <td data-bbox="955 1349 1094 1424">F.8.a.iii</td> <td data-bbox="1094 1349 1304 1424">Initiates inquiries</td> <td data-bbox="1304 1349 1881 1424">NSH's progress report indicated that the lack of compliance regarding the opening of</td> </tr> </table>	1.	<i>Notification by the lab was made to the Infection Control Department when an individual has a positive culture for MRSA.</i>	80%	2.	<i>Notification by the lab was made to the unit housing the individual that a positive culture for MRSA was obtained.</i>	76%	3.	<i>The individual is placed on contact precaution per MRSA policy.</i>	92%	4.	<i>The appropriate antibiotic was ordered for treatment of the infection(s).</i>	100%	5.	<i>The public health office contacts the unit RN and provides MRSA protocol and guidance for the care of the individual.</i>	100%	6.	<i>A Focus 6 is opened for MRSA.</i>	82%	7.	<i>Appropriate objective is written to include prevention of spread of infection.</i>	50%	8.	<i>Appropriate interventions are written to include contact precautions.</i>	50%	F.8.a.ii	Assesses these data for trends	NSH indicated in its progress report that it has generally been in substantial compliance on all items except those regarding documentation in the individual's WRP. However, there own data suggests items 1, 2, 6, 7 and 8 are not in substantial compliance.	F.8.a.iii	Initiates inquiries	NSH's progress report indicated that the lack of compliance regarding the opening of
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			regarding problematic trends	a Focus 6 was due to internal facility practices. No other information was provided.
		F.8.a.iv	Identifies necessary corrective action	Specific corrective actions were not provided by NSH.
		F.8.a.v	Monitors to ensure that appropriate remedies are achieved	No specific information was provided by NSH addressing this requirement
<p>This monitor's review of the charts of 10 individuals with MRSA (AM, BTM, DCH, DKB, DLP, FBT, JAC, RW, RZ and WRQ) found that all 10 were placed on contact precautions and placed on the appropriate antibiotic. However, seven did not have an open Focus 6, objectives or interventions.</p> <p><u>Lab/Diagnostic Refusals</u> Using the DMH IC Refused Admitting or Annual Lab Work or Diagnostic Test Auditing Form, NSH assessed its compliance based on 100% of individuals who refuse their admission lab work, admission PPD, or annual PPD for the month (February through May 2008; January 2008 data not reliable). The following is a summary of NSH's data:</p>				
		1.	<i>Notification by the unit that the individual refused his/her admission or annual lab work or admission or annual PPD, is sent to the Infection Control Department.</i>	73%
		2.	<i>There is a Focus opened for the lab work or PPD refusal.</i>	3%
		3.	<i>There are appropriate objectives written for the lab</i>	3%

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			<i>work or PPD refusal.</i>	
		4.	<i>There are appropriate interventions written for the lab work or PPD refusal.</i>	3%
		F.8.a.ii	Assesses these data for trends	NSH indicated that Item 1, Notification has increased to substantial compliance in May. However, the overall mean for this review period did not reflect substantial compliance. Items 2, 3 and 4 regarding the documentation in the WRP regarding refusals has not improved this review period.
		F.8.a.iii	Initiates inquiries regarding problematic trends	NSH's progress report indicated that the lack of compliance regarding the opening of a Focus 6 was due to internal facility practices. No other information was provided.
		F.8.a.iv	Identifies necessary corrective action	Specific corrective actions were not provided by NSH.
		F.8.a.v	Monitors to ensure that appropriate remedies are achieved	NSH will continue to monitor this requirement.
		<p>This monitor's review of the charts of 14 individuals who refused admitting or annual lab work or diagnostic testing (CCR, DB, DKN, DMP, FAG, HJM, MAB, RH, RME, RR, SWS, TLB, VZ and WJT) found that none had this addressed in the WRPs.</p>		

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		<p><u>STDs</u> Using the DMH IC Sexually Transmitted Disease (STD) Auditing Form, NSH assessed its compliance based on 100% of individuals who tested positive for an STD during the month (January through May 2008). No STDs were noted during March, April and May 2008. The following is a summary of NSH's data:</p> <table border="1" data-bbox="955 487 1858 1096"> <tr> <td>1.</td> <td><i>Notification by the lab was made to the Infection Control Department of a positive STD.</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>Notification by the lab was made to the unit housing the individual that he/she has a STD</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>An RPR is ordered during the admission process for each individual.</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>An HIV antibody test is offered to every individual upon admission.</i></td> <td>100%</td> </tr> <tr> <td>5.</td> <td><i>A Chlamydia and Gonorrhea test are ordered during the admission process for all female individuals</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>If the individual was involved in a sexual incident, he/she was offered appropriate STD testing.</i></td> <td>NA</td> </tr> <tr> <td>7.</td> <td><i>A Focus 6 is opened for an individual testing positive for an STD.</i></td> <td>NA</td> </tr> <tr> <td>8.</td> <td><i>Appropriate objective(s) are written</i></td> <td>NA</td> </tr> <tr> <td>9.</td> <td><i>Appropriate interventions are written.</i></td> <td>NA</td> </tr> </table> <table border="1" data-bbox="955 1128 1879 1421"> <tr> <td data-bbox="955 1128 1092 1421">F.8.a.ii</td> <td data-bbox="1092 1128 1291 1421">Assesses these data for trends</td> <td data-bbox="1291 1128 1879 1421">NSH's progress report indicated that it was in substantial compliance with items 1-5. However, since the two individuals who tested positive were found not to have any active disease, items addressing the Focus 6 and WRP objectives and interventions (7-9) were not applicable for this review period.</td> </tr> </table>	1.	<i>Notification by the lab was made to the Infection Control Department of a positive STD.</i>	100%	2.	<i>Notification by the lab was made to the unit housing the individual that he/she has a STD</i>	100%	3.	<i>An RPR is ordered during the admission process for each individual.</i>	100%	4.	<i>An HIV antibody test is offered to every individual upon admission.</i>	100%	5.	<i>A Chlamydia and Gonorrhea test are ordered during the admission process for all female individuals</i>	100%	6.	<i>If the individual was involved in a sexual incident, he/she was offered appropriate STD testing.</i>	NA	7.	<i>A Focus 6 is opened for an individual testing positive for an STD.</i>	NA	8.	<i>Appropriate objective(s) are written</i>	NA	9.	<i>Appropriate interventions are written.</i>	NA	F.8.a.ii	Assesses these data for trends	NSH's progress report indicated that it was in substantial compliance with items 1-5. However, since the two individuals who tested positive were found not to have any active disease, items addressing the Focus 6 and WRP objectives and interventions (7-9) were not applicable for this review period.
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		F.8.a.iii	Initiates inquiries regarding problematic trends	None for this review period.
		F.8.a.iv	Identifies necessary corrective action	None for this review period.
		F.8.a.v	Monitors to ensure that appropriate remedies are achieved	NSH will continue to monitor these items regarding STDs.
<p>This monitor's review of the charts of two individuals who tested positive for STDs (CJH and RLF) found that both had an RPR ordered upon admission and were offered an HIV antibody test. Since neither individual had an active disease, there was no need to open a focus in the WRP.</p> <p>Other findings: The data continue to indicate that systems within the Infection Control (IC) Department are consistent. However, compliance continues to be low when IC activities are dependent on implementation at the unit level. Overall, this monitor's findings supported NSH findings in each of the above areas.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Provide data analysis, barriers to compliance, and specific plans of correction as required by the Court Monitor in the progress report 				

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		<p>for next review.</p> <p>2. Continue to monitor this requirement.</p>
F.8.a.ii	assesses these data for trends;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, January 2008: Provide data in a format that demonstrates compliance with this requirement.</p> <p>Findings: See F.8.a.i.</p> <p>Recommendation 2, January 2008: Continue to monitor this requirement.</p> <p>Findings: See F.8.a.i.</p> <p>Other findings: From review of NSH's IC Committee meeting minutes, data regarding unit trends for PPDs were identified. Also, facility trends for TB, Hepatitis B, Hepatitis C, HIV, MRSA, Pneumonia, and Immunizations were identified.</p> <p>Compliance: Substantial.</p> <p>Current: Continue current practices.</p>
F.8.a.iii	initiates inquiries regarding problematic trends;	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: See F.8.a.i.</p>

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		<p>Findings: See F.8.a.i</p> <p>Other findings: NSH's IC Committee meeting minutes validated that the problematic trends found on the IC audits (See data in F.8.a.i) were addressed by the facility. Specific solutions, action steps, person responsible, and date intervention/action due was included for each problematic trend.</p> <p>NSH meeting minutes validated that additional inquires regarding problematic trends regarding proactive treatment to Hepatitis C converters; tracking new Hepatitis C and HIV converters; Infectious Disease Key Indicators; use of 2-stype PPD; opening up focus problem for refusals; x-rays for new positive PPDs; and contact precautions for MRSA.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practices.</p>
F.8.a.iv	identifies necessary corrective action;	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: See F.8.a.i.</p> <p>Findings: See F.8.a.i.</p> <p>Other findings: This monitor's review of the minutes of the IC committee meetings, Infectious Disease minutes, the Medical Executive Committee meeting</p>

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		<p>minutes, HIV Sub-Committee meeting minutes, Nursing Coordinator meeting minutes, Risk Reduction Oversight Committee meeting minutes found that the Actions/Recommendations were documented and implemented regarding corrective actions for the issues noted in the IC data.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
F.8.a.v	monitors to ensure that appropriate remedies are achieved; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: See F.8.a.i.</p> <p>Findings: NSH's progress report and raining rosters indicated that the IC staff has been trained to review the Plato data regarding IC issues to identify areas out of acceptable compliance range. The IC staff meets with the Risk Reduction Oversight Committee to discuss the interpretation and plans of actions of the data demonstrating low compliance. In addition, the IC staff review and analyze their data monthly.</p> <p>This monitor's review of a number of meeting minutes addressing IC issues as well as from my interviews with the IC staff, they are implementing a number of interventions to increase areas of low compliance and are regularly monitoring the data regarding the effectiveness of their interventions. They have added and hired an additional nurse to work with the unit staff regarding refusals, immunizations, and vaccinations. Again, IC activities conducted on the unit level, such as integration of IC issues and refusals into the WRPs continue to be at very low compliance rates.</p>

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		<p>Compliance: Partial.</p> <p>Current recommendation: See F.8.a.i.</p>
F.8.a.vi	<p>integrates this information into each State hospital's quality assurance review.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, January 2008: Provide data/reports/minutes addressing this requirement.</p> <p>Findings: NSH provided reports and minutes of meetings adequately addressing this recommendation.</p> <p>Recommendation 2, January 2008: See F.8.a.i.</p> <p>Findings: See F.8.a.i</p> <p>Other findings: This monitor's review of the minutes of the IC committee meetings, Infectious Disease meeting minutes, the Medical Executive Committee meeting minutes, HIV Sub-Committee meeting minutes, Nursing Coordinator meeting minutes, Risk Reduction Oversight Committee meeting minutes found that a number if IC issues have been discussed and plans of action integrated into the different departments and into the Risk Reduction Oversight Committee. Some of these include:</p> <ul style="list-style-type: none"> • Development of the Two-step PPD policy and procedure • MRSA policy and procedure

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		<ul style="list-style-type: none">• Immunization policy and procedure• Expansion of Nurse practitioner duties• Hepatitis C tracking was implemented and routine evaluation for Hepatitis A and Hepatitis B vaccination was implemented• More coordination of information communicated between IC and other departments have been developed. <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practices.</p>
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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> Craig B. Story, DDS, Chief Dentist</p> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. NSH's progress report and data 2. NSH Dental Department Manual 3. Treatment Timeline tracking data 4. Dental Cancellation Monitoring data 5. Memo dated 5/27/08 regarding Resumption of Preventative and Restorative Dentistry, Priority Level 1 6. Charts of the following 76 individuals: ALR, AM, AS, AT, ATB, AWD, BAM, BR, BTM, CB, CCR, CHM, CIC, CK, CR, DCH, DFP, DJM, DKB, DLP, DM, DN, EAB, EAH, EL, EM, ERM, ET, FBT, FEG, FMS, FP, FR, GMW, GVC, IMP, JAC, JC, JEK, JHM, JLW, JMM, JRM, JRQ, JRV, JS, JSW, JY, KSW, LRW, LY, MCA, MD, MDD, MEP, MFN, MHJ, NJI, PSA, PSR, RAC, RAG, RD, RGP, RH, RJT, RW, RZ, SS, ST, TBH, TG, TMR, VH, WB and WRQ
F.9.a	<p>Each State hospital shall retain or contract with an adequate number of qualified dentists to provide timely and appropriate dental care and treatment to all individuals it serves;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: Continue implementing monitoring system to track Dental Services in alignment with EP requirements.</p> <p>Findings: NSH implemented the DMH Dental Services Audit form to monitor EP requirements in April 2008. Consequently, some requirements will only have two months of data.</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Other findings: NSH has added additional staff to the Dental Department, including:</p> <ol style="list-style-type: none"> 1. A Permanent-Intermittent Dentist (started on April 1, 2008) 2. One Dental Hygienist (started May 16, 2008) 3. A fourth Dental Assistant (started on April 1, 2008) 4. A Permanent-Intermittent Dental Hygienist (started June 2, 2008) <p>The addition of staff for the Dental Department should help increase areas of low compliance.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>			
F.9.b	Each State hospital shall develop and implement policies and procedures that require:	Please see sub-cells for compliance findings.			
F.9.b.i	comprehensive and timely provision of dental services;	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: Continue to monitor this requirement.</p> <p>Findings: The facility used the DMH Dental Services Audit form, based on an average sample of 17% of individuals scheduled for comprehensive dental exams during the review month (April and May 2008), to assess compliance with this requirement. The following table summarizes the data:</p> <table border="1" data-bbox="989 1377 1885 1414"> <tr> <td data-bbox="989 1377 1066 1414">1.a</td> <td data-bbox="1066 1377 1774 1414"><i>Comprehensive dental exam was completed.</i></td> <td data-bbox="1774 1377 1885 1414">100%</td> </tr> </table>	1.a	<i>Comprehensive dental exam was completed.</i>	100%
1.a	<i>Comprehensive dental exam was completed.</i>	100%			

Section F: Specific Therapeutic and Rehabilitation Services

		<p>NSH's progress report indicated that that sample size was below 20% due to implementation of the new DMH monitoring tool.</p> <p>This monitor's review of the charts of 20 individuals (ALR, BAM, CHM, DJM, DN, EAH, ERM, FMS, GMW, GVC, JEK, JHM, JLW, JRV, KSW, MCA, MDD, MFN, MHJ and PSR) found that 12 had a comprehensive dental exam completed and eight individuals refused the exam.</p> <p>The facility also used the DMH Dental Services Audit form, based on a 100% sample of individuals who have been hospitalized for 90 days or less during the review month (January and May 2008), to assess compliance. The following table summarizes the data:</p> <table border="1" data-bbox="991 708 1887 784"> <tr> <td data-bbox="991 708 1066 784">1.b</td> <td data-bbox="1066 708 1774 784"><i>Admission examination date was 90 days or less after admission.</i></td> <td data-bbox="1774 708 1887 784">67%</td> </tr> </table> <p>NSH's analysis of the data demonstrated that there was a decrease in compliance with this item; the compliance rate was 70% in December 2007 compared to 61% in May 2008. NSH indicated that errors and delays in scheduling by new staff members and refusals were issues related to the low compliance rates. NSH has implemented a "mid-month" check to ensure that Admission Exams due are timely scheduled. In addition, the Dental Hygienists will oversee the scheduling of all exams to increase compliance.</p> <p>This monitor reviewed the charts of the 20 individuals listed above and found, similar to NSH's findings, that 12 were seen in a timely manner and eight refused the initial admission exam.</p> <p>The facility also used the DMH Dental Services Audit form, based on a 100% sample of individuals due for annual routine dental examination during the review month (January and May 2008), to assess compliance.</p>	1.b	<i>Admission examination date was 90 days or less after admission.</i>	67%
1.b	<i>Admission examination date was 90 days or less after admission.</i>	67%			

Section F: Specific Therapeutic and Rehabilitation Services

		<p>The following table summarizes the data:</p> <table border="1" data-bbox="991 264 1881 342"> <tr> <td data-bbox="991 264 1052 342">1.c</td> <td data-bbox="1052 264 1801 342"><i>Annual examination date of examination was within anniversary month of admission.</i></td> <td data-bbox="1801 264 1881 342">61%</td> </tr> </table> <p>NSH's analysis of the data demonstrated that there was a slight decrease in compliance with this item from 59% in December 2007 to 54% in May 2008. Barriers and plan of correction were the same as noted above.</p> <p>This monitor's review of the charts of 20 individuals (AM, ATB, BTM, CCR, CR, DCH, DKB, DLP, FBT, FEG, JAC, JRQ, JSW, LRW, PSA, RAC, RJT, RW, RZ and WRQ) found that 12 were seen within their admission anniversary month.</p> <p>Data regarding individuals with identified problems on admission or annual examination receiving follow-up care, as indicated, in a timely manner only consisted of one individual in the sample, which is not representative regarding compliance for this item. In addition, data regarding individuals with identified problems during their hospital stay, other than on admission or annual examination, receiving follow-up care, as indicated, in a timely manner included only one month of data. Again, this is not representative regarding compliance for this item.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Increase sample size to 20%. 2. Collect data for the full review period. 3. Continue to monitor this requirement. 	1.c	<i>Annual examination date of examination was within anniversary month of admission.</i>	61%
1.c	<i>Annual examination date of examination was within anniversary month of admission.</i>	61%			

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, January 2008: Ensure that dental information in the Dental Clinic record and in the unit medical record is consistent.</p> <p>Findings: NSH has a contract to purchase dental software from the Patterson Dental Company. The software and necessary hardware will be installed by the next review. In addition, a digital dental X-ray system was installed in March 2008. The dentists are placing the Dental Treatment Plan Update into the individuals' records at every appointment. However, this monitor's review of 20 dental clinic records and individuals' charts (AS, AWD, CIC, EAB, EL, EM, FP, IMP, JRM, JS, JY, MEP, NJI, RAG, RD, RJT, SS, TBH, TMR and VH) found that there were discrepancies between the two records for all 20 individuals. The corrective actions noted above should remedy this issue.</p> <p>Recommendation 2, January 2008: Continue to monitor this requirement.</p> <p>Findings: NSH used the DMH Dental Services Audit form, based on an average, sample of 28% of individuals scheduled for a dental appointment during the month (January and May 2008), to assess compliance with this requirement. The following table summarizes the data:</p> <table border="1" data-bbox="991 1188 1887 1382"> <tr> <td>2.a</td> <td><i>The current status</i></td> <td>100%</td> </tr> <tr> <td>2.b</td> <td><i>Findings of the examination</i></td> <td>99%</td> </tr> <tr> <td>2.c</td> <td><i>Plan of care</i></td> <td>99%</td> </tr> <tr> <td>2.d</td> <td><i>The plans of care are consistent with examination findings</i></td> <td>91%</td> </tr> </table>	2.a	<i>The current status</i>	100%	2.b	<i>Findings of the examination</i>	99%	2.c	<i>Plan of care</i>	99%	2.d	<i>The plans of care are consistent with examination findings</i>	91%
2.a	<i>The current status</i>	100%												
2.b	<i>Findings of the examination</i>	99%												
2.c	<i>Plan of care</i>	99%												
2.d	<i>The plans of care are consistent with examination findings</i>	91%												

Section F: Specific Therapeutic and Rehabilitation Services

		<p>This monitor's review of the charts of 20 individuals found that all had the current status, findings of examination and plan of care consistent with the findings documented.</p> <p>Other findings: NSH included data from the facility's Daily Chart Monitoring form. However, the data could not be interpreted or accurately compared to the data from the DMH Dental Services Monitoring form.</p> <p>Compliance: Substantial.</p> <p>Current recommendations: Continue to monitor this requirement.</p>									
F.9.b.iii	use of preventive and restorative care whenever possible; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: Continue to monitor this requirement.</p> <p>Findings: NSH used the DMH Dental Services Audit form, based on an average sample of 21% of individuals due for annual routine dental examination during the month (April and May 2008), to assess compliance with this requirement. The following table summarizes the data:</p> <table border="1" data-bbox="991 1154 1885 1344"> <tr> <td data-bbox="991 1154 1066 1230">3.a</td> <td data-bbox="1066 1154 1774 1230"><i>Preventive care was provided, including but not limited to cleaning, root planing, sealant, fluoride application</i></td> <td data-bbox="1774 1154 1885 1230">5%</td> </tr> <tr> <td data-bbox="991 1230 1066 1268">3.b</td> <td data-bbox="1066 1230 1774 1268"><i>Oral hygiene instruction</i></td> <td data-bbox="1774 1230 1885 1268">14%</td> </tr> <tr> <td data-bbox="991 1268 1066 1344">3.c</td> <td data-bbox="1066 1268 1774 1344"><i>Restorative care was provided including permanent or temporary restorations (fillings)</i></td> <td data-bbox="1774 1268 1885 1344">21%</td> </tr> </table> <p>NSH indicated that on May 27, 2008, the Dental Department issued a</p>	3.a	<i>Preventive care was provided, including but not limited to cleaning, root planing, sealant, fluoride application</i>	5%	3.b	<i>Oral hygiene instruction</i>	14%	3.c	<i>Restorative care was provided including permanent or temporary restorations (fillings)</i>	21%
3.a	<i>Preventive care was provided, including but not limited to cleaning, root planing, sealant, fluoride application</i>	5%									
3.b	<i>Oral hygiene instruction</i>	14%									
3.c	<i>Restorative care was provided including permanent or temporary restorations (fillings)</i>	21%									

Section F: Specific Therapeutic and Rehabilitation Services

		<p>memo advising the dental staff to start performing level 1 priority dentistry. Up to this time, the Dental Department was only able to see admission and annual exams and emergencies, accounting for the low compliance rates for the provision of preventative and restorative care.</p> <p>This monitor's review of the charts of 20 individuals (AM, ATB, BTM, CCR, CR, DCH, DKB, DLP, FBT, FEG, JAC, JRQ, JSW, LRW, PSA, RAC, RJT, RW, RZ and WRQ) found that three were provided preventative care and seven were provided restorative care.</p> <p>Other findings: See F.9.b.ii.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Collect data for the full review period. 2. Continue to monitor this requirement. 			
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 recommendation:</p> <p>Recommendation, January 2008: Continue current practice.</p> <p>Findings: NSH used the DMH Dental Services Audit form, based on a 100% sample of individuals who had tooth extraction during the month (April and May 2008), to assess compliance. The following table summarizes the data:</p> <table border="1" data-bbox="989 1338 1885 1412"> <tr> <td data-bbox="989 1338 1066 1412">4.a</td> <td data-bbox="1066 1338 1774 1412"><i>Periodontal conditions, requirement for denture construction, non-restorable tooth or severe decay</i></td> <td data-bbox="1774 1338 1885 1412">100%</td> </tr> </table>	4.a	<i>Periodontal conditions, requirement for denture construction, non-restorable tooth or severe decay</i>	100%
4.a	<i>Periodontal conditions, requirement for denture construction, non-restorable tooth or severe decay</i>	100%			

Section F: Specific Therapeutic and Rehabilitation Services

		<table border="1"> <tr> <td data-bbox="987 198 1066 232">4.b</td> <td data-bbox="1066 198 1768 232"><i>Other reason stated is clinically appropriate</i></td> <td data-bbox="1768 198 1881 232">NA</td> </tr> </table>	4.b	<i>Other reason stated is clinically appropriate</i>	NA												
4.b	<i>Other reason stated is clinically appropriate</i>	NA															
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>This monitor's review of the charts of 17 individuals who had a tooth extraction (AT, BR, CB, CK, DFP, DM, ET, FR, JC, JMM, LY, MD, RGP, RH, ST, TG and WB) found that all had clinical justification documented in the records.</p> <p>Other findings: See F.8.b.ii.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p> <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: Continue to monitor this requirement.</p> <p>Findings: The facility used the DMH Dental Services Audit form, based on an average sample of 30% of individuals who received comprehensive dental examination or follow-up dental care during the month (January and May 2008), to assess compliance. The following table summarizes NSH's data:</p> <table border="1" data-bbox="987 1230 1881 1414"> <tr> <td data-bbox="987 1237 1066 1271">5.a</td> <td data-bbox="1066 1237 1768 1271"><i>Physical health impact on dental services</i></td> <td data-bbox="1768 1237 1881 1271">99%</td> </tr> <tr> <td data-bbox="987 1271 1066 1305">5.b</td> <td data-bbox="1066 1271 1768 1305"><i>Medications</i></td> <td data-bbox="1768 1271 1881 1305">99%</td> </tr> <tr> <td data-bbox="987 1305 1066 1339">5.c</td> <td data-bbox="1066 1305 1768 1339"><i>Allergies that impact on dental service</i></td> <td data-bbox="1768 1305 1881 1339">99%</td> </tr> <tr> <td data-bbox="987 1339 1066 1373">5.d</td> <td data-bbox="1066 1339 1768 1373"><i>General condition of current oral environment</i></td> <td data-bbox="1768 1339 1881 1373">100%</td> </tr> <tr> <td data-bbox="987 1373 1066 1408">5.e</td> <td data-bbox="1066 1373 1768 1408"><i>When individual complaint is noted within the findings</i></td> <td data-bbox="1768 1373 1881 1408">48%</td> </tr> </table>	5.a	<i>Physical health impact on dental services</i>	99%	5.b	<i>Medications</i>	99%	5.c	<i>Allergies that impact on dental service</i>	99%	5.d	<i>General condition of current oral environment</i>	100%	5.e	<i>When individual complaint is noted within the findings</i>	48%
5.a	<i>Physical health impact on dental services</i>	99%															
5.b	<i>Medications</i>	99%															
5.c	<i>Allergies that impact on dental service</i>	99%															
5.d	<i>General condition of current oral environment</i>	100%															
5.e	<i>When individual complaint is noted within the findings</i>	48%															

Section F: Specific Therapeutic and Rehabilitation Services

		<p style="text-align: center;"><i>there is a documentation related to exam results</i></p> <p>NSH's data analysis indicated that items 5.a-d are basically at substantial compliance. With the additional staff and anticipated increase in the number of preventive and restorative dental treatments provided, NSH indicated that it expects to see the numbers of dental complaints decrease. However, there was no plan of correction specifically addressing the low compliance for item 5.e.</p> <p>This monitor's review of the charts of 20 individuals (AM, ATB, BTM, CCR, CR, DCH, DKB, DLP, FBT, FEG, JAC, JRQ, JSW, LRW, PSA, RAC, RJT, RW, RZ and WRQ) found that all 20 addressed physical health, medication, allergies and overall oral condition. Six had dental complaints documented and three were included in the findings of the exam.</p> <p>Other findings: See F.8.b.ii.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Develop a plan of correction addressing item 5.e. 2. Continue to monitor this requirement.
F.9.d	Each State hospital shall ensure that transportation and staffing issues do not preclude individuals from attending dental appointments, and individuals' refusals are addressed to facilitate compliance.	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: Continue to monitor this requirement.</p> <p>Findings: NSH's data shows that transportation issues are not a major cause of</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<p>missed dental appointments. The December 2007 percentage (0%) is the same as May 2008 (0%) and has been consistent during the course of this review period. In addition, staff-related missed appointments continue at very low levels (0-5%), with very little change between December 2007 and May of 2008. Refusal by individuals account for the majority of missed clinic appointments. (See F.9.e)</p> <p>Compliance: Partial.</p> <p>Current recommendation: See F.9.e.</p>
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>Recommendations 1-3, January 2008:</p> <ol style="list-style-type: none"> 1. Provide training to unit staff regarding policies, procedures and expectations for addressing individuals' refusals of dental services. 2. Continue to monitor the units' compliance with refusal procedures. 3. Continue to monitor this requirement. <p>Findings: No data was provided by NSH regarding these recommendations.</p> <p>Other findings: This monitor's review of the Risk Reduction Oversight Committee minutes found that NSH is in the process of developing a plan to address treatment refusals. The Dental Department needs to be kept informed of the progress of the corrective action plan.</p> <p>Compliance: Partial.</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Current recommendations:</p> <ol style="list-style-type: none">1. Ensure that the Dental Department is involved in the development of a plan of correction addressing this requirement.2. Continue to monitor this requirement.
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Section G: Documentation

G. Documentation		
G	<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>Summary of Progress: Please refer to Sections D, E, F and H for judgments on the progress NSH has made towards aligning documentation practices with the requirements of the EP.</p>

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

H. Restraints, Seclusion, and PRN and Stat Medication		
H		<p>Summary of Progress:</p> <ol style="list-style-type: none"> 1. NSH has developed the Medical Restraints Observation Audit form addressing the use of medical restraints for individuals on the Skilled Nursing Units and medical units. 2. NSH has achieved substantial compliance with the requirement that seclusion and restraints are not used as part of a behavioral intervention. 3. NSH has implemented a number of strategies which have eradicated the use of side rails as a restraint.
H	Each State hospital shall ensure that restraints, seclusion, psychiatric PRN medications, and Stat medications are used consistent with generally accepted professional standards of care.	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Alisha McPherson, RN, HSS 2. Anabelle Trajano, RN 3. Bernadette Ezike, Nurse Administrator 4. Catherine Mangapot, RN 5. Cheryll Villamor, RN 6. Cindy Black, Director Standards Compliance 7. Ed Faulk, RN, MBA, EdD, Executive Director 8. Eve Arcala, ACNS 9. Joellyn Arce, Nurse Coordinator, Headquarters 10. Kuldib Dhaliwal, ACNS 11. Lilly Anne Salveron, RN 12. Valerie Perkins, Nurse Coordinator <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. NSH's progress report and data 2. AD 758, Medical Restraint 3. AD 761 Behavioral Seclusion or Restraint 4. NPP 1506.1, Medical Restraint (Draft)

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

		<ol style="list-style-type: none"> 5. NPP 1506, Behavioral Seclusion or Restraint (draft) 6. NPP 1501, Assaultive Individuals: Guidelines for Interventions 7. NPP 1131, PRN or Stat Medication Use for Physical and Psychiatric Symptom Management 8. NPP 113, Care of the Individual in Bed-Bound Status 9. NSH Medical Restraint Observation Record form and data 10. NSH inter-rater agreement data 11. Training rosters 12. Course curriculum for Restraint and Seclusion Documentation Inservice 13. NSH Medical Staff Rules and Regulations 203, Administration of PRN/Stat Medications 14. Letter of Non-Compliance with Competency Validation 15. Initial Safety Restraint Assessment form 16. Safety Restraint Observation Records for individuals on Unit A4 17. Charts of the following 42 individuals: AL, AS, AVC, BS, CDC, CMK, DB, DBC, DF, DJM, DMH, DP, DPA, EAL, EH, FBT, GR, GVA, IS, JAG, JCR, JDN, JM, JY, KDC, LK, LRW, MR, MV, PB, PIM, PLB, PN, PRM, RG, RLJ, RN, RRW, RS, SWH, VH and WGH <p><u>Observed:</u> Individuals on Unit A-4.</p>
H.1	<p>Each State hospital shall revise, as appropriate, and implement policies and procedures regarding the use of seclusion, restraints, psychiatric PRN medications, and Stat Medications consistent with generally accepted professional standards of care. In particular, the policies and procedures shall expressly prohibit the use of prone restraints, prone containment and prone transportation and shall list the types of restraints that are acceptable for use.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, January 2008:</p> <ol style="list-style-type: none"> 1. Provide data from the Safety Restraint Observation Monitoring Form. 2. Continue to monitor this requirement. <p>Findings: NHS used the Medical Restraints Observation Audit form based on a 100% sample of individuals in medical restraints for the month</p>

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

		(January-May2008). The following table summarizes NSH's data:																																							
		<table border="1"> <tr> <td>1.</td> <td><i>Initial Safety Assessment documented</i></td> <td>77%</td> </tr> <tr> <td>2.</td> <td><i>Date and time of physician's order documented (order shall not exceed 24 hours)</i></td> <td>59%</td> </tr> <tr> <td>3.</td> <td><i>Physician order includes medical condition, type of restraints, symptom/ assessment/treatment, duration, release parameters are recorded. (All criteria addressed.)</i></td> <td>37%</td> </tr> <tr> <td>4.</td> <td><i>Is the appropriate reason for restraint box checked?</i></td> <td>83%</td> </tr> <tr> <td>5.</td> <td><i>Any nursing alerts identified and recorded?</i></td> <td>83%</td> </tr> <tr> <td>6.</td> <td><i>Safety restraint was observed not less than every hour and documented.</i></td> <td>93%</td> </tr> <tr> <td>7.</td> <td><i>Safety restraint was released minimally every 2 hours for ROM and change of position and documented.</i></td> <td>81%</td> </tr> <tr> <td>8.</td> <td><i>Circulation documented at least hourly and as indicated. Restraints properly applied.</i></td> <td>94%</td> </tr> <tr> <td>9.</td> <td><i>Pain level documented every hour and s indicated.</i></td> <td>90%</td> </tr> <tr> <td>10.</td> <td><i>Toileting done every 2 hours and PRN and documented.</i></td> <td>63%</td> </tr> <tr> <td>11.</td> <td><i>Skin care and skin check done every 2 hours and documented.</i></td> <td>73%</td> </tr> <tr> <td>12.</td> <td><i>Fluids given every hour and PRN and % of meal consumed documented.</i></td> <td>87%</td> </tr> <tr> <td>13.</td> <td><i>Any changes in bio-psychosocial function/condition recorded in the IDN.</i></td> <td>87%</td> </tr> </table>	1.	<i>Initial Safety Assessment documented</i>	77%	2.	<i>Date and time of physician's order documented (order shall not exceed 24 hours)</i>	59%	3.	<i>Physician order includes medical condition, type of restraints, symptom/ assessment/treatment, duration, release parameters are recorded. (All criteria addressed.)</i>	37%	4.	<i>Is the appropriate reason for restraint box checked?</i>	83%	5.	<i>Any nursing alerts identified and recorded?</i>	83%	6.	<i>Safety restraint was observed not less than every hour and documented.</i>	93%	7.	<i>Safety restraint was released minimally every 2 hours for ROM and change of position and documented.</i>	81%	8.	<i>Circulation documented at least hourly and as indicated. Restraints properly applied.</i>	94%	9.	<i>Pain level documented every hour and s indicated.</i>	90%	10.	<i>Toileting done every 2 hours and PRN and documented.</i>	63%	11.	<i>Skin care and skin check done every 2 hours and documented.</i>	73%	12.	<i>Fluids given every hour and PRN and % of meal consumed documented.</i>	87%	13.	<i>Any changes in bio-psychosocial function/condition recorded in the IDN.</i>	87%
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12.	<i>Fluids given every hour and PRN and % of meal consumed documented.</i>	87%																																							
13.	<i>Any changes in bio-psychosocial function/condition recorded in the IDN.</i>	87%																																							
		<p>NSH indicated that an administrative review of medical restraints was initiated by the Clinical Administrator in March 2008. In April 2008, training, verified by training rosters, was conducted for NPP 1506.1 and Medical Restraint Observation sheets. Training for Health Services Specialists (HSSs) and Unit Supervisors was completed for 31 Nursing staff in May 2008.</p>																																							

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

		<p>This monitor's review of Safety Restraint Observation Records for individuals on Unit A-4 found similar problematic issues to those captured by NSH's data regarding the documentation of date and time of physician's order; physician order includes medical condition, type of restraints, symptom/assessment/treatment, duration, release parameters are recorded; and toileting done every two hours and PRN and documented.</p> <p>Other findings: This monitor found no indication of the use of prone restraints, prone containment and prone transportation at NSH.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
H.2	Each State hospital shall ensure that restraints and seclusion:	Please see sub-cells for compliance findings.
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, January 2008: Establish reliability of auditors.</p> <p>Findings: NSH provided data indicating that inter-rater agreement was 91%, with a range from 70 to 100%.</p> <p>Recommendation 2, January 2008: Provide training regarding this requirement.</p>

		<p>Findings: NSH's progress report indicated that they found the training conducted during this review period ineffective and auditing reliability was inconsistent. NSH implemented the statewide tool for this section in May 2008. A new curriculum was developed in June 2008 by Nursing Education in collaboration with Nursing Coordinators and Standards Compliance. There were 14 trained regarding train-the-trainers in June 2008 and Unit Supervisors and Nursing Coordinators will complete the training of level of care nursing staff by July 11, 2008. Training rosters provided by NSH verified the above.</p> <p>Recommendation 3, January 2008: Continue to monitor this requirement.</p> <p>Findings: NSH used the DMH Restraints, Seclusion and PRN and Stat Medication Audit Form based on a 100% sample of initial orders for seclusion each month (January-May 2008). The following table summarizes NSH's data:</p> <table border="1" data-bbox="989 932 1896 1422"> <tr> <td colspan="3">As applicable to seclusion</td> </tr> <tr> <td>2.</td> <td><i>Are used in a documented manner</i></td> <td></td> </tr> <tr> <td>2.a</td> <td><i>The IDN described specific behavior that was imminently dangerous to self or others.</i></td> <td>67%</td> </tr> <tr> <td>2.b</td> <td><i>The physician's order described specific behavior that was imminently dangerous to self or others;</i></td> <td>59%</td> </tr> <tr> <td>3.</td> <td><i>Only when individuals pose an imminent danger to self or others</i></td> <td></td> </tr> <tr> <td>3.a</td> <td><i>The justification for seclusion was to prevent harm to self or to others</i></td> <td>82%</td> </tr> <tr> <td>3.b</td> <td><i>Did not include prevention of harm from others.</i></td> <td>92%</td> </tr> <tr> <td>4.</td> <td><i>After a hierarchy of less restrictive measures has been considered in a clinically justifiable manner or</i></td> <td>63%</td> </tr> </table>	As applicable to seclusion			2.	<i>Are used in a documented manner</i>		2.a	<i>The IDN described specific behavior that was imminently dangerous to self or others.</i>	67%	2.b	<i>The physician's order described specific behavior that was imminently dangerous to self or others;</i>	59%	3.	<i>Only when individuals pose an imminent danger to self or others</i>		3.a	<i>The justification for seclusion was to prevent harm to self or to others</i>	82%	3.b	<i>Did not include prevention of harm from others.</i>	92%	4.	<i>After a hierarchy of less restrictive measures has been considered in a clinically justifiable manner or</i>	63%
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Section H: Restraints, Seclusion, and PRN and Stat Medication

		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 5%;"></td> <td style="width: 85%;"><i>exhausted</i></td> <td style="width: 10%;"></td> </tr> </table> <p>This monitor's review of 20 incidents of seclusion involving 11 individuals (AVC, DBC, DPA, EH, FBT, IS, JDN, JY, KDC, PN and RLJ) found that the documentation for 12 incidents described behaviors indicating that the seclusion was in response to behaviors that demonstrated an imminent danger to self or others. The physician's orders for nine incidents included specific behaviors and nine incidents included the use of less restrictive measures.</p> <p>NSH used the DMH Restraints, Seclusion and PRN and Stat Medication Audit Form based on an average sample of 52% of initial orders for restraint each month (January-May 2008). The following table summarizes NSH's data:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th colspan="3" style="text-align: left;">As applicable to restraint</th> </tr> <tr> <td style="width: 5%;">2.</td> <td style="width: 85%;"><i>Are used in a documented manner</i></td> <td style="width: 10%;"></td> </tr> <tr> <td>2.a</td> <td><i>The IDN described specific behavior that was imminently dangerous to self or others.</i></td> <td style="text-align: center;">88%</td> </tr> <tr> <td>2.b</td> <td><i>The physician's order described specific behavior that was imminently dangerous to self or others;</i></td> <td style="text-align: center;">53%</td> </tr> <tr> <td>3.</td> <td><i>Only when individuals pose an imminent danger to self or others</i></td> <td></td> </tr> <tr> <td>3.a</td> <td><i>The justification for seclusion was to prevent harm to self or to others</i></td> <td style="text-align: center;">92%</td> </tr> <tr> <td>3.b</td> <td><i>Did not include prevention of harm from others.</i></td> <td style="text-align: center;">96%</td> </tr> <tr> <td>4.</td> <td><i>After a hierarchy of less restrictive measures has been considered in a clinically justifiable manner or exhausted</i></td> <td style="text-align: center;">79%</td> </tr> </table> <p>NSH's analysis of the data reflected that the compliance regarding restraints has not changed during the reporting period, indicating that the training provided was not effective. When NSH implemented the</p>		<i>exhausted</i>		As applicable to restraint			2.	<i>Are used in a documented manner</i>		2.a	<i>The IDN described specific behavior that was imminently dangerous to self or others.</i>	88%	2.b	<i>The physician's order described specific behavior that was imminently dangerous to self or others;</i>	53%	3.	<i>Only when individuals pose an imminent danger to self or others</i>		3.a	<i>The justification for seclusion was to prevent harm to self or to others</i>	92%	3.b	<i>Did not include prevention of harm from others.</i>	96%	4.	<i>After a hierarchy of less restrictive measures has been considered in a clinically justifiable manner or exhausted</i>	79%
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		<p>use of the statewide tool for this section, it was recognized that some of the items had not been included in the training, which affected compliance rates. The plan for re-training is outlined under findings for Recommendation 2 above.</p> <p>This monitor's review of 30 incidents of restraints involving 13 individuals (AS, AVC, CDC, DBC, DMH, EAL, EH, FBT, KDC, RN, RRW, SWH and VH) found that the documentation for 22 incidents described behaviors indicating that the use of restraints was in response to behaviors that demonstrated an imminent danger to self or others. The physician's orders for 17 incidents included specific behaviors and 24 incidents included the use of less restrictive measures.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Conduct re-training as planned. 2. Continue to monitor this requirement.
H.2.b	are not used in the absence of, or as an alternative to, active treatment, as punishment, or for the convenience of staff;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, January 2008: Establish appropriate criteria for indicators for this requirement.</p> <p>Findings: Appropriate criteria were established in the statewide tool approved May 2008, addressing this recommendation.</p> <p>Recommendation 2, January 2008: Establish acceptable inter-rater reliability (85% or above).</p>

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		<p>Findings: See H.2.a, findings for Recommendation 1.</p> <p>Recommendation 3, January 2008: Continue to monitor this requirement.</p> <p>Findings: NSH used the DMH Restraints, Seclusion and PRN and Stat Medication Audit Form based on an average sample of 63% of orders for seclusion each month (January-May 2008). The following table summarizes NSH's data:</p> <table border="1" data-bbox="991 638 1890 1424"> <tr> <td colspan="3">As applicable to seclusion</td> </tr> <tr> <td>5.</td> <td><i>Are not used in the absence of, or as an alternative to, active treatment</i></td> <td></td> </tr> <tr> <td>5.a</td> <td><i>There is a Focus of Hospitalization that targets the behavior that required the individuals to be placed in Restraint or seclusion</i></td> <td>66%</td> </tr> <tr> <td>5.b</td> <td><i>Linked objective</i></td> <td>61%</td> </tr> <tr> <td>5.c</td> <td><i>Linked intervention (any formal group, individual therapy, or behavioral intervention) for the target behavior that required the individual to be placed in Restraints or Seclusion.</i></td> <td>55%</td> </tr> <tr> <td>6.</td> <td><i>As punishment</i></td> <td>42%</td> </tr> <tr> <td>6.a</td> <td><i>The staff did not use restraints or seclusion in an abusive manner.</i></td> <td>86%</td> </tr> <tr> <td>6.b</td> <td><i>The staff did not keep the individual in restraints or seclusion even when the individual was calm.</i></td> <td>48%</td> </tr> <tr> <td>6.c</td> <td><i>The staff did not use restraints or seclusion in a manner to show a power differential that exists between staff and the individual.</i></td> <td>92%</td> </tr> <tr> <td>6.d</td> <td><i>The staff did not use restraints or seclusion as coercion.</i></td> <td>94%</td> </tr> </table>	As applicable to seclusion			5.	<i>Are not used in the absence of, or as an alternative to, active treatment</i>		5.a	<i>There is a Focus of Hospitalization that targets the behavior that required the individuals to be placed in Restraint or seclusion</i>	66%	5.b	<i>Linked objective</i>	61%	5.c	<i>Linked intervention (any formal group, individual therapy, or behavioral intervention) for the target behavior that required the individual to be placed in Restraints or Seclusion.</i>	55%	6.	<i>As punishment</i>	42%	6.a	<i>The staff did not use restraints or seclusion in an abusive manner.</i>	86%	6.b	<i>The staff did not keep the individual in restraints or seclusion even when the individual was calm.</i>	48%	6.c	<i>The staff did not use restraints or seclusion in a manner to show a power differential that exists between staff and the individual.</i>	92%	6.d	<i>The staff did not use restraints or seclusion as coercion.</i>	94%
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<p>NSH has incorporated the criteria for release from seclusion or restraint after a one 15-minute period of calm into its updated training addressing the low compliance rates for item 6. This will also be added to the Draft Nursing policy and procedure. In addition, item 7 was not scored since NSH does not yet have the statewide form "Seclusion or Restraint Preference and family notification," which is needed to monitor this item appropriately.</p> <p>This monitor's review of the charts of 11 individuals who were placed in seclusion (AVC, DBC, DPA, EH, FBT, IS, JDN, JY, KDC, PN and RLJ) found that four had documentation in the WRP addressing behaviors and the use of seclusion. Fourteen out of a total of 20 incidents of seclusion indicated that seclusion was being used for punishment. In 13 incidents, the individual was not released when calm.</p> <p>NSH used the DMH Restraints, Seclusion and PRN and Stat Medication Audit Form based on an average sample of 52% of orders for restraint each month (January-May 2008). The following table summarizes NSH's data:</p>																	
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		6. <i>As punishment</i>	52%
		6.a <i>The staff did not use restraints or seclusion in an abusive manner.</i>	95%
		6.b <i>The staff did not keep the individual in restraints or seclusion even when the individual was calm.</i>	55%
		6.c <i>The staff did not use restraints or seclusion in a manner to show a power differential that exists between staff and the individual.</i>	92%
		6.d <i>The staff did not use restraints or seclusion as coercion.</i>	96%
		7. <i>Or for the convenience of staff;</i>	NA
<p>NSH's data analysis demonstrated that nursing staff are not releasing individuals when calm. The lack of an adequate definition of what constitutes calm and past practices of releasing individuals after 30 minutes rather than the required 15 minutes have contributed to low compliance rates. Training is being provided to the nursing staff in June 2008 to increase compliance rates in these areas.</p> <p>This monitor's review of the charts of 13 individuals who were placed in restraints (AS, AVC, CDC, DBC, DMH, EAL, EH, FBT, KDC, RN, RRW, SWH and VH) found that the nine had documentation in the WRP addressing behaviors and the use of restraints. Nine out of a total of 30 incidents of restraint indicated that it was being used for punishment. In seven incidents the individual was not released when calm.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>			

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<p>H.2.c</p>	<p>are not used as part of a behavioral intervention; and</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, January 2008:</p> <ol style="list-style-type: none"> 1. Provide monitoring data regarding this requirement to demonstrate compliance. 2. Continue to monitor this requirement. <p>Findings: NSH assessed its compliance with this requirement using the DMH Psychology Services Monitoring Form based on a 100% sample of new Behavior Guidelines and Positive Behavior Support Plans each month (January-May 2008). The following table summarizes NSH's data:</p> <table border="1" data-bbox="991 673 1885 824"> <tr> <td data-bbox="991 673 1066 824">8.</td> <td data-bbox="1066 673 1774 824"><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></td> <td data-bbox="1774 673 1885 824">97%</td> </tr> </table> <p>NSH's analysis of the data indicated an increase in compliance from 86% in December 2007 to 100% in May 2008.</p> <p>This monitor's chart reviews did not find any indication that seclusion or restraint was used as part of a behavioral intervention.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>	8.	<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>	97%
8.	<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>	97%			
<p>H.2.d</p>	<p>are terminated as soon as the individual is no longer an imminent danger to self or others.</p>	<p>Current findings on previous recommendation:</p>			

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		<p>Recommendation, January 2008: Continue to monitor this requirement.</p> <p>Findings: NSH used the DMH Restraints, Seclusion and PRN and Stat Medication Audit Form based on an average sample of 63% of orders for seclusion and an average sample of 52% of orders for restraint each month (January-May 2008). The following table summarizes NSH's seclusion and restraint data:</p>	
		Seclusion	Restraint
9.	<i>Are terminated as soon as the individual is no longer an imminent danger to self or others.</i>		
9.a	<i>The individual was released from restraints/seclusion as soon as the violent or dangerous behavior that created the emergency was no longer displayed or met the release criteria on the restraints or seclusion order.</i>	50%	47%
9.b	<i>The individual did not continue to be in restraints/seclusion after remaining calm for 15 minutes.</i>	46%	51%
9.c	<i>The individual did not continue to be in restraints/seclusion because he/she was unable to contract for safety. (Contract for safety is not implied or stated in the documentation.)</i>	92%	90%
9.d	<i>The individual did not continue to be in restraints/seclusion because he/she was unable to agree to cease using offensive language.</i>	95%	85%

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		9.e	<i>The individual did not continue to be in restraints/seclusion because he/she did not cease making verbal threats.</i>	89%	77%
		9.f	<i>Even if he/she was unable to say he/she recognizes what behavior prompted the restraint/seclusion episode.</i>	95%	93%
		9.g	<i>Even if he/she was unable to say he/she is sorry for his/her actions.</i>	98%	95%
		<p>NSH's analysis of the data indicated that based on review of the sub-criteria, there is inconsistency in the implementation of policies and procedures. Training was provided in May 2008 for trainers and the unit staff's training began in June 2008. Mentoring of unit staff will be provided by the Unit Supervisors and Nursing Coordinators in alignment with audit results for these items.</p> <p>See H2.b.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>			
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 recommendation:</p> <p>Recommendation, January 2008: Continue to monitor this requirement.</p> <p>Findings: NSH used the DMH Restraints, Seclusion and PRN and Stat Medication Audit Form based on an average sample of 63% of episodes of seclusion and an average sample of 52% of episodes of restraint each month</p>			

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(January-May 2008). The following tables summarize NSH's seclusion and restraint data:

Seclusion		
10.	<i>The individual was assessed by a physician within one hour after being placed in seclusion.</i>	
10.a	<i>The order was obtained within 15 minutes from the initiation of seclusion</i>	100%
10.b	<i>The RN conducted an assessment within 15 minutes of the initiation of seclusion and documented in the IDN.</i>	48%
10.c	<i>The Physician conducted a face-to-face evaluation of the individual in seclusion within one hour from the initiation of seclusion and documented in the Physician Progress Note.</i>	77%

Restraint		
10.	<i>The individual was assessed by a physician within one hour after being placed in restraint.</i>	
10.a	<i>The order was obtained within 15 minutes from the initiation of restraint.</i>	100%
10.b	<i>The RN conducted an assessment within 15 minutes of the initiation of restraint and documented in the IDN.</i>	69%
10.c	<i>The Physician conducted a face-to-face evaluation of the individual in restraint within one hour from the initiation of restraint and documented in the Physician Progress Note.</i>	87%

The facility's analysis of the data demonstrated that the RNs do not consistently conduct assessments as scheduled. However, they are done more frequently for episodes of restraint than for seclusion. In addition, the physicians do not consistently conduct a face-to-face evaluation within one hour of the individual being placed in seclusion or restraints. Again, however, this is done more often with restraint than

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		<p>for seclusion. NSH indicated that staff may be more fearful of conducting assessments for individuals in seclusion than in restraint due to personal safety concerns. NSH plans to increase the number of staff assisting with the assessment to address this issue and improve compliance. In addition, the hierarchy of response to high risk factors will be incorporated into the statewide risk management process, Protection from Harm system.</p> <p>This monitor's review of 20 incidents of seclusion from 11 individuals (AVC, DBC, DPA, EH, FBT, IS, JDN, JY, KDC, PN and RLJ) found that orders were obtained within 15 minutes for all 20 episodes; the RN conducted a timely assessment in eight episodes; and the physician conducted a timely face-to-face evaluation in 12 episodes.</p> <p>This monitor's review of 30 incidents of restraints from 13 individuals (AS, AVC, CDC, DBC, DMH, EAL, EH, FBT, KDC, RN, RRW, SWH and VH) found that orders were obtained within 15 minutes for all 30 episodes; the RN conducted a timely assessment in 22 episodes; and the physician conducted a timely face-to-face evaluation in 27 episodes. NSH's training rosters indicted the following regarding competency-based training for seclusion and restraint for three levels of Positive Management of Assaultive Behavior courses:</p> <table border="1" data-bbox="991 1042 1831 1195"> <thead> <tr> <th></th> <th>Licensed Nursing staff</th> <th>Unlicensed staff</th> </tr> </thead> <tbody> <tr> <td>PMAB I</td> <td>77%</td> <td>73%</td> </tr> <tr> <td>PMAB II</td> <td>49%</td> <td>37%</td> </tr> <tr> <td>PMAB III</td> <td>77%</td> <td>80%</td> </tr> </tbody> </table> <p>Compliance: Partial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>		Licensed Nursing staff	Unlicensed staff	PMAB I	77%	73%	PMAB II	49%	37%	PMAB III	77%	80%
	Licensed Nursing staff	Unlicensed staff												
PMAB I	77%	73%												
PMAB II	49%	37%												
PMAB III	77%	80%												

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

<p>H.4</p>	<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 recommendation:</p> <p>Recommendation, January 2008: Continue to monitor this requirement.</p> <p>Findings: NSH's data indicated that the accuracy of PRN/Stat data improved from 79% in November 2007 to 95% in June 2008. However, no supporting documentation was provided by NSH to verify this.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Provide supporting data to verify compliance. 2. Provide documentation addressing the accuracy of seclusion and restraint data. 3. Continue to monitor this requirement.
<p>H.5</p>	<p>Each State hospital shall revise, as appropriate, and implement policies and procedures to require the review within three business days of individuals' therapeutic and rehabilitation service plans for any individuals placed in seclusion or restraints more than three times in any four-week period, and modification of therapeutic and rehabilitation service plans, as appropriate.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, January 2008:</p> <ol style="list-style-type: none"> 1. Address barriers to compliance with this requirement. 2. Continue to monitor this requirement. <p>Findings: NSH used the DMH Restraints, Seclusion and PRN and Stat Medication Audit Form based on one individual who met the trigger for seclusion and six individuals who met the trigger for restraints each month (March-May 2008). The data indicated that there was no response to triggers by the WRPT. NSH did not provide barriers or a plan of correction for this requirement.</p>

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		<p>This monitor's review of the charts of eight individuals who met the trigger criteria for seclusion or restraints (AS, CDC, DBC, EAL, EH, MR, RN and SWH) found that there was no indication that the WRPTs had responded to the triggers by reviewing/revising the WRPs.</p> <p>Compliance: Noncompliance.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Assess barriers to compliance and develop a plan of correction for this requirement. 2. Continue to monitor this requirement.
H.6	<p>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>	<p>Compliance: Partial.</p>
H.6.a	<p>such medications are used in a manner that is clinically justified and are not used as a substitute for adequate treatment of the underlying cause of the individual's distress.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: Implement monitoring of this requirement and provide data.</p> <p>Findings: NSH provided a grid regarding individuals who triggered for PRN and Stat medication use. Results indicated that of 17 individuals who triggered for PRNs (AL, BS, CDC, DB, DBC, DF, DP, GA, GR, JDN, KDC, LK, MV, PB, PIM, PRM and SWH), nine were not addressed by the WRPTs. In addition, the WRPTs did not respond to any of the six individuals who triggered for Stats (CDC, DB, DBC, GR, JDN and KDC). These results were verified from by this monitor's review. NSH did not provide barriers to compliance or a plan of correction for this</p>

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

		<p>requirement.</p> <p>Compliance: Partial.</p> <p>Current recommendation: See H.5.</p>															
H.6.b	<p>PRN medications, other than for analgesia, are prescribed for specified and individualized behaviors.</p>	<p>Findings:</p> <p>NSH using the DMH Monthly PPN Audit based on an average sample of 28% of individuals receiving PRN and Stat medication each month (April and May 2008). The following table summarizes the data:</p> <table border="1" data-bbox="991 711 1890 1235"> <tr> <td data-bbox="991 711 1087 857">7.</td> <td data-bbox="1087 711 1795 857"><i>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</i></td> <td data-bbox="1795 711 1890 857"></td> </tr> <tr> <td data-bbox="991 857 1087 932">7.a</td> <td data-bbox="1087 857 1795 932"><i>Describes the rationale/specific indications for all PRN orders.</i></td> <td data-bbox="1795 857 1890 932">64%</td> </tr> <tr> <td data-bbox="991 932 1087 1047">7.b</td> <td data-bbox="1087 932 1795 1047"><i>Reviews (including circumstances of use and individual's response) the PRNs and Stats used during the interval period.</i></td> <td data-bbox="1795 932 1890 1047">60%</td> </tr> <tr> <td data-bbox="991 1047 1087 1122">7.c</td> <td data-bbox="1087 1047 1795 1122"><i>Discusses use of PRN/Stat as indicated to reduce the risk of restrictive interventions.</i></td> <td data-bbox="1795 1047 1890 1122">50%</td> </tr> <tr> <td data-bbox="991 1122 1087 1235">7.d</td> <td data-bbox="1087 1122 1795 1235"><i>Describes modification of regularly scheduled medication regimen based on the use of PRN/Stat medications.</i></td> <td data-bbox="1795 1122 1890 1235">48%</td> </tr> </table> <p>NSH's data analysis shows that some improvement from the last review period. NSH did not provide barriers to compliance or a plan of correction for this requirement.</p>	7.	<i>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</i>		7.a	<i>Describes the rationale/specific indications for all PRN orders.</i>	64%	7.b	<i>Reviews (including circumstances of use and individual's response) the PRNs and Stats used during the interval period.</i>	60%	7.c	<i>Discusses use of PRN/Stat as indicated to reduce the risk of restrictive interventions.</i>	50%	7.d	<i>Describes modification of regularly scheduled medication regimen based on the use of PRN/Stat medications.</i>	48%
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Section H: Restraints, Seclusion, and PRN and Stat Medication

		<p>This monitor's review of 50 incidents of PRN medications for eight individuals (DMH, JCR, LRW, PLB, RN, RRW, SWH and VH) found that 18 orders indicated specific behaviors.</p> <p>This monitor's review of 50 incidents of Stat medications for 13 individuals (AS, CDC, CMK, DJM, DMH, JAG, PLB, RG, RRW, RS, SWH, VH and WGH) found that 25 orders indicated specific behaviors.</p> <p>Compliance: Partial.</p> <p>Current recommendation: See H.5.</p>
H.6.c	PRN medications are appropriately time limited.	<p>Findings: NSH's Medical Executive Committee and Pharmacy & Therapeutics Committee approved a 14-day limit for PRN orders in August 2008.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
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 recommendation:</p> <p>Recommendation, January 2008: Continue to monitor this requirement.</p> <p>Findings: NSH used the DMH Nursing Services Monitoring form for PRN and Stat medication based on an average sample of 32% of PRN and Stat medications given each month (February-May 2008) to assess compliance with this item . The results are listed below:</p>

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

		<table border="1"> <tr> <td data-bbox="989 228 1087 342">3.b.i</td> <td data-bbox="1087 228 1793 342"><i>In the IDN there is a comprehensive assessment of the individual's response to the administered PRN medications.</i></td> <td data-bbox="1793 228 1890 342">34%</td> </tr> <tr> <td data-bbox="989 342 1087 418">3.b.ii</td> <td data-bbox="1087 342 1793 418"><i>The comprehensive assessment was completed within one hour of administration.</i></td> <td data-bbox="1793 342 1890 418">88%</td> </tr> </table> <table border="1"> <tr> <td data-bbox="989 456 1087 570">3.b.i</td> <td data-bbox="1087 456 1793 570"><i>In the IDN there is a comprehensive assessment of the individual's response to the administered Stat medications.</i></td> <td data-bbox="1793 456 1890 570">41%</td> </tr> <tr> <td data-bbox="989 570 1087 646">3.b.ii</td> <td data-bbox="1087 570 1793 646"><i>The comprehensive assessment was completed within one hour of administration.</i></td> <td data-bbox="1793 570 1890 646">72%</td> </tr> </table> <p data-bbox="989 683 1850 862">NSH's data analysis indicated that there was a system problem regarding the medication nurse and designated responsibility for the documentation of response. The Nursing policy and procedure was revised to clarify responsibility in July 2008, which should increase compliance.</p> <p data-bbox="989 906 1142 938">See F.3.a.iii.</p> <p data-bbox="989 982 1142 1047">Compliance: Partial.</p> <p data-bbox="989 1091 1457 1156">Current recommendation: Continue to monitor this requirement.</p>	3.b.i	<i>In the IDN there is a comprehensive assessment of the individual's response to the administered PRN medications.</i>	34%	3.b.ii	<i>The comprehensive assessment was completed within one hour of administration.</i>	88%	3.b.i	<i>In the IDN there is a comprehensive assessment of the individual's response to the administered Stat medications.</i>	41%	3.b.ii	<i>The comprehensive assessment was completed within one hour of administration.</i>	72%
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3.b.ii	<i>The comprehensive assessment was completed within one hour of administration.</i>	72%												
H.6.e	A psychiatrist conducts a face-to-face assessment of the individual within 24 hours of the administration of a Stat medication. The assessment shall address reason for Stat administration, individual's response, and, as appropriate, adjustment of current treatment	<p data-bbox="989 1203 1577 1235">Current findings on previous recommendation:</p> <p data-bbox="989 1279 1409 1344">Recommendation, January 2008: Same as in D.1.f, F.1.b and H.6.a.</p>												

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

	and/or diagnosis.	<p>Findings: Same as in D.1.f, F.1.b and H.6.a.</p> <p>Current recommendations: Same as in D.1.f, F.1.b and H.6.a.</p>
H.7	Each State hospital shall ensure that all staff whose responsibilities include the implementation or assessment of seclusion, restraints, psychiatric PRN medications, or Stat medications successfully complete competency-based training regarding implementation of all such policies and the use of less restrictive interventions.	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, January 2008:</p> <p>5. Provide compliance data regarding new hires and existing staff. 6. Continue to monitor this requirement.</p> <p>Findings: Since January 2008, NSH requires that new hires complete the Psych Nursing 101 course, which addresses this requirement. Training rosters indicated that of 94 new hires from January-May 2008, 74 (80%) passed the course and demonstrated competency. NSH has sent out non-competency letters to those who did not pass. See F.3.1 and H.3.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
H.8	Each State hospital shall:	<p>Compliance: Substantial.</p>
H.8.a	develop and implement a plan to reduce the use of side rails as restraints in a systematic and gradual way to ensure individuals' safety; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: Continue current practice.</p>

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

		<p>Findings: NSH has implemented a number of strategies which have eradicated the use of side rails as a restraint. The facility has secured a number of electric high/low beds for individuals with safety issues. In addition, beds with half-rails have also been utilized to prevent the side rail from becoming a restraint device. Upon admission to Unit A-4, an assessment of adaptive equipment is completed and the findings sent to CNS, the Program Director and Chief of Rehabilitation to ensure that proper devices are acquired for the individual. This monitor's observations of Unit A-4 found no use of side rails as a restraint device.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
H.8.b	<p>ensure that, as to individuals who need side rails, their therapeutic and rehabilitation service plans expressly address the use of side rails, including identification of the medical symptoms that warrant the use of side rails, methods to address the underlying causes of such medical symptoms, and strategies to reduce the use of side rails, if appropriate.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: Continue current practice.</p> <p>Findings: See H.8.a,</p> <p>Compliance: Not applicable.</p> <p>Current recommendation: See H.8.a.</p>

Section I: Protection from Harm

I. Protection from Harm		
I	<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. The investigations conducted by the Office of Special Investigations have shown improvement in the use of the revised SIR definitions and in the use of the face sheet produced by the Record Management System. 2. The Record Management System has the potential to produce the types of incident data reports that the Enhancement Plan requires. This work is ongoing at both the facility and statewide levels. 3. The Standards Compliance Department is ensuring that the SIRs accurately identify the incident type. The Hospital Police Department and Standards Compliance are sharing data to ensure that all allegations of abuse/neglect show up in each database and each has been reported on an SIR and on an SOC 341. 4. The facility is now producing some trend and pattern reports based on incident data. These reports are being reviewed by the Incident Review Committee. The committee will be reviewing the circumstances underlying the findings related to the location of incidents. 5. The Incident Review Committee and the Office of Special Investigations have agreed that the committee will receive and review the entire investigation summaries for all serious incidents, regardless of the determination. 6. The facility has initiated an Interdisciplinary Review of deaths. A list of documents to be reviewed for each death has been developed. The Mortality Interdisciplinary Review Committee has developed a tracking form that identifies problems, solutions, the staff member responsible and the due date. 7. The Risk Reduction Oversight Committee and its five subcommittees have identified systemic issues that require further study and have identified actions to be taken in response. This represents a significant stride in efforts to meet the facility's service goals.

Section I: Protection from Harm

		<ol style="list-style-type: none"> 8. Protection from Harm-Phase 1, the statewide incident management data system, will be ready for testing within the next several months. 9. NSH has made substantive changes to honor the dignity of the individuals in the former Safety Unit. The door separating the Safety Wing has been unlocked, individuals have been provided adaptive eating utensils and toothbrushes, training on BY CHOICE has been provided for the individuals and the staff, PBS supports are being put in place, and there are plans to individualize and decorate the sterile environment. 10. The facility is addressing environmental safety issues, prioritizing work to be done within the available resources. New storage units for bedrooms that are low and do not block the view into the room and have no parts that can be ripped off and used as weapons are being provided to individuals.
<p>1. Incident Management</p>		
<p>I.1</p>	<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: <u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. C. Black, Director of Standards Compliance 2. C. Caruso, Clinical Administrator 3. D. Daly, Chief of Police 4. D. Grundman, Special Investigator 5. D. Matteucci, Hospital Administrator 6. D. Hauscarriague, Supervising Special Investigator 7. E. Foulk, Executive Director 8. K. Cooper, Enhancement Plan Coordinator 9. K. Patterson, Chair, Psychology Special Services Committee 10. M. McCandless, Standards Compliance Coordinator 11. M. McQueeney, Assistant Hospital Administrator 12. M. Stolp, Program 1 Director 13. P. Tyler, Acting Medical Director

Section I: Protection from Harm

		<p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Minutes of the Mortality Interdisciplinary Review Committee 2. Six Special Investigator death reports and other material related to four of these deaths 3. Twelve investigation reports completed by the Office of the Special Investigator 4. Minutes of the Incident Review Committee 5. Minutes of the Risk Reduction Oversight Committee 6. AD (draft): Incident Review Committee 7. Rights affidavits in 14 individuals' records 8. Training, mandatory reporting forms and background clearance for 12 staff members 9. Four HQ completed briefing forms and the tracking sheet for HQ briefs to ensure completion 10. AD 020: Incident Management Review Committee <p><u>Attended:</u> Incident Review Committee meeting on July 23, 2008</p>
I.1.a	Each State hospital shall review, revise, as appropriate, and implement incident management policies, procedures and practices that are consistent with generally accepted professional standards of care. Such policies, procedures and practices shall require:	<p>Compliance: Partial.</p>
I.1.a.i	that each State hospital not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of individuals;	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: Provide each staff member attending training a copy of the AD. Add a statement at the head of the sign-in roster that includes an acknowledgment of receipt of the AD at both the orientation training and the annual refresher training.</p>

		<p>Findings: The facility provided evidence that this recommendation was implemented.</p> <p>Other findings: Although the revised SIR definitions are taught at annual abuse/neglect (A/N) training and at orientation, staff members are not consistently using them when they enter A/N allegations into the WaRMSS data system. May data showed 35 allegations of A/N. Further review by Standards Compliance revealed that 29 of the incidents were not related to staff misconduct, but rather were incidents of peer aggression. The Standards Compliance Director met with the Enhancement Plan Coordinator and the Chair of Psychology Special Services. Recognizing that the statewide incident management system will eliminate the problem, the three developed an interim plan, the major elements of which include the following:</p> <ul style="list-style-type: none">• Upon receipt of an SIR regarding A/N, SC will check WaRMSS Quick Hits to ensure it is coded accurately.• Members of the Psychology Special Services Committee (PSSC) will provide training to senior psychologists on using Quick Hits. When an individual is identified by PSSC as high risk, Standards Compliance will provide SIR data to augment the Quick Hits data. This will provide a more complete profile of the individual.• Standards Compliance will produce a monthly report from WaRMSS on A/N, using the narrative field to ensure accuracy in describing the incident type.• Discussions will continue and will include Incident Review Committee members, WRP trainers and Program Representatives to identify other process improvements to assist with analysis of individual cases and patterns and trends.
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Section I: Protection from Harm

		<p>Current recommendation: Implement the plan described above to mitigate the likelihood of taking action based on false WaRMSS data regarding allegations of abuse.</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, including school settings;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: Continue to review SIRs to ensure their accuracy. Designate additional "types" for any incident when the investigation identifies additional events that would constitute an incident not identified in the original SIR.</p> <p>Findings: The facility reported that Standards Compliance is ensuring the accuracy of the classification of incident type by a daily review of the SIRs. The incident type in the investigations reviewed was correctly identified except in the allegation of sexual abuse that was labeled non-consensual contact (victim=ST, date of incident 4/11/08).</p> <p>Current recommendation: Continue current practice.</p>
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 1, January 2008: Train hospital police on the new information management system and ensure its implementation as quickly as possible.</p> <p>Findings: The facility provided training records to support its report that on February 15, 2008, all hospital police officers and the five staff of the Office of Special Investigations received training on the Record Management System (RMS). The RMS is now in use at the facility.</p>

		<p>A review of 12 incident investigations found that the face sheets produced by the Incident Management System were not accurate in two instances. The date of the alleged sexual abuse of VH actually occurred on 4/4/08, not 4/14/08 as on the face sheet. The alleged physical abuse of RR occurred on 4/25, 4/28 and 4/29 rather than 4/29 as reported on the face sheet.</p> <p>Recommendation 2, January 2008: Continue current practice of addressing the reassignment of the staff member in the investigation report.</p> <p>Findings: The issue of reassignment of the named staff member was addressed in a minority of investigations reviewed. These included the investigation of the allegation of sexual abuse made by ST on 4/16/08 and the allegation of verbal abuse of RS made on 5/8/08.</p> <p>Other findings: With the exception of the investigations noted above, the investigation reports reviewed did not address the decision to remove a named staff member from contact with individuals or provide a rationale for not removing the staff member. This facility and the others are working on developing criteria for determining whether an allegation is credible. A credible allegation would require reassignment of the named staff member.</p> <p>Current recommendations:</p> <ol style="list-style-type: none">1. Provide a statement in the investigation of allegations of A/N that addresses whether the named staff member was reassigned and a rationale for the decision.2. Seek legal counsel, if necessary, in developing a definition of and criteria for determining whether an allegation is credible.
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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 recommendation:</p> <p>Recommendation, January 2008: Continue to review the training records to ensure that employees attend the annual abuse/neglect training near their birthday month.</p> <p>Findings: The facility provided documentation that 649 staff members had received training regarding A/N and had received a copy of AD 755 during 2008.</p> <p>Other findings: Review of the A/N training records for 12 staff members whose names appeared in various documents reviewed revealed that eight of the 12 had not completed the training within the last year.</p> <table border="1" data-bbox="991 821 1883 1357"> <thead> <tr> <th>Staff Initial</th> <th>Date of Hire</th> <th>Criminal Clearance</th> <th>Mandatory Reporter Signed</th> <th>Most recent A/N training</th> </tr> </thead> <tbody> <tr> <td>_P</td> <td>7/1/03</td> <td>6/27/03</td> <td>7/1/03</td> <td>9/20/05</td> </tr> <tr> <td>_N</td> <td>7/18/05</td> <td>6/8/05</td> <td>7/18/05</td> <td>1/30/07</td> </tr> <tr> <td>_I</td> <td>5/16/84</td> <td>5/16/84</td> <td>12/28/89</td> <td>11/21/07</td> </tr> <tr> <td>_E</td> <td>4/10/06</td> <td>3/8/06</td> <td>4/10/06</td> <td>4/19/06</td> </tr> <tr> <td>_K</td> <td>2/17/04</td> <td>1/21/04</td> <td>2/17/04</td> <td>8/13/07</td> </tr> <tr> <td>_W</td> <td>1/3/06</td> <td>1/5/06</td> <td>1/3/06</td> <td>11/22/05</td> </tr> <tr> <td>_E</td> <td>6/1/00</td> <td>3/9/00</td> <td>6/1/00</td> <td>4/25/08</td> </tr> <tr> <td>_W</td> <td>1/1/03</td> <td>9/30/02</td> <td>1/2/03</td> <td>3/10/03</td> </tr> <tr> <td>_P</td> <td>7/1/99</td> <td>6/16/99</td> <td>7/1/99</td> <td>7/25/02</td> </tr> <tr> <td>_R</td> <td>11/8/06</td> <td>9/12/06</td> <td>11/8/06</td> <td>11/20/06</td> </tr> <tr> <td>_O</td> <td>10/1/07</td> <td>6/15/07</td> <td>10/1/07</td> <td>10/3/07</td> </tr> <tr> <td>_M</td> <td>10/3/05</td> <td>9/2/05</td> <td>10/3/05</td> <td>1/19/06</td> </tr> </tbody> </table> <p><i>Only last initial is provided to protect confidentiality.</i></p>	Staff Initial	Date of Hire	Criminal Clearance	Mandatory Reporter Signed	Most recent A/N training	_P	7/1/03	6/27/03	7/1/03	9/20/05	_N	7/18/05	6/8/05	7/18/05	1/30/07	_I	5/16/84	5/16/84	12/28/89	11/21/07	_E	4/10/06	3/8/06	4/10/06	4/19/06	_K	2/17/04	1/21/04	2/17/04	8/13/07	_W	1/3/06	1/5/06	1/3/06	11/22/05	_E	6/1/00	3/9/00	6/1/00	4/25/08	_W	1/1/03	9/30/02	1/2/03	3/10/03	_P	7/1/99	6/16/99	7/1/99	7/25/02	_R	11/8/06	9/12/06	11/8/06	11/20/06	_O	10/1/07	6/15/07	10/1/07	10/3/07	_M	10/3/05	9/2/05	10/3/05	1/19/06
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_P	7/1/99	6/16/99	7/1/99	7/25/02																																																															
_R	11/8/06	9/12/06	11/8/06	11/20/06																																																															
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		<p>Despite the annual A/N training, staff are not using the revised SIR definitions when entering A/N incidents into WaRMSS.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Take necessary action to ensure that staff members complete annual A/N training. 2. Ensure that the annual A/N training stresses the need to use the revised definitions in coding A/N allegations in WaRMSS.
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 recommendation:</p> <p>Recommendation, January 2008: Continue current practice in ensuring that new employees sign the mandated reporter form when they are hired.</p> <p>Findings: A log is kept of new hires and the date on which each new hire signed the mandatory reporting form. The facility reports 100% compliance with the requirement that employees sign the mandatory reporter form when they are hired. This is consistent with this monitor's finding that 11 of the 12 staff reviewed signed the form on the date they were hired. The twelfth staff member was hired before the form was required. He signed it later.</p> <p>Other findings: Discussion at the Incident Review Committee revealed that there is no expectation that all failures to report allegations of A/N in a timely manner will be met with some corrective action.</p> <p>In the investigation of the allegation of physical abuse made by MS (5/4/08), MS alleged that he was assaulted (kicked multiple times by another individual) and despite requests, staff did not report the</p>

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		<p>incident. No investigation work was done to identify the staff and interview them. [The allegation was made several months after the fact, so this may have factored into the conduct of this investigation.]</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. To avoid the appearance that measures taken in response to the failure to report allegations of A/N in a timely manner are arbitrary or capricious, establish a minimum response that will be applied in all cases where more serious action is not required. 2. Ensure that investigations pursue allegations that incidents were not reported in a timely manner.
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 recommendation:</p> <p>Recommendation, January 2008: Continue current practice.</p> <p>Findings: This monitor found no evidence that individuals did not know how to report suspected A/N. Forms for making a complaint to the PRA were available on the units toured.</p> <p>Current recommendation: Continue current practice.</p>
I.1.a.vii	<p>posting in each living unit and day program site a brief and easily understood statement of individuals' rights, including information about how to pursue such rights and how to report violations of such rights;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: Continue current practice.</p> <p>Findings: Each unit toured had a poster on the wall explaining the rights of individuals and providing the name and telephone number of the</p>

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		<p>Patients Rights Advocate.</p> <p>Other findings: This monitor found a current signed affidavit by the individual that he/she understood his/her rights in the clinical records of nine of 14 individuals:</p> <table border="1" data-bbox="991 451 1497 1026"> <thead> <tr> <th>Individual</th> <th>Most recent signing</th> </tr> </thead> <tbody> <tr><td>JG</td><td>9/14/07</td></tr> <tr><td>EM</td><td>1/16/08</td></tr> <tr><td>RW</td><td>12/5/07</td></tr> <tr><td>JY</td><td>4/25/07</td></tr> <tr><td>AC</td><td>Legal chart not located</td></tr> <tr><td>MG</td><td>6/4/07</td></tr> <tr><td>WM</td><td>4/1/08</td></tr> <tr><td>DT</td><td>1/15/08</td></tr> <tr><td>WL</td><td>2/8/07</td></tr> <tr><td>AR</td><td>4/12/08</td></tr> <tr><td>LB</td><td>12/28/07</td></tr> <tr><td>LF</td><td>5/1/08</td></tr> <tr><td>MS</td><td>5/1/08</td></tr> <tr><td>MD</td><td>1/15/08</td></tr> </tbody> </table> <p>Current recommendation: Ensure that rights and responsibilities are discussed with individuals during their annual WRPCs and ask that they sign the affidavit attesting that they understand their rights.</p>	Individual	Most recent signing	JG	9/14/07	EM	1/16/08	RW	12/5/07	JY	4/25/07	AC	Legal chart not located	MG	6/4/07	WM	4/1/08	DT	1/15/08	WL	2/8/07	AR	4/12/08	LB	12/28/07	LF	5/1/08	MS	5/1/08	MD	1/15/08
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MD	1/15/08																															
I.1.a.viii	procedures for referring, as appropriate, allegations of abuse or neglect to law enforcement; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: Continue current practice.</p>																														

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		<p>Findings: Members of the hospital police force are first on the scene of any incident alleging A/N and would recognize a violation of criminal law. This monitor saw no evidence that incidents requiring referral to outside law enforcement were not recognized and dealt with appropriately.</p> <p>Current recommendation: Continue current practice.</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 not limited to reprimands, discipline, harassment, threats or censure, except for appropriate counseling, reprimands or discipline because of an employee's failure to report an incident in an appropriate or timely manner.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: Maintain vigilance in looking for instances when there may be reason to suspect that an individual or a staff member might be the victim of retaliatory threats or actions.</p> <p>Findings: This monitor found no instances in the investigation reports reviewed in which there was reason to believe that an individual or a staff member might be the victim of retaliatory threats or actions.</p> <p>Current recommendation: Encourage the IRC, as it expands its duties, to be mindful of the possibility that a staff member or individual might be the victim of retaliatory threats or actions.</p>
I.1.b	<p>Each State hospital shall review, revise, as appropriate, and implement policies and procedures to ensure the timely and thorough performance of investigations, consistent with generally accepted professional standards of care. Such policies and</p>	<p>Compliance: Partial.</p>

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	<p>procedures shall:</p>	
<p>I.1.b.i</p>	<p>require investigations of all deaths, as well as allegations of abuse, neglect, serious injury, and theft. The investigations shall be conducted by qualified investigator(s) who have no reporting obligations to the program or elements of the facility associated with the allegation and have expertise in conducting investigations and working with persons with mental disorders;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, January 2008: Continue Incident Management training until all relevant persons are trained.</p> <p>Findings: The facility reports that approximately half of the program and clinical staff have received Incident Management training. The second and third shift staff members will be trained using the videotape of this training.</p> <p>Recommendation 2, January 2008: Remove the expansive conclusion from the Final Death Reports.</p> <p>Findings: In a memo dated April 17, 2008, the Supervising Special Investigator instructed the hospital police to cease using the expansive conclusion from the Final Death Reports. The offending statement was not present in the death investigation reports reviewed during this tour.</p> <p>Recommendation 3, January 2008: Implement the death review process described in Special Order 205.04, adopted on January 15, 2008 and review any death case using these procedures that was open as of February 1, 2008.</p> <p>Findings: The facility has taken steps to implement the death review process envisioned in Special Order 205.04 with the convening of a Mortality Interdisciplinary Review Committee to review each death. The Committee has standardized procedures that identify the documents that the Committee will review. The Committee has been successful in</p>

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		<p>identifying areas in which corrective actions would improve the delivery of services, such as in the deaths of AV, JH, FB, and JL. These actions are documented on a grid with the name of the responsible staff member and a due date. There is, however, no documentation of whether the tasks have been completed and no mechanism for evaluating the effectiveness of the measures. See also I.1.d.vi.</p> <p>A physician recently declined to provide a review of the death of DW, on the advice of counsel.</p> <p>Recommendation 4, January 2008: Adopt a consistent form for the First Level Death Review.</p> <p>Findings: This finding has been implemented and the First Level Death Reviews reviewed all used the same format.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to refine the review of deaths, including procedures for ensuring the effective implementation of corrective measures identified by the Mortality Interdisciplinary Review Committee. 2. DMH should continue to address the legal questions raised by physicians and other licensed clinicians required to cooperate in the review of deaths.
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 recommendation:</p> <p>Recommendation, January 2008: Complete Incident Management Training according to the proposed schedule which anticipates that all staff and officers will be trained by the end of April 2008.</p>

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		<p>Findings: See I.1.b.i.</p> <p>Current recommendation: Continue with plans to provide Incident Management training to the remaining program and clinical staff.</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 1, January 2008: Continue to review the accuracy of the monitoring forms.</p> <p>Findings: Some of this responsibility will be shared with the IRC when it begins to review the entire investigation summary. This will add an objective eye in monitoring performance of investigations as identified in the EP.</p> <p>Recommendation 2, January 2008: When photos are taken and are not included in the investigation report file, document in the report where they are stored.</p> <p>Findings: Although several investigations reviewed referenced photos having been taken, this monitor did not find documentation in the investigation report that stated where photos were stored.</p> <p>Other findings: The investigation report on the possession of a controlled substance by a staff member (4/16/08) revealed conscientious safeguarding of the physical evidence.</p> <p>Current recommendation: When photos and other physical evidence are taken during an</p>

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		investigation, reference where they are stored.
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 recommendation:</p> <p>Recommendation, January 2008: Review the investigations for completeness and to ensure that conclusions rest on solid findings. This responsibility is shared by the supervising officer and by the Incident Review Committee.</p> <p>Findings: The Incident Review Committee has available to it the investigation reports of the cases it might choose to review. As of yet, the IRC has not reviewed investigations for completeness. It has reviewed only a short summary of the investigation. With some exceptions, the IRC has focused primarily on a small number of sustained cases.</p> <p>The facility stated in its progress report that the Supervising Special Investigator began reviewing all investigations for completeness and to ensure that the conclusions rest on solid findings on March 1, 2008.</p> <p>Other findings: In an interview, several members of the IRC indicated that the committee has spent much of its meeting time determining process—what and how to review incidents.</p> <p>Current recommendation: Expand the work of the IRC to include a review of the entire investigation file of all incidents of alleged A/N, serious injuries and deaths, so that it can look critically at the quality of the investigation and the rationale for the determination and identify any recommendations for corrective, preventive actions. This review should not be limited to sustained cases.</p>

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<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 1, January 2008: Proceed in changing procedures for the receipt of incident information by the hospital police.</p> <p>Findings: Effective February 1, 2008, new procedures were put in place that have reduced the time lag between the incident occurrence and the assignment of a Special Investigator in some cases. This procedure identifies the dispatcher as the officer responsible for receiving all SOC 341 forms and reports of abuse and neglect. The Dispatch Center assigns a tracking number and sends a hospital police officer to conduct an initial investigation. This initial investigation report is to be completed by the end of the officer's shift and then forwarded to the Office of Special Investigations (OSI) when appropriate.</p> <p>In the investigations reviewed, these initial interviews were completed on the day the incident was reported. However, in a number of the cases reviewed, there was a substantial delay between the report of the incident and the first interview conducted by the Special Investigator as described below:</p> <ul style="list-style-type: none"> • The 2/14/08 allegation of verbal abuse was referred to the OSI on 3/9/08. • The victim in the 3/18/08 allegation of sexual abuse was interviewed by the OSI on 4/3/08. • The victim in a 2/23/08 allegation of physical abuse was interviewed by OSI on 4/1/08. • Thirteen days lapsed between the reporting of the 5/8/08 allegation of physical abuse and the interview of the victim by OSI on 5/21/08. • Eighteen days lapsed between the reporting of the 4/28/08
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		<p>allegation of sexual abuse and the 5/15/08 interview by OSI.</p> <p>Recommendation 2, January 2008: Train officers and begin using the new hospital police information system as quickly as possible.</p> <p>Findings: The Record Management System was used to produce the face sheet of each of the investigation summaries reviewed. The substantial majority of the face sheets were accurate; those with inaccuracies are described in I.1.a.iii.</p> <p>Recommendation 3, January 2008: Continue to maintain the hospital police and Special Investigator logs until the new hospital police incident information system is in use.</p> <p>Findings: The Office of Special Investigations continues to maintain its log, which tracks the case number, allegation, unit, named staff person or individual aggressor, victim, date of the incident report, name of the investigator assigned, date completed and disposition.</p> <p>Current recommendation: Reduce the amount of time between the reporting of the incident and the first interviews by the OSI.</p>
I.1.b.iv. 2	investigations be completed within 30 business days of the incident being reported, except that investigations where material evidence is unavailable to the investigator, despite best efforts, may be completed within 5 business days of its availability;	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: Monitor the progress of investigations to ensure they meet the timelines in the Enhancement Plan.</p>

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		<p>Findings: The facility reports that 83% of the OSI investigations completed between 1/1/08 and 5/31/08 were completed within 30 business days. This is consistent with this monitor's findings. Ten of 12 investigations reviewed were completed within 30 business days of the report of the incident.</p> <table border="1" data-bbox="991 451 1843 987"> <thead> <tr> <th>Type</th> <th>Date reported</th> <th>Date completed</th> </tr> </thead> <tbody> <tr> <td>Verbal abuse allegation</td> <td>2/14/08</td> <td>5/1/08</td> </tr> <tr> <td>Sexual abuse allegation</td> <td>3/18/08</td> <td>4/11/08</td> </tr> <tr> <td>Physical abuse allegation</td> <td>2/23/08</td> <td>4/8/08</td> </tr> <tr> <td>Sexual abuse allegation</td> <td>4/14/08</td> <td>5/7/08</td> </tr> <tr> <td>Sexual abuse allegation</td> <td>4/16/08</td> <td>5/12/08</td> </tr> <tr> <td>Physical abuse allegation</td> <td>4/14/08</td> <td>5/12/08</td> </tr> <tr> <td>Verbal and physical abuse allegation</td> <td>4/29/08</td> <td>6/3/08</td> </tr> <tr> <td>Physical abuse allegation</td> <td>5/8/08</td> <td>6/12/08</td> </tr> <tr> <td>Death</td> <td>3/18/08</td> <td>3/28/08</td> </tr> <tr> <td>Sexual abuse allegation</td> <td>4/28/08</td> <td>5/19/08</td> </tr> <tr> <td>Psychological abuse allegation</td> <td>3/18/08</td> <td>5/5/08</td> </tr> <tr> <td>Death</td> <td>5/7/08</td> <td>5/19/08</td> </tr> </tbody> </table> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue current practice of completing OSI investigations within 30 business days. 2. Ensure that initial OSI interviews occur as near to the date on which the incident is reported as possible. 	Type	Date reported	Date completed	Verbal abuse allegation	2/14/08	5/1/08	Sexual abuse allegation	3/18/08	4/11/08	Physical abuse allegation	2/23/08	4/8/08	Sexual abuse allegation	4/14/08	5/7/08	Sexual abuse allegation	4/16/08	5/12/08	Physical abuse allegation	4/14/08	5/12/08	Verbal and physical abuse allegation	4/29/08	6/3/08	Physical abuse allegation	5/8/08	6/12/08	Death	3/18/08	3/28/08	Sexual abuse allegation	4/28/08	5/19/08	Psychological abuse allegation	3/18/08	5/5/08	Death	5/7/08	5/19/08
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I.1.b.iv. 3	each investigation result in a written report, including a summary of the investigation, findings and, as appropriate, recommendations for corrective action. The report's contents	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, January 2008: Revise the Function statement in the draft AD to include the review of</p>																																							

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	<p>shall be sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly and separately:</p>	<p>the investigation reports for serious incidents.</p> <p>Findings: AD 020, Incident Management Review Committee, effective June 26, 2008 requires the Supervising Special Investigator to provide to the committee a "written report including a summary of the investigation findings...[that] will include findings related to the substantiation of the allegations as well as findings about staff adherence to programmatic requirements." This does not address two critical issues: the IRC needs to review the entire investigation report (not simply a summary) of all serious incidents and to review them regardless of whether substantiated or unfounded.</p> <p>Recommendation 2, January 2008: Provide the members of the Committee a copy of the investigation reports to be reviewed during the week prior to the meeting date, so that the members will be prepared to discuss them.</p> <p>Findings: This recommendation was not implemented. IRC members were reviewing only a short summary of sustained investigations.</p> <p>Recommendation 3, January 2008: Ensure that reports and interviews are accurately dated.</p> <p>Findings: All incident investigations and interviews were accurately dated with the exception of the date of the alleged sexual abuse of VH, which actually occurred on 4/4/08, not 4/14/08 as on the face sheet and the date of the alleged physical abuse of RR that occurred on 4/25, 4/28 and 4/29, rather than 4/29 as reported on the face sheet.</p>
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		<p>Current recommendation: Revise AD 020 to clarify that the IRC is to receive a copy of the complete investigation report for serious incidents, regardless of whether they are unfounded or substantiated.</p>
I.1.b.iv. 3(i)	each allegation of wrongdoing investigated;	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: Continue current practice of specifically addressing each allegation of wrongdoing.</p> <p>Findings: The investigations reviewed identified and addressed the allegation of wrongdoing. However, in one incident of alleged abuse (2/23/08), the synopsis of the circumstances of the incident describes the individual's problem behaviors, but gives no description of the alleged abuse.</p> <p>Current recommendation: Continue current practice of specifically addressing each allegation of wrongdoing and ensure the synopsis addresses the allegation under investigation.</p>
I.1.b.iv. 3(ii)	the name(s) of all witnesses;	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: Document attempts to find witnesses other than those identified on the SIR form.</p> <p>Findings: The facility reports that 31 interviewees were asked if there were additional witnesses to incidents. It is impossible to determine if this finding is consistent with the monitor's findings.</p>

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		<p>Efforts to find and/or interview witnesses to an incident were inadequate in six investigations as discussed below:</p> <ul style="list-style-type: none">• An allegation of verbal abuse (2/14/08) stemmed from an incident that occurred as individuals lined up to go out into the courtyard. Two witnesses were identified—one individual and one nurse. No other individuals who were in line were questioned about whether they saw or heard any portion of the incident.• A restraint was the scene of the allegation of physical abuse that occurred on 4/13/08. The investigator did not interview one of the two staff members who were directly involved in the restraint and holding the individual's arms.• The investigator of an allegation of verbal abuse (5/8/08) that occurred during a nature walk did not interview the individuals participating with the exception of one individual who was identified as a witness.• In the investigation of the death of FB, an individual alleged that one staff member to whom he reported FB's state took no immediate action; the investigator did not interview this named staff member.• The physical abuse allegation made on 2/23/08 stemmed from the accusation made by the individual (GJ) that the named staff member took food off the meal trays meant for individuals and ate the food himself. The investigator interviewed one individual who confirmed that the named staff member took food off individuals' trays and one staff member who was not asked about the practice. No other individuals were asked about the alleged stealing of food by the named staff member.• In the investigation of the allegation of sexual abuse by RW on 3/18/08, the victim stated that while being assessed for release from restraints, she made the allegation to a named staff person. This staff person was not interviewed.
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		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that efforts are made to identify persons who may have seen or heard an incident. 2. Ensure that all parties to an incident are interviewed.
I.1.b.iv.3(iii)	the name(s) of all alleged victims and perpetrators;	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: Continue current practice.</p> <p>Findings: All investigations reviewed clearly stated the names of 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 recommendation:</p> <p>Recommendation, January 2008: Avoid phone interviews unless there is no reasonable alternative. When phone interviews are conducted, document in the report why this was necessary.</p> <p>Findings: There were no phone interviews in the investigation reports reviewed. The Supervising Special Investigator advised the investigators to avoid phone interviews if possible.</p> <p>Other findings: See findings in I.1.b.iv.3(ii).</p>

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		<p>Current recommendation: See recommendations in I.1.b.iv.3(ii).</p>
I.1.b.iv.3(v)	a summary of each interview;	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: Implement proposed changes in the process for notifying the hospital police of an incident to permit the timely assignment of incidents for investigation and timely interviews.</p> <p>Findings: See findings in I.1.b.iv.1 regarding delays in initial OSI interviews of the individual alleging abuse or neglect. See also I.1.b.iv.3(ix) for a description of an interview that should not have occurred under the conditions that it did.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Take measures to ensure that interviews completed by Special Investigators are conducted as quickly as possible after the incident is reported. 2. Avoid interviewing individuals and staff members in circumstances that jeopardize their ability to answer questions knowingly and freely.
I.1.b.iv.3(vi)	a list of all documents reviewed during the investigation;	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: Consult WRPs, other documents, and clinicians as necessary during investigations.</p> <p>Findings: In the investigation of the allegation of physical abuse made by MS (5/4/08), the investigator noted that he reviewed the IDN notes back</p>

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		<p>to the date of the alleged occurrence in December 2007.</p> <p>Current recommendation: Continue current practice.</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 1, January 2008: Expedite the development and implementation of the Incident Management System.</p> <p>Findings: The work on Protection from Harm 1, the Incident Management System, is presently a priority with active information gathering and review of proposed screens.</p> <p>Recommendation 2, January 2008: Review the incident history of individuals and staff members involved in incidents investigated by the Office of the Special Investigator and note patterns of behavior.</p> <p>Findings: Compliance with this cell varied among the investigations reviewed. For example, the incident history of the named staff person was not reviewed in the investigation of the 4/4/08 allegation of sexual abuse made by VH. In contrast, the investigation of the sexual abuse allegation made by ST on 4/16/08 states that the hospital police have not had prior contact with either the victim or named staff member. In the investigation of the allegation of sexual abuse of GR on 4/27/08, the investigator documented the incident history of both the victim and the named staff member.</p>

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		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that the incident history of both the alleged victim and the named staff member is reviewed and documented. 2. Proceed with plans to put Protection from Harm 1 on line.
I.1.b.iv. 3(viii)	<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 recommendation:</p> <p>Recommendation, January 2008: Specifically cite the portion(s) of the SIR definition that the investigation addresses to assist in focusing the rationale for the determination.</p> <p>Findings: The incident investigations reviewed all cited the SIR definition of the misconduct under review with the exception of the allegation of sexual abuse that was labeled non-consensual contact (victim=ST, date of incident=4/11/08).</p> <p>Other findings: The finding of "not substantiated" in the incident involving ST and the sexual contact by a staff member that allegedly occurred on 4/11/08 is questionable. The investigator places great weight on the inconsistencies of the victim, nearly ignoring the other evidence, including the language choices of the named staff member. This investigation should be reviewed closely by the IRC.</p> <p>Current recommendation: IRC should review the investigation of alleged sexual abuse of ST on 4/11/08.</p>
I.1.b.iv. 3(ix)	<p>the investigator's reasons for his/her conclusions, including a summary indicating how potentially conflicting evidence was</p>	<p>Current findings on previous recommendation:</p>

	<p>reconciled; and</p>	<p>Recommendation, January 2008: Conduct second interviews when necessary in order to reconcile conflicting evidence.</p> <p>Findings: In the investigation of the allegation of sexual abuse made by VH on 4/14/08, the investigator conducted a second interview of the victim (after the first interview by the hospital police) while she was in five-point restraint. The report notes that the victim's speech was not clear and she could not speak in complete sentences. (Most likely she had been medicated, but the investigation did not address this.) The investigator asked her if the actions she alleged could have been a dream, to which she replied, "Uh, huh." This interview was inappropriate and placed the victim at considerable disadvantage. No information from this interview should be considered reliable.</p> <p>Other findings: Several investigations reviewed drew conclusions without attempts to reconcile conflicting evidence.</p> <ul style="list-style-type: none"> • In the investigation of the allegation of sexual abuse made on 3/18/08, the named staff person said that a Plant Operations staff member was in the room where the misconduct allegedly occurred. The Plant Operations staff member said he was in an adjacent room and did not see the incident, but heard the individual make the complaint. The conflicting evidence was not pursued and reconciled. • In the investigation of the allegation of physical abuse made on 2/23/08, the investigator made no attempt through additional interviews to determine whether the named staff persons took food from the individuals' meal trays. <p>Current recommendations: 1. Do not permit interviews of persons who are in restraint. Do not</p>
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		<p>permit interviews of persons whose reasoning and recall functions have been compromised by recently administered medications.</p> <p>2. Take measures to resolve conflicting information.</p>
I.1.b.iv. 4	<p>staff supervising investigations review the written report, together with any other relevant documentation, to ensure that the investigation is thorough and complete and that the report is accurate, complete, and coherent. Any deficiencies or areas of further inquiry in the investigation and/or report shall be addressed promptly. As necessary, staff responsible for investigations shall be provided with additional training and/or technical assistance to ensure the completion of investigations and investigation reports consistent with generally accepted professional standards of care.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: Look carefully for problems in the investigation and in the written report and correct them before investigation reports are finalized.</p> <p>Findings: In view of the findings reported in previous cells, there is evidence to conclude that closer review of incident investigations is required. While not impacting the determination, the special circumstances by which the named staff member in the allegation of verbal abuse of DT on 2/14/08 is variously referred to as both male and female (by use of pronouns—he/she, his/her) were not explained, leading the reader to conclude that the investigation was carelessly or callously done.</p> <p>Current recommendation: In exercising its expanded duties, the Incident Review Committee, in reviewing the quality of investigations, should consider the elements of a comprehensive investigation as outlined in the EP.</p>
I.1.c	<p>Each State Hospital shall ensure that whenever disciplinary or programmatic action is necessary to correct a situation or prevent reoccurrence, each State hospital shall implement such action promptly and thoroughly, and track and document such actions and the corresponding outcomes.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: Ensure the Incident Review Committee identifies programmatic corrective actions in individual incidents as well as addresses patterns and trends.</p>

		<p>Findings: The IRC has access to a tracking sheet that documents the recommendations from investigations completed by the OSI. However, since there is limited information on the tracking form related to the date on which the recommendation was made and the date the action was completed, it leaves guesswork in determining whether timely implementation is occurring. For example, the July 21, 2008 tracking form provides a report number of 08-01-009 for the first incident. This tells the reader that the incident occurred in January 2008. The description of the "action taken" reads that the responsible individual is in the process of "drafting a formal program policy for handling the mail, including torn mail." This suggests that the policy has been under development for six months. [The "action taken" also describes the present system for handling mail.]</p> <p>Other findings: The July 21, 2008 tracking sheet for OSI investigations reveals that for the months of March and April, each of the eight recommendations (March 3, April 5) have been completed. For the four recommendations made in May, two have yet to be implemented, one has been implemented, and the last has no action taken or planned to address the recommendation to provide CPR training to all of the Unit A-7 staff and the named physician.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Add information about the incident type, date of recommendation, date completed, and responsible staff person to the tracking log for OSI investigations. 2. Ensure the tracking sheet addresses all recommendations.
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I.1.d	Each State hospital shall have a system to allow the tracking and trending of investigation results. Trends shall be tracked by at least the following categories:	Compliance: Partial.
I.1.d.i	type of incident;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, January 2008: Standards Compliance Department, in discussion with the Incident Review Committee, determines which tracking and trending reports would be most useful to the Committee.</p> <p>Findings: The facility produced a report of Special Incidents by type for the period January—June 2008, calculated on 1000 patient days. Incidents of physical aggression far exceeded any other type of incident at 1.88/1000 patient days. The second highest, Medical/Health and Safety was more than three times less frequent at 0.47/1000 patient days.</p> <p>Recommendation 2, January 2008: Ensure that the minutes of the Review Committee document the review, discussion and recommendations related to the trending reports.</p> <p>Findings: This recommendation has been partially implemented. The IRC has reviewed the report on the location of incidents and will be taking further measures to understand the reasons behind the findings.</p> <p>Current recommendation: The IRC and other appropriate groups should continue to review pattern and trend reports on incidents.</p>

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I.1.d.ii	staff involved and staff present;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, January 2008: Implement the Incident Management system as quickly as possible.</p> <p>Findings: Work on the Protection from Harm 1 portion of WaRMSS is progressing.</p> <p>Recommendation 2, January 2008: Begin producing monthly tracking and trending reports for review by the Incident Review Committee.</p> <p>Findings: Review of data reports indicate that they have been produced for time periods ranging from two months to six months. See also the cells in this section describing particular types of reports produced.</p> <p>Current recommendation: Continue with plans to increase the number of reports produced and ensure their distribution to appropriate forums for review.</p>
I.1.d.iii	individuals directly and indirectly involved;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, January 2008: Develop reports on individuals and staff who appear frequently in incidents for review by the Incident Review Committee.</p> <p>Findings: This recommendation has not yet been implemented.</p> <p>Recommendation 2, January 2008: Include a review of the incident history of persons involved in</p>

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		<p>investigations in the investigation reports completed by the Office of Special Investigations.</p> <p>Findings: See I.1.b.iv.3(vii).</p> <p>Current recommendations: Develop reports for review by the Incident Review Committee on individuals and staff who appear frequently in incidents.</p>
I.1.d.iv	location of incident;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, January 2008: Continue development for the Incident Management System.</p> <p>Findings: Work on the Incident Management System (Protection from Harm 1) is progressing.</p> <p>Recommendation 2, January 2008: Identify those variables identified in the EP that would be most helpful to the facility and begin tracking them for review by the Incident Review Committee.</p> <p>Findings: See below.</p> <p>Other findings: NSH has produced a report identifying the number of incidents of aggressive acts toward staff resulting in major injury (January—April) by hospital unit. The A units ranked highest in these incidents with A-10, A-4 and A-1 leading.</p>

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		<p>The facility has produced a report of the location (on and off the units) of peer-to-peer aggressive acts (April–June) that identifies hallways as by far the most common site. The IRC will be looking more closely to determine if the incidents occur while individuals are waiting in line.</p> <p>Current recommendation: Implement the plan to have the IRC look closely at the location of incidents and identify measures that might be influencing the data. IRC minutes should reflect this work.</p>
I.1.d.v	date and time of incident;	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: Using the EP as a guide, provide the Incident Review Committee with trend and pattern reports for review, discussion and recommendations for corrective measures.</p> <p>Findings: NSH has produced a pattern report for Special Incidents from January–June 2008 that calculates the number of SIRs per 1000 patient days for weekdays. This report reveals only slight variability, with Friday having the highest number of incidents and Monday the lowest.</p> <p>The facility also produced a report on the time of day that incidents of aggression to peers occurred during the period January–April 2008. The report indicates that the highest concentration of Special Incidents occurred between 3:00 PM and 7:00 PM.</p> <p>Current recommendation: Provide the information on location, day and time of incidents to the appropriate committees for review and action.</p>

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<p>I.1.d.vi</p>	<p>cause(s) of incident; and</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, January 2008: Diligently complete sections IV (Analysis, which includes contributing factors), V and VI of the briefing form within 90 days of the incident.</p> <p>Findings: Section IV of one of four completed briefing forms reviewed did not identify contributing factors, but rather reiterated the actions taken after the incident occurred. The briefing form related to the sexual assault of a staff member on 4/6/08 and stated that staff responded to the alert, hospital police arrived, the assailant was put into five-point restraint and later taken to jail.</p> <p>Recommendation 2, January 2008: Monitor the completion of the briefing forms.</p> <p>Findings: Implementation of this recommendation needs to be ongoing, with staff reviewing the briefs and returning them for correction when they fail to address the various sections appropriately.</p> <p>Recommendation 3, January 2008: Produce a report of contributing factors identified on Headquarters Reportable Brief forms for review by the Incident Review Committee and any other appropriate bodies.</p> <p>Findings: This recommendation cannot be implemented until the Analysis sections of the HQ briefs are accurately completed.</p> <p>Other findings: The facility has 60 business days to complete HQ Briefs. NSH</p>
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		<p>reported that seven of the nine briefs from March and April incidents have been completed and finalized. None of the 11 briefs for May incidents have been finalized.</p> <p>The HQ brief related to the death of HJ cited a recommendation that all staff on the unit receive training in AD 676 (Routine Monitoring of Individuals). Review of this training record indicated that all nursing and psych tech staff received this training. The clinical staff did not attend.</p> <p>The HQ brief related to the death of DW contained a recommendation that a survey be conducted to identify day halls that cannot be monitored from outside the room when the door is closed. This survey was completed and identified all of the rooms on Program 2 except one and several others on other units.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Complete HQ briefs in a timely manner. 2. Review the implementation of corrective measures on at least a sample basis.
I.1.d.vii	outcome of investigation.	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: Ensure that both repeat victims and aggressors are identified and an appropriate response is forthcoming. Spot-check implementation of these measures.</p> <p>Findings: Repeat victims have not yet been identified and protective measures taken.</p>

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		<p>Other findings: Review of the Special Investigations Case log for the period January-July 23, 2008 indicates that of the 80 investigations undertaken, nine were sustained in part or in whole. The majority of these sustained cases involved staff misconduct other than abuse or neglect. Of the 32 investigations of abuse/neglect closed in that time period, one allegation of verbal abuse was founded; the remainder were either unfounded or not sustained.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Include a thoughtful weighing of the evidence (to determine if the preponderance standard has been reached) when investigations are reviewed by the Incident Review Committee. 2. Ensure that both repeat victims and aggressors are identified and an appropriate response is forthcoming. Spot-check implementation of these measures.
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 recommendation:</p> <p>Recommendation, January 2008: Provide guidelines that direct the reassignment of staff under specific conditions to ensure uniform application.</p> <p>Findings: This recommendation has not yet been implemented. The facility reports that beginning in June, a committee will review the definition of a "credible" allegation for statewide use.</p> <p>Other findings: See also the table in I.1.a.iv. The criminal background checks for all 12 staff members reviewed had cleared prior to, on, or near the date of hire.</p>

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		<p>Compliance: Partial.</p> <p>Current recommendation: Develop guidelines that direct the reassignment of staff when allegations of misconduct have been made.</p>
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2. Performance Improvement		
I.2	Each State hospital shall develop, revise as appropriate, and implement performance improvement mechanisms that enable it to comply fully with this Plan, to detect timely and adequately problems with the provision of protections, treatment, rehabilitation, services and supports, and to ensure that appropriate corrective steps are implemented. Each State hospital shall establish a risk management process to improve the identification of individuals at risk and the provision of timely interventions and other corrective actions commensurate with the level of risk. The performance improvement mechanisms shall be consistent with generally accepted professional standards of care and shall include:	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. C. Black, Director of Standards Compliance 2. D. Chupinski, SSA, Standards Compliance 3. H. Towney, SSA, Standards Compliance 4. K. Patterson, PhD, Chair, Psychology Special Services Committee 5. K. Cooper, PsyD, Enhancement Plan Coordinator 6. P. Tyler, MD, Acting Medical Director <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Minutes of the Risk Reduction Oversight Committee 2. Draft policies governing the Psychology Special Services Committee, Medical Key Indicator Committee, Psychiatric Key Indicator Committee, and the Incident Review Committee 3. Minutes of the committees listed above. 4. Graphed data on aggression and restraint and seclusion use. 5. Action tables depicting the expected response by staff title to several types of incidents.
I.2.a	Mechanisms for the proper and timely identification of high-risk situations of an immediate nature as well as long-term systemic problems. These mechanisms shall include, but not be limited to:	<p>Compliance: Partial.</p>
I.2.a.i	data collection tools and centralized databases to capture and provide information on various categories of high-risk situations;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, January 2008: Clarify that the one-to-one meetings in response to restraint and seclusion triggers should be documented and spot-check to ensure compliance.</p>

		<p>Findings: The facility's response to this recommendation implies that the Psychology Special Services Committee would address this issue as it reviews the WRPT's response when an individual has reached a restraint/seclusion trigger.</p> <p>Recommendation 2, January 2008: Continue the development of the hierarchy of interventions in response to triggers. Require WRPTs to indicate the actions taken, as envisioned by AD 801.</p> <p>Findings: The development of a hierarchy of interventions is proceeding on a statewide basis, guaranteeing uniformity across the facilities. The facility's Risk Reduction Oversight Committee has identified the need for feedback from the WRPTs and has decided to begin collecting this data from teams in response to suicide attempts and enhanced supervision initially.</p> <p>Recommendation 3, January 2008: Spot-check the implementation of actions indicated by the WRPTs in response to triggers.</p> <p>Findings: This recommendation will not be implemented until the hierarchy of interventions is developed.</p> <p>Recommendation 4, January 2008: Ensure that actions are taken to protect individuals who are repeat victims of aggression by peers.</p> <p>Findings: This recommendation has not yet been implemented.</p>
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		<p>Other findings: Facility data indicates that the use of restraint and seclusion as measured by total combined hours has declined since January 2008, due in large measure to a reduction in the use of seclusion. Restraint use as measured in hours has remained fairly stable. Information on the use of restraint and seclusion is broken down by program.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Expedite to the degree possible the development of a hierarchy of interventions to be used by all of the facilities as the foundation of their Risk Management Systems. 2. Implement plans to have teams report the interventions put in place for individuals who have reached an enhanced supervision or suicide attempt trigger.
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, January 2008: Finalize and disseminate the hierarchy of interventions and develop a feedback loop to the Clinical Administrator or Standards Compliance for WRPT responses.</p> <p>Findings: See findings above.</p> <p>Recommendation 2, January 2008: Review and revise the hierarchy of interventions for alleged abuse and neglect.</p> <p>Findings: A table was developed which designates the action response of each staff member/discipline when an allegation of abuse is made. This table</p>

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		<p>does not include the review by the Incident Review Committee. The hierarchy of interventions will be developed for use by the all facilities and will conform to the Protection from Harm Special Order presently under development.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Include the review of the investigation by the IRC in the table. 2. Proceed with the development and implementation of the Protection from Harm Special Order.
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 1, January 2008: Implement any outstanding recommendations from the ACT#4 study of aggression.</p> <p>Findings: The ACT has been reformed into five different subcommittees whose work is reported to the Risk Reduction Oversight Committee. In response to aggression with very serious consequences that occurred in this and other facilities, NSH initiated Violence Reduction Efforts (per memo to C. Radavsky, 4/10/08). This outlines 17 immediate and planned actions.</p> <p>Recommendation 2, January 2008: Identify individuals who are repeat victims and ensure that measures are taken to protect them.</p> <p>Findings: At present, repeat victims have not been identified facility-wide nor corrective actions taken.</p>

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		<p>Other findings: In addition to the data on restraint and seclusion, the facility has produced graphical data on aggression to staff and unique aggressive acts by program.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Identify individuals who are repeat victims and ensure that measures are taken to protect them. 2. Ensure implementation of the violence abatement steps outlined in the April 2008 memo to C. Radavsky.
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 recommendation:</p> <p>Recommendation, January 2008: Continue work on reducing the use of enhanced supervision while providing appropriate interventions.</p> <p>Findings: The Risk Reduction Oversight Committee has addressed the task of reducing the number of individuals requiring enhanced supervision. Presently, only persons who have attempted suicide or for whom the Medical Director has given approval are placed on enhanced supervision.</p> <p>Other findings: The Risk Reduction Oversight Committee drafted a new enhanced supervision policy, which appeared to have resulted in a substantial reduction in the use of this intervention. However, the facility's key indicator data suggested an initial decline in April 2008 followed by a</p>

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		<p>steady increase in the use of 1:1 observation. These data might suggest that the effectiveness of this policy is not yet clear.</p> <p>The Psychology Special Services Committee will review individually the persons on the enhanced supervision list to ensure that other interventions are being successfully implemented.</p> <p>The Psychiatry Key Indicator Committee developed a hierarchy of interventions addressing combined pharmacotherapy, ECT, polydipsia, suicides and PRN and Stat medications.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue sharing information among the subcommittees to coordinate responses. 2. Continue work on the statewide hierarchy of interventions in response to triggers.
I.2.b.ii	timely corrective actions by teams and/or disciplines to address systemic trends and patterns;	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: The Incident Review Committee and the Risk Reduction Oversight Review Committee should develop procedures to facilitate the sharing of information and identification of opportunities for cooperation.</p> <p>Findings: There is evidence in the review of the minutes of the various committees and the Risk Reduction Oversight Committee that the committees are sharing information. For example, the Psychiatric Key Indicator Committee raised concern about the high use of benzodiazepines, particularly with individuals with substance abuse histories. That committee, the Psychology Special Services Committee and the Risk Reduction Oversight Committee have all identified the need to expand and improve Substance Recovery services.</p>

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		<p>Other findings: The various committees are identifying and addressing issues in need of review and corrective actions. For example, the need to monitor corrective actions related to aspiration pneumonia and bowel obstruction has been identified as has the use of benzodiazepines. Questions have been raised in committees about the accuracy of the suicide attempt trigger data and the skin integrity trigger data. The Psychiatric Key Indicator Committee has raised the need for a policy regarding referral to a neurologist for individuals with refractory seizures, and the Medical Key Indicator Committee has raised the question of the practicality (in terms of expense) of vaccinating all individuals against Hepatitis A and B.</p> <p>Current recommendation: Continue to identify high-risk issues within the committee structure, share information, and identify a multi-disciplinary corrective action whenever possible.</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 recommendation:</p> <p>Recommendation, January 2008: Identify the next triggers for which to initiate a procedure that will allow for monitoring of a team's response to an individual reaching a trigger and implement the procedure.</p> <p>Findings: The facility has identified enhanced supervision and the suicide attempts as the next triggers for which it will monitor the WRPTs' responses.</p> <p>Current recommendations: 1. Implement plans to monitor the responses of WRPTs to triggers</p>

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		<p>related to enhanced supervision and suicide attempts.</p> <p>2. Research the question of whether the trigger data for suicide attempts is accurate; identify and take actions to correct the cause of any problems.</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 recommendation:</p> <p>Recommendation, January 2008: Identify the next triggers for which to initiate a procedure that will allow monitoring of a team's response to an individual reaching a trigger and implement the procedure.</p> <p>Findings: This recommendation has been implemented. See findings above.</p> <p>Other findings: NSH decided not to require a response from the WRPTs to Standards Compliance identifying the actions taken in response to a trigger until the Protection from Harm module of WaRMSS is operational.</p> <p>Current recommendation: Implement plans to require a response from WRPTs to Standards Compliance when an individual reaches a trigger for suicide attempt and enhanced observation.</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 recommendation:</p> <p>Recommendation, January 2008: Encourage the work of the Incident Review Committee and the Risk Reduction Oversight Committee and cooperation between the two to identify and monitor strategies to reduce risks to individuals.</p>

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		<p>Findings: The Risk Reduction Oversight Committee, as reported, is identifying through its subcommittees issues to be studied and corrective actions identified. Monitoring and oversight function has yet to be defined and implemented.</p> <p>Current recommendation: Develop a plan for monitoring the timely implementation of corrective actions related to triggers.</p>
I.2.c	Utilize, on an ongoing basis, appropriate performance improvement mechanisms to assess and address the facility's compliance with its identified service goals.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, January 2008: Continue the analysis of the factors contributing to individuals reaching triggers and involvement in incidents.</p> <p>Findings: This recommendation has not yet been implemented.</p> <p>Recommendation 2, January 2008: Empower the Risk Reduction Oversight Committee and the Incident Review Committee with the ability to monitor the implementation of their recommendations with support from the Standards Compliance Department.</p> <p>Findings: See finding above.</p> <p>Other findings: The facility has developed through its Risk Reduction Oversight Committee and the five subcommittees reasonable and apparently effective methods for identifying issues that need study and correction in order to meet its service goal.</p>

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		<p>Compliance: Partial.</p> <p>Current recommendation: Continue the development of the Risk Reduction Oversight Committee and its subcommittees.</p>
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3. Environmental Conditions		
I.3	<p>Each State hospital shall develop and implement a system to review regularly all units and areas of the hospital to which individuals being served have access to identify any potential environmental safety hazards and to develop and implement a plan to remedy any identified issues, consistent with generally accepted professional standards of care. Such a system shall require that:</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. C. Caruso, Clinical Administrator 2. D. Matteucci, Hospital Administrator 3. M. McQueeney, Assistant Hospital Administrator 4. Several individuals and staff during tour <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Plant Operations Quarterly Work Order Audit Reports for April and July 2008. 2. Monthly Environmental Issues/Risks Tables 3. Monthly Environment of Care Risk Reduction Report 4. Environment of Care Percentage Compliance Report, January-June 2008 <p><u>Toured:</u></p> <ol style="list-style-type: none"> 1. Unit A-1 2. Unit A-7 3. Unit A-8 4. Unit Q 5-6 5. Unit T-7
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, January 2008: Continue making the environmental changes needed to reduce the risk of suicides.</p> <p>Findings: The facility presented a listing of six major undertakings to increase safety since the last tour. These include:</p>

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		<ul style="list-style-type: none">• Covered all ventilation louvers with perforated covers in the high-risk areas of Building 168.• Installed and activated personal alarm systems in all courtyards used by individuals.• Installed over 100 steel toilet seat cover dispensers and 41 steel paper towel dispensers.• Began providing new lockers and wardrobes to units.• Awaiting materials for replacing shower/tub valves and electrical outlets in some units.• Submitted funding requests to DMH for security enhancements. <p>Escorts discussed these measures and pointed to their installation as we toured the units.</p> <p>Recommendation 2, January 2008: Replace burnt-out lights.</p> <p>Findings: Burnt-out lights were not a problem during this tour. The Environment of Care Percentage Compliance Report indicates that 100% of stairwells are properly lit and 90% of the areas are free from broken or missing light fixtures or outlet covers.</p> <p>Recommendation 3, January 2008: Convene clinicians and administrators to address the demeaning practices on Units A-1 and A-8. Ensure that no other units are engaging in similar practices.</p> <p>Findings: A tour of Unit A-1 revealed that substantive positive changes have been made: the door to the main living space has been unlocked, individuals are provided adaptive flatware for eating and adaptive</p>
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		<p>toothbrushes, and the seclusion room was converted to a mini exercise room. WRPTs are convening to individualize recovery plans. Additional staffing resources have been provided as needed. Intensive BY CHOICE training was provided to staff.</p> <p>Other findings: Hall handrails that have a gap between the rail and the wall are present on some units where individuals do not need them. They represent a safety hazard should they be used as a weapon or for self-harm. The Assistant Hospital Administrator recognized this problem and asked staff to write work orders to have the rails removed. New storage units for bedrooms that are low and do not block the view and have no parts that can be ripped off and used as weapons are being provided to individuals.</p> <p>Strong urine odor was present in one of the bedrooms, one bathroom and the seclusion room on A-7. A bathroom on T-7 was very dirty and had many paper towels scattered on the floor. There was also a strong urine odor in one bedroom (triple) on A-1.</p> <p>Compliance: Substantial compliance as related to addressing potential suicide/safety hazards.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Address the cleanliness issues noted. 2. Remove handrails in units where they are not needed.
I.3.b	All areas of the hospital that are occupied by individuals being served have adequate temperature control and deviations shall be promptly corrected;	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2008: Continue current practice of responding to complaints regarding temperature on the units.</p>

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		<p>Findings: The facility reports that complaints regarding temperatures on the units have declined by nearly one-third.</p> <p>Other findings: All units were comfortable in temperature during this monitor's tours. The Environment of Care Percentage Compliance Report indicates that 100% of the areas had adequate heating and air conditioning. In February, for example, there were only four work orders to address units that were too cold. In the same month, there were also four work orders for areas reported as too hot.</p> <p>Compliance: Substantial, based on limited information.</p> <p>Current recommendation: Continue current practice.</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 recommendation:</p> <p>Recommendation, January 2008: Provide guidance to teams to alert them to all of the expectations for addressing the problem of incontinence.</p> <p>Findings: The facility reports that Focus 6 addressed incontinence in 71% of the 21 WRPs reviewed in May, but only 10% of the objectives promoted dignity and self-reliance. This monitor's data below is consistent with the facility's data related to Focus 6 inclusion of incontinence. The facility reports that beginning in July, Nursing Coordinators will provide a monthly report of corrective actions taken to improve staff performance related to the treatment of incontinence.</p>

		<p>Other findings: Review of the WRPs of nine individuals identified in May has having the problem of incontinence revealed no objectives or interventions addressing the problem for two of the individuals.</p> <table border="1" data-bbox="991 414 1881 834"> <thead> <tr> <th>Individual</th> <th>Dx or on Medical Problem list?</th> <th>Focus 6</th> <th>Objective and Interventions</th> </tr> </thead> <tbody> <tr> <td>AC</td> <td>No</td> <td>Yes</td> <td>Yes</td> </tr> <tr> <td>KM</td> <td>Yes</td> <td>No (skin tx)</td> <td>Yes</td> </tr> <tr> <td>EM</td> <td>No</td> <td>Yes</td> <td>Yes</td> </tr> <tr> <td>BC</td> <td>No</td> <td>No</td> <td>No</td> </tr> <tr> <td>MJ</td> <td>No</td> <td>Yes</td> <td>Yes</td> </tr> <tr> <td>GS</td> <td>Yes</td> <td>Yes</td> <td>Yes</td> </tr> <tr> <td>WB</td> <td>Yes</td> <td>Yes</td> <td>Yes</td> </tr> <tr> <td>WF</td> <td>No</td> <td>Yes</td> <td>Yes</td> </tr> <tr> <td>LT</td> <td>Yes</td> <td>No</td> <td>No</td> </tr> </tbody> </table> <p>The monitoring tool asks if the individual verbalizes that staff act quickly to assist him/her when he/she experiences an episode of incontinence. It is unclear from the data if individuals who cannot or will not answer the question are scored as a "No," which could have lowered the compliance rate to 9% as reported for May 2008.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Implement plans for receiving feedback on measures taken to improve staff performance in addressing incontinence. 2. Clarify with auditors that only responses expressly indicating the negative are counted for question #6 on the monitoring form. 	Individual	Dx or on Medical Problem list?	Focus 6	Objective and Interventions	AC	No	Yes	Yes	KM	Yes	No (skin tx)	Yes	EM	No	Yes	Yes	BC	No	No	No	MJ	No	Yes	Yes	GS	Yes	Yes	Yes	WB	Yes	Yes	Yes	WF	No	Yes	Yes	LT	Yes	No	No
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<p>I.3.d</p>	<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, January 2008: Determine the cause of the poor performance in alerting the psychiatrist and in ensuring the provision of psychological care and correct the problem.</p> <p>Findings: NSH noted that several ADs address this issue and do not present a unified message on expectations when staff respond to incidents of sexual contact. Discussions are underway to define these expectations in a single document to be used by all of the facilities.</p> <p>Recommendation 2, January 2008: Ensure nurses understand their responsibilities in instances in which individuals report sexual contact.</p> <p>Findings: The facility reported that in August 2008, it will provide a grid that addresses notification, assessment, treatment and documentation of incidents of sexual contact to provide guidance to staff.</p> <p>Other findings: Facility data indicates that in each of the three sexual incident cases in May (100% sample), the psychiatrist was not notified, the individual was not advised why intervention was necessary, and neither psychological care nor sexual education was provided. In contrast, a physician and program management was notified in each instance.</p> <p>This monitor's review of two sexual incidents revealed that in the incident on 3/10/08, the psychologist saw AC and a team conference was held. A WRP attachment was generated addressing the individual's need to report sexual incidents on 3/12/08. The 3/19/08 monthly</p>
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		<p>psychiatrist's note mentions that the incident occurred. In the 5/08 incident in which an individual inappropriately touched a staff member, the RN wrote a note describing her conversation with LM about respecting females and the psychiatrist evaluated LM and made a change in his medication. The incident was mentioned in the present status section of the monthly review in mid-June.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Implement plans to clarify expectations for staff performance when a sexual incident has occurred.</p>
I.3.e	<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 recommendation:</p> <p>Recommendation, January 2008: Continue current practice.</p> <p>Findings: The facility reports that of the 36 non-clinical Mall providers, four had completed all required trainings and one was in progress.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Facilitate the required training of the non-clinical staff members who are conducting Mall groups.</p>

J. First Amendment and Due Process		
J		<p>Summary of Progress:</p> <ol style="list-style-type: none"> 1. The Cooperative Advisory Council continues to discuss at their meetings and in facility meetings significant issues that impact the quality of their lives. The members of the Council have made reasonable and reasoned suggestions for addressing such problems as peer-to-peer violence and realignment of Mall hours and free time. Members expressed appreciation for being included in meetings held to design the rewriting of Administrative Directives to reflect the Wellness and Recovery Model. 2. The Council has acknowledged the treatment efficacy for many of active participation in wellness and recovery planning, but members have also recognized that many individuals do not know how to engage in this process and have suggested that Mall groups be conducted to teach individuals how to ask questions, how to conduct themselves in conferences and other skills that will enable them to use the conferences to best advantage. 3. There is documentation throughout the meeting minutes that members of the leadership team at the facility regularly attend Council meetings, answer questions and engage in dialogue with the members.
J	Each State hospital unconditionally permits individuals to exercise their constitutional rights of free speech, including the right to petition the government for redress of grievances without State monitoring, and provides them due process.	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Officers of the Cooperative Advisory Council 2. Several individuals during unit tours <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Written complaints made by individuals 2. Minutes of the Cooperative Advisory Council 3. Individuals' Survey Comments

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		<p>4. Individual Personal Property Allowance List</p> <p><u>Attended:</u> Meeting of the Council officers</p>
J		<p>Current findings on previous recommendations:</p> <p>Recommendation 1, January 2008: Revise survey question #14 to eliminate multiple questions where a "yes" answer can be both positive and negative.</p> <p>Findings: The survey has been revised as recommended. Question #14 now reads, "When in restraints or seclusion, staff helped you calm first, you were restrained when calm." A positive response to this question was received from 29% of the respondents.</p> <p>Recommendation 2, January 2008: Address the issues related to individuals having personal computers.</p> <p>Findings: The facility reports that individuals have access to personal computers. Laptop computers and flash drives are on the Individual Personal Property Allowable List.</p> <p>Recommendation 3, January 2008: Address the wellness center and BY CHOICE store accessibility issues.</p> <p>Findings: The officers of the Council reported that the Fitness Center has been reopened. The Plant Operations Quarterly Work Order Audit dated July 7, 2008 states that the project for providing ADA access to the BY CHOICE stores in Buildings 168 and 194 is about 80% complete.</p>

		<p>Other findings: The officers of the Cooperative Advisory Council discussed several issues impacting the quality of life at the facility. These included the following:</p> <ul style="list-style-type: none"> • The compression of free time at the end of the workday for showering and attending to other personal needs is particularly trying. The officers suggested starting the Mall groups earlier, so as to free up some time at the end of the afternoon, and holding one or two Mall groups on the weekend that would count toward total Mall hours. • Cutbacks have occurred in recreation, e.g. Crossroads is no longer open, there are often not enough staff to escort individuals to Tuesday night socials, and open, drop-in time at the Music Room is no longer available. • How to protect oneself from violent individuals remains a problem. Violent individuals not only place others in physical jeopardy, but also threaten to delay others' release from the facility, should the other attempt to defend himself when no staff are present to identify the aggressor and describe the assault. Officers recommended the facility open more unlocked units for individuals who have demonstrated self-control. • CONREP has too few placements available to accommodate all of the individuals who have met their discharge criteria. Officers suggested that release to responsible family members should be considered for some individuals. • The Officers acknowledged improvement in the conduct of WRPCs and in the quality of Mall groups, particularly those that address the nature of mental illness. They suggested forming Mall groups on building the skills and confidence to assist individuals to engage fully in their WRPCs. • Officers noted that the process for accessing their records is
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		<p>often dysfunctional as it is circular and the individual ends up requesting access from the WRPT where s/he began.</p> <ul style="list-style-type: none"> • Too many individuals are still getting only \$12.50/month spending money, although prices for many canteen items have increased. <p>Results of surveys in May completed by 81 individuals revealed that 73% of the respondents indicated they were treated with respect, and 69% and 65% respectively indicated the environment was clean and safe and they themselves felt safe. In contrast, 29% indicated that the grievance process worked.</p> <p>Review of the minutes of the Cooperative Advisory Council revealed that on several occasions, individuals expressed concern over the lack of recycling items from batteries to newspapers. During the March 12, 2008 meeting, individuals suggested ways to reduce the number of individuals on enhanced observation status with the Clinical Administrator and the Acting Medical Director.</p> <p>A question was raised in the minutes about the hours that individuals can use the law library. There was no follow-up to answer the question.</p> <p>Compliance: Partial. Will move to Substantial once issues, if any, with accessing records are addressed and the law library is opened for a reasonable number of hours without undue restrictions.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Through discussion with the Council, determine the specific problems in accessing records. 2. Implement plans already developed to open additional open units. 3. DMH should continue working with CONREP and other entities to open more placements. 4. Discuss mall scheduling with members of the Council.
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		5. Advise the Council on the hours the law library is open and any other conditions for using it.
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