

**REPORT 2
NAPA STATE HOSPITAL EVALUATION**

January 29-February 2, 2007

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

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Introduction

A. Background Information

The evaluation team, consisting of the Court Monitor (Mohamed El-Sabaawi, M.D.) and three expert consultants (Vicki Lund, Ph.D., M.S.N, A.R.N.P.; Ramasamy Manikam, Ph.D.; and Elizabeth Chura, M.S.R.N.) visited Napa State Hospital (NSH) from January 29 to February 2, 2007 to evaluate the facility's progress regarding compliance with the Enhancement Plan (EP). The evaluators' objective was to develop a detailed assessment of the status of compliance with all action steps of the EP.

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

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

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

B. Methodology

The evaluation team reviewed a variety of documents prior to, during and after the on-site evaluation. The documents included, but were not limited to, charts of individuals, facility administrative directives, 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 ensure accuracy and reliability.

C. Findings

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

1. Key Indicator Data

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

- a) The key indicator data provide a global assessment of and insights into the clinical and process outcomes at the facility over time and should not be seen as just another requirement of the EP.
- b) At present, the key indicators lack completeness, consistency and reliability. As a result, the data cannot provide the basis for an accurate global assessment and thus be used reliably to improve the functional status of the individuals and/or drive changes in processes at the system level. Specific deficiencies include:
 - i. While NSH has added more data series than it was able to provide in July 2006 (such as medication variance data beginning in December 2006), data are still not provided on all required areas. Missing data include the fields of homicidal threats or ideation, non-adherence to Wellness and Recovery Plans, waist circumference and change, and certain data related to neurological and medical conditions (seizure disorders, diabetes mellitus, hepatitis C, dysphagia, fractures, osteoporosis, MRSA).
 - ii. Some data appears out of line with expectations for a facility of NSH's size. Examples include:
 1. Aggressive acts to self are lower than expected.
 2. The number of individuals receiving or referred for electroconvulsive treatment is quite low given the population size.
 - iii. Other data display patterns over time that should be investigated to ensure data integrity and sound medical practice. One example is that some segments of body mass index change display spiky patterns from month to month, in which the monthly trend direction (increase or decrease) consistently reverses in the following month.
 - iv. The data collection systems and the definition of many key indicators appear to vary from facility to facility. One example that suggests data definition and collection variance across facilities is the trigger rates for medication variance categories. Definitions and data collection standards should be uniform statewide and trigger rates should be examined

across facilities to ensure data integrity as well as to detect opportunities for learning from facilities that have verifiably lower trigger rates than other facilities in certain categories.

- v. The reliability of the data is an issue that must be addressed by the facility.
- c) Key indicator data reveals trends that should be investigated and explained by the facility. It is not sufficient for the facilities to simply report data without context or explanation; this leads to the impression that the data are not reviewed thoroughly to gain insights that are subsequently used to inform practice. Examples of trends that should be investigated and explained include (by no means exhaustively):
 - i. Between August and December 2006, the facility has seen an increase in the number of individuals experiencing weight change greater than 10 percent over six months. It is not clear what is driving this increase, whether it is a medical phenomenon or a result of better counting. Given that the number of individuals experiencing lesser weight gains over shorter time periods is generally declining, the trend bears examination.
 - ii. The number of individuals testing positive for illegal substance use has risen from seven to 18 between September and December 2006. This trend should be commented upon by the facility. For example, is the increase driven by a change in individual population, better detection by the facility, or one or more other factors?
 - iii. The number of individuals on 1:1 observation declined approximately 50 percent between July and November 2006, then spiked upward in December. What were the reasons for this spike? Was the spike due to a small number of individuals or to systemic factors at the facility that affect individual behavior?
 - iv. The number of individuals diagnosed with polydipsia rose steadily between October and December 2006. Is this due to a change in individual population, to increased clinical sensitivity to the condition, to better recordkeeping, or to some other factor(s)?
- d) Key indicators also reveal some trends that are generally promising. For example:
 - i. The number of individuals receiving four or more interclass psychotropic medications for psychiatric reasons has declined approximately 20 percent between April and December 2006. This decline points to greater attention to the practice, risks and benefits of combined pharmacotherapy at NSH.
 - ii. The facility reported that no individuals experienced three or more falls in any 30-day period between June and December 2006, which points to enhanced attention to the mitigation of fall risks.

2. Monitoring

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

- a) The California Department of Mental Health (DMH) has refined, streamlined and standardized three tools that are used to monitor the process and content of the Wellness and Recovery Plan (WRP). These tools are well-aligned with requirements of the EP. Following training by the State's Chief CRIPA Consultant, these tools should be used statewide.
- b) Each hospital should have a consistent and enduring group of trained staff to collect data using each of these tools.
- c) The DMH has developed written instructions that accompany the WRP monitoring tools. These instructions contain appropriate operational guidelines regarding the use of each tool.
- d) The three WRP monitoring tools should be used to collect monthly data on each of the following WRPs (Chart Audits and Clinical Chart Audits) and WRP conferences (Observations): 7-day, 14-day, monthly and annual. Data should be collected on a 20% sample of each WRP conference or WRP, or the total sample if the number of "cases" is less than 20, whichever is the larger number.
- e) The facility has continued the process of internal monitoring using the above mentioned tools in addition to a variety of other forms that are aligned with the requirements of the EP. Examples of the other forms include the tools related to court assessments, inter-unit transfers, high risk medication uses (e.g. PRN medications, benzodiazepines, anticholinergics and polypharmacy) and psychological assessments.
- f) The facility has developed appropriate monitoring tools to assess the quality of care provided to individuals that suffer from Diabetes Mellitus and Asthma/COPD.
- g) Some of the facility's monitoring tools require refinements to address quality of services and to ensure better alignment with requirements of the EP. Examples include tools related to psychiatric and medical assessments and reassessments.
- e) Not all the tools are accompanied by instructions and operational definitions that can standardize the use within and across the facilities.
- f) There is no reliability data on internal monitoring. Approximately 20% of the data collected should be assessed for reliability.
- g) Most often the sample size is too small and the method of selection is unstated. The sample size must be representative of the total population or subpopulations that are being assessed. In general, the sample size should be 20% of the total population or target population. If the target sample is very small (i.e., less than 20), the total target population should be sampled.
- h) Monitoring is not undertaken by staff that is knowledgeable and dedicated specifically to monitoring. This is a system deficit that is evident in many disciplines. New positions are needed in each discipline to undertake this function. For example, monitoring in psychiatry may be best performed by a senior or lead psychiatrist within a new oversight model that provides dedicated positions for chief of service and a lead for each program.
- i) Given the amount of monitoring that is required, the tools and data collection must be automated.

3. Self-Evaluation

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

- a) The above-mentioned monitoring deficiencies must be corrected to ensure that that the process is meaningful.
- b) The facility's progress report minimally followed requirements of the Court Monitor as presented to the facilities by the Chief CRIPA Consultant.
- c) Some section leaders did not do the necessary work in preparation for the monitor's evaluation.
- d) In some areas, raw data were presented instead of summary data.
- e) The facility's report contained significant amount of process information on what will be done when the requirement was to report on what had been done since the baseline assessment.
- f) In the process of verifying the validity and reliability of the data, the Court Monitor and expert consultants require that the facilities readily demonstrate methods of data collection, where the data is documented and specific information about timeliness, completeness and quality of the documentation. A summary report of specific progress must be presented for each recommendation and each step.
- g) To ensure the proper utilization of the current monitoring tools in the process of self-evaluation, the tools must address quality of services and not be limited to timeliness and presence or absence of various components. It is expected that quality indicators change slowly overtime, but the process must be oriented to these indicators from the beginning.

4. Implementation of the EP

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

- iv. The Psychosocial Rehabilitation Mall (PSR) mall is state-of-the-art in terms of its potential for delivering recovery-focused services.
- b) Function of current and planned implementation:
- i. The DMH WRP Manual has been revised to fully meet all requirements of the EP. This manual is an excellent guide in the principles and practice of the recovery model. To facilitate and standardize implementation of the recovery model, the manual should be the main reference for Wellness and Recovery Planning in the facilities.
 - ii. The extensive training in the WRP, psychiatric rehabilitation and therapeutic milieu has been of very high quality. However, this training has not translated into practice on a day-to-day basis.
 - iii. The overall leadership of the Central Program Services (CPS), which currently encompasses the PSR Mall, is ineffective. This has resulted in a dysfunctional PSR Mall. The CPS/PSR Mall system at NSH does not comport with generally accepted professional standards of psychosocial rehabilitation. The CPS system siphons skilled staff and provides services for a small minority of individuals who need mall services. NSH should have a single entity—the PSR Mall—that provides mall services. During mall hours, the Mall Director should be responsible for all staffing and mall services. This will entail the Mall Director having supervisory responsibility during mall hours over all staff that provides mall-based services. Having the Mall Director appointed at a senior level and reporting directly to the Clinical Administrator should facilitate this task.
 - iv. NSH has instituted Narrative Restructuring Therapy (NRT) to enhance individuals' participation in their WRP interventions. This is a specialized therapeutic modality that, similar to PBS, requires a core of trained clinicians to provide therapy as their primary responsibility.
 - v. The Forensic Review Panel is fully operational, which has resulted in some noticeable progress in the quality of court reports submitted for individuals under PC 1026 and PC 1370.
 - vi. Nutrition Services continue to make good progress.
 - vii. The facility has developed an excellent manual regarding the training of its investigators.
 - viii. The facility has implemented some of the Court Monitor's baseline recommendations.
 - ix. Overall, the facility has made insufficient progress since the baseline evaluation. This is disheartening given the many positive findings listed in the baseline assessment.
 - x. The main reasons for the limited progress appear to include serious shortage of clinical staff (see below), unanticipated losses, absences and pending departure of many key leaders of the facility (e.g. Executive Director, Hospital Administrator, Clinical Administrator and Medical Director) and shortfalls in the current implementation of the matrix system.
 - xi. Many of the staff members that we met on the units and in various programs are very enthusiastic, caring and motivated to provide quality services.
 - xii. A significant number of staff members are not familiar with the actual requirements of the EP and therefore have little knowledge of the key changes that they need to make.

xiii. Functional outcomes of the current structural changes are yet to be developed and implemented to guide further implementation.

5. Staffing

The NSH staffing table below shows the staffing pattern at the hospital as of February 1, 2007. These data were provided by the facility. The table shows that there is a major shortage of staff in several key areas: staff psychiatrists, senior psychiatrists, psychologists, pharmacists, social workers and rehabilitation therapists.

Napa State Hospital Vacancy Totals as of 2/1/2007				
Identified Clinical Positions	Allocated Positions, Third Quarter	Filled	Vacancies	Vacancy Rate
Assistant Coordinator of Nursing Services	5.00	5.00	0.00	0.00%
Assistant Director of Dietetics	3.00	3.00	0.00	0.00%
Audiologist I	0.00	0.00	0.00	0.00%
Chief Dentist	1.00	1.00	0.00	0.00%
Chief Physician & Surgeon	1.00	1.00	0.00	0.00%
Chief, Central Program Services	0.00	0.00	0.00	0.00%
Chief Psychologist	1.00	0.00	1.00	100.00%
Clinical Dietician/Pre-Reg. Clin. Dietician	10.00	6.00	4.00	40.00%
Clinical Laboratory Technologist	3.00	4.00	-1.00	-33.33%
Clinical Social Worker	74.46	60.20	14.26	19.15%
Coordinator of Nursing Services	1.00	1.00	0.00	0.00%
Coordinator of Volunteer Services	1.00	1.00	0.00	0.00%
Dental Assistant	3.00	2.00	1.00	33.33%
Dentist	2.00	1.50	0.50	25.00%
Dietetic Technician	0.00	0.00	0.00	0.00%

Napa State Hospital Vacancy Totals as of 2/1/2007				
Identified Clinical Positions	Allocated Positions, Third Quarter	Filled	Vacancies	Vacancy Rate
E.E.G. Technician	0.00	0.00	0.00	0.00%
Food Service Technician I	90.00	84.50	5.50	6.11%
Hospital Worker	5.00	5.00	0.00	0.00%
Health Record Technician I	15.00	8.00	7.00	46.67%
Health Record Techn II Sp	1.00	1.00	0.00	0.00%
Health Record Techn II Sup	1.00	1.00	0.00	0.00%
Health Record Techn III	1.00	1.00	0.00	0.00%
Health Services Specialist	30.00	29.00	1.00	3.33%
Institution Artist Facilitator	1.00	1.00	0.00	0.00%
Licensed Vocational Nurse	49.80	49.80	0.00	0.00%
Medical Technical Assistant	0.00	0.00	0.00	0.00%
Medical Transcriber	7.00	6.00	1.00	14.29%
Medical Transcriber Sup	0.00	0.00	0.00	0.00%
Sr Medical Transcriber	3.00	2.00	1.00	33.33%
Nurse Instructor	9.00	6.00	3.00	33.33%
Nurse Practitioner	2.00	2.00	0.00	0.00%
Nursing Coordinator	7.00	7.00	0.00	0.00%
Office Technician	36.50	37.75	-1.25	-3.42%
Pathologist	1.00	0.00	1.00	100.00%
Pharmacist I	13.50	2.50	11.00	81.48%
Pharmacist II	2.00	1.00	1.00	50.00%
Pharmacy Services Manager	1.00	1.00	0.00	0.00%
Pharmacy Technician	15.00	13.00	2.00	13.33%
Physician & Surgeon	16.00	15.40	0.60	3.75%

Napa State Hospital Vacancy Totals as of 2/1/2007				
Identified Clinical Positions	Allocated Positions, Third Quarter	Filled	Vacancies	Vacancy Rate
Podiatrist	1.00	1.00	0.00	0.00%
Pre-licensed Pharmacist	0.00	0.00	0.00	0.00%
Pre-licensed Psychiatric Technician	2.00	2.00	0.00	0.00%
Program Assistant	7.00	4.00	3.00	42.86%
Program Consultant (RT, PSW)	2.00	2.00	0.00	0.00%
Program Director	7.00	6.00	1.00	14.29%
Psychiatric Nursing Education Director	1.00	1.00	0.00	0.00%
Psychiatric Technician*	260.30	260.30	0.00	0.00%
Psychiatric Technician Trainee	0.00	0.00	0.00	0.00%
Psychiatric Technician Assistant	314.50	351.00	-36.50	-11.61%
Psychiatric Technician Instructor	2.00	2.00	0.00	0.00%
Psychologist-HF, (Safety)	54.62	56.20	-1.58	-2.89%
Public Health Nurse II/I	1.00	1.00	0.00	0.00%
Radiologic Technologist	2.00	2.00	0.00	0.00%
Registered Nurse*	271.30	271.30	0.00	0.00%
Reg. Nurse Pre Registered	1.00	1.00	0.00	0.00%
Rehabilitation Therapist	72.27	56.60	15.67	21.68%
Special Investigator	4.00	1.00	3.00	75.00%
Special Investigator, Senior	1.00	1.00	0.00	0.00%
Speech Pathologist I	0.00	0.00	0.00	0.00%
Sr. Psychiatrist	6.00	1.00	5.00	83.33%
Sr. Psychologist	13.00	0.00	13.00	100.00%
Sr. Psych Tech(Safety)	51.00	51.00	0.00	0.00%
Sr. Radiologic Technologist (Specialist)	0.00	0.00	0.00	0.00%

Napa State Hospital Vacancy Totals as of 2/1/2007				
Identified Clinical Positions	Allocated Positions, Third Quarter	Filled	Vacancies	Vacancy Rate
Sr. Voc. Rehab. Counselor/Voc. Rehab. Counselor	1.00	1.00	0.00	0.00%
Staff Psychiatrist *	64.50	39.80	24.70	38.29%
Supervising Psychiatric Social Worker	5.00	0.00	5.00	100.00%
Supervising Registered Nurse	17.00	17.00	0.00	0.00%
Supervising Rehabilitation Therapist	5.00	0.00	5.00	100.00%
Teacher-Adult Educ./Vocational Instructor	7.00	7.00	0.00	0.00%
Teaching Assistant	0.00	0.00	0.00	0.00%
Unit Supervisor	29.00	24.00	5.00	17.24%
Vocational Services Instructor	0.00	0.00	0.00	0.00%

The staffing shortage at NSH has been worsened by the recent actions of the Court Receiver at the California Department of Corrections and Rehabilitation (CDCR), especially the pay raise in the specialties of psychiatry, psychology and pharmacy. Staffing shortages are also a concern for nursing, psychiatric technicians, rehabilitation therapists, social workers, and dieticians. The depletion of staffing resources in needed critical specialties has reached a level that may threaten the safety and security of both individuals and staff at this and other DMH facilities. At this stage, this shortage is the most significant barrier that impedes efforts in the further implementation of the EP. This is a crisis that requires decisive and prompt action from the state to restore appropriate balance to its system of compensating professionals in its various institutions. The State should respond before the negative impact on its mental health institutions becomes irreversible.

D. Monitor's Evaluation of Compliance

The status of compliance is assessed considering the following factors:

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

4. An assessment of the stability of the facility's current structure and functions in terms of potential for self-sustenance in order adequately meet the needs of individuals currently and in the future.
5. Assessment of trends and patterns of change rather than single and/or temporary occurrences of compliance or noncompliance that is inconsistent with these patterns and trends.
6. When no instance of a specific requirement was found in the baseline assessment, the compliance was rated as Not Applicable for This Evaluation.

E. Next Steps

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

	March	April	May	June	July	August	September	October	November	December
ASH		23-27						15-19		
PSH				4-8					26-30	
NSH					23-27					
MSH	19-23					27-31				

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

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

	<p>address each individual's needs and to assist individuals in meeting their specific recovery and wellness goals, consistent with generally accepted professional standards of care. Each State hospital shall ensure clinical and administrative oversight, education, and support of its staff in planning and providing care and treatment consistent with these standards.</p>	
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C	Integrated Therapeutic and Rehabilitation Services Planning	
	<p>Each State hospital shall provide coordinated, comprehensive, individualized protections, services, supports, and treatments (collectively "therapeutic and rehabilitation services") for the individuals it serves, consistent with generally accepted professional standards of care. In addition to implementing the therapeutic and rehabilitation planning provisions set forth below, each State hospital shall establish and implement standards, policies, and practices to ensure that therapeutic and rehabilitation service determinations are consistently made by an interdisciplinary team through integrated therapeutic and rehabilitation service planning and embodied in a single, integrated therapeutic and rehabilitation service plan.</p>	<p>Summary of Progress:</p> <ol style="list-style-type: none"> 1. The DMH Wellness and Recovery Planning manual has been revised and currently meets all requirements of the EP. The manual contains all required elements to serve as the main reference for WRP statewide. 2. The DMH has refined, streamlined and standardized the monitoring instruments related to WRP. The revised instruments are aligned with requirements of the EP. 3. DMH has developed appropriate operational instructions that accompany the monitoring instruments. 4. NSH has established a WRP Consultation Group to serve as trainers to the WRP teams. 5. NSH has implemented the WRP post-test and established a competency profile for WRP team members. 6. NSH has implemented the revised WRP monitoring instruments. 7. NSH has improved the sample sizes in its monitoring of WRP. 8. NSH presented data to review its progress since the baseline evaluation. 9. In general, the interdisciplinary staff members at NSH are caring, well-intentioned and motivated to provide quality services to individuals entrusted to their care. 10. NSH has initiated training of clinicians in Narrative Restructuring Therapy (NRT) that focuses on moving individuals from precontemplation to contemplation stages of change. The data show that this therapy is effective with individuals who are non-adherent with their WRP.
1	Interdisciplinary Teams	
	<p>The interdisciplinary team's membership shall be dictated by the particular needs and strengths of the individual in the team's care. At a minimum, each State Hospital shall ensure that the team shall:</p>	<p>Methodology: Attended WRP team meetings for quarterly reviews of individuals HS (Program II) and DT (Program III) and monthly review of individual DP (Program V).</p>

		<p>Reviewed revised DMH Wellness Recovery Plan (WRP) Manual (Draft January 2007).</p> <p>Reviewed final (and approved) DMH WRP Manual (March 2007).</p> <p>Reviewed NSH AD # 785 regarding the Wellness Recovery Plan (WRP).</p> <p>Reviewed WRP Conference Report Monitor Report for all programs at NSH (July to December 2006).</p> <p>Interviewed Carmen Caruso, Treatment Enhancement Coordinator.</p> <p>Interviewed Garry Walters, Clinical Administrator.</p> <p>Reviewed NSH Administrative Directive (AD) #785 regarding Wellness and Recovery Plan (WRP).</p> <p>Interviewed Jasenn Zaejain, PhD., Consulting Psychologist, DMH</p> <p>Reviewed WRP Process Observation Form.</p> <p>Reviewed Process Observation summary data of Quarterly and Annual WRP meetings (July to December 2006).</p> <p>Reviewed DMH WRP Clinical Chart Auditing Form.</p> <p>Reviewed DMH WRP Clinical Chart Auditing From Instructions.</p> <p>Reviewed the WRP Conference Monitor Report raw data.</p> <p>Reviewed the revised Psychiatric Physician's Manual.</p> <p>Reviewed training database of members of the WRP Consultation Group.</p> <p>Reviewed WRP training post-test.</p> <p>Reviewed qualitative profile of WRP post-test.</p> <p>Reviewed the facility's training roster regarding WRP.</p>
a	<p>Have as its primary objective the provision of individualized, integrated therapeutic and rehabilitation services that optimize the individual's recovery and ability to sustain himself/herself in the most integrated, appropriate setting based on the individual's strengths and functional and legal status and support the individual's ability to exercise his/her liberty interests, including the interests of self determination and independence.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006: Finalize, approve and implement the DMH WRP manual.</p> <p>Findings: The manual has been revised (January 2007) to address recommendations from the baseline report. The finalized and approved version of the DMH WRP Manual (March 2007) incorporates the</p>

		<p>changes requested during the Court Monitor's current evaluation of NSH.</p> <p>Recommendations 2 and 3, July 2006:</p> <ul style="list-style-type: none">• Provide documentation that WRP trainers and WRP team members have been trained to competency.• Continue and strengthen current training program. In particular, the facility needs to make further efforts to build the competency of program trainers and to increase training sessions for all members of the WRPTs (WRP teams). <p>Findings:</p> <p>The facility started an interdisciplinary Wellness and Recovery Planning Consultation Group consisting of WRP program trainers (psychologists), nursing WRP trainers (HSSs), Discipline Chiefs, Standards Compliance WRP monitoring reviewers, Positive Behavior Support (PBS) team members, the Mall Director, the BY CHOICE Coordinator and nursing quality improvement coordinator. The Treatment Enhancement Coordinator (TEC) has provided 20 hours of training since August 30, 2006 to build the competency of this group. The group's purpose is to provide training to all WRPT in the facility. The training rosters provide documentation that this group was trained to competency using the WRP training post-test.</p> <p>In addition, the TEC has provided training to all admission teams and the skilled nursing teams. Some of the other WRPT received some training provided by members of the consultation group. The facility established baseline competency profiles for almost all WRPT members throughout the facility using the same post-test. This test addresses the basic elements of WRP. The facility has yet to implement the recommendation to increase the training sessions for the WRPTs.</p>
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		<p>Recommendation 4, July 2006: Streamline and refine current WRP monitoring instruments to reflect the specific recommendations in sections b through g below.</p> <p>Findings: The facility has modified the process observation, chart audit and case formulation (now incorporated in the DMH WRP Clinical Chart Auditing Form) monitoring instruments to eliminate redundancy and improve alignment with the EP requirements. These monitoring instruments have been standardized statewide. Each form is now accompanied by instructions that provide clear and adequate definitions of the appropriate operational components of each item.</p> <p>Recommendation 5, July 2006: Ensure that the AD regarding WRP is aligned with the DMH WRP Manual.</p> <p>Findings: AD #785 remains in draft form pending implementation of the revised WRP manual.</p> <p>Other findings: Chart reviews (please see Section C.2 below) indicate that, in general, the process and content of Wellness Recovery Planning at NSH are deficient and that the principles and practice elements outlined in the DMH WRP manual have yet to be properly implemented.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Implement the revised DMH WRP Manual. 2. Continue training provided to WRP trainers and documentation of
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		<p>training to competency.</p> <ol style="list-style-type: none"> 3. Increase training sessions to all members of the WRPTs and provide documentation of training to competency. 4. Ensure that all WRPTs at the facility receive the same level of training. 5. Establish new employee WRP training (for non-nursing disciplines). 6. Utilize the review questions listed for each chapter of the DMH WRP manual in the WRP competency evaluation. 7. Ensure that the AD regarding WRP is aligned with the revised DMH WRP Manual.
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, July 2006: Present data regarding presence of team leaders in terms of designated leader and coverage when the designated leader is not present.</p> <p>Findings: Using the WRP Process Observation Monitoring Form, the facility reviewed an unspecified sample of WRPT conferences from October to December 2006. The data provided show 90% compliance with the requirement that each team is led by a clinical professional who is involved in the care of the individual. The facility has a WRP Conference Monitor report that tracks absence of core team members. The report provides information regarding coverage of the teams when the designated leader is absent, but the facility has yet to aggregate the data.</p> <p>Recommendations 2 and 3, July 2006:</p> <ul style="list-style-type: none"> • Monitor both presence and proper participation by the team leaders.

		<ul style="list-style-type: none"> • Develop and implement a peer mentoring system to ensure competency in team leadership skills. <p>Findings: The facility has not implemented these recommendations. The main barrier to implementation is the difficulty in recruitment of senior psychiatrists.</p> <p>Recommendation 4, July 2006: The Psychiatric Physician Manual should include specific requirements regarding WRP leadership. The requirements must be aligned with the WRPT responsibilities that are outlined in the DMH WRP manual.</p> <p>Findings: The facility has revised its Psychiatric Physician Manual to address this recommendation. However, the revision does not address the leader's responsibility to ensure a sequence of tasks that facilitates WRP and to ensure proper participation by individuals in the WRP conferences.</p> <p>Recommendations 5-8, July 2006:</p> <ul style="list-style-type: none"> • The DMH WRP manual should include information regarding the leader's responsibility to ensure appropriate parameters for participation by the individual in the team meeting. • The DMH WRP manual should address the leader's responsibility to ensure that members provide concise presentation of the results of their assessments prior to the discussion of objectives and interventions. • The DMH WRP manual should address the leader's responsibility to ensure that the present status section of the case formulation is updated during the WRPT meetings and that other sections in the formulation are consequently updated as clinically indicated.
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		<ul style="list-style-type: none"> • The DMH WRP manual should combine tables 5.1 and 5.2 regarding team responsibilities during WRP reviews to include the same expectations regarding discussion of PBS data, MOSES data and the individual's current medical condition. <p>Findings: The revised DMH WRP manual meets all the above requirements.</p> <p>Other findings: None.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to monitor presence of team leaders and aggregate data regarding coverage of the leader role. 2. Standardize the current WRP Conferences Monitor Report for statewide use. 3. Develop and implement a monitoring tool to assess proper participation by the team leader in the WRP conferences. 4. Develop and implement a peer mentoring system to ensure competency in team leadership skills. 5. The revised Psychiatric Physician Manual should address the leader's responsibility to ensure a sequence of tasks that facilitates WRP as well as proper participation by individuals in the WRP conferences.
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c	Function in an interdisciplinary fashion.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006: Same as in C.1.a and b.</p> <p>Findings: Same as in C.1.a. and b.</p> <p>Recommendation 2, July 2006: Ensure that WRP Process Observation Form is also used to assess team functions at the 7-day and 14-day conferences.</p> <p>Findings: The facility does not have compliance data regarding this recommendation.</p> <p>Recommendation 3, July 2006: Ensure that monitoring items are aligned with the requirements of each action step of the EP.</p> <p>Findings: As in C.1.a (findings relevant to July 2006 recommendation #4).</p> <p>Other findings: The facility used the WRP Observation Monitoring Form and reviewed an unspecified sample of team conferences from October to December 2006. The data show 0% compliance with the requirement that each team functions in an interdisciplinary fashion as evidenced by compliance with all operational components of this item. The operational components, as outlined in the form instructions, address the presentation and updates of disciplinary/integrated assessments, review and updates of the WRP Task Tracking Form, the presentation of assessments and consultations as listed in the Task Tracking Form</p>
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		<p>and the discussion of specific outcomes for the WRP review period.</p> <p>Chart reviews (as per Section C.2) by this monitor also demonstrate deficiencies in the content of planning (e.g. proper development and revision of case formulations, foci of hospitalization and interventions) that are at least partly a result of ineffective interdisciplinary functions.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Use the WRP Process Observation Form to assess team functions at the 7-day and 14-day conferences. 2. Continue to monitor all WRP conferences regarding this requirement.
d	<p>Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary, and appropriate psychiatric and medical care.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006: Same as in C.1.a, b and c.</p> <p>Findings: Same as in C.1.a., b. and c.</p> <p>Recommendation 2, July 2006: NSH should continue the current practice of surveying team members regarding the functions of their designated leaders.</p> <p>Findings: The facility has not continued its practice pending more adequate training to the WRPT leaders.</p>

		<p>Compliance: Partial.</p> <p>Other findings: The facility has developed a DMH WRP Clinical Chart Auditing Form to be completed only by clinicians. The tool and its operational instructions adequately address this requirement. Implementation is pending.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Resume the practice of surveying team members once adequate training has been provided to the team leaders. 2. Implement the DMH WRP Clinical Chart Auditing Form.
e	<p>Ensure that each member of the team participates appropriately in competently and knowledgeably assessing the individual on an ongoing basis and in developing, monitoring, and, as necessary, revising the therapeutic and rehabilitation services.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, July 2006:</p> <ul style="list-style-type: none"> • Same as in C.1.a through C.1.d. • Same as in D.1.a through D.1.e. <p>Findings: Same as in C.1.a through C.1.d. and D.1.a through D.1.e.</p> <p>Recommendation 3, July 2006: Improve clinical oversight to ensure competency in the processes of assessments, reassessments, interdisciplinary team functions and proper development and timely and proper updates of case formulations, foci of hospitalization, objectives and interventions.</p>

		<p>Findings: The CA DMH has approved clinical positions for Senior Clinicians in the disciplines of psychiatry, psychology, social work and rehabilitation therapy. The facility has yet to recruit any of these positions pending the completion of the State's procedure regarding the establishment of a list of qualified candidates.</p> <p>Recommendation 4, July 2006: Ensure that the monitoring tools adequately address the quality of assessments.</p> <p>Findings: The DMH has tasked all the discipline chiefs statewide to work together to establish a monitoring tool for the disciplinary assessments that will address the quality of the assessments. So far, only Psychology has developed this instrument.</p> <p>Other findings: The facility has process observation data (July through December 2006) that indicate 0% compliance with this requirement.</p> <p>The team meetings attended by the monitor reveal a general pattern of deficiencies in the implementation of all the key process elements in this section. In addition, this monitor found deficiencies in the implementation of all the main content elements of the WRP system as outlined in Section C (case formulation, foci of hospitalization, objectives and interventions) and Section D (psychiatric assessments and reassessments). The deficiencies in both process and content render the current implementation of the WRP system ineffective in meeting the treatment, rehabilitation and enrichment needs of the individuals. As mentioned earlier, the revised DMH WRP manual fully meets plan requirements. Proper implementation of this manual in the day-to-day practice of WRP is necessary to achieve compliance.</p>
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		<p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure recruitment of needed senior clinicians. 2. Finalize and implement the new audit regarding quality of assessments for all disciplines. 3. Continue to monitor this requirement using process observation. 4. Assess and correct factors related to low compliance with this requirement.
f	<p>Ensure that assessment results and, as clinically relevant, consultation results, are communicated to the team members, along with the implications of those results for diagnosis, therapy and rehabilitation by no later than the next review.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006: Same as in C.1.a through C.1.e.</p> <p>Findings: Same as in C.1.a through C.1.e.</p> <p>Recommendation 2, July 2006: Ensure that monitoring items are not redundant and/or overinclusive.</p> <p>Findings: As in C.1.a (findings relevant to July 2006 recommendation #4).</p> <p>Other findings: The facility has process observation data based on an unspecified sample of the conferences from October to December 2006. The data show 11% compliance.</p> <p>Observations of the team meetings attended by the monitor indicate general deficiency in the requirements of presenting results of the</p>

		<p>assessments and analyzing those results to assess implications for diagnosis, treatment and/or rehabilitation of individuals.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to monitor this requirement using process observation. 2. Assess and correct factors related to low compliance rates.
g	<p>Be responsible for the scheduling and coordination of assessments and team meetings, the drafting of integrated treatment plans, and the scheduling and coordination of necessary progress reviews.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, July 2006:</p> <ul style="list-style-type: none"> • Ensure that all assessments are completed on all units according to the schedule established in the DMH WRP manual. • Ensure that WRPs are completed and reviewed according to the schedule established in the DMH WRP manual. <p>Findings: Since the baseline evaluation, the facility has not made progress on this recommendation. The assessments and WRP reviews are still being completed only on the two admission units. Most teams review the plans only quarterly. The clinical administrator indicates that the main barrier to compliance is that NSH has been unable to staff the units according to the ratios established in the EP.</p> <p>Recommendation 3, July 2006: Evaluate the current method for assigning responsibilities for coordination and completion of assessments and WRPs and ensure compliance.</p>

		<p>Findings: The facility has reviewed the current method and has concluded that inadequate compliance with the scheduled meetings was related to inadequate staffing rather than the coordination of meetings.</p> <p>Recommendation 4, July 2006: Revise current monitoring instruments to address above recommendations.</p> <p>Findings: The process observation and chart audits monitoring tools were revised to be aligned with the schedules established in the MDH WRP manual</p> <p>Other findings: The facility has process observation data (unspecified sample from July to December 2006) that indicates 42% compliance with the requirement that the team identified someone to be responsible for implementation of this requirement.</p> <p>Review of charts by this monitor (see Section D) shows lack of progress regarding the implementation of assessments and WRP reviews according to schedules required by the EP.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Assess and correct factors related to the shortage of staff needed to implement the EP. 2. Ensure that all assessments are completed on all units as per the schedule established in the DMH WRP manual. 3. Ensure that WRPs are completed and reviewed as per the
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		<p>schedule established in the DMH WRP manual.</p> <p>4. The State must address factors related to recruitment and retention of needed staff.</p>
h	<p>Consist of a stable core of members, including at least the individual served; the treating psychiatrist, treating psychologist, treating rehabilitation therapist, the treating social worker; registered nurse and psychiatric technician who know the individual best; and one of the individual's teachers (for school-age individuals), and, as appropriate, the individual's family, guardian, advocates, attorneys, and the pharmacist and other staff.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006: Recruit clinical staff and fill vacancies ASAP to ensure compliance with this requirement.</p> <p>Findings: The facility has been unable to comply with this recommendation.</p> <p>Recommendation 2, July 2006: Complete the process of monitoring the attendance by core team membership.</p> <p>Findings: The facility has no data regarding this requirement.</p> <p>Other findings: See the data outlined in the cell below. The Clinical Administrator stated that the three teams currently in compliance with the required staff-to-individual ratios are the only teams at NSH that meet the requirement regarding core membership.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Assess and correct factors related to low compliance rates. 2. Complete the process of monitoring the attendance by core team membership.

<p>i</p>	<p>Not include any core treatment team members with a case load exceeding 1:15 in admission teams (new admissions of 90 days or less) and, on average, 1:25 in all other teams at any point in time.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, July 2006: Same as in C.1.h #1.</p> <p>Findings: Same as in C.1.h</p> <p>Other findings: At this monitor's request, the Clinical Administrator prepared the following data regarding:</p> <ol style="list-style-type: none"> The number of teams that meet required staff-to-individual ratios. The data show that only three teams at NSH are in compliance with this requirement. <table border="1" data-bbox="1083 821 1837 1089"> <thead> <tr> <th>Program</th> <th>Teams meeting 1:15 ratio</th> <th>Teams that average 1:25 ratio</th> </tr> </thead> <tbody> <tr> <td>I</td> <td>None</td> <td>T-8</td> </tr> <tr> <td>II</td> <td>None</td> <td>None</td> </tr> <tr> <td>III</td> <td>None</td> <td>None</td> </tr> <tr> <td>IV</td> <td>A-3 and A-9</td> <td>A-8</td> </tr> <tr> <td>V</td> <td>None</td> <td>None</td> </tr> </tbody> </table> <ol style="list-style-type: none"> Status of staffing in the core disciplines regarding numbers hired and numbers departed since the baseline evaluation. The discipline chiefs of Psychiatry, Psychology and Nursing offered staffing counts that differed from those provided by the administrator (data provided by discipline chiefs listed in parentheses). 	Program	Teams meeting 1:15 ratio	Teams that average 1:25 ratio	I	None	T-8	II	None	None	III	None	None	IV	A-3 and A-9	A-8	V	None	None
Program	Teams meeting 1:15 ratio	Teams that average 1:25 ratio																		
I	None	T-8																		
II	None	None																		
III	None	None																		
IV	A-3 and A-9	A-8																		
V	None	None																		

Discipline	Number hired since July 2007*	Number departed since July 2007*
Psychiatry	4 (4.75)	8 (18)
Psychology	14 (11)	10
Social Work	8 (11)	10 (9)
Rehabilitation Therapy	6 (10)	4 (10)
Registered Nurses	49 (45)	9 (7)
Psychiatric Technicians	18	11

3. The number of additional staff in the core disciplines that is needed to comply with this requirement.

Discipline	Number needed to meet 1:15 ratios	Number needed to meet 1:25 ratios
Psychiatry	3	16.7
Psychology	2	11
Social Work	2	2
Rehabilitation Therapy	2	5
Registered Nurses	0	0
Psychiatric Technicians	0	0

Compliance:
Partial.

		<p>Current recommendation: Same as in C.1.h.</p>
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 recommendations:</p> <p>Recommendation 1, July 2006: Same as in C. 1.a through C.1.f.</p> <p>Findings: Same as in C.1.a through C.1.f.</p> <p>Recommendation 2, July 2006: Implement the WRP training post-test to ensure competency of staff.</p> <p>Findings: The TEC stated that all members of the WRPTs completed a WRP post-test as a baseline evaluation of their competency. The average score was 80%. As mentioned earlier, the test material addresses the basic principles of WRP.</p> <p>Recommendation 3, July 2006: Include WRP training in new employee orientation and in the proctoring and mentoring of new employees during their first year of employment.</p> <p>Findings: The facility has yet to implement this recommendation.</p> <p>Other findings: This monitor's observations of team meetings reveals that most team leaders and members are not yet fully trained to meet the expectations in this step.</p>

		<p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue and strengthen training to all WRPT leaders and members regarding development and implementation of the WRP. 2. Include WRP training in new employee orientation and in the proctoring and mentoring of new employees during their first year of employment. 3. Same as in C.1.a recommendation #6.
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: Attended WRPT meetings for monthly review of individual DP (Program V) and quarterly reviews of individuals HS (Program II) and DT (Program III). Attended WRPT meetings (MH and BN). Observed mall groups of five individuals (KH, BRC, NF, ESL and BCV). Observed mall activities (Women's Support Group, Substance Recovery, and CONREP). Interviewed Carmen Caruso, Treatment Enhancement Coordinator. Interviewed Scott Sutherland, D.O., Staff Psychiatrist. Interviewed Anthony Rabin, Ph.D. Director of Mall Services. Interviewed Regina Ott, M.S. Program Director, Central Program Services. Interviewed Kathy Michaels, Resource Coordinator and Assistant Chief, Central Program Services. Interviewed Jim Jones, Acting Chief of Psychology. Interviewed Virginia Tones, PT. Interviewed Toby Lamb, Ph.D., Psychologist. Interviewed Paula Neese, RT. Interviewed Candida Asuncion, Nurse.</p>

		<p>Interviewed five individuals (HTS, TLA, EH, RMF and KH).</p> <p>Reviewed charts of 43 individuals (LK, NP, RT, WLW, JLW, LH, EGC, VDB, JMR, NK, DPN, RA, ZH, WFO, RVG, RLM, WZ, EA, MP, TE, TLG, AT, FNG, FT, EG, TCG, RH, BRC, NF, KH, MR, JT, RW, LY, AT, PR, JS, TLR, RMH, HTS, BV, TLA, EH and RMF).</p> <p>Reviewed revised DMH WRP Manual (Draft January 2007).</p> <p>Reviewed final (and approved) DMH WRP Manual (March 2007).</p> <p>Reviewed NSH AD # 785 regarding the Wellness Recovery Plan (WRP).</p> <p>Reviewed DMH WRP Observation Monitoring Form.</p> <p>Reviewed Observation Monitoring Data Summary (July to December 2006).</p> <p>Reviewed DMH WRP Chart Auditing Form.</p> <p>Reviewed Chart Auditing Data Summary (July to December 2006).</p> <p>Reviewed "My Activity and Participation Plan (MAPP)" database regarding hours of active treatment scheduled and attended.</p> <p>Reviewed PSR Mall Schedule.</p> <p>Reviewed PSR Mall curricula and manuals.</p> <p>Reviewed Mall Alignment Protocol.</p> <p>Reviewed database of therapists verifying competency training and certification in substance abuse counseling.</p> <p>Reviewed list of all individuals by program x unit x scheduled hours of mall groups or individual therapy x actual hours attended.</p> <p>Reviewed list of all individuals by program x unit x actual hours of attendance during enrichment activities (outside of mall hours).</p> <p>Reviewed database of therapists verifying competency training and certification in substance abuse counseling.</p> <p>Reviewed list of all individuals by program x unit x scheduled medication education group (if needed) x actual attendance.</p> <p>Reviewed DMH WRP Case Formulation Monitoring Form.</p> <p>Reviewed DMH WRP Case Formulation Monitoring Form Instructions.</p> <p>Reviewed Case Formulation Data Summary (January 2007).</p> <p>Reviewed Substance Abuse Screening Policy.</p> <p>Reviewed Substance Abuse Check List.</p>
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		<p>Reviewed Substance Abuse Check List summary data (July to December 2006).</p> <p>Reviewed new form regarding PSR Mall Facilitator Monthly Progress Note.</p> <p>Reviewed the Wellness and recovery orientation Post-test (for individuals).</p> <p>Reviewed WRP training roster and hand outs provided by the Treatment Enhancement Coordinator (TEC).</p> <p>Reviewed Wellness Recovery Orientation 12-Week Lesson Plan, including post-tests.</p> <p>Reviewed list of substance recovery providers that received training in approved substance abuse curriculum.</p> <p>Reviewed NSH Substance Recovery Training Plan.</p> <p>Reviewed NSH Key Indicator (trigger) Data.</p>
a	<p>Individuals have substantive input into the therapeutic and rehabilitation service planning process, including but not limited to input as to mall groups and therapies appropriate to their WRP.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2006: Continue and strengthen WRP training that focuses on the process of engaging the individual in providing substantive input.</p> <p>Findings: The training provided by the TEC (20 hours since August 30, 2006) has included discussions related to this recommendation.</p> <p>The facility has process observation data (unspecified sample of all conferences July to December 2006) that show 3% compliance with this requirement.</p> <p>Other Findings: None.</p>

		<p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue WRP training that focuses on the process of engaging the individual in providing substantive input. 2. Address and correct factors related to low compliance with this requirement.
b	Therapeutic and rehabilitation service planning provides timely attention to the needs of each individual, in particular:	<p>Compliance: Partial.</p>
b.i	initial therapeutic and rehabilitation service plans (Admission-Wellness and Recovery Plan ("A-WRP")) are completed within 24 hours of admission;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006: Implement the A-WRP within the first 24 hours on all admission teams.</p> <p>Findings: The facility has implemented the A-WRP on all three teams on the admission unit. The facility has recently begun to implement the A-WRP on all admission teams (#9) on all units in the facility. The facility does not currently monitor this item.</p> <p>Recommendation 2, July 2006: Develop and implement a chart audit to ensure timeliness, completeness and quality of documentation.</p> <p>Findings: The facility revised its chart audit form to address this requirement. Using this form, the facility reviewed samples that varied from 3% to 14% each month from July to December 2006. A compliance rate of 13% is reported for this requirement.</p>

		<p>Recommendation 3, July 2006: Ensure implementation by skilled nursing unit of C.2. bi through C.2. b.iii.</p> <p>Findings: The facility has implemented this recommendation. Training was provided (by the TEC) to all teams on the skilled nursing units regarding the principles and practice of WRP.</p> <p>Other findings: This monitor reviewed the charts of 11 individuals (DT, LK, NP, RT, WLW, JLW, LH, EGC, VDB, JMR and NK) that were randomly selected from all units in the facility. Only one chart (NK) met compliance with this requirement.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue implementation of the A-WRP within 24 hours of the admission. 2. Monitor implementation of the A-WRP within 24 hours of all admission. 3. Ensure that monitoring of the A-WRP includes 20% sample of all admissions.
b.ii	<p>master therapeutic and rehabilitation service plans ("Wellness and Recovery Plan" (WRP)) are completed within 7 days of admission; and</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006: Begin implementation of master WRPs within 7 days of admission in all units.</p> <p>Findings: The facility has yet to implement this recommendation.</p>

		<p>Recommendation 2, July 2006: Implement an audit system to ensure timeliness, completeness and quality of documentation.</p> <p>Findings: The facility revised its chart audit form to address this requirement. Using the revised form, the facility reviewed samples from all units (admissions and long-term). The sample sizes varied from 3% to 14% each month from July to December 2006. Data indicate 25% compliance with the requirement to develop the master WRP within 7 days of admission. To address the quality of the documentation, the DMH developed a Clinical Chart Auditing Form to be completed only by clinicians. This tool is to be combined with the DMH Case Formulation Monitoring Form. The current chart auditing Form will continue to be used by Standards Compliance Reviewers focusing on timeliness and completeness of the documentation.</p> <p>Other findings: Reviewing the above mentioned 11 charts, this monitor found compliance in five charts (LK, RT, NK, WLW and JLW) and non-compliance in six.</p> <p>Current recommendations:</p> <ol style="list-style-type: none">1. Implement master WRPs within 7 days of admission in all units.2. Monitor the implementation of the master WRP within 7 days of all admissions.3. Ensure that monitoring of the master WRP includes a 20% sample of all admissions.4. Implement the DMH Clinical Chart Auditing Form.
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b.iii	<p>therapeutic and rehabilitation service plan reviews are performed every 14 days during the first 60 days of hospitalization and every 30 days thereafter. The third monthly review is a quarterly review and the 12th monthly review is the annual review.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006: Begin implementation of the required WRP conference schedule on all admission and long-term teams.</p> <p>Findings: As mentioned in the baseline report, all three teams on the admissions' unit have implemented this recommendation. In other teams, the reviews are conducted quarterly. The facility recently began to implement the requirement for monthly WRP reviews on 10 (of 49) long-term teams.</p> <p>Recommendation 2, July 2006: Develop and implement an audit system to ensure timeliness, completeness and quality of documentation.</p> <p>Findings: The facility revised its chart audit form to address this requirement. Using the revised form, the facility reviewed samples from all units (admissions and long-term). The sample sizes varied from 3% to 14% each month from July to December. The data indicate 48% compliance with this requirement. This revision does not include measures relating to the quality of the documentation. However, the new DMH WRP Clinical Chart Auditing Form meets the requirement regarding the quality of documentation in all WRPs. The implementation of this form is pending.</p> <p>Other findings: The 11 charts reviewed by this monitor show compliance in two (RT and JLW), partial compliance in seven (DT, LK, RT, NK, WLW, VDP, LH and EGC) and non-compliance in two (LK and NP).</p>
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		<p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Implement the required WRP conference schedule on all admission and long-term teams. 2. Monitor the implementation of the required WRP conference schedule on all admission and long-term teams. 3. Ensure that monitoring of the WRP reviews includes a 20% sample of all admissions. 4. Implement the DMH Clinical Chart Auditing Form.
c	<p>Treatment rehabilitation and enrichment services are goal-directed, individualized, and informed by a thorough knowledge of the individual's psychiatric, medical, and psychosocial history and previous response to such services;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006: Continue and strengthen training of WRPTs to ensure that:</p> <ul style="list-style-type: none"> • The case formulation includes appropriate review and analysis of assessments to identify the individual's needs in the psychiatric, medical and psychosocial domains, and • Foci of hospitalization addresses all identified needs of the individual in the above domains. <p>Findings: Review of the WRP training roster and handouts indicates that the training provided by the TEC has adequately addressed this recommendation.</p> <p>Recommendation 2, July 2006: Develop and implement audit items to ensure that cognitive disorders, if present, are documented as a focus and that individualized and appropriate objectives and interventions are provided.</p>

		<p>Findings: The facility has yet to implement this recommendation.</p> <p>Recommendation 3, July 2006: Develop and implement audit items to ensure that substance abuse, if present, is documented as a focus and that individualized and appropriate objectives and interventions are provided.</p> <p>Findings: The facility has a chart audit item that assesses the documentation of substance abuse as a focus and the presence of at least one objective and intervention regarding this focus. This item does not assess whether the objectives and interventions are individualized and appropriate (e.g. relative to the stages of change). Using the DMH WRP Chart Audit form, the facility has data that show 65% compliance with the requirement that when substance abuse is diagnosed on Axis I it is documented in Focus 5 and there is at least one corresponding objective and intervention.</p> <p>Recommendation 4, July 2006: Develop and implement audit items to ensure that seizure disorders, if present, are documented as a focus and that individualized and appropriate objectives and interventions are provided. The documentation needs to address the interface between seizure disorders (and its treatment), psychiatric status (and its treatment) and psychosocial functioning of the individual.</p> <p>Findings: The facility has yet to implement this recommendation.</p> <p>Other findings: Chart reviews by this monitor indicate that the WRPs currently performed at NSH generally fail to comply with this requirement. For</p>
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		<p>example, treatment, rehabilitation and enrichment services tend to ignore the needs of individuals suffering from a range of disorders that require specialized objectives and interventions. The following are chart examples of individuals in each category of these disorders:</p> <ol style="list-style-type: none"> 1. Seizure disorders: <ol style="list-style-type: none"> a. DPN and ZH are individuals receiving regular treatment with phenytoin but their WRPs do not include the diagnosis of seizure disorder or any seizure-related focus, objectives or interventions. b. RVG is an individual receiving regular treatment with phenytoin, but the WRP does not include interventions to assess the risks of treatment and to minimize its possible negative impact. c. JRD receives combined treatment with phenytoin and phenobarbital, but the WRP does not include any seizure-related objectives or interventions 2. Cognitive disorders: <ol style="list-style-type: none"> a. WFO is diagnosed with Cognitive Disorder NOS with right parietal lobe dysfunction. The WRP does not address the cognitive impairment in any of the foci, objectives and interventions. b. RLM has a diagnosis of Vascular Dementia with Depressed Mood that is identified as a focus on the WRP, but no objectives or interventions that address dementia are listed. c. RA carries a diagnosis of Cognitive Disorder NOS. The WRP does not include focus, objectives or interventions that address the cognitive impairment. d. RAVG is diagnosed with Dementia due to Head Injury and Alcohol Abuse without evidence of objectives or interventions related to the dementia. 3. Substance abuse: See monitor's examples in C.2.o.
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		<p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue training of WRPTs to ensure that: <ol style="list-style-type: none"> a. The case formulation includes appropriate review and analysis of assessments to identify the individual's needs in the psychiatric, medical and psychosocial domains, and b. Foci of hospitalization address all identified needs of the individual in the above domains. 2. Develop and implement audit items to ensure that seizure disorders, if present, are documented as a focus and that individualized and appropriate objectives and interventions are provided. The documentation needs to address the interface between seizure disorders (and their treatment), psychiatric status (and its treatment) and psychosocial functioning of the individual. 3. Develop and implement audit items to ensure that cognitive disorders, if present, are documented as a focus and that individualized and appropriate objectives and interventions are provided. 4. Develop and implement audit items to ensure that substance abuse, if present, is documented as a focus and that individualized and appropriate objectives and interventions are provided.
d	Therapeutic and rehabilitation service planning is based on a comprehensive case formulation for each individual that emanates from interdisciplinary assessments of the individual consistent with generally accepted professional standards of care. Specifically, the case formulation shall:	<p>Compliance: Partial.</p>

d.i	<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>Recommendations 1 and 2, July 2006:</p> <ul style="list-style-type: none"> • Same as in C.2.c. • Continue and strengthen training of the WRPTs to ensure that the case formulation includes adequate review and analysis of assessments to establish appropriate diagnosis and differential diagnosis. <p>Findings: This recommendation was addressed as part of the training provided by the TEC.</p> <p>Recommendation 3, July 2006: Implement the newly developed case formulation monitoring instrument. This instrument should consolidate most of the items in the current variety of tools as well as provide a more meaningful process. It should serve as the main tool to assess quality of case formulations.</p> <p>Findings: This facility has implemented this recommendation. Using the DMH WRP Case Formulation Monitoring Form, the facility reviewed a 12% sample during January 2007. NSH reports an average compliance rate of 3% with the requirement that the case formulation is derived from analysis of the information gathered from interdisciplinary assessments, including diagnosis and differential diagnosis. The case formulation form instructions include appropriate operational components of this requirement.</p> <p>Other findings: Chart reviews by this monitor show evidence of case formulations that, in general, are not based on careful analysis of the information in the</p>
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		<p>assessments. As a result, these formulations do not provide the basis for proper delineation of diagnosis and development and finalization of a differential diagnosis (e.g. CR, NJ, AA and KP). This finding is also applicable to C.2.d.ii through C.2.d.i.v.</p> <p>Almost all the charts reviewed by this monitor demonstrate a pattern of significant deficiencies in the quality and completeness of case formulations. The key deficiencies include:</p> <ol style="list-style-type: none"> 1. The case formulations are not consistently completed in the 6-p format. 2. The linkages within different components of the formulations are often missing. 3. The formulations contain inadequate analysis of assessments and derivation of hypothesis regarding the individual's treatment, rehabilitation and enrichment needs. 4. There is inadequate linkage between the material in the case formulations and other key components of the WRP (e.g. foci of hospitalization, life goals, objectives and interventions). <p>These deficiencies are such that the current case formulations performed at NSH generally fail to address the requirements in C.2.d.i through C.2.d.iv.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Same as in C.2.c. 2. Continue the case formulation training related to this requirement and ensure that the training includes clinical case examples. 3. Continue to monitor this requirement and ensure a 20% sample of the target population. 4. Address and correct factors related to low compliance.
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d.ii	include a review of: pertinent history; predisposing, precipitating and perpetuating factors; previous treatment history, and present status;	<p>Current findings on previous recommendations:</p> <p>Recommendation, July 2006: Continue and strengthen the implementation of the WRP by WRPTs to ensure that the case formulations are consistently completed in the 6-p format and that the content of different sections accords with the information in the DMH WRP manual.</p> <p>Findings: Using the DMH Case Formulation Monitoring Form, the facility has data that show compliance rates varying from 31% to 44% with the six components of this requirement. As mentioned earlier, the data are based on a review done in January 2007. This review provided a baseline assessment.</p> <p>Other findings: As in C.2.d.i.</p> <p>Current recommendations: Same as above.</p>
d.iii	consider biomedical, psychosocial, and psychoeducational factors, as clinically appropriate, for each category in § [III.B.4.b] above	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2006: Continue and strengthen the implementation of the WRP by WRPTs to ensure that the case formulations are consistently completed in the 6-p format and that the content of different sections accords with the information in the DMH WRP manual.</p> <p>Findings: The facility has data based on the Case Formulation Monitoring Form. The data show a compliance rate of 15% with this requirement. The form instructions provide an appropriate operational definition of this</p>

		<p>requirement.</p> <p>Other findings: Same as in C.2.d.i</p> <p>Current recommendations: Same as above.</p>
d.iv	<p>consider such factors as age, gender, culture, treatment adherence, and medication issues that may affect the outcomes of treatment and rehabilitation interventions;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2006: Same as in C.2.c.</p> <p>Findings: Same as in C.2.c.</p> <p>Other findings: The facility has monitoring data based on the DMH Case Formulation Monitoring Form. The data indicate 21% compliance with this requirement.</p> <p>This monitor's findings are outlined in C.2.d.i.</p> <p>Current recommendations: Same as above.</p>
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>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2006: Same as in C.2.d.i and D.1.C.iii.</p> <p>Findings: Same as in C.2.d.i and D.1.c.iii.</p>

		<p>Other findings: The facility's monitoring data indicate overall compliance rate of 1% with this requirement. The data are based on the Case Formulation Monitoring Form. The form instructions include appropriate operational definitions of this requirement.</p> <p>Current recommendations: Same as in C.1.d.i and D.1.c.iii.</p>
d.vi	enable the interdisciplinary team to reach sound determinations about each individual's treatment, rehabilitation, enrichment and wellness needs, the type of setting to which the individual should be discharged, and the changes that will be necessary to achieve discharge.	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2006: Same as in C.2.d.i through C.2.d.iv.</p> <p>Findings: Same as in C.2.d.i through C.2.d.iv.</p> <p>Other findings: The facility has monitoring data that show 13% compliance with this requirement based on the Case Formulation Monitoring Form. The form instructions include an adequate operational definition of this requirement.</p> <p>This monitor's findings are outlined in C.2.d.i.</p> <p>Current recommendation: As above.</p>
e	The therapeutic and rehabilitation service plan specifies the individual's focus of hospitalization (goals), assessed needs (objectives), and how the staff will assist the individual to achieve his or her goals/objectives (interventions);	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006: Same as in C.2.c, C.2.f, C.2.g and C.2.o.</p>

		<p>Findings: Same as in C.2.c, C.2.f and C.2.o.</p> <p>Recommendation 2, July 2006: Ensure that process observation and chart audit data are consolidated and aligned with the operational items spelled out in the EP.</p> <p>Findings: As mentioned earlier, the facility has revised the process observation and chart audit forms. The revised forms have been standardized for statewide use and the monitoring items and form instructions are aligned with requirements of the EP. Using the chart audit form, the facility reports a compliance rate of 3%.</p> <p>Other findings: Chart reviews by this monitor indicate that, in almost all cases, the foci of hospitalization are incomplete, usually limited to one or two areas, are identified in generic terms and do not offer meaningful targets for individuals' treatment, rehabilitation and enrichment. Deficiencies are noted in the following areas:</p> <ol style="list-style-type: none">1. Identification of foci of hospitalization that address individuals' special needs (see monitor's findings in C.2.c and C.2.o).2. Proper formulation and execution of objectives and interventions (see the monitor's findings in C.2.f).3. Appropriate revision of foci and objectives (see the monitor's finding in C.2.g). <p>Compliance: Partial.</p>
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		<p>Current recommendations: Same as in C.2.c, C.2.f, C.2.g and C.2.o.</p>
f	<p>Therapeutic and rehabilitation service planning is driven by individualized needs, is strengths-based (i.e., builds on an individual's current strengths), addresses the individual's motivation for engaging in wellness activities, and leads to improvement in the individual's mental health, health and well being, consistent with generally accepted professional standards of care. Specifically, the interdisciplinary team shall:</p>	<p>Compliance: Partial.</p>
f.i	<p>develop and prioritize reasonable and attainable goals/objectives (e.g., at the level of each individual's functioning) that build on the individual's strengths and address the individual's identified needs and, if any identified needs are not addressed, provide a rationale for not addressing the need;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006: Continue and strengthen training of WRPTs to ensure that objectives and interventions are implemented in accordance with the requirements in the DMH WRP manual.</p> <p>Findings: See findings in C.1.a and C.1.J.</p> <p>Recommendation 2, July 2006: Assess the reason for (and correct) the discrepancies between process and audit data that address similar concepts and operations.</p> <p>Findings: NSH revised the chart audit forms to better address this requirement. This requirement was appropriately removed from the new process observation form. The facility has monitoring data based on the DMH WRP Chart Auditing Form. The data show 5% compliance with this requirement (July to December, 2006).</p>

		<p>Recommendation 3, July 2006: Develop and implement a monitoring system to assess if goals/ objectives are reasonable and attainable, if they address the identified need and if there is a rationale for not addressing the need.</p> <p>Findings: The new chart audit form clearly meets this requirement.</p> <p>Other findings: This monitor reviewed five charts and found partial compliance in two (EA and RAVG) and non-compliance in three (RLM, MP and TE).</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue training of WRPTs to ensure that objectives and interventions are implemented in accordance with the requirements in the DMH WRP manual. 2. Continue to monitor this requirement. 3. Address and correct factors related to low compliance with this requirement.
f.ii	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>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006: Same as in recommendation #1 in C.2.f.i.</p> <p>Findings: Same as in C.2.f.i.</p> <p>Recommendation 2, July 2006: Develop and implement monitoring tools that clearly address the key required elements.</p>

		<p>Findings: The facility's revised DMH WRP Chart Auditing Form clearly meets this requirement. Using this form, the facility reports a compliance rate of 5% (October to December 2006 with samples varying from 3% to 14%).</p> <p>Recommendation 3, July 2006: Same in C.2.e.</p> <p>Findings: Same as in C.2.e.</p> <p>Other findings: This monitor reviewed six charts (RLM, EA, RAVG, MP, TE and TLG) and found non-compliance in all cases.</p> <p>Current recommendations: As above.</p>
f.iii	write the objectives in behavioral, observable, and/or measurable terms:	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2006: Same as in recommendation #1 in C.2.f.i.</p> <p>Findings: Same as in C.2.f.i.</p> <p>Other findings: The facility has chart audit data that show 16% compliance with this requirement (July to December 2006).</p> <p>This monitor found non-compliance in all six charts reviewed (RLM, EA, RAVG, MP, TLG and TE).</p>

		<p>Current recommendations: As above.</p>
f.iv	include all objectives from the individual's current stage of change or readiness for rehabilitation, to the maintenance stage for each focus of hospitalization, as clinically appropriate;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006: Same as in recommendation #1 in C.2.f.i.</p> <p>Findings: Same as in C.2.f.i.</p> <p>Recommendation 2, July 2006: Same as in C.2.e.</p> <p>Findings: Same as in C.2.e.</p> <p>Recommendation 3, July 2006: Assess the reason for (and correct) the discrepancies among audit data that address similar concepts and operations.</p> <p>Findings: NSH revised the chart audit form to better address this requirement. This requirement was appropriately removed from the new process observation form. Using the DMH WRP Chart Auditing Form, the facility reports 13% compliance with this requirement (July to December 2006).</p> <p>Other findings: This monitor found non-compliance in all five charts reviewed (RLM, EA, RAVG, MP and TE). In all these cases, the stages of change were not identified appropriately.</p>

		<p>Current recommendations: As above.</p>
f.v	<p>ensure that there are interventions that relate to each objective, specifying who will do what, within what time frame, to assist the individual to meet his/her needs as specified in the objective;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2006: Same as in recommendation#1 in C.2.f.i.</p> <p>Findings: Same as in C.2.f.i.</p> <p>Other findings: The facility has chart audit data that show 3% compliance with this requirement (July to December 2006).</p> <p>This monitor found partial compliance in one chart (RAVG) and non-compliance in four charts (RLM, EA, MP and TE).</p> <p>Current recommendations: As above.</p>
f.vi	<p>implement interventions appropriately throughout the individual's day, with a minimum of 20 hours of active treatment per week. Individual or group therapy included in the individual's WRP shall be provided as part of the 20 hours of active treatment per week;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, July 2006:</p> <ul style="list-style-type: none"> • Assess and address the factors related to inadequate scheduling by the WRPTs and participation by individuals to ensure compliance with the requirement. • Continue efforts to monitor hours of active treatment (scheduled and attended). <p>Findings: The facility has no data to indicate an assessment of the factors</p>

regarding the inadequate scheduling by the WRPTs and participation by individuals to ensure compliance with the requirement.

The facility has reviewed active treatment hours scheduled and attended during one week in December 2006 as per My Activity Participation Plan (MAPP). The facility's data show that this requirement is not met in most cases. The data are as follows:

Program	Scheduled hours	Actual attended hours
I	5.0	2.7
II	4.3	1.7
III	7.7	3.9
IV	11.8	5.1
V	7.9	3
Average totals	7.3	3.3

Other findings:

This monitor reviewed five charts to determine the number of hours scheduled per the WRP and MAPP and the actual hours attended per MAPP. As the following data demonstrate, the WRPs generally fail to identify the required hours. In addition, there is inconsistency between WRP and MAPP data regarding scheduled hours, and MAPP data show inadequate implementation of this requirement in four out of five cases.

Individual	Scheduled hours (WRP)	Scheduled hours (MAPP)	Attended hours (MAPP)
RLM	Not specified	5	1
EA	Not correctly specified	13	13

		<table border="1" data-bbox="1024 228 1866 529"> <thead> <tr> <th data-bbox="1024 228 1203 305">Individual</th> <th data-bbox="1203 228 1423 305">Scheduled hours (WRP)</th> <th data-bbox="1423 228 1644 305">Scheduled hours (MAPP)</th> <th data-bbox="1644 228 1866 305">Attended hours (MAPP)</th> </tr> </thead> <tbody> <tr> <td data-bbox="1024 305 1203 381">RAVG</td> <td data-bbox="1203 305 1423 381">7</td> <td data-bbox="1423 305 1644 381">13</td> <td data-bbox="1644 305 1866 381">7</td> </tr> <tr> <td data-bbox="1024 381 1203 457">NP</td> <td data-bbox="1203 381 1423 457">Not correctly specified</td> <td data-bbox="1423 381 1644 457">14</td> <td data-bbox="1644 381 1866 457">8</td> </tr> <tr> <td data-bbox="1024 457 1203 529">TE</td> <td data-bbox="1203 457 1423 529">Not correctly specified</td> <td data-bbox="1423 457 1644 529">5</td> <td data-bbox="1644 457 1866 529">3</td> </tr> </tbody> </table> <p data-bbox="1010 574 1346 602">Current recommendations:</p> <ol data-bbox="1037 610 1892 824" style="list-style-type: none"> <li data-bbox="1037 610 1892 751">1. Assess and address the factors related to inadequate scheduling by the WRPTs, inaccurate reporting of hours scheduled on the WRP, disconnection between WRP and MAPP data and inadequate participation by individuals. <li data-bbox="1037 760 1761 824">2. Continue efforts to monitor hours of active treatment (scheduled and attended). 	Individual	Scheduled hours (WRP)	Scheduled hours (MAPP)	Attended hours (MAPP)	RAVG	7	13	7	NP	Not correctly specified	14	8	TE	Not correctly specified	5	3
Individual	Scheduled hours (WRP)	Scheduled hours (MAPP)	Attended hours (MAPP)															
RAVG	7	13	7															
NP	Not correctly specified	14	8															
TE	Not correctly specified	5	3															
f.vii	<p data-bbox="281 873 978 1049">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 data-bbox="1010 873 1598 901">Current findings on previous recommendation:</p> <p data-bbox="1010 946 1383 974">Recommendation, July 2006:</p> <p data-bbox="1010 982 1707 1010">Assess and correct factors related to lack of programs.</p> <p data-bbox="1010 1055 1125 1083">Findings:</p> <p data-bbox="1010 1091 1885 1305">According to the TEC, the facility currently has about 200 civilly committed individuals and a total census of approximately 1200. The facility has monitoring data that show 25% compliance with this requirement. The data are based on a review of sample sizes that varied from 3% to 14% (July to December 2006). The facility has not assessed factors related to lack of programs.</p> <p data-bbox="1010 1351 1209 1378">Other findings:</p> <p data-bbox="1010 1386 1871 1414">This monitor reviewed six charts of civilly committed individuals (EA,</p>																

		<p>RAVG, NP, RT, WZ and LK) and found non-compliance in all cases.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Monitor 20% sample of civilly committed individuals. 2. Assess and correct factors related to lack of programs.
f.viii	<p>ensure that each therapeutic and rehabilitation service plan integrates and coordinates all services, supports, and treatments provided by or through each State hospital for the individual in a manner specifically responsive to the plan's therapeutic and rehabilitation goals. This requirement includes but is not limited to ensuring that individuals are assigned to mall groups that link directly to the objectives in the individual's WRP and needs.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, July 2006:</p> <ul style="list-style-type: none"> • Develop and implement a mechanism to ensure proper linkage between type and objectives of mall activities and objectives outlined in the WRP as well as documentation of this linkage. • Revise the WRP/mall alignment check protocol to address the key element in question. <p>Findings: The facility has yet to implement these recommendations.</p> <p>Recommendation 3, July 2006:</p> <ul style="list-style-type: none"> • Implement electronic progress note documentation by all mall and individual therapy providers. <p>Findings: A statewide group developed the format for a new electronic progress note regarding mall activities. The PSR Mall Facilitator Monthly Progress Note includes the individual's current objectives as listed in the WRP, total sessions scheduled, number attended for the month, the individual's level of participation for the reporting period, stage of change at which active treatment is presented, individual's progress on the objective during the reporting period and recommendations to the WRPT. Effective January 2007, five WRPTs have begun the implementation of this format.</p>

		<p>Other findings: Chart reviews by this monitor demonstrate lack of compliance with this requirement. This monitor reviewed five charts (RLM, EA, RAVG, MP and TE) and found lack of documentation that supports compliance with the two elements of this requirement in all cases.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a mechanism to ensure proper linkage between type and objectives of mall activities and objectives outlined in the WRP as well as documentation of this linkage. 2. Revise the WRP/mall alignment check protocol to address this requirement. 3. Continue the implementation of electronic progress notes by all mall and individual therapy providers.
g	Therapeutic and rehabilitation service plans are revised as appropriate to ensure that planning is based on the individual's progress, or lack thereof, as determined by the scheduled monitoring of identified criteria or target variables, consistent with generally accepted professional standards of care. Specifically, the interdisciplinary team shall:	<p>Compliance: Partial.</p>
g.i	revise the focus of hospitalization, objectives, as needed, to reflect the individual's changing needs and develop new interventions to facilitate attainment of new objectives when old objectives are achieved or when the individual fails to make progress toward achieving these objectives;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006: Ensure that the DMH WRP manual contains specific requirements for review and revision of foci, objectives and interventions to address changes in the individual's status.</p> <p>Findings: The revised DMH WRP manual (sections 1.2.g, 10.3 and 10.4.2) contains the specific requirements as recommended.</p>

		<p>Recommendation 2, July 2006: Continue and strengthen training to WRPTs to ensure that foci and objectives are reviewed and revised and that new interventions are developed and implemented as clinically needed.</p> <p>Findings: See findings in C.1.a and C.1.J.</p> <p>Other findings: The facility has monitoring data based on the DMH WRP Observation Monitoring Form (July to December 2006). The data show a compliance rate of 8%.</p> <p>This monitor reviewed five charts (EA, TE, TLG, AT and FNG) and found non-compliance in all cases.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue training to WRPTs to ensure that foci and objectives are reviewed and revised and that new interventions are developed and implemented as clinically needed. 2. Continue to monitor this requirement. 3. Address and correct factors related to low compliance.
g.ii	review the focus of hospitalization, needs, objectives, and interventions more frequently if there are changes in the individual's functional status or risk factors (i.e., behavioral, medical, and/or psychiatric risk factors);	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006: Same as above.</p> <p>Findings: Same as above.</p> <p>Recommendation 2, July 2006: Revise current monitoring tool to include individuals whose functional</p>

		<p>status has improved.</p> <p>Findings: The facility has yet to implement this recommendation.</p> <p>Other findings: The facility has monitoring data based on the DMH WRP Observation Monitoring Form (unspecified sample from July to December 2006) and Chart Auditing Form (samples from 3% to 14% from July to December 2006). The data show compliance rates of 24% and 15%, respectively.</p> <p>This monitor reviewed the charts of five individuals (RT, WZ, FT, EG and TCG) who have experienced restrictive interventions (seclusion and/or restraints) in the past year. The review shows compliance in one chart (TCG) and non-compliance in the other four.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Same as above. 2. Revise current monitoring tool to include individuals whose functional status has improved.
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, July 2006 Continue and strengthen training to WRPTs to ensure consistent implementation of this requirement.</p> <p>Findings: See findings in C.1.a and C.1.J.</p> <p>Recommendation 2, July 2006: Assess reason for and correct discrepancies in process observation data that address similar concepts and operations.</p>

		<p>Findings: As mentioned earlier, the process observation form has been revised and streamlined. The new DMH WRP Observation Monitoring Form is aligned with EP requirements.</p> <p>Other findings: The facility has process observation data that show a compliance rate of 19% with this requirement. The data are based on the DMH Observation Monitoring Form (unspecified sample from July to December 2006).</p> <p>This monitor reviewed five charts (EA, RAVG, MP, AT and FNG). The review shows that discharge criteria were outlined in all cases (the criteria were not specific in the case of RAVG). All the charts (with the possible exception of RAVG) show no evidence of documentation, in the present status section, of a discussion of the individual's progress related to discharge.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue training of WRPTs to ensure consistent implementation of this requirement. 2. Continue to monitor this requirement. 3. Address and correct factors related to low compliance.
g.iv	base progress reviews and revision recommendations on data collected as specified in the therapeutic and rehabilitation service plan.	<p>Current findings on previous recommendations:</p> <p>Chart reviews by this monitor (RLM, EA, RAVG, MP and TE) demonstrate failure to conduct data-based reviews in the WRP.</p> <p>Recommendation 1, July 2006: Same as in C.2.g.i.</p>

		<p>Findings: Same as in C.2.g.i.</p> <p>Recommendation 2, July 2006: Same as recommendation #3 in C.2.f.viii.</p> <p>Findings: Same as in C.2.f.viii.</p> <p>Recommendation 3, July 2006: Same as recommendation #2 in C.2.f.ii.</p> <p>Findings: Same as in C.2.f.ii.</p> <p>Recommendation 4, July 2006: Ensure that each monitoring item addresses only one team function.</p> <p>Findings: The revised process observation and chart audit forms adequately addressed this recommendation.</p> <p>Other findings: The facility has process observation data (July to December, 2006) that show 15% compliance with this requirement.</p> <p>All chart reviews by this monitor (RLM, EA, RAVG, MP and TE) demonstrate failure to conduct data-based reviews in the WRP.</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. Same as in C.2.f.ii.
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h	Individuals in need of positive behavior supports in school or other settings receive such supports consistent with generally accepted professional standards of care.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006: Ensure that PBS psychologists have the authority to write orders for the implementation of PBS plans.</p> <p>Findings: The AD has been revised (AD #850) to address psychology orders. PBS psychologists now have the authority to write orders for the implementation of PBS plans and educational assessments.</p> <p>Recommendation 2, July 2006: Ensure that all staff implement PBS plans and collect reliable and valid outcome data.</p> <p>Findings: Interviews with PBS team leaders, the Mall Director and a review of PBS plans and implementation/outcome data showed that none of the three existing PBS plans were implemented in settings other than the residential unit.</p> <p>Other findings: None.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Implement the revised AD that allows the PBS Psychologist to write an order for the PBS plan across settings. 2. Ensure that staff in all settings has been trained to competency on all PBS plans.
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		3. Provide documentation that staff in all treatment settings have been trained to competency on all PBS plans.
i	Adequate active psychosocial rehabilitation is provided, consistent with generally accepted professional standards of care, that:	Compliance: Partial.
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>Recommendation 1, July 2006: All discipline-specific assessments should include a section that states the implications of the assessment for rehabilitation activities.</p> <p>Findings: According to Jim Jones, Acting Chief of Psychology, only the psychology discipline assessments include a section on the implications of the assessments for rehabilitation activities. Review of four WRPs (RH, BRC, NF, and KH) showed that assessments do not fully address the individual's strengths, cognition, educational and social factors to benefit the individual's rehabilitation services programming. Recommendations are general and vague.</p> <p>Recommendation 2, July 2006: The WRPT should integrate these assessments and prioritize the individual's assessed needs.</p> <p>Findings: NSH's progress report showed that 9% of the assessments reviewed met this requirement. There is little evidence that WRPTs consistently receive information on rehabilitation activities from the discipline specific assessments to integrate the information and to prioritize individuals' needs. All progress notes are not received by WRPTs.</p>

		<p>Recommendation 3, July 2006:</p> <p>The WRPT should select all available group and individual therapies that will meet the needs of the individual and then allow the individual to choose from these interventions.</p> <p>Findings:</p> <p>The expectations are clearly defined in the Revised DMH WRP Manual, (January 2007, sec. 92). However, this requirement is yet to be fully implemented. Many of the individuals interviewed by this monitor (PF, BN, JS, and MH), reported that their WRPTs did not fully explain the curriculum/objectives of the groups that they were requested/ suggested to attend. Others (BV and AT) are attending groups other than those scheduled, and neither the WRPT nor the facilitators have noticed or done anything about it.</p> <p>Four cases (MR, JT, RW, and LY) using Narrative Restructuring Therapy were reviewed. This was the only systematic method of behavior change that included documentation by the provider on objectives, measurable outcomes, and standardized empirical methodology. Furthermore, this was the only therapy used at NSH during this evaluation period that demonstrated data-based, positive change in the individuals' stage of change. The data indicated that when the individuals' objectives and interventions are aligned with assessed needs and appropriate therapy is provided, their quality of life improves.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Revise all discipline-specific assessments to include a section that states the implications of the assessment for rehabilitation activities.
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		<ol style="list-style-type: none"> 2. Assess the WRP for integration of this element of the assessments into the WRP 3. Finalize the Mall Alignment tool to monitor the match between assessed needs in the WRP and the psychosocial services provided. 4. Ensure that there is a match amongst the WRP plan, Mall activity schedule, and the group individual's attend.
i.ii	Has documented objectives, measurable outcomes, and standardized methodology	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, July 2006:</p> <ul style="list-style-type: none"> • Ensure that the psychosocial rehabilitation objectives are written in behavioral, observable and/or measurable terms, as specified in the DMH WRP Manual. • Ensure that the learning outcomes are stated in measurable terms. <p>Findings: Review of WRPs, scheduled mall groups versus actual mall groups and observations of the mall groups of four individuals (RH, BRC, NF, and KH) showed that WRP objectives are not relevant to assessed needs, mall objectives did not exist, individuals were not in the groups they were assigned to (but had data in the WRP about progress in the group), outcomes for the group that the individual was actually attending was not documented or reported to the WRPT.</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.

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, July 2006: Ensure that all therapies and rehabilitation services provided in the malls are aligned with the assessed needs of the individuals.</p> <p>Findings: A review of the charts revealed that the WRPTs are not writing meaningful and informed objectives in the individual's WRP (AT, PR, JS, KH, TLR, RMH, HTS, NF, BRC, RH, BV, AV, and EH) and this results in the assigned psychosocial activities being a poor match. In some WRPs (AT, PR, AV, and BV), objectives were not staged correctly and/or clearly linked to their relevant foci and again resulted in a poor match in psychosocial activities. For example, AT's objectives were not staged correctly; his group is focused on forensic issues, which is not appropriate for the objectives and foci found in the WRP.</p> <p>In a few cases, the objectives were correctly developed, but the individuals' psychosocial activities are not always aligned with the objectives that are identified in their WRPs. A number of WRPs reviewed by this monitor were deficient in meeting this requirement.</p> <p>Other findings: NSH has completed a needs assessment on Focus 1 (psychiatric/ psychological) of individuals for their psychiatric and psychological needs using the WRP-Identification of Needs form. The data obtained is yet to be analyzed.</p> <p>The PSR Mall Alignment tool does not fully address all required elements.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that all therapies and rehabilitation services provided in
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		<p>the malls are aligned with the assessed needs of the individuals.</p> <p>2. Revise and implement the PSR Mall Alignment tool.</p>
i.iv	utilizes the individual's strengths, preferences, and interests;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006: Ensure that the individual's strengths, preferences, and interests are clearly specified in the interventions in the individual's WRP in accordance with the DMH WRP manual to inform the delivery of mall services.</p> <p>Findings: NSH's progress report showed only 5 % compliance with this requirement. Only two (HTS and TLA) out of eight charts (HTS, TLA, EH, RH, BRC, NF, RMH, and KH) reviewed by this monitor noted any identified strengths, preferences, and interests of the individual relating to their psychosocial activities.</p> <p>Recommendation 2, July 2006: Ensure that the group facilitators and individual therapists know and use the individual's strengths, preferences and interests when delivering rehabilitation services.</p> <p>Findings: The PSR Mall Alignment tool is in revision.</p> <p>This monitor observed a number of mall groups (Substance Recovery, Spanish/English ESL Literacy, Socials Skills Women's Group, and CONREP), and interviewed a number of facilitators and co-facilitators and individuals from these groups. Only one (ESL group facilitator) out of the eight facilitators and co-facilitators had sufficient knowledge about all individuals in the group, and showed evidence of incorporating</p>

		<p>the strengths, interests and preferences of these individuals into their activities.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that the individual's strengths, preferences, and interests are clearly specified in the interventions in the individual's WRP in accordance with the DMH WRP manual. 2. Ensure that the group facilitators and individual therapists know and use the individual's strengths, preferences and interests when delivering rehabilitation services.
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>Recommendation 1, July 2006: Undertake clinical case formulation as a team rather than by assigning the task to a team member or to non-team members.</p> <p>Findings: The WRP training has addressed this recommendation. NSH used the DMH WRP Case Formulation Monitor to assess compliance with this item. The facility has data that indicate 11% compliance with the requirement that the case formulation is interdisciplinary, containing information that reflect participation by all relevant disciplines. The data are based on a baseline assessment done in January 2007.</p> <p>Recommendation 2, July 2006: Include the individual's vulnerabilities in the case formulation under predisposing, precipitating, and perpetuating factors.</p> <p>Findings: The facility has monitoring data that show a compliance rate of 32%. The case formulation form instructions include adequate operational components of this requirement.</p>

		<p>Recommendation 3, July 2006: Include in the present status an update on the current status of these vulnerabilities.</p> <p>Findings: The facility's data do not clearly address this recommendation.</p> <p>Recommendations 4 and 5, July 2006:</p> <ul style="list-style-type: none">• Use the staged model of substance abuse training for group facilitators.• Use the staged model of substance abuse manual for delivering rehabilitation services to individuals with substance abuse issues. <p>Findings: Since the baseline evaluation, the facility has started training for group facilitators in the preparation and action stages. The training for pre-contemplative and contemplative stages had begun in December 2005. So far, approximately 65 group facilitators have been trained to competency. The training is provided by Dr. Sutherland, Cathy Michaels and guest speakers, including Anthony Rabin and Daniel Gutkind, PhD.</p> <p>Recommendation 6, July 2006: Provide groups on Wellness Recovery Action Plan to all individuals to preempt relapse.</p> <p>Findings: The mall director developed a curriculum on Wellness Recovery Action Plan, with lesson plans. Plans are underway to begin groups on the mall in February 2007.</p>
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		<p>Other findings: Chart reviews and staff interviews by this monitor reveal that case formulations using the 6-p format are uneven in quality, have limited analysis, and do not follow the content guidelines established in the DMH WRP Manual. Most of the case formulations are a cut-and-paste from old notes, which defeats the intent of the formulation in serving as the functional bridge between the assessments and the WRP. In general, there is not a clear focus of treatment on those factors that precipitated readmission due to relapse. The groups assigned are varied and often global. The case formulations inadequately address the individual's vulnerability to relapse. There is no subsequent focus on developing objectives and interventions that are related to these vulnerabilities.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Address and correct factors related to low compliance with the recommendation to include the individual's vulnerabilities in the case formulation under predisposing, precipitating, and perpetuating factors. 2. Present monitoring data regarding the recommendation to include in the present status an update on the current status of these vulnerabilities. 3. Implement substance abuse training on all stages of change to all group facilitators. 4. Implement the new curriculum to provide groups on Wellness Recovery Action Plan to all individuals to preempt relapse.
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 and 2, July 2006:</p> <ul style="list-style-type: none"> • PSR Mall groups must address the assessed cognitive levels of the individuals participating in the groups. • Psychologists must assess all individuals suspected of cognitive

		<p>disorders, mental retardation and developmental disabilities and other conditions that may adversely impact an individual's cognitive status.</p> <p>Findings: Mall groups, when they are formed, do not take into consideration the individual's cognitive functioning. WRPTs do not use the WRP Treatment Activity Request Form to inform the Mall Director of needed groups. NSH's DCAT team has compiled a database of individuals that meet this criterion and is in the process of assessing the needs of the individuals.</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. 5. Complete and implement the WRP/mall alignment tool.
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, July 2006:</p> <ul style="list-style-type: none"> • Ensure that all group and individual therapy providers provide the WRPTs with progress reports on all individuals prior to each individual's scheduled WRP review. • Automate this system to make it feasible for the group facilitators and individual therapists to provide progress

		<p>reports in a timely manner.</p> <p>Findings: NSH's progress report shows that five WRPTs (two teams from T-16, two teams from T-3, and one team from A-9) were said to be implementing the PSR Mall Facilitator Monthly Progress Note effective January 2007. However, 20% of the charts were reviewed and none had the PSR Mall Facilitator Monthly Progress Notes available. Staff was not able to produce supporting documents to verify that providers have written progress reports and have made them available for review by the Wellness and Recovery Teams.</p> <p>Other Findings: Statewide meetings have been held to complete the WARMSS WRP Module, which will include linkage with the PSR/Mall Facilitator Monthly Progress Note.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Implement the PSR Mall Facilitator Monthly Progress Notes. 2. Automate this system to make it feasible for the group facilitators and individual therapists to provide progress reports in a timely manner.
viii	is provided five days a week, for a minimum of four hours a day (i.e., two hours in the morning and two hours in the afternoon each weekday), for each individual or two hours a day when the individual is in school, except days falling on State holidays;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006: Provide PSR mall groups as required by the EP, five days a week, for a minimum of four hours a day (i.e., two hours in the morning and two hours in the afternoon each weekday) for each individual or two hours a day when the individual is in school, except days falling on state holidays.</p>

		<p>Findings: NSH's progress report states that PSR mall groups are provided five days a week, for 3-4 hours a day. The two morning hours are structured mall services. However, the services provided in the afternoons and in the residential units (e.g. in Program 3 and 4) are not structured and do not comport with current professional standards.</p> <p>Recommendation 2, July 2006: 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: According to NSH's progress report, members of the General Management Meeting are to take required training for non-clinical providers. They are expected to facilitate groups effective April 2007.</p> <p>Other findings: None of the disciplines consistently meet the required hours of services to mall activities. NSH is facing a shortage of psychiatrists. Due to the shortage, psychiatrists have been given permission to not facilitate groups. However, a number of psychiatrists continue to support mall activities when their schedule permits.</p> <p>Recommendation 3, July 2006: All Mall sessions must be 50 minutes in length.</p> <p>Findings: NSH's mall activity schedules identify mall group times to be 50 minutes in duration. Observation of groups and interview of group facilitators showed that groups were scheduled for 50 minutes, but often were late in starting and early in termination.</p>
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		<p>Other findings: Groups observed by this monitor (CONREP, Substance Recovery, Women's Support Group, and Social Skills) technically 'met' for about 50 minutes. Other facilitators were running late or still prompting individuals to their groups. In the groups observed by this monitor, learning/instruction/participation times were less than 50 minutes. Some groups took as much as ten minutes to settle down before beginning the session. Late arrivals, poor organization, and individuals engaging facilitators in personal needs outside the scope of the curriculum consumed valuable time. One individual engaged a facilitator for 12 minutes only for the facilitator to respond after the 12 minutes, saying, "I am not a medical provider and I cannot answer your question."</p> <p>Recommendation 4, July 2006: Provide groups as needed by the individuals and written in the individuals' WRPs.</p> <p>Findings:</p> <p>The PSR Mall does not provide enough groups for the individuals to choose from in order to fulfill the required elements.</p> <p>Documentation in the WRPs is poor. Groups are sometimes not identified, or the individuals are not attending the groups stated in their WRP. For example, BCV attended substance abuse recovery group, but the group is not identified in his WRP and he has no diagnosis of substance abuse. Also, AT's Social Skill Group was not listed in her WRP.</p> <p>Interview of the Acting Chief of Psychology and the Mall Director indicated that NSH is unable to provide an adequate number of groups</p>
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		<p>due to staff shortages as well as certain disciplines not providing enough groups per clinician.</p> <p>NSH is not taking opportunity of the individuals in their facility. Individuals who have the ability and interest could be engaged to facilitate or co-facilitate groups.</p> <p>Recommendation 5, July 2006: Add new groups as the needs are identified in new/revised WRPs.</p> <p>Findings: NSH has developed and implemented a WRP Treatment Activity Request Form. The process and program is in place. However, the form is not being utilized by teams.</p> <p>NSH's groups are largely driven by what is available, not what is important/appropriate for the individual.</p> <p>Other findings: None.</p> <p>Current recommendations:</p> <ol style="list-style-type: none">1. Ensure that PSR mall groups are offered for two hours in the afternoon each weekday.2. Mandate that all staff at NSH, other than those who attend to emergency medical needs of individuals, will provide services at the PSR mall. This includes clinical, administrative and support staff.3. Ensure that WRTs use the WRP Treatment Activity Request Form to inform the mall of needed services.4. Ensure that the mall develops the treatment activities that are needed.
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i.ix	<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 recommendations:</p> <p>Recommendation 1, July 2006: Include individual skill-building activities with bed-bound individuals commensurate with their cognitive status, medical health, and physical limitations.</p> <p>Findings: NSH has developed a procedure for staff to provide mall activity services for individuals who are non-ambulatory or have limited mobility (NSH Program 4 Procedure Manual, Program Procedure # 2.10, Section II, Subject: Treatment Services for Individuals with Conditions that Limit Access to Traditional Services).</p> <p>Interview with a rehabilitation therapist revealed that she is aware and understands on the need for skill-building activities with bed-bound individuals (activities cited included television, reading, music, books on tape, movies, socialization, and canine companions).</p> <p>Shortage of staff and time are barriers to better programming of activities for individuals in Programs 3 and 4.</p> <p>Recommendation 2, July 2006: Therapy can be provided in any physical location within the hospital as long as the services are structured and consistent with scheduled mall activities.</p> <p>Findings: NSH provides care in many locations including open areas, central malls, and unit-based malls. According to staff, when possible bed-bound individuals are taken out into the hallway or included with the group, as long as their presence is not too disruptive to the group as a whole.</p>
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		<p>At the time of this tour, individuals were receiving therapeutic services in a room with two facilitators. Interviews revealed that it is uncommon for both facilitators to be present. The four bed-bound individuals were not part of the group nor were they receiving any services.</p> <p>Other Findings: The SNF unit has a capacity for 29 individuals. At the time of this visit, the census was 27 individuals including four bed-bound individuals. There is one rehabilitation therapist to serve all 27 individuals. One other therapist, an occupational therapist assigned to the SNF unit, is on medical leave. Hours of services provided to these individuals are inadequate. There is no fixed schedule for therapeutic services. As the staff put it, the individuals that need the most services are getting the least therapeutic interventions. There is minimal documentation of mall services provided to individuals in bed-bound status. Of those services, little is done in the way of sensory stimulation. The staff reported that individuals in the SNF unit do not get to attend the barber shop or the beauty shop, affecting their self-esteem and quality of life. These services are offered for only two hours on Thursdays, for all individuals in the unit.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that bed-bound individuals receive appropriate services following EP guidelines including hours of services. 2. Implement and document the skills-building activities.
i.x	routinely takes place as scheduled;	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, July 2006:</p> <ul style="list-style-type: none"> • Implement a more focused mall program that is regularly scheduled, implemented, and provided within the individual's cognitive, medical, physical and functional status.

		<ul style="list-style-type: none"> • Ensure that mall groups and individual therapies are cancelled rarely, if ever. <p>Findings: Cancellation rates of group activities are extremely high. A review of the list of Summary of Cancellation Rates by Program for the week of January 8-12, 2007, showed that the average active treatment cancellation rate for all programs was 18.9% (Program1-14.9%, Program2-34.2%, Program3-33.6%, Program4-1.5%, and Program5-10.5%).</p> <p>Other Findings: NSH has mandated that mall services are provided as scheduled. A no-cancellation policy is in effect for Program 4. When unable to make their groups, providers are to inform the mall director/designee to enable staff to find alternate means of managing the group. Program directors and discipline chiefs receive group cancellation reports. This monitor observed that many individuals (up to 20 people) sit/play in the hall section of the mall and fail to attend mall group activities. When interviewed, the mall director agreed with this observation. This monitor did not observe any prompting or organized effort to get these individuals engaged in their assigned groups and that two staff remained in the central office space while individuals were not engaged.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Expand the no-cancellation policy to all mall groups. 2. Ensure that mall group activities routinely take place as scheduled. 3. Inform the WRPT when an individual is not engaging in the assigned treatment. 4. Develop a plan for engaging the individuals not going to assigned treatment activities.
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i.xi	includes, in the evenings and weekends, additional activities that enhance the individual's quality of life; and	<p>Current findings on previous recommendations:</p> <p>Recommendations 1, 2 and 3, July 2006:</p> <ul style="list-style-type: none"> • Develop a list of all enrichment activities available along with staff names competent in facilitating the activities in accordance with generally accepted professional standards of care. • 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: NSH has developed a list of enrichment activities with names of facilitators.</p> <p>The rate of participation of individuals to scheduled hours of activities is poor. NSH data from the attendance roster of scheduled versus attended hours, for the week of December 4th to 8th, 2006, averaged only 3.3 hours (43% of the hours of scheduled activities).</p> <p>Other findings: Partial.</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
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		<p>such activities.</p> <p>2. Increase the number of hours of enrichment activities per individual provided in the evenings and on weekends.</p>
i.xii	<p>is consistently reinforced by staff on the therapeutic milieu, including living units.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006: Ensure that all WRPs have therapeutic milieu interventions clearly specified in the intervention sections.</p> <p>Findings: NSH's progress report data (DMH WRP chart audit) showed 11% compliance. Most charts reviewed by this monitor did not consistently specify the therapeutic milieu in the intervention sections.</p> <p>Recommendation 2, July 2006: 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: Review of NSH's DMH Monitoring Plan - Therapeutic Milieu Observation form showed that the rate of staff discussing individuals' mall activities progressively increased from 0% in July 2006, to 10% in January 2007</p> <p>Observation by this monitor of staff in the units showed that a majority of staff when interacting with individuals provided verbal praise and encouragement for the individual's behaviors at that time. However, there was almost no discussion of what the individuals are learning in the malls or individual therapies.</p>

		<p>Other Findings: The DMH WRP Manual contains information that captures this requirement. Chart reviews showed that some WRPs included therapeutic milieu in the intervention section but observations and staff interviews showed that this did not occur in the residential units.</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.
j	<p>Adequate, individualized group exercise and recreational options are provided, consistent with generally accepted professional standards of care.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006: Establish group exercise and recreational activities for all individuals.</p> <p>Findings: NSH has developed a comprehensive list of group and recreational activities. A review of the psychosocial enrichment activity list shows that while the list of activities is extensive, a good number of activities are redundant, providing the same activity/psychosocial experience (e.g. baseball practice and baseball game).</p> <p>Recommendation 2, July 2006: Provide training to mall facilitators to conduct the activities appropriately.</p> <p>Findings: According to the mall director, staff training has not been provided to all mall facilitators to conduct activities appropriately.</p>

		<p>Recommendation 3, July 2006: Track and review individuals' participation in scheduled group exercise and recreational activities.</p> <p>Findings: Interviews reveal that a tracking system is needed. It has not been completed at this time.</p> <p>Recommendation 4, July 2006: Implement corrective action if participation is low.</p> <p>Findings: No corrective actions are being taken to address low participation of individuals in individual, group, and recreational activities.</p> <p>Other Findings: According to the Chief of Psychology, WRPTs, program directors, and discipline chiefs are to develop a system to review MAPP and enrichment activity data and take corrective actions.</p> <p>Enrichment and MAPP schedules show that group exercises and recreational activities are provided but not in sufficient quantity to meet the needs of all individuals.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Review the developed list for redundancy. 2. Continue to provide training to mall facilitators to conduct the activities appropriately. 3. Develop the system to track and review participation of individuals in scheduled group exercise and recreational
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		<p>activities.</p> <p>4. Implement corrective action, if participation is low.</p>
k	<p>Individuals who have an assessed need for family therapy services receive such services in their primary language, as feasible, consistent with generally accepted professional standards of care and that these services, and their effectiveness for addressing the indicated problem, are comprehensively documented in each individual's chart.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006: Conduct a needs assessment with individuals and/or their families.</p> <p>Findings: According to Ann Long, Chief of Social Work, Chiefs of Social Work across the State are to develop a tool to address this requirement. The tool has not been developed.</p> <p>Recommendation 2, July 2006: Use individual discharge plan goals as a way to identify families that may need family therapy to help them assist and support their family members upon discharge.</p> <p>Findings: According to Ann Long, Chief of Social Work, a section will be included in the Family Therapy section of the Individual/Family Therapy Needs Assessment. The section has not been completed.</p> <p>Recommendation 3, July 2006: Review pre-admission reports and services/treatments provided to identify the need for family therapy services.</p> <p>Findings: According to Ann Long, Chief of Social Work, a section will be included to review preadmission reports and services/treatments provided as an item in the Family Therapy section of the Individual/Family Therapy Needs Assessment. This section was not completed at the time of this monitor's visit.</p>

		<p>Compliance: Non-compliance.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Conduct a needs assessment with individuals and/or their families. 2. Use individual discharge plan goals as a way to identify families that may need family therapy to help them assist and support their family members upon discharge. 3. Review pre-admission reports and services/treatments provided to identify the need for family therapy services.
L	<p>Each individual's therapeutic and rehabilitation service plan identifies general medical diagnoses, the treatments to be employed, the related symptoms to be monitored by nursing staff (i.e., registered nurses ["RNs"], licensed vocational nurses ["LVNs"] and psychiatric technicians) and the means and frequency by which such staff shall monitor such symptoms, consistent with generally accepted professional standards of care.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, July 2006: Develop and implement a monitoring and tracking system to address the key elements of this requirement.</p> <p>Findings: NSH has developed the NSH WRP Chart Auditing form. However, this tool does not address the elements of this requirement.</p> <p>Other findings: From my review, there is no monitoring tool that addresses the elements of this requirement.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Develop and implement a monitoring and tracking system to address the elements of this requirement.</p>

M	The children and adolescents it serves receive, consistent with generally accepted professional standards of care:	MSH only
m.i	Therapy relating to traumatic family and other traumatic experiences, as clinically indicated; and	
m.ii	reasonable, clinically appropriate opportunities to involve their families in treatment and treatment decisions.	
n	Policies and procedures are developed and implemented consistent with generally accepted professional standards of care to ensure appropriate screening for substance abuse, as clinically indicated.	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, July 2006:</p> <ul style="list-style-type: none"> • Revise the screening policy to address the above deficiency. • Finalize and implement the policy and procedure. <p>Findings: The facility has yet to revise the policy.</p> <p>Other findings: None.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Revise the screening policy to ensure that screening and assessment of substance abuse is available and used to provide therapeutic and rehabilitation services that are consistent with generally accepted professional standards of care. 2. Finalize and implement the policy and procedure.

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, July 2006: Develop a formalized substance recovery program with designated administrative and clinical leadership.</p> <p>Findings: The facility has yet to implement the recommendation to designate the clinical leadership. The facility has an administrative leadership in place. The current psychiatry vacancy rate is such that the facility is unable to provide dedicated leadership by a psychiatrist who has specialty certification in substance abuse.</p> <p>Recommendation 2, July 2006: The substance recovery program should develop and utilize clinical outcomes for individuals and process outcomes for the program.</p> <p>Findings: The facility has yet to implement this recommendation.</p> <p>Recommendation 3, July 2006: Assess the reason for (and correct) the discrepancy between facility's data regarding identification of stages of change and the monitor's findings from chart reviews.</p> <p>Findings: The facility has made a change in the process of internal monitoring by requiring that all monitoring is done by psychiatry. Using the substance abuse checklist, NSH reviewed a number of charts that varied from 36 to 100 each month from July to December. The facility did not provide data regarding size of target population. The following is an outline of the compliance data:</p>
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		<ol style="list-style-type: none"> 1. Substance abuse is identified in the 6-ps: 78%. 2. There is an objective and corresponding intervention under focus #5-Substance Abuse: 73%. 3. Individual's current stage of change is identified in the WRP: 73%. 4. Identified stage of change is consistent with corresponding objective (s) and intervention (s) under Focus #5: 72%. 5. Active treatment identified in the WRP matches what is reflected on the individual's MAPP schedule: 69%. <p>The above data do not address whether the stages of change are correctly identified or not.</p> <p>Recommendation 4, July 2006: Complete the training curriculum to address the maintenance phase of change.</p> <p>Findings: The facility is in the process of implementing this recommendation.</p> <p>Recommendation 5, July 2006: Same as in recommendation #3 in C.2.c.</p> <p>Findings: See other findings below.</p> <p>Recommendation 6, July 2006: Ensure that substance abuse monitoring items are aligned with the principles outlined in the current training curriculum.</p> <p>Findings: The facility has yet to implement this recommendation.</p>
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		<p>Other findings: This monitor reviewed five charts (AT, TLG, TE, RAVG and EA) and found the following deficiencies:</p> <ol style="list-style-type: none">1. Substance abuse is not listed as a diagnosis on the WRP of an individual diagnosed with alcohol-induced dementia despite documentation in the case formulation to indicate that substance abuse is a current problem (RAVG).2. Objectives are not correctly identified as objectives (i.e. do not specify what the individual will learn) (AT).3. Objectives are not linked to appropriate stages of change (EA, RAVG, TE, TLG and AT).4. No interventions are listed (EA).5. There is not evidence of recovery-based interventions (RAVG, TE, TLG and AT).6. In general, the case formulations do not adequately address the factors that precipitate relapse and readmission and the WRPs do not address the interventions needed to overcome these factors. <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none">1. Ensure that the substance abuse program has a dedicated clinical leadership.2. The substance recovery program should develop and utilize clinical outcomes for individuals and process outcomes for the program.3. Revise the substance abuse check list to ensure that the stages of change are correctly identified and that monitoring accounts for the correct identification of these stages.
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		<ol style="list-style-type: none"> 4. Complete the training curriculum to address the maintenance phase of change. 5. Ensure that substance abuse monitoring items are aligned with the principles outlined in the current training curriculum. 6. Ensure monitoring of a 20% sample of the target population.
p	<p>Group facilitators and therapists providing therapeutic and rehabilitation services (in groups or individual therapy) are verifiably competent regarding selection and implementation of appropriate approaches and interventions to address therapeutic and rehabilitation services objectives, are verifiably competent in monitoring individuals' responses to therapy and rehabilitation, and receive regular, competent supervision.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2006: Monitor the competency of group facilitators and therapists in providing rehabilitation services</p> <p>Findings: NSH does not have a system to monitor group facilitator competency. According to Jim Jones, Chief of Psychology, disciplines are to develop a monitor.</p> <p>Other Findings: None.</p> <p>Compliance: Non-compliance.</p> <p>Current recommendation: Develop a system to monitor the competency of group facilitators and therapists in providing rehabilitation services.</p>
q	<p>Group facilitators and therapists providing therapeutic and rehabilitation services in the field of substance abuse should be certified substance abuse counselors.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006: Ensure that all providers complete the NSH substance abuse training curriculum at NSH.</p>

		<p>Findings: NSH's progress report indicates that a training plan was drafted on January 1, 2007. However, training is said to be slow due to non-availability of trainers.</p> <p>Recommendation 2, July 2006: Clarify and streamline staff competency criteria to ensure their alignment with the current training curriculum.</p> <p>Findings: NSH has assigned this task to Discipline Chiefs. This task is not completed.</p> <p>Recommendation 3, July 2006: Ensure that training includes all of the five stages of change.</p> <p>Findings: NSH is training the staff and expects training to be completed by March, 2007.</p> <p>Recommendation 4, July 2006: Establish a review system to evaluate the quality of services provided by these trained facilitators.</p> <p>Findings: NSH has assigned Discipline Chiefs with Addictionist and Substance Recovery Workgroup to develop a system.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Identify trainers for the substance abuse training curriculum.
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		<ol style="list-style-type: none"> 2. Ensure that all providers complete the NSH substance abuse training curriculum at NSH. 3. Clarify and streamline staff competency criteria to ensure their alignment with the current training curriculum. 4. Ensure that training includes all of the five stages of change. 5. Provide data that training has occurred. 6. Develop a review system to evaluate the quality of services provided by these trained facilitators.
r	<p>Transportation and staffing issues do not preclude individuals from attending appointments.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, July 2006:</p> <ul style="list-style-type: none"> • Review reasons for cancellations and assess and correct factors contributing to such events. • Assess why individuals refuse medical appointments and find ways to resolve their concerns. <p>Findings: NSH's missed appointment data revealed that nearly 245 appointments were missed in three months (August, November, and December) in 2006. Transportation and staffing issues were not reasons for the missed appointments (except LT's missed appointment listed as 'outside appointment' without any other clarifying information). The largest group of missed appointments came from individuals who refused to go for their appointments. Assessments and corrections for factors contributing to missed appointment were not conducted.</p> <p>Recommendation 3, July 2006: Complete and implement the Medical Scheduler.</p> <p>Findings: NSH's progress report states that WRP module has been the automation priority. Medical Scheduler is not yet completed.</p>

		<p>Other findings: None.</p> <p>Compliance: Non-compliance.</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.
s	<p>Adequate oversight to treatment, rehabilitation and enrichment groups is provided to ensure that individuals are assigned to groups that are appropriate to their assessed needs, that groups are provided consistently and with appropriate frequency, and that issues particularly relevant for this population, including the use of psychotropic medications and substance abuse, are appropriately addressed, consistent with generally accepted professional standards of care.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2006: Develop and implement monitoring systems that address the required elements.</p> <p>Findings: NSH's WRP mall alignment protocol is under revision. NSH does not have a monitoring system to address this requirement. There are no data to assess if the individuals are assigned to groups appropriate for their assessed needs. There are no data to show that the individuals benefit from the groups they actually attend.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Develop and implement monitoring systems that address the required elements.</p>

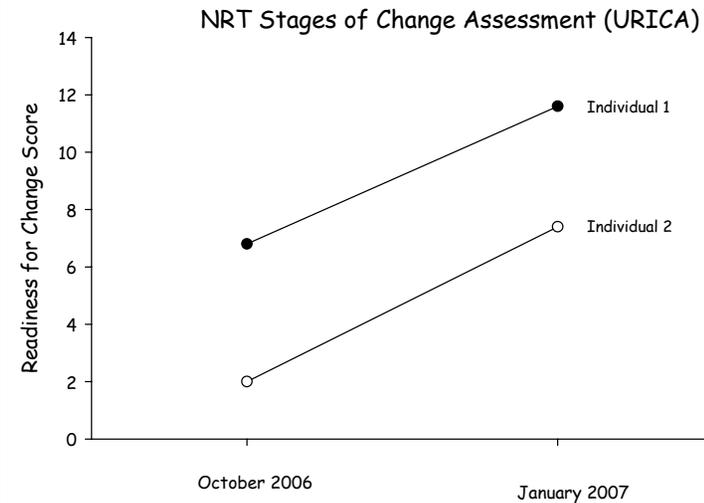
†	<p>Treatment, rehabilitation and enrichment services are monitored appropriately against rational, operationally-defined target variables and revised as appropriate in light of significant developments, and the individual's progress, or lack thereof;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2006: Develop and implement needed instruments.</p> <p>Findings: NSH has chosen to address this requirement through monthly progress notes and WRP conferences. Instructions and progress note templates have been developed (Mall Facilitator Monthly Progress Notes). NSH's progress report indicates that five WRPTs (on units T-3, T-16, A-9) were implementing the process effective January, 2007. Data were not available to verify the implementation of this requirement.</p> <p>Other findings: None.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Ensure that the newly developed process is fully implemented and addresses all of the elements of this requirement.</p>
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, July 2006: Implement the newly developed mall curriculum to ensure compliance with this item.</p> <p>Findings: The facility has begun implementation of this recommendation on two admission units (A 9 and T 3). A group of providers developed a Wellness and Recovery Orientation Curriculum for educating individuals</p>

		<p>on the principles of recovery, the WRP process and the By Choice program. Individuals who receive this information are assessed to ensure that they retained the material through post-tests.</p> <p>Recommendation 2 July 2006: Develop and implement a monitoring tool to address the requirement.</p> <p>Findings: The facility has yet to implement this requirement.</p> <p>Recommendation 3, July 2006: Ensure that individuals are provided a copy of their WRP based on clinical judgment.</p> <p>Findings: The facility has implemented this recommendation. The DMH WRP manual contains this requirement.</p> <p>Other findings: None.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none">1. Fully implement the Wellness and Recovery Orientation mall curriculum.2. Develop and implement a monitoring tool to address the requirement.
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v	<p>Staff educates individuals about their medications, the expected results, and the potential common and/or serious side effects of medications, and staff regularly asks individuals about common and/or serious side effects they may experience.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006: Increase the number of mall groups that offer education regarding medication management.</p> <p>Findings: The facility has yet to implement this recommendation. The Mall Director indicated that the main barriers are the shortage of psychiatrists and lack of a curriculum that contains a lesson plan.</p> <p>Recommendation 2, July 2006: The DMH WRP manual needs to include guidelines to WRPTs to assist individuals in making choices based on need and available services.</p> <p>Findings: The revised DMH WRP manual section 9.2 includes the recommended guidelines.</p> <p>Other findings: At this time, some mall groups offer education about medication management, but the number appears to be inadequate to meet the needs of individuals.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a curriculum with a lesson plan regarding medication education that is consistent with recovery philosophy. 2. Increase the number of mall groups that address this requirement. 3. Provide monitoring data regarding this requirement.
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w	Interdisciplinary teams review, assess, and develop positive clinical strategies to overcome individual's barriers to participation in therapeutic and rehabilitation services.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006: Provide Key Indicator data regarding individuals' non-adherence to interventions in the WRP.</p> <p>Findings: This process is still in development.</p> <p>Recommendation 2, July 2006: Assess barriers to individuals' participation in their WRPs and provide strategies to individuals to facilitate participation.</p> <p>Findings: In a personal interview, the TEC indicates that MAPP data is currently available to discipline chiefs and program directors regarding non-adherence to WRP and that the next step is to review the MAPP data prior to the next scheduled conference for each individual and to incorporate the data in the planning process.</p> <p>Recommendation 3, July 2006: Ensure that the DMH WRP manual includes guidelines to WRPTs regarding assessment methodology and strategies, including cognitive interventions, to facilitate individuals' participation.</p> <p>Findings: Section 3.4 of the revised WRP manual provides needed information.</p> <p>Recommendation 4, July 2006: Develop and implement monitoring tools to assess compliance with this item.</p>
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		<p>Findings: The facility has yet to implement this recommendation.</p> <p>Other findings: At present, the WRPTs have yet to fully implement the guidelines in the revised DMH WRP manual to assess individuals' barriers to participation.</p> <p>NSH has recently started providing individuals with a clinical strategy to help them achieve readiness to engage in group activities. In December, 2006, NSH initiated training and certification of five clinicians in Narrative Restructuring Therapy (NRT). The training is provided by Dr. Robert Wahler and Dr. Judy Singh, two experts in the field of NRT. When fully trained the NSH clinicians will work directly with individuals who are non-adherent with WRP, and who have triggered this Key Indicator. NRT is an innovative method of re-engaging individuals in the WRP process and attendance at PSR Malls.</p> <p>During their training, each clinician worked with one individual who was at the precontemplation stage. Data for two individuals who have been in therapy for a quarter show that they moved significantly towards contemplation (on the URICA) as shown below:</p>
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Additional data presented by NSH show that NRT can be taught to clinicians in intensive training sessions followed by weekly conference calls and a booster intensive training followed by a further set of weekly conference calls. The data show that consistent use of NRT enables individuals who are at the precontemplation stage of change to begin moving towards contemplation. These are individuals with a history of refusing to attend Mall groups. A strength of this approach is that the hospital is able to provide quantitative evidence of the competency of the therapists as well as the outcome for the individuals. Further, this is one of the few individual therapies that is specifically driven by the individual and is fully recovery-focused. This type of data should be collected for all individual therapies provided in the hospital.

The efforts of the Treatment Enhancement Coordinator and the DMH CRIPA Business Manager have been instrumental in the initiation of NRT training at NSH. Such training is critical for clinicians who work with individuals with serious and persistent mental illness who are non-

		<p>adherent to WRP.</p> <p>NSH should ensure that:</p> <ol style="list-style-type: none"> 1. Therapists providing NRT participate in the individual's WRP review conferences. 2. NRT is included in the Objectives and Interventions in the individual's WRP. 3. If the WRPT has selected NRT to enable an individual to move from a precontemplation level to contemplation level with regards to adherence to scheduled WRP, then it is imperative that the individual does not unilaterally decide to drop out of the NRT. The WRPT and the individual should discuss this at a WRP conference and determine what steps will be taken to re-engage the individual in NRT. 4. There is a core of trained and dedicated therapists to undertake specialist therapies with individuals who are non-adherent to WRP interventions. <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Finalize process to provide Key Indicator data regarding individuals' non-adherence to interventions in the WRP. 2. Ensure that certified NRT therapists provide individual therapy to individuals who trigger non-adherence to WRP in the Key Indicator. 3. Assess barriers to individuals' participation in their WRPs and provide strategies to individuals to facilitate participation. 4. Develop and implement monitoring tools to assess compliance with this item.
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D	Integrated Assessments	
	<p>Each State hospital shall ensure that, consistent with generally accepted professional standards of care, each individual shall receive, promptly after admission to each State hospital, an accurate and comprehensive assessment of the conditions responsible for the individual's admission, to the degree possible given the obtainable information at the time of admission. Thereafter, each individual shall receive an accurate and comprehensive reassessment of the reasons for the individual's continued hospitalization whenever there has been a significant change in the individual's status, or a lack of expected improvement resulting from clinically indicated treatment. The individual's interdisciplinary team shall be responsible for investigating the past and present medical, nursing, psychiatric, and psychosocial factors bearing on the individual's condition, and, when necessary, for revising assessments and therapeutic and rehabilitation plans in accordance with new information that comes to light. Each State hospital shall monitor, and promptly address deficiencies in the quality and timeliness of such assessments.</p>	<p>Summary of Progress:</p> <ol style="list-style-type: none"> 1. NSH has a fully operational Forensic Review Panel that provides needed oversight to the WRPTs. This mechanism appears to have improved the quality of many of the court reports submitted for individuals admitted under PC 1026 and PC 1370. 2. The facility has continued the implementation of the new system of integrated assessment. When fully implemented, the system provides comprehensive assessments of the individual's needs and serves as the basis for a meaningful recovery model of service planning. 3. In general, the facility has maintained its practice of timely implementation of the admission medical and psychiatric assessments, psychiatric reassessments on the long-term units and the transfer assessments. 4. NSH has continued the process of internal monitoring using instruments that meet most of the requirements of the EP in the areas of psychiatric assessments and reassessments. 5. NSH is in the process of revising its Medical Staff Manual to address requirements of the EP.
1	Psychiatric Assessments and Diagnoses	
	<p>Each State hospital shall provide all of the individuals it serves with routine and emergency psychiatric assessments and reassessments consistent with generally accepted professional standards of care; and,</p>	<p>Methodology: Interviewed David Thomas, Acting Medical Director. Interviewed Rachel Bramble, PsyD, Standards Compliance Psychologist. Interviewed six staff psychiatrists. Reviewed charts of 36 individuals (DT, LK, NP, RT, NK, SLD, WLW, JLW, LH, EGC, VDB, JMR, VH, GC, JW, CH, KP, TE, WQ, DAT, ALM, CS, DB, HTS, DLT, BN, GS, RT, JL, DT, JTS, NHB, DWW, EWK, GRP and RDA). Reviewed a roster of all psychiatrists at NSH and their board certification status.</p>

		<p>Reviewed revised Physician's Manual (Draft). Reviewed the Initial Admission Assessment Monitoring Tally. Reviewed the Initial Admission Assessment Monitoring summary data (July to December 2006). Reviewed Napa Psychiatric Evaluation Monitoring Form. Reviewed Psychiatric Evaluation Monitoring summary data (July to December 2006). Reviewed NSH Monthly Progress Notes Monitoring (Psychiatry) Form. Monthly Psychiatry Progress Notes Monitoring summary data (July to December 2006). Reviewed Physician Transfer Summary Monitoring Form. Reviewed Physician Transfer Summary Monitoring summary data (July to December 2006).</p>
<p>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>Recommendation 1, July 2006: Develop and implement a monitoring instrument to assess accuracy of psychiatric diagnoses.</p> <p>Findings: The Initial Admission Assessment Monitoring Tally is used to monitor the accuracy of diagnosis listed on the initial psychiatric assessments. This form has an appropriate indicator that assesses whether the diagnosis is consistent with the history and presentation. Using this indicator, peer psychiatrists reviewed a number of charts varying from 20 to 28 each month from July to December 2006 (except for November). The review was limited to the admissions units. The data indicate overall compliance rate of 87% with this item. The facility did not provide data on the size of the target population.</p> <p>The Napa Psychiatric Evaluation Monitoring Form is used to monitor the accuracy of psychiatric diagnosis on the Integrated Psychiatric</p>

		<p>Assessment. This form contains several indicators that assess the presence of psychiatric diagnosis, diagnostic formulation and differential diagnosis, but do not clearly address the issue of accuracy of the diagnosis. The facility has monitoring data that do not specifically address the requirement.</p> <p>NSH uses the Monthly Progress Notes Monitoring (Psychiatry) Form to monitor the accuracy of diagnosis on the psychiatric progress notes. This form contains adequate indicators regarding the justification of diagnosis, but do not clearly address the finalization of deferred/RO/NOS diagnosis. Based on the current form, peer psychiatrists reviewed randomly selected samples from each program in the facility from July to December 2006 (excluding August 2006). The monthly sample sizes varied from 3% to 11%.</p> <p>The overall compliance data are reported as follows:</p> <ol style="list-style-type: none"> 1. Is current diagnosis currently justifiable? 88%. 2. If not clinically justifiable, is there indication it will be changed or eliminated in the psychiatric progress notes? 6%. 3. Is the justification for the diagnosis based on DSM IV or DSM IV check list? 83%. 4. Is there a deferred, rule out/ or NOS diagnosis present? 31%. <p>Recommendation 2, July 2006: Address all recommendations in section D.1. July 2006:</p> <p>Findings: See all sections in D.1.</p> <p>Other findings: Chart reviews by this monitor indicate that, by and large, psychiatric diagnoses are stated in terminology that is consistent with the current version of DSM. However, admission and integrated psychiatric assessments (see D.1.c.i through D.1.c.iii) are inconsistently completed</p>
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		<p>and the information needed for adequate diagnostic formulations does not consistently provide the basis for the most reliable diagnosis.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that the Psychiatric Evaluation Monitoring Form clearly addresses the accuracy of diagnosis. 2. Ensure that Monthly Progress Notes Monitoring (Psychiatry) Form adequately addresses the finalization of deferred, rule-out and/or NOS diagnoses. 3. Continue to monitor this requirement and ensure sample sizes of 20% of the target populations. 4. Standardize the names of the monitoring instruments Statewide and ensure that the facilities' progress reports use these names consistently. 5. Address and correct factors related to low compliance.
b	Each State hospital shall ensure that all psychiatrists responsible for performing or reviewing psychiatric assessments:	<p>Compliance: Partial.</p>
2.i	are certified by the American Board of Psychiatry and Neurology ("ABPN") or have successfully completed at least three years of psychiatry residency training in an Accreditation Counsel for Graduate Medical Education accreditation program, and	<p>Current findings on previous recommendations:</p> <p>Recommendation, July 2006: Continue current practice and encourage all staff to obtain board certification.</p> <p>Findings: According to the Acting Medical Director, the facility has lost 18 psychiatrists and hired 4.75 FTE psychiatrists since the baseline evaluation. In personal interviews, the Acting Medical Director and</p>

		<p>several staff psychiatrists stated that the main reason for this loss is the departure of psychiatrists for significantly higher salaries at the CDCR. The current psychiatrist-to-individual ratios are 1:30 (admissions) and 1: 45 (long-term). Since the baseline evaluation, two additional psychiatrists became board-certified and five are currently in the process of taking the examinations. All staff psychiatrists at NSH have completed three years of psychiatry residency training approved by the ACGME Residency Review Committee (or osteopathic equivalent). The NSH revised Physician's Manual includes a statement that all psychiatrists are encouraged to obtain board certification and that the facility provides wage incentive for board certification and considers reasonable time off for psychiatrists that pursue certification.</p> <p>Other findings: None.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Address and correct factors regarding psychiatry staff shortage, including the pay differential versus other State institutions. 2. Consider the hiring of mental health nurse practitioners to support current psychiatry staff.
<p>2.ii</p>	<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 recommendations:</p> <p>Recommendation 1, July 2006: Ensure that the reprivileging process incorporates a quality profile that includes competency in the diagnosis, assessment and reassessment of individuals.</p> <p>Findings: The facility has yet to implement this recommendation.</p>

		<p>Recommendation 2, July 2006: Ensure that the medical staff manual includes orientation regarding the facility's expectations regarding competency in diagnosis, assessments and reassessments.</p> <p>Findings: The facility is in the process of revising the manual to address this recommendation.</p> <p>Other findings: None.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that the repriviliging process incorporates a quality profile that includes competency in the diagnosis, assessment and reassessment of individuals. 2. Ensure that the medical staff manual includes the facility's expectations regarding competency in diagnosis, assessments and reassessments.
c	Each State hospital shall ensure that:	<p>Compliance: Partial.</p>
c.i	Within 24 hours of an individual's admission to each State hospital, the individual receives an Admission Medical Assessment that includes:	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, July 2006: Ensure completeness of the admission medical examination within the specified time frame. Ensure that there is a rationale for deferral of items on the examination and that deferred items are subsequently addressed to ensure compliance with the intent of this item.</p>

		<p>Findings: The draft revision of the medical staff manual adequately addresses the requirement for completeness of the physical examination, including deferrals of certain portions of the examination. The facility continues to use the same monitoring mechanism based on the Initial Admission Assessment Monitoring tally. The monitoring data are based on a review by peer physicians of a number of charts varying from 22 to 28 each month from July to December 2006 (except for November). The review was limited to the admissions unit. The facility did not provide data on the size of the target population. The compliance rates are identified below for each applicable cell. The monitoring instrument and the data do not address the rationale and follow up regarding deferral of portions of physical examination.</p> <p>Recommendation 3, July 2006: Update the medical staff manual to include the requirements regarding D.1. c.i.1 through D.1.c.i.5.</p> <p>Findings: The draft revision adequately addresses this requirement.</p> <p>Recommendation 4, July 2006: Ensure that monitoring of the admission physical examination addresses completeness of the examination and that the overall compliance rate considers incomplete items.</p> <p>Findings: The facility has yet to implement this recommendation.</p> <p>Other findings: This monitor review of 12 charts (RT, DT, NK, EGC, NP, LK, SLD, LH, JMR, JLW, WLW and VDB) corroborate the facility's data regarding review of systems, medical history, diagnostic impressions and</p>
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		<p>management plan when acute medical problems are identified. However, the monitor found a much lower compliance rate regarding completeness of the examination due to the following examples:</p> <ol style="list-style-type: none"> 1. No documentation of follow up regarding deferral of genital and rectal examinations (LH and JMR) or individual's refusal of these examinations (SLD); 2. Inadequate documentation of follow up regarding the individual's refusal of the physical examination (DT, NK and EGC); 3. No documentation of follow up regarding the individual's inability to cooperate with neurological examination (RT) or cooperate with the review of systems (NP); and 4. Lack of documented timely gynecological follow up regarding deferral of female genital and rectal examination. <p>This monitor found evidence of timely and appropriate follow up by consultants regarding identified medical problems (WLW) and by gynecology regarding examination of female genitals and rectum (JLW).</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to monitor completeness of the admission medical examination within the specified time frame. 2. Monitor the rationale for deferral of items on the examination and follow up regarding the deferral/refusal of the examination. 3. Ensure monitoring of a 20% sample of the target population.
c.i.1	a review of systems;	93%.

c.i.2	medical history;	95%.
c.i.3	physical examination;	87%.
c.i.4	diagnostic impressions; and	91%.
c.i.5	management of acute medical conditions	94%.
c.ii	within 24 hours of an individual's admission to each State hospital, the individual receives an Admission Psychiatric Assessment that includes:	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006: Ensure that the mental examinations are completed on all admission psychiatric assessments. An adequate narrative must be entered whenever indicated to complete the section titled "elaborate on positive mental status examination."</p> <p>Findings: The facility has monitoring data based on the Initial Admission Assessment Monitoring Tally. As mentioned earlier, the review was conducted on the admissions units. The compliance rates for specific items are identified for each corresponding cell below. The data do not account for the above recommendation.</p> <p>Recommendation 2, July 2006: Update the medical staff manual to include the requirements regarding D.1. c.ii.1 through D.1.c.ii.6.</p> <p>Findings: The draft revision of the medical staff manual does not clearly address this recommendation.</p> <p>Recommendation 3, July 2006: Ensure that monitoring of the admission psychiatric examination</p>

		<p>addresses completeness of the examination and that overall compliance rate accounts for the completeness of each item.</p> <p>Findings: The facility has yet to implement this recommendation.</p> <p>Recommendation 4, July 2006: Ensure that monitoring of the item regarding consultations accounts for the intent of monitoring, i.e. compliance rate in only those cases where the reviewer felt that consultations were indicated.</p> <p>Findings: The facility has yet to implement this recommendation.</p> <p>Other findings: Chart reviews by this monitor demonstrate a much lower compliance rate regarding completeness of the mental status examination. The main deficiency is the lack of needed narrative to elaborate on positive mental status findings. This includes history of aggression (LK), feelings to hurt others (NK), suicidal thoughts (DT), auditory hallucinations to hurt self (DT), auditory hallucinations (EGC), auditory/visual hallucinations (LK and NK), visual hallucinations (VDB), nature of persecutory (NP, NK, WLW and JLW) and somatic (LK) delusions and impaired cognition (LK) and judgment (LK). The reviews also demonstrate missing documentation regarding a plan of care.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that the mental examinations are completed on all admission psychiatric assessments. An adequate narrative must be entered whenever indicated to complete the section
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		<p>titled "elaborate on positive mental status examination."</p> <ol style="list-style-type: none"> 2. Ensure documentation of a provisional plan of care upon the completion of the initial psychiatric examination. 3. Update the medical staff manual to include the requirements regarding D.1. c.ii.1 through D.1.c.ii.6. 4. Ensure that monitoring of the admission psychiatric examination addresses completeness of the examination and that overall compliance rate accounts for the completeness of each item. 5. Ensure that monitoring of the item regarding consultations accounts for the intent of monitoring, i.e. compliance rate in only those cases where the reviewer felt that consultations were indicated. 6. Ensure monitoring of a 20% sample of the target population.
c.ii.1	psychiatric history, including a review of presenting symptoms;	80%.
c.ii.2	complete mental status examination;	98%.
c.ii.3	admission diagnoses;	95%.
c.ii.4	completed AIMS;	78%.
c.ii.5	laboratory tests ordered; and	95%.
c.ii.6	consultations ordered.	69%.
c.iii	within 7 days (60/72 hrs) of an individual's admission to each State hospital, the individual receives an Integrated Psychiatric Assessment that includes:	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006: Ensure completeness of the integrated assessment within the specified timeframe. The assessment must integrate information that cannot be obtained at the time of admission but becomes available</p>

		<p>during the first 7 days of admission.</p> <p>Findings: The facility does not monitor this item.</p> <p>Recommendation 2, July 2006: Update the medical staff manual to include the requirements regarding D.1. c.iii.1 through D.1.c.iii.10.</p> <p>Findings: The draft revision of the Medical Staff Manual does not address this recommendation.</p> <p>Recommendation 3, July 2006: Ensure that monitoring of the integrated psychiatric examination addresses completeness of the examination and that overall compliance rate accounts for the completeness of each item.</p> <p>Findings: Using the Psychiatric Evaluation Monitor, peer psychiatrists reviewed a number of charts varying from 16 to 40 each month from July to December 2006 on the admissions units. The facility did not provide data on the size of the target population. The compliance rates are identified for each corresponding cell below.</p> <p>Recommendation 4, July 2006: Ensure that monitoring of the integrated assessment addresses the practice of conducting the assessments so early that the purpose is defeated.</p> <p>Findings: The Acting Medical Director reports that the staff psychiatrists have been given verbal instructions during departmental meetings regarding</p>
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this item. The draft revision of the Medical Staff Manual does not clearly address this issue.

Other findings:

In reviewing 12 charts (DT, LK, NP, RT, NK, SLD, WLW, JLW, LH, EGC, VDB and JMR), this monitor found much lower compliance due a pattern of deficiencies as shown in the following examples:

1. The integrated assessment is missing (LK).
2. Important components are missing, including:
 - a. Chief complaint (DT);
 - b. Family history (DT and NK);
 - c. Educational, occupational, marital or sexual history (DT);
 - d. Strengths (DT, NP and NK);
 - e. Diagnostic formulation (DT, NP, NK and JMR); and
 - f. Differential diagnosis (DT, NP, NK and JMR).
3. Important components are inadequately assessed, including:
 - a. Strengths (WLW and LH);
 - b. Diagnostic formulation (LH); and
 - c. Risk assessment (JMR).
4. Incomplete mental status examinations, including:
 - a. Attitude/appearance (DT and NK);
 - b. Motor activity/speech (NK);
 - c. Specifics regarding suicidal intent (NK);
 - d. Perceptual alterations (NK);
 - e. Nature of auditory hallucinations (DTL)
 - f. Specifics regarding command hallucinations (NP);
 - g. Cognitive examination (NK and LH); and
 - h. Specifics regarding impaired judgment and insight (RT, NP, NK, WLW, LH and JMR).

An example of an integrated assessment that meets requirements of the EP is found in the chart of JLW.

		<p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure completeness of the integrated assessment within the specified timeframe. The assessment must integrate information that cannot be obtained at the time of admission but becomes available during the first 7 days of admission. 2. Update the medical staff manual to include the requirements regarding D.1. c.iii.1 through D.1.c.iii.10. 3. Ensure that monitoring of the integrated psychiatric examination addresses completeness of the examination and that overall compliance rate accounts for the completeness of each item. 4. Ensure that monitoring of the integrated assessment addresses the practice of conducting the assessments so early that the purpose is defeated. 5. Ensure monitoring of a 20% sample of the target population.
c.iii.1	psychiatric history, including a review of present and past history;	99%.
c.iii.2	psychosocial history;	96%.
c.iii.3	mental status examination;	75%.
c.iii.4	strengths;	86%
c.iii.5	psychiatric risk factors;	59%.
c.iii.6	diagnostic formulation;	76%.
c.iii.7	differential diagnosis;	48%.

c.iii.8	current psychiatric diagnoses;	100%.
c.iii.9	psychopharmacology treatment plan; and	No data.
c.iii.10	management of identified risks.	74%.
d	Each State hospital shall ensure that:	Compliance: Partial.
d.i	Clinically justifiable diagnoses are provided for each individual, and all diagnoses that cannot be clinically justified for an individual are discontinued no later than the next review;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006: Provide continuing medical education to psychiatry staff to improve competency in the area of assessment of cognitive and other neuropsychiatric disorders.</p> <p>Findings: The facility has yet to implement this recommendation.</p> <p>Recommendation 2, July 2006: Revise current monitoring tool to address justification of diagnosis, differential diagnosis, as clinically indicated, and appropriate updates of diagnosis.</p> <p>Findings: Same as in C.1.a.</p> <p>Other findings: Chart reviews by this monitor show a pattern of inadequate evaluation and updates of a variety of diagnostic categories that are listed on the most current WRP and/or court reports. Examples include:</p>

		<ol style="list-style-type: none"> 1. Depressive Disorder, NOS (VH, GC, JW and CH); 2. Dementia NOS (KP, TE, WQ and CH); 3. Psychotic Disorder, NOS (DAT, ALM and CS); 4. Cognitive Disorder NOS and Amnesic Disorder Due to Head Trauma (DAT); 5. Cognitive Disorder, NOS (DB); and 6. Impulse Control Disorder, NOS (HTS and DLT). <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Provide continuing medical education to psychiatry staff to improve competency in the area of assessment of cognitive and other neuropsychiatric disorders. 2. Same as in C.1.a.
<p>d.ii</p>	<p>The documented justification of the diagnoses is in accord with the criteria contained in the most current DSM (as per DSM-IV-TR Checklist);</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, July 2006: Assess reason for (and correct) discrepancies in results of monitoring of items that contain similar concepts.</p> <p>Findings: The facility has yet to address this recommendation.</p> <p>Other findings: None.</p> <p>Compliance: Partial.</p>

		<p>Current recommendation: Same as in recommendations #1, 2 and 3 in D.1.a.</p>
d.iii	<p>Differential diagnoses, "deferred," or "rule-out" diagnoses, and diagnoses listed as "NOS" ("Not Otherwise Specified") are timely addressed (i.e., within 60 days), through clinically appropriate assessments, and resolved in a clinically justifiable manner; and</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006: Update the medical staff manual to include the requirements in this cell.</p> <p>Findings: The revised draft of the manual adequately addresses this requirement.</p> <p>Recommendation 2, July 2006: Ensure regular monitoring of an adequate sample of charts.</p> <p>Findings: The facility has yet to implement this recommendation.</p> <p>Other findings: Same as in D.1.d.i.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Same as above.</p>

<p>d.iv</p>	<p>"no diagnosis" is clinically justified and documented.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, July 2006: Continue current practice.</p> <p>Findings: The Acting Medical Director states that no individual currently has Axis I "no diagnosis" listed.</p> <p>Other findings: Chart reviews by this monitor did not show any Axis I diagnosis listed as "no diagnosis."</p> <p>Compliance: In compliance.</p> <p>Current recommendation: Continue current practice.</p>
<p>e</p>	<p>Each State hospital shall ensure that psychiatric reassessments are conducted at a frequency that reflects the individual's clinical needs. At a minimum the reassessments are completed weekly for the first 60 days on the admissions units and monthly on other units.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, July 2006: Assess and correct factors related to non-compliance with the requirement for weekly progress notes on the admission teams.</p> <p>Findings: The facility has yet to address this requirement.</p> <p>Other findings: This monitor reviewed charts of five individuals on the acute admissions unit (BN, GS, RT, JL and DT). None of these charts included documentation of a weekly psychiatric note.</p>

		<p>Compliance: Non-compliance.</p> <p>Current recommendation: Assess and correct factors related to non-compliance with the requirement for weekly progress notes on the admission teams.</p>
f	<p>Each State hospital shall ensure that psychiatric reassessments are documented in progress notes that address the following:</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006: Develop and implement a standardized format for psychiatric reassessments that address and correct the deficiencies identified above.</p> <p>Findings: The facility has yet to implement this recommendation.</p> <p>Recommendation 2, July 2006: When the individuals receive both pharmacological and behavioral interventions, the reassessments need to address the following specific items:</p> <ul style="list-style-type: none"> • Review of behavioral plans prior to implementation as documented in progress notes and/or behavioral plan; • Review of individual's progress in behavioral treatment; • Differentiation, as clinically appropriate, of learned behaviors from behaviors that are targeted for pharmacological treatment; and • Modification, as clinically appropriate, of diagnosis and/or pharmacological treatment based on above reviews/assessments. <p>Findings: The facility has yet to address this recommendation.</p>

		<p>Recommendation 3, July 2006: Update the medical staff manual to specify requirements regarding documentation of psychiatric reassessments.</p> <p>Findings: The revised draft medical staff manual has adequately addressed most of the requirements.</p> <p>Recommendation 4, July 2006: Ensure that monitoring instruments are aligned with the above expectations.</p> <p>Findings: The facility has yet to implement this recommendation.</p> <p>Other findings: Using the Monthly Progress Notes (Psychiatry) Form, peer psychiatrists reviewed randomly selected samples from each program in the facility from July to December 2006 (excluding August 2006). The monthly sample sizes varied from 3% to 11%. The overall compliance rate is 51%. The compliance rates are listed for each corresponding cell below. The monitoring indicators adequately assess corresponding items f.i through f.vi. The assessment of item f.vii that pertains to the integration of behavioral and pharmacological interventions is limited to whether or not the psychiatrist has reviewed the behavioral plan and has discussed it with the psychologist.</p> <p>In almost all the charts reviewed by this monitor, there is a pattern of reassessments that do not meet the required elements. These reviews indicate compliance rates that are concordant with the facility's data in item f.vi but are much lower in all other items. In general, the reassessments show the following deficiencies:</p>
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		<ol style="list-style-type: none">1. The assessment of interval events is lacking and does not adequately cover significant clinical developments. Most of the reassessments are cross-sectional and more oriented towards current crisis events.2. The diagnoses are not updated in a timely manner. As mentioned earlier, there is little justification for diagnoses listed as not otherwise specified and the diagnostic formulations and differential diagnoses are not adequate when needed. There is little or no documentation to indicate that the psychiatrist has used information regarding the individual's response to specific treatments as data to refine diagnosis.3. The risks and benefits of current treatments are not reviewed in a systematic manner.4. The assessment of risk factors is limited to some documentation of crises that lead to use of restrictive interventions. There is no evidence of proactive evaluation of risk factors or timely and appropriate modification of interventions in order to minimize the risk on an ongoing basis.5. There is limited or no documentation of actual and/or potential side effects of benzodiazepines, anticholinergic medications and/or new generation antipsychotics. This pattern is noted even when these medications are used in individuals who are particularly vulnerable to the risks.6. There is no review of the specific indications for the use of PRN or STAT medication, the circumstances for the administration of these medications, the individual's response to this use or modification of treatment based on this review.7. When behavioral interventions are provided, there is no documentation to indicate an integration of pharmacological and behavioral modalities. In addition, there is little or no discussion of the contextual basis and functional significance of the current symptoms.
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		<p>8. There is no documentation of the goals of individual psychotherapy and of the individual's progress in treatment when the WRP indicates that the psychiatrist is providing this intervention.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a standardized format for psychiatric reassessments that address and correct the deficiencies identified above. 2. When the individuals receive both pharmacological and behavioral interventions, the reassessments need to address the following specific items: <ol style="list-style-type: none"> a) Review of behavioral plans prior to implementation as documented in progress notes and/or behavioral plan; b) Review of individual's progress in behavioral treatment; c) Differentiation, as clinically appropriate, of learned behaviors from behaviors that are targeted for pharmacological treatment; and d) Modification, as clinically appropriate, of diagnosis and/or pharmacological treatment based on above reviews/assessments. 3. Update the medical staff manual to specify all the requirements regarding documentation of psychiatric reassessments. 4. Ensure that monitoring instruments are aligned with the above expectations.
f.i	significant developments in the individual's clinical status and of appropriate psychiatric follow up;	72%.
f.ii	Timely and justifiable updates of diagnosis and	34%.

	treatment, as clinically appropriate;	
f.iii	Analyses of risks and benefits of chosen treatment interventions;	43%.
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;	74%.
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;	54%.
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	32%.
f.vii	Verification in a clinically justifiable manner, that psychiatric and behavioral treatments are properly integrated. The psychiatrist shall review the positive behavior support plan prior to implementation to ensure consistency with psychiatric formulation, document evidence of regular exchange of data or information with psychologists regarding differentiation of learned behaviors and behaviors targeted for psychopharmacological treatments, and document evidence of integration of treatments.	48%.
g	When individuals are transferred between treatment teams, a psychiatric transfer note shall be completed addressing: review of medical and psychiatric course of hospitalization, including medication trials; current target symptoms; psychiatric risk assessment; current barriers to discharge; and anticipated benefits of transfer.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006: Update the medical staff manual to include requirements regarding inter-unit transfer assessments.</p>

		<p>Findings: The draft revision adequately addresses this recommendation.</p> <p>Recommendation 2, July 2006: Continue to monitor using current instrument.</p> <p>Findings: Using the Physician Transfer Summary Monitoring Form, peer psychiatrists reviewed a 100% sample of inter-unit transfers from July to December 2006. The following is an outline of the compliance rates and corresponding monitoring indicators:</p> <ol style="list-style-type: none"> 1. Reason for transfer: 76%; 2. Five Axis Diagnosis: 48%; 3. Psychiatric course of hospitalization: 60%; 4. Medical history and current medical problems: 66%; 5. Medical course of hospitalization: 47%; 6. Medication trials: 21%; 7. Current target symptoms: 70%; 8. Psychiatric risk factors: 43%; 9. Review of medications: 68%; 10. Current barriers to discharge: 27%; and 11. Anticipated benefits of transfer: 31%. <p>Recommendation 3, July 2006: Refrain from the practice of administrative transfers that have no clinical rationale.</p> <p>Findings: The facility has yet to implement this recommendation.</p> <p>Recommendation 4, July 2006: Ensure that individuals who present severe management problems and</p>
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		<p>require frequent inter-unit transfers receive PBS plans that are adequately designed and implemented prior to transfers.</p> <p>Findings: The facility has yet to implement this recommendation.</p> <p>Other findings: This monitor reviewed charts of six individuals who required inter-unit transfers for psychiatric indications during the past year (JTS, NHB, DWW, EWK, GRP and RDA). An inter-unit transfer assessment was present in all charts. However, the reviews indicate that the required components of the assessment are either inconsistently addressed (e.g. reason for transfer, psychiatric and medical course, medication trials, medication trials and current target symptoms) or almost consistently missing (e.g. psychiatric risk factors/interventions to reduce the risk, barriers to discharge, anticipated benefits of the transfer). The transfer summary of RDA is in substantial compliance with this requirement.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to monitor using current instrument. 2. Ensure that individuals who present severe management problems and require frequent inter-unit transfers receive PBS plans that are adequately designed and implemented prior to transfers.
2	Psychological Assessments	
		<p>Methodology: Interviewed Dr. Jim Jones, Acting Chief of Psychology. Interviewed Dr. Kathleen Patterson, Acting Senior Psychologist,</p>

		<p>Supervisor. Interviewed Dr. Ann Hoff, Acting Senior Psychologist, Supervisor Reviewed charts of (WP, FH, RT, CR, HF, TH, RH, CP, LK, VH, TZ , AL, AM, JC, JA, RT, JP, KH, and BB). Reviewed list of neuropsychological referrals and assessments. Reviewed list of individuals whose primary/preferred language is not English. Reviewed DMH psychology monitoring form. Reviewed Psychology Staff Manual. Reviewed DSM-IV-TR checklists. Reviewed database on psychologists verifying education, training, privileges, certification and licensure. Reviewed psychological and neurological assessments. Reviewed NSH behavior guidelines. Reviewed NSH progress report data. Reviewed neuropsychological assessments. Reviewed structural assessments. Reviewed functional analysis assessments. Reviewed hospital organizational chart. Reviewed PBS technical manual. Reviewed NSH inventory of assessments. Reviewed documentation of assessments referred and completed.</p>
<p>a</p>	<p>Each State hospital shall develop and implement standard psychological assessment protocols, consistent with generally accepted professional standards of care. These protocols shall address, at a minimum, diagnostic neuropsychological assessments, cognitive assessments, and I.Q./achievement assessments, to guide psychoeducational (e.g., instruction regarding the illness or disorder, and the purpose or objectives of treatments for the same, including medications), educational, rehabilitation, and habilitation interventions, and behavioral assessments (including</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, July 2006:</p> <ul style="list-style-type: none"> • Develop and implement a statewide psychology manual that embodies the requirements of the EP. • The manual should include: <ul style="list-style-type: none"> • A generic section that applies to all hospitals, and • Orientation information for newly hired psychologists and clinical practices that is specific to each hospital.

	<p>functional assessment of behavior in schools and other settings), and personality assessments, to inform positive behavior support plans and psychiatric diagnoses.</p>	<p>Findings: NSH now has a DMH Psychology Manual. AD 853 Cognitive Screening is included in the Manual. According to Jim Jones, Acting Chief of Psychology, each psychologist has a hard copy of the Manual. All NSH psychologists were trained on November 29, 2006.</p> <p>Other findings: Senior psychologists interviewed by this monitor showed good understanding when explaining the various psychological assessments and interventions carried out in NSH.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue with current practice.</p>
b	<p>Each State hospital shall require the completion of cognitive and academic assessments within 30 days of admission of all school-age and other individuals, as required by law, unless comparable testing has been performed within one year of admission and is available to the interdisciplinary team.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, July 2006:</p> <ul style="list-style-type: none"> • Implement this requirement of the EP. • Develop and implement monitoring and tracking instruments to assess the key requirement of this step. <p>Findings: NSH's progress report indicates that 20 individuals at NSH met criteria for testing (for the period between July 1, 2006 and December 31, 2006). Eight (40%) of these individuals were tested, however, none of them were tested within the 30 days, as required by law. Review and analysis of the data on individuals meeting criteria for cognitive and academic assessments by this monitor confirmed NSH's progress report.</p>

		<p>Other findings: DMH Psychology Monitor Form and Instructions to track this requirement was completed on 1/13/07.</p> <p>According to Jim Jones, Acting Chief of Psychology, academic and cognitive test assessment tools were made available to the psychology staff only in the last few weeks. The psychology department has included a section into the Integrated Assessment-Psychology section to address this requirement.</p> <p>Mr. Jones is to arrange with the Standards and Compliance department to notify the psychology team of new admissions that meet this criterion for assessments. He will also meet with Erika Popuch, Chief of Education, to coordinate the intellectual and academic assessments.</p> <p>Compliance: Non-compliance.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Implement this requirement of the EP. 2. Develop and implement monitoring and tracking instruments to assess the key requirement of this step.
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 recommendations:</p> <p>Recommendation, July 2006: Continue current practice.</p> <p>Findings: A review of the credentialing lists and curriculum vitae, and interviews with psychologists by this monitor showed that all licensed psychologists in the department have the appropriate education and credentialing as defined by their professional titles and job</p>

		<p>responsibilities. All non-licensed psychologists have provisional, affiliate, or active credentials. All interns are under supervision by licensed psychologists.</p> <p>Other findings: None.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
d	Each State hospital shall ensure that all psychological assessments, consistent with generally accepted professional standards of care, shall:	<p>Compliance: Partial.</p>
d.i	expressly state the clinical question(s) for the assessment;	<p>Current findings on previous recommendations:</p> <p>Recommendation, July 2006: Ensure that statement of reason for referral is clear and brief.</p> <p>Findings: NSH's progress report showed that 80% of their sample fulfilled this requirement. This monitor reviewed 10 focused assessments (VH, TZ, AL, AM, JC, JA, RT, JP, KH, and BB). Nine of the 10 assessments included a clearly stated referral/clinical question for the assessments.</p> <p>Other findings: NSH is training psychologists on writing clearly stated referral/clinical questions for the assessments.</p>

		<p>Compliance: Substantial.</p> <p>Current recommendation: Continue to train psychologists on writing clearly stated referral/ clinical questions.</p>
d.ii	include findings specifically addressing the clinical question(s), but not limited to diagnoses and treatment recommendations;	<p>Current findings on previous recommendations:</p> <p>Recommendation, July 2006: Continue current practice.</p> <p>Findings: NSH's progress report showed that 38% (10 out of 26) assessments failed to fulfill this criterion. Two (VH and AM) of the 10 (VH, TZ, AL, AM, JC, JA, RT, JP, KH, and BB) charts reviewed by this monitor failed to fully address all referral questions as well as related information.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Ensure that psychological assessments include all findings relevant to the clinical question(s), but not limited to diagnoses and treatment recommendations.</p>
d.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, July 2006: Ensure that all psychological assessments specify whether the individual would benefit from individual therapy or group therapy.</p>

		<p>Findings: NSH's progress report showed that 53% of assessments failed to meet this requirement. Six (AL, AM, RT, JP, KH, and BB) of the 10 (VH, TZ, AL, AM, JC, JA, RT, JP, KH, and BB) assessments reviewed by this monitor failed to meet this criterion.</p> <p>Other findings: NSH finalized the format and instructions for focused assessments on November 11, 2006. Psychologists were trained on this requirement on November 29, 2006.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to train psychologists on the requirement that all psychological assessments specify whether the individual would benefit from individual therapy or group therapy. 2. Provide data and lists of the number of psychologists trained and the number still needing to be trained.
d.iv	be based on current, accurate, and complete data;	<p>Current findings on previous recommendations:</p> <p>Recommendation July 2006: Continue current practice.</p> <p>Findings: NSH's progress report showed that 61% of the assessments failed to meet this requirement. Three (VH, KH, and BB) of the ten assessments (VH, TZ, AL, AM, JC, JA, RT, JP, KH, and BB) were missing the sources of information and or records reviewed.</p>

		<p>Other findings: None.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Provide training to psychologists on so that assessments include current, accurate, and complete data.</p>
<p>d.v</p>	<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 recommendations:</p> <p>Recommendation, July 2006: Ensure that all psychological assessments of individuals with maladaptive behavior meet this requirement.</p> <p>Findings: NSH's progress report showed that none of the 26 assessments addressed matters relating to behavioral supports and interventions. Six (AM, JC, RT, JP, KH, BB) of the nine (VH, AL, AM, JC, JA, RT, JP, KH, and BB) assessments reviewed by this monitor failed to meet this requirement.</p> <p>Other findings: None.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Continue to provide training and supervision to all psychologists to ensure that all psychological assessments of individuals with maladaptive behavior meet this requirement.</p>

d.vi	include the implications of the findings for interventions;	<p>Current findings on previous recommendations:</p> <p>Recommendation, July 2006: Ensure that all focused psychological assessments include the implications of the findings for interventions, especially psychosocial rehabilitation.</p> <p>Findings: NSH's progress report showed that 42% (11 out of 26) of the assessments failed to meet this requirement. Two of eight assessments reviewed by this monitor failed to meet all elements of this requirement, especially in considering and recommending psychosocial rehabilitation activities.</p> <p>Other findings: None.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Continue to provide training to psychologists to ensure that all focused psychological assessments include the implications of the findings for interventions, especially psychosocial rehabilitation.</p>
d.vii	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>Current findings on previous recommendations:</p> <p>Recommendation, July 2006: Ensure that all focused psychological assessments meet this requirement.</p> <p>Findings: NSH's progress report showed that 84% (22 out of 26) of the</p>

		<p>assessments failed to meet this requirement. Only one of the nine assessments reviewed by this monitor identified and resolved unresolved issues, and in addition specified additional evaluations, observations, and record reviews.</p> <p>Other findings: According to Jim Jones, Acting Chief of Psychology, psychologists are being trained to understand and comply with the requirements for this cell.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Ensure that all focused psychological assessments specify whether there is a need for further observations, record review, interviews, or re-evaluations.</p>
<p>d.viii</p>	<p>Use assessment tools and techniques appropriate for the individuals assessed and in accordance with the American Psychological Association Ethical Standards and Guidelines for testing.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, July 2006:</p> <ul style="list-style-type: none"> • Continue current practice. • Abide by the American Psychological Association Ethical Standards and Guidelines for testing. <p>Findings: NSH's progress report showed that 76% of the assessments failed to meet this requirement. Six (66%) of the nine assessments reviewed by this monitor failed to meet this requirement.</p> <p>Other findings: According to Jim Jones, Acting Chief of Psychology, additional test instruments will be added to NSH's inventory of testing instruments.</p>

		<p>Compliance: Partial.</p> <p>Current recommendation: Ensure that psychologists use tools and techniques appropriate for individuals and in accordance with the American Psychological Association Ethical Standards and Guidelines for testing.</p>
<p>e</p>	<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 recommendations:</p> <p>Recommendation, July 2006: Ensure that psychological tests are completed as required.</p> <p>Findings: NSH's progress report showed that 53% (289 out of 549) of the charts reviewed were completed as required. Seven of the nine (FH, RT, CR, HF, TH, CP, WP, RH, and LK) charts reviewed by this monitor were completed as required.</p> <p>Other findings: According to Jim Jones, Acting Chief of Psychology, all psychologists are undergoing mandatory training on requirements of Psychology Assessments. Many of the assessments were conducted using the old format for the Integrated Psychological Assessments. The old format is restricted in scope, especially in DSM diagnosis.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Ensure that psychological tests are completed as required.</p>

<p>f</p>	<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>
<p>f.i</p>	<p>before an individual's therapeutic and rehabilitation service plan is developed, a psychological assessment of the individual shall be performed that will:</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, July 2006: Ensure that integrated psychological assessments are conducted in a timely manner as required.</p> <p>Findings: NSH's progress report showed that 53% (289 out of 549) of the charts reviewed included Integrated Psychological Assessments. Four (WP, FH, BB, and RT) of the nine (VH, AL, AM, JC, JA, RT, JP, KH, and BB) charts reviewed by this monitor failed to meet this requirement. For example, WP did not have an achievement test, FH did not have a Spanish interpreter for translation, and RT's assessment was not timely.</p> <p>Other findings: None.</p> <p>Current recommendation: Ensure that integrated psychological assessments are conducted in a timely manner as required.</p>

f.i.1	address the nature of the individual's impairments to inform the psychiatric diagnosis; and	<p>Current findings on previous recommendations:</p> <p>Recommendation, July 2006: Ensure that integrated psychology assessments address the nature of the individual's impairments to inform the psychiatric diagnosis.</p> <p>Findings: NSH's progress report showed that 80% of the assessments failed to address the nature of the individual's impairments relating to their psychiatric diagnosis. Three (WP, RT, and RH) of the four (WP, RT, FH, and RH) assessments reviewed by this monitor failed to meet this requirement.</p> <p>Other findings: Many of the assessments reviewed by this monitor were incomplete. WP, for example, did not have a completed DSM-IV-TR Checklist, achievement tests were not conducted, behavior interventions were not checked, and there was no explanation on how diagnosis was derived. RT did not have documented symptoms, external sources of information were not included, and behavioral interventions were not addressed.</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.
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 recommendations:</p> <p>Recommendation, July, 2006: Ensure accurate evaluation of psychological functioning that informs the WRPT of the individual's rehabilitation service needs.</p>

		<p>Findings: NSH's progress report showed that 80% of the assessments failed to meet this requirement. Six evaluations (WP, RT, CR, HF, TH, and LK) reviewed by this monitor failed to meet this requirement.</p> <p>Other findings: Many of the psychological assessments failed to include cognitive and personality assessments to fully explore an individual's psychological functioning.</p> <p>Current Recommendation: Ensure accurate evaluation of psychological functioning that informs the WRPT of the individual's rehabilitation service needs.</p>
f.ii	<p>if behavioral interventions are indicated, a structural and functional assessment shall be performed, consistent with generally accepted professional standards of care, by a professional having demonstrated competency in positive behavior supports; and</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, July 2006: Ensure appropriate structural and functional assessments are undertaken by a qualified psychologist when an individual has learned maladaptive behavior.</p> <p>Findings: NSH's progress report showed that all of the 21 Integrated Psychological Assessments reviewed did not indicate a need for any behavioral interventions. This monitor reviewed all 21 Integrated Psychological Assessments sampled in NSH's progress report. This monitor's findings are in agreement with NSH's progress report.</p> <p>Other findings: Many of the items in Integrated Psychological Assessments reviewed by this examiner were found to be incomplete. In many cases, record reviews were not conducted.</p>

		<p>The Integrated Psychological Assessments used the old version of the form.</p> <p>Current recommendation: Ensure appropriate structural and functional assessments are undertaken by a qualified psychologist when an individual has learned maladaptive behavior that has not responded to a behavior guideline.</p>
f.iii	<p>additional psychological assessments shall be performed, as appropriate, where clinical information is otherwise insufficient, and to address unresolved clinical or diagnostic questions, including differential diagnosis, "rule-out," "deferred," "no-diagnosis" and "NOS" diagnoses.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006: Ensure that additional psychological assessments are performed, as appropriate, where clinical information is otherwise insufficient, and address unresolved clinical or diagnostic questions, including differential diagnosis, "rule-out," "deferred," "no-diagnosis" and "NOS" diagnoses.</p> <p>Findings: NSH's progress report showed that 71% of the cases did not follow through with additional evaluations to resolve clinical/diagnostic questions. Nineteen (90%) of 21 (EA, TA, AM, MP, RB, BB, MB, TB, BC, JC, MD, CD, JC, SD, DF, AF, HF, AG, HF, DG, JG) charts reviewed by this monitor failed to follow with appropriate follow up evaluations to resolve diagnostic/clinical questions.</p> <p>Recommendation 2, July 2006: Ensure that the facility's monitoring instruments that address "no diagnosis" are aligned with the key requirement, i.e. that "no diagnosis" is backed up by clinical data, especially in individuals with forensic issues.</p>

		<p>Findings: NSH has a DMH Psychology Monitoring Form to address this requirement. The form requires that additional assessments be conducted for the various diagnostic/clinical uncertainties including no diagnosis, rule-out, deferred, NOS, and differential diagnosis. Each diagnostic category is tracked under a different cell in the monitoring form.</p> <p>Other findings: According to Jim Jones, Chief of Psychology, indicated that medical staff is aware of the need to resolve diagnostic questions. Psychologists are to complete DSM-IV Checklist.</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>
<p>g</p>	<p>For individuals whose primary language is not English, each State hospital shall endeavor to assess them in their own language; if this is not possible, each State hospital will develop and implement a plan to meet the individuals' assessment needs, including, but not limited to the use of interpreters in the individual's primary language and dialect, if feasible.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, July 2006:</p> <ul style="list-style-type: none"> • Ensure that examiners consider cultural aspects when choosing assessment instruments with individuals whose preferred language is not English. • Ensure that psychological assessments are provided in the individual's preferred language using interpreters. <p>Findings: NSH's progress report showed that 48% of evaluations did not meet these criteria. Five (31%) out of 16 charts (JT, AO, JR, DS, FM, JE, TF, MG, RL, GV, CH, JM, LR, IG, LL, and RC) reviewed by this monitor failed to meet this requirement.</p>

		<p>Other findings: NSH has developed a referral form for individuals requiring interpreters. According to Jim Jones, Acting Chief of Psychology, mandatory training sessions to train psychologists in meeting this requirement is arranged. Procedures for obtaining interpreters have been given to all psychologists. Mr. Jones is contracting with outside agencies to obtain examiners in the examinee's native language.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to train psychologists on the procedure for obtaining interpreters 2. Monitor the use of the procedure for those individuals whose preferred language is not English. 3. Implement the referral system for individual's requiring interpreters.
3	Nursing Assessments	
		<p>Methodology: Interviewed Ann Rust, MSN, Nursing QI Coordinator. Interviewed Eve Arcala, Assistant Nursing Coordinator. Interviewed Nickey Jones RN, Coordinator of Nursing Services Interviewed Charlene Paulson RN, Assistant Coordinator Nursing Services Interviewed Larry Turner RN, Health Services Specialist Interviewed Michelle Patterson RN, Health Services Specialist Interviewed Natalie Allen RN, Psychiatric Nursing Toured units A4, T18, T17, Q9, Q11, and Q 5&6. Attended shift report for unit Q 5&6. Reviewed charts of eight individuals (KH, VH, AG, MP, GB, ES, JB, AND JA).</p>

		<p>Reviewed Nursing Process Documentation Review Audit summary data (January to June 2006).</p> <p>Reviewed Medication Pass and Treatment Administration Review (January to June 2006).</p> <p>Reviewed Nursing Education Orientation Competency Checklist.</p> <p>Reviewed Nursing policies and procedures manual.</p> <p>Reviewed Medication Treatment Records (MTR) on 3 units (A4, Q11, and Q 5&6).</p> <p>Reviewed Controlled Drug log on three units.</p> <p>Reviewed 30 new nursing/psychiatric technician personnel files.</p> <p>Reviewed hiring packet.</p> <p>Interviewed Candida Asuncion, Supervising RN for skilled nursing unit.</p> <p>Reviewed Nursing Table of Organization.</p> <p>Reviewed NOC audit tool.</p> <p>Reviewed Special Order (SO) for Minimum Nursing Staff to Patient Ratios.</p> <p>Reviewed Administrative Directive for Nursing Services dated June 23, 2005.</p> <p>Reviewed procedure for Nightly Audits.</p> <p>Reviewed New Hire Orientation Competency Validation Tracking System Report.</p> <p>Reviewed PRN & STAT Progress Notes Monitoring Form and data.</p> <p>Reviewed Administrative Directive for Unit Staffing of Nursing Personnel.</p> <p>Reviewed Medication Variance Data Report for March and April 2006.</p> <p>Reviewed Initial Nursing Assessment Quality Control Summary (January to June 2006).</p> <p>Reviewed Nursing Weekly Note Review data (May 2001 to June 2006).</p>
a	<p>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>	<p>Compliance: Partial.</p>

<p>a.i</p>	<p>a description of presenting conditions;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006: Develop and implement monitoring and tracking instruments to measure the key elements of this requirement (a.i, a.ii, a.iii, a.iv, a.v, a.vi, a.vii, a.viii, and a.ix).</p> <p>Findings: NSH has developed an Admission Nursing Assessment Form addressing the requirements as outlined in the EP. The nursing quality improvement department is collecting the data for this requirement.</p> <p>Recommendation 2, July 2006: Develop, update, revise, and implement policies and procedures addressing the key elements of this requirement.</p> <p>Findings: New policy was developed to address this requirement. The policy was approved on January 5, 2007 and implemented on January 15, 2007.</p> <p>Other findings: Data submitted from NSH from July to December 2006 indicated the following compliance for description of presenting condition. The data for items D.3. a.ii through D.3.a.ix are illustrated for each corresponding cell below:</p> <table border="1" data-bbox="1012 1154 1898 1230"> <thead> <tr> <th>July 06</th> <th>Aug 06</th> <th>Sept 06</th> <th>Oct 06</th> <th>Nov 06</th> <th>Dec 06</th> </tr> </thead> <tbody> <tr> <td>0%</td> <td>31%</td> <td>12%</td> <td>12%</td> <td>15%</td> <td>16%</td> </tr> </tbody> </table> <p>Current recommendation: Continue to monitor this requirement.</p>	July 06	Aug 06	Sept 06	Oct 06	Nov 06	Dec 06	0%	31%	12%	12%	15%	16%
July 06	Aug 06	Sept 06	Oct 06	Nov 06	Dec 06									
0%	31%	12%	12%	15%	16%									

a.ii	current prescribed medications;	July 06	Aug 06	Sept 06	Oct 06	Nov 06	Dec 06
		0%	22%	12%	15%	19%	16%
a.iii	vital signs;	July 06	Aug 06	Sept 06	Oct 06	Nov 06	Dec 06
		100%	91%	100%	95%	96%	94%
a.iv	allergies;	July 06	Aug 06	Sept 06	Oct 06	Nov 06	Dec 06
		50%	81%	94%	88%	74%	81%
a.v	pain;	July 06	Aug 06	Sept 06	Oct 06	Nov 06	Dec 06
		100%	94%	100%	93%	93%	91%
a.vi	use of assistive devices;	July 06	Aug 06	Sept 06	Oct 06	Nov 06	Dec 06
		50%	84%	94%	88%	96%	94%
a.vii	activities of daily living;	July 06	Aug 06	Sept 06	Oct 06	Nov 06	Dec 06
		50%	97%	94%	78%	89%	97%
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	July 06	Aug 06	Sept 06	Oct 06	Nov 06	Dec 06
		0%	66%	12%	71%	56%	66%
a.ix	conditions needing immediate nursing interventions.	July 06	Aug 06	Sept 06	Oct 06	Nov 06	Dec 06
		0%	70%	70%	80%	60%	61%

<p>b</p>	<p>Nursing may use a systems model (e.g., Johnson Behavioral System Model) for the nursing evaluation.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, July 2006:</p> <ul style="list-style-type: none"> • Revise policies and procedures to include WRP language. • Implement WRMMS Nursing Assessments and Integrated Nursing Assessments. <p>Findings: NSH has been revising its nursing policies to include the WRP language. In addition, the facility continues to use the admission nursing assessment and integrated nursing assessments. The facility is currently looking at a Role Recovery Nursing Assessment from Florida State Hospital and has submitted it statewide for consideration.</p> <p>Other findings: None.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to revise policies and procedures to include WRP language. 2. Continue to implement WRMMS Nursing Assessments and Integrated Nursing Assessments.
<p>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</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, July 2006: Continue current system to ensure that all nurses who are employed at Napa State Hospital shall have graduated from an approved nursing program, shall have passed the National Council Licensure Examination for Registered Nurses (NCLEX-RN) and shall have a license to practice</p>

	<p>California.</p>	<p>in the State of California.</p> <p>Findings: NSH continues to use its current system to ensure compliance with this requirement.</p> <p>Other findings: NSH data reported 100% compliance with this requirement.</p> <p>Compliance: Full compliance.</p> <p>Current recommendations: Continue current system to ensure that all nurses who are employed at Napa State Hospital shall have graduated from an approved nursing program, shall have passed the NCLEX-RN and shall have a license to practice in the State of California.</p>
<p>d</p>	<p>Each State hospital shall ensure that nursing assessments are undertaken on a timely basis, and in particular, that:</p>	
<p>d.i</p>	<p>Initial nursing assessments are completed within 24 hours of the individual's admission;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, July 2006: Develop and implement a system that reviews, monitors, and tracks the key element of this requirement daily.</p> <p>Findings: NSH has developed and implemented the HSS admission and integrated assessment monitoring log to address this recommendation.</p> <p>Other findings: Data presented by NSH indicated the following compliance with this</p>

		<p>requirement:</p> <table border="1" data-bbox="1012 264 1898 342"> <thead> <tr> <th>July 06</th> <th>Aug 06</th> <th>Sept 06</th> <th>Oct 06</th> <th>Nov 06</th> <th>Dec 06</th> </tr> </thead> <tbody> <tr> <td>100%</td> <td>97%</td> <td>94%</td> <td>93%</td> <td>78%</td> <td>97%</td> </tr> </tbody> </table> <p>Compliance: Partial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	July 06	Aug 06	Sept 06	Oct 06	Nov 06	Dec 06	100%	97%	94%	93%	78%	97%
July 06	Aug 06	Sept 06	Oct 06	Nov 06	Dec 06									
100%	97%	94%	93%	78%	97%									
<p>d.ii</p>	<p>Further nursing assessments are completed and integrated into the individual's therapeutic and rehabilitation service plan within seven days of admission; and</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006: Continue implementation of WRP.</p> <p>Findings: NSH continues to implement this system.</p> <p>Recommendation 2, July 2006: Provide ongoing Wellness and Recovery training to all staff.</p> <p>Findings: NSH has developed a schedule for ongoing training for current staff and new hires.</p> <p>Recommendation 3, July 2006: Implement appropriate timeframes for key element of this requirement.</p> <p>Findings: NSH has developed and implemented the HSS admission and integrated assessment monitoring log to address completion and</p>												

		<p>integration into the individual's therapeutic and rehabilitation plan within seven days of admission.</p> <p>Recommendation 4, July 2006: Develop and implement a monitoring system to address the key elements of this requirement.</p> <p>Findings: NSH has implemented the WRP chart audit addressing this requirement.</p> <p>Other findings: NSH reported 0%, 47%, 59%, 35%, 41% and 38% compliance with this requirement from July to December 2006, respectively.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue implementation of WRP. 2. Continue to provide ongoing Wellness and Recovery training to all staff. 3. Identify and implement appropriate timeframes for the elements of this requirement. 4. Continue to monitor this requirement.
d.iii	<p>Nursing assessments are reviewed every 14 days during the first 60 days of admission and every 30 days thereafter and updated as appropriate. The third monthly review shall be a quarterly review and the 12th monthly review shall be the annual review.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006: Revise policies and procedures to include Nursing assessments are reviewed every 14 days during the first 60 days of admission and every 30 days thereafter and updated as appropriate. The third monthly review shall be a quarterly review and the 12th monthly review shall be</p>

		<p>the annual review.</p> <p>Findings: NSH submitted Nursing policy #101.3-Nursing Assessment. The policy was revised to incorporate timelines for nursing assessments.</p> <p>Recommendation 2, July 2006: Develop and implement a monitoring system address the key elements of this requirement.</p> <p>Findings: NSH has recently implemented the WRP chart audit addressing this requirement.</p> <p>Other findings: None.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Monitor this requirement.</p>
4	Rehabilitation Therapy Assessments	
		<p>Methodology: Interviewed Karen Zanetell, Chief of Rehabilitation Services. Interviewed Nancy Rooney, SLP, Dysphagia-Certified. Interviewed Rich Pike, PT, GCS. Interviewed Karen Breckenridge, PT. Interviewed Eve Arcala, RN, Assistant Coordinator of Nursing Services. Interviewed Candida Asuncion, SRN for unit A4. Interviewed Larry Turner, RN, HSS. Reviewed sections of the Rehabilitation Therapy Professional Practice</p>

		<p>Group Operations Manual. Reviewed draft of the Integrated Rehabilitation Therapy Assessment and instructions. Reviewed Comprehensive Team Assessment for Physical And Nutritional Management form. Reviewed Training and Development Rosters for Dysphagia training and Enhancement Documentation. Reviewed Bailey and Associates consultant report dated December 2006. Reviewed Dysphagia Administrative Committee meeting minutes dated January 26, 2007. Reviewed Dysphagia 101 information sheets, which provide basic information regarding Dysphagia.. Reviewed duty statements for rehabilitation service assistive technology trainee and service assistant from the Veterans Home. Reviewed Rehabilitation Therapy Documentation Monitoring Tool data. Reviewed Rehabilitation therapy services staffing. Observed individuals and adaptive equipment on unit A4.</p>
<p>a</p>	<p>Each State hospital shall develop standard rehabilitation therapy assessment protocols, consistent with generally accepted professional standards of care, for satisfying the necessary components of a comprehensive rehabilitation therapy assessment.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006: Continue process of revising, reassessing and developing integrated rehabilitation therapy assessments to ensure that they are comprehensive and meet the individuals' needs.</p> <p>Findings: NSH has developed a draft of the Integrated Rehabilitation Therapy Assessment. Finalization and implementation is pending review by the specialty therapies: OT, PT, and speech therapy.</p> <p>Recommendation 2, July 2006: Revise, update, and implement policies, procedures, operations manuals and ADs to address this requirement.</p>

		<p>Findings: NSH has revised its Rehabilitation Therapy Professional Practice Group Operations Manual. Since the Rehabilitation Therapy Department has merged with the specialty therapies and is in the process of developing systems for assessments and integrated interventions, policies and procedures will require ongoing development and revisions.</p> <p>Other findings: Although there is a significant amount of work to be completed by the Rehabilitation Therapy Department, they have already demonstrated a committed effort to develop and implement systems required by the EP since the baseline review in July 2006. The Rehabilitation Therapy Department has merged with the specialty therapies of OT, PT, and Speech Therapy. The department has focused much energy on collaboration and beginning the process of identifying some of the unmet needs of the individuals in the area of rehabilitation.</p> <p>In addition, a schedule for regular State-wide communication among the Rehabilitation Chiefs have been implemented as well as regular meetings for the Rehabilitation Therapy sub-committee to keep the process moving forward.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none">1. Finalize and implement the Integrated Rehabilitation Therapy Assessment to ensure that individuals are receiving a comprehensive rehabilitative assessment to meet their needs.2. Continue to revise, update, and implement policies, procedures, operations manuals and ADs to address this requirement as systems evolve.
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b	Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:	Compliance: Partial.
b.i	Is accurate and comprehensive as to the individual's functional abilities;	<p>Current findings on previous recommendations:</p> <p>Recommendations 1, 2 and 3, July 2006:</p> <ul style="list-style-type: none"> • Revise appropriate policies, procedures, and manuals to include the required key elements. • Train RT staff regarding changes implemented. • Develop and implement a system for monitoring and tracking the key elements of this requirement. <p>Findings: As described above in D.4.a.</p> <p>Recommendation 4, July 2006: Secure a consultant with expertise in the area of dysphagia to assist the teams in assessments and the development of 24-hour, proactive WRPs for individuals at risk and at high risk for aspiration.</p> <p>Findings: The State secured the services of Bailey and Associates, who specialize in dysphagia and mobility issues. These consultants provided an initial training at MSH and then came on-site to NSH (December 11-14, 2006) regarding Physical and Nutritional Management. In response to the consultants' recommendations, NSH established a Physical and Nutritional Management Plan team (PNMP). The PNMP consists of the speech therapist that is the clinical team leader, two PTs, two RN supervisors, a Health Services Supervisor, a dietician, a unit supervisor, a physician and dentist consultant from the facility, a respiratory therapist, an OT, and a psychology consultant from the facility. Currently the PNMP team meets weekly. A schedule for ongoing training</p>

		<p>and consultation by Bailey and Associates is in the process of being developed.</p> <p>Recommendation 5, July 2006: Provide ongoing training to all team members regarding dysphagia.</p> <p>Findings: As mentioned above, the initial training regarding dysphagia has begun. Training rosters were provided by NSH documenting the staff that attended this training. In addition, facility-wide training regarding dysphagia is being implemented in February 2007 as well as adding dysphagia training to the orientation and nursing education programs.</p> <p>Recommendations 6 and 7, July 2006:</p> <ul style="list-style-type: none"> • Obtain a wheelchair specialist to assist the teams in assessing the mobility needs and fabricating individual wheelchairs that promote appropriate body alignment for individuals who depend on the use of wheelchairs for the majority of their mobility. • Streamline the process of obtaining adaptive equipment. <p>Findings: The facility has yet to address this recommendation.</p> <p>Recommendations 8, 9 and 10, July 2006:</p> <ul style="list-style-type: none"> • Provide and document training to individuals and staff regarding the appropriate use of adaptive equipment. • Develop a monitoring system to ensure that individuals have access to their adaptive equipment and that it is in proper working condition, and that it is being used appropriately. • Re-evaluate the adaptive equipment at least annually or in response to individuals' status changes to ensure that it is meeting the individuals' needs.
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		<p>Findings: The facility had begun the process of taking inventory of the wheelchairs currently being utilized by individuals and assessing the need for repairs and/or replacement.</p> <p>Recommendation 11, July 2006: Develop a collaborative relationship with Developmental specialists in Sonoma, CA for assistance with positioning and wheelchair fabrication.</p> <p>Findings: NSH reported that there has been some initial communication and exchange of information with the Veterans Home and Sonoma Developmental Center. Duty statements were obtained for rehabilitation service assistive technology trainee and service assistant from the Veterans Home. However, there has been no collaboration thus far regarding positioning and wheelchair fabrication.</p> <p>Other findings: NSH has identified 52 individuals as being Level 1 risk, the highest risk for aspiration. As part of the consultants' training regarding Dysphagia, comprehensive assessments, physical nutritional management plans and dining plans were completed for three Level 1 individuals (JC, JM, and DB). NSH reported that they had also completed an additional five comprehensive assessments for Level 1 individuals. However, at the time of this review, many of the interventions identified had not been initiated for these individuals.</p> <p>In addition, there has been no system put in place to monitor and document any clinical symptoms/triggers to assign a priority status for other Level 1 individuals awaiting the completion of a comprehensive assessment by the PNMP team.</p>
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		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to revise appropriate policies, procedures, and manuals regarding this requirement. 2. Provide ongoing training to RT staff regarding changes implemented. 3. Continue to develop and implement a system for monitoring and tracking the elements of this requirement. 4. Provide ongoing training to all team members regarding dysphagia. 5. Obtain a wheelchair specialist to assist the teams in assessing the mobility needs and fabricating individual wheelchairs that promote appropriate body alignment for individuals who depend on the use of wheelchairs for the majority of their mobility. 6. Streamline the process of obtaining adaptive equipment. 7. Provide and document training to individuals and staff regarding the appropriate use of adaptive equipment. 8. Develop a monitoring system to ensure that individuals have access to their adaptive equipment and that it is in proper working condition, and that it is being used appropriately. 9. Re-evaluate the adaptive equipment at least annually or in response to individuals' status changes to ensure that it is meeting the individuals' needs. 10. Develop a plan outlining how training, implementation of interventions, and monitoring will be executed for the units that have Level 1 risk individuals. 11. Implement the trigger flow sheets to actively collect clinical objective data in order to identify which individuals warrant priority standing for the completion of comprehensive assessments.
b.ii	Identifies the individual's current functional status and the skills and supports needed to facilitate transfer to the next level of care; and	As above.
b.iii	Identifies the individual's life goals, strengths, and	As above.

	motivation for engaging in wellness activities.	
c	Each State hospital shall ensure that all clinicians responsible for performing or reviewing rehabilitation therapy assessments are verifiably competent in performing the assessments for which they are responsible	<p>Current findings on previous recommendations:</p> <p>Recommendation, July 2006: Develop and implement a system for monitoring and tracking the key elements of this requirement.</p> <p>Findings: The facility has not yet addressed this recommendation but reported the possible use of inter-facility peer review to meet this requirement.</p> <p>Other findings: None.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Develop and implement a system for monitoring and tracking the elements of this requirement.</p>
d	Each State hospital shall ensure that all rehabilitation therapy assessments of all individuals who were admitted to each State hospital before the Effective Date hereof shall be reviewed by qualified clinicians and, as indicated, revised to meet the criteria in § [IV.D.2], above.	<p>Current findings on previous recommendations:</p> <p>Recommendation, July 2006: Continue the process of reassessing and developing integrated rehabilitation therapy assessments for individuals who were admitted before June 1, 2006.</p> <p>Findings: NSH is in the final stages of revising and implementing a new comprehensive Rehabilitation Therapy Assessment. Once this occurs, the process of reassessing individuals admitted to NSH prior to June 1, 2006 will begin.</p>

		<p>Other findings: None.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Initiate process of reassessing and developing integrated rehabilitation therapy assessments for individuals who were admitted before June 1, 2006 upon approval of newly developed comprehensive Rehabilitation Therapy Assessment.</p>
5	Nutrition Assessments	
	<p>Each State hospital shall provide nutrition assessments, reassessments, and interventions consistent with generally accepted professional standards of care. A comprehensive nutrition assessment will include the following:</p>	<p>Methodology: Interviewed Wen Pao, Dietetic Director. Interviewed Kameo Camprsi, Assistant Dietetic Director. Reviewed the charts of 62 individuals (TCC and NF RWE, KJ, CH, CC, SP, JG, RL, TP, IS, JH, GD, JD, NF, LW, KB, RC, PR, WW, WC, CW, JM, SS, AG JC, TA, JRD, JG, MF, MAW, KL, OR, CS, AB, GS, LH, CH, JL, AY, TW, RB, AB, CW, SM, CN, JH, TH, FT, DO, SC, VB, MM, DK, PM DS, AM, PMA, ROK, LG, JAB, and LR). Reviewed the updated Statewide Nutrition Care Monitoring Tool (NCMT) and instructions. Reviewed the Statewide Nutrition Care Monitoring data for July-November 2006. Reviewed training rosters for Assessment, Timeliness, and Appropriate Documentation. Reviewed NSH Dietetics Department Meeting minutes dated September 18, October 24, November 27-28, December 5 and December 22, 2006, and January 16, 2007. Reviewed Dysphagia/Choking Precaution List. Reviewed list of individuals receiving enteral feedings.</p>

		<p>Reviewed list of individuals admitted directly into the medical-surgical unit.</p> <p>Reviewed list of individuals directly admitted into the skilled nursing facility.</p> <p>Reviewed list of individuals who were new admissions with identified nutrition triggers.</p> <p>Reviewed individuals BMI list and distribution.</p> <p>Reviewed list of individuals with diabetes.</p>
a	<p>For new admissions with high risk referral (e.g., type I diabetes mellitus, enteral/parenteral feeding, dysphagia/recent choking episode), or upon request by physician, a comprehensive Admission Nutrition Assessment will be completed within 24 hours of notification to the dietitian.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, July 2006: Develop and implement a high-risk referral monitoring and tracking system to identify individuals who meet this criterion to ensure that they receive adequate nutrition assessments.</p> <p>Findings: The facility has developed a High Risk Nutritional Referral Form that is pending approval.</p> <p>Other findings: NSH reported that one individual met this criterion at 100% compliance for timeliness for the review period of July to November 2006.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Implement the high-risk referral monitoring and tracking system to identify individuals who meet this criterion to ensure that they receive adequate nutrition assessments.</p>

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 recommendations:</p> <p>Recommendation 1, July 2006: Report scores for self-assessment tool broken down by items as well as overall scores to provide more specific and accurate data regarding strengths and problem areas.</p> <p>Findings: NSH has reported the scores for the self-assessment tool broken down by items, which provides specific and accurate data and better identifications of strengths and problem areas.</p> <p>Recommendation 2 and 3, July 2006:</p> <ul style="list-style-type: none"> • Retrain appropriate staff regarding deficiencies and appropriate procedures for Admission Nutrition Assessments. • Document the above as corrective action including date(s) completed. <p>Findings: NSH submitted training rosters adequately addressing these issues.</p> <p>Other findings: 100% compliance was reported by NSH for this requirement. A total of four records were reviewed that met this criterion.</p> <p>Compliance: Partial.</p> <p>Current recommendations: Continue to monitor this requirement to ensure compliance with the EP.</p>
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<p>c</p>	<p>For new admissions directly into the skilled nursing facility unit, a comprehensive Admission Nutrition Assessment will be completed within 7 days of admission.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, July 2006: Develop and implement a monitoring and tracking system for individuals directly admitted into the skilled nursing facility to identify individuals who meet this criterion to ensure that they receive adequate nutrition assessments.</p> <p>Findings: The facility has developed a High Risk Nutritional Referral Form that is pending approval. In addition, the Statewide Nutrition Care Monitoring Tool (NCMT) addresses this requirement.</p> <p>Other findings: NSH reported 100% compliance for one record that met this criterion during the review period.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Implement the high-risk referral monitoring and tracking system to identify individuals who meet this criterion to ensure that they receive adequate nutrition assessments. 2. Continue to monitor this requirement to ensure compliance with the EP.
<p>d</p>	<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</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006: Ensure that Admission Nutrition Assessments for Assessment Type Ds are completed in a timely manner.</p>

	<p>Admission Nutrition Assessment will be completed within 7 days of admission.</p>	<p>Findings: NSH reported 40% compliance for this requirement. As mentioned previously, a High Risk Nutrition Referral Form is pending approval. This referral will be sent by nursing to alert the Dietetics Department in a timely manner when nutritional triggers are identified so that they may complete the Admission Nutrition Assessment in the appropriate timeframe. This appears to be a promising system and should be implemented swiftly due to the health status of the individuals who would fall into this criterion to ensure timely assessments.</p> <p>Recommendation 2, July 2006: Report scores for self-assessment tool broken down by items as well as overall scores to provide more specific and accurate data regarding strengths and problem areas.</p> <p>Findings: As above in b, under findings for recommendation #1, 2006.</p> <p>Recommendations 3 and 4, July 2006:</p> <ul style="list-style-type: none"> • Retrain appropriate staff regarding deficiencies and appropriate procedures for Admission Nutrition Assessments. • Document the above as corrective action including date(s) completed. <p>Findings: NSH submitted training rosters adequately addressing these issues.</p> <p>Other findings: The NSH data also indicated that there were some issues noted regarding the quality of the assessments. From my review of two records meeting this criterion (TCC and NF), I found similar problems with both timeliness and quality of the assessments. NSH submitted minutes of their Dietetics Department meetings where it was evident that the</p>
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		<p>findings of each month's NCMT audit were reviewed with the dieticians and corrective actions taken at that time. This is an excellent approach for addressing, in a timely manner, problematic issues that are identified on the NCMT audit.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Identify issues/barriers that prevent Admission Nutrition Assessments for Assessment Type Ds from being completed in a timely manner. 2. Implement the high-risk referral monitoring and tracking system to identify individuals who meet this criterion to ensure that they receive adequate and timely nutrition assessments. 3. Continue to retrain appropriate staff regarding deficiencies and appropriate procedures for Admission Nutrition Assessments. 4. Document the corrective actions taken.
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 recommendations:</p> <p>Recommendation 1, July 2006: Ensure that Admission Nutrition Assessments for Assessment Type Es are completed in a timely manner.</p> <p>Findings: NSH reported 67% compliance for 27 records that met this criterion. From my review of 23 records (RWE, KJ, CH, CC, SP, JG, RL, TP, IS, JH, GD, JD, NF, LW, KB, RC, PR, WW, WC, CW, JM, SS and AG), 14 were found to be in compliance with this requirement.</p> <p>Recommendation 2, July 2006: Report scores for self-assessment tool broken down by items as well as</p>

		<p>overall scores to provide more specific and accurate data regarding strengths and problem areas.</p> <p>Findings: As above in D.5.b under findings for recommendation #1, 2006.</p> <p>Recommendations 3 and 4, July 2006:</p> <ul style="list-style-type: none"> • Retrain appropriate staff regarding deficiencies and appropriate procedures for Admission Nutrition Assessments. • Document the above as corrective action including date(s) completed. <p>Findings: NSH submitted training rosters adequately addressing these issues.</p> <p>Other findings: From both NSH's and my review, problems continue to exist related to the quality of the assessments. From the documentation submitted by NSH, these problem areas are being identified by the NCMT and are being addressed during the department meetings.</p> <p>In addition, there were a number of incomplete Nutrition Assessments found by both NSH and myself that are basically thrown out of the sample and not tracked with the existing data. This appears to be a significant issue that warrants tracking and follow-up.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Identify issues/barriers that prevent Admission Nutrition Assessments for Assessment Type Es from being completed in a timely manner.
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		<ol style="list-style-type: none"> 2. Continue to retrain appropriate staff regarding deficiencies and appropriate procedures for Admission Nutrition Assessments. 3. Document the corrective actions taken. 4. Implement a system within the current monitoring system to track and follow up on nutritional assessments that were incomplete.
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, July 2006: Ensure that Admission Nutrition Assessments for Assessment Type Fs are completed in a timely manner.</p> <p>Findings: From NSH's review of 15 records, 67% compliance was reported for this requirement. From my review of eight records that met this criterion (JC, TA, JRD, JG, MF, MAW, KL, and OR), I found that six were in compliance with this requirement.</p> <p>Recommendation 2, July 2006: Report scores for self-assessment tool broken down by items as well as overall scores to provide more specific and accurate data regarding strengths and problem areas.</p> <p>Findings: As above in D.5. b, under findings for recommendation #1, 2006.</p> <p>Recommendations 3 and 4, July 2006:</p> <ul style="list-style-type: none"> • Retrain appropriate staff regarding deficiencies and appropriate procedures for Admission Nutrition Assessments. • Document the above as corrective action including date(s) completed.

		<p>Findings: NSH submitted training rosters adequately addressing these issues.</p> <p>Other findings: Issues with overall quality and completeness were noted from my review as well as the data presented by NSH.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Identify issues/barriers that prevent Admission Nutrition Assessments for Assessment Type Fs from being completed in a timely manner. 2. Continue to retrain appropriate staff regarding deficiencies and appropriate procedures for Admission Nutrition Assessments. 3. Document the corrective actions taken. 4. Implement a system within the current monitoring system to track and follow up on nutritional assessments that were incomplete.
g	For all other individuals, a comprehensive Admission Nutrition Assessment will be completed within 30 days of admission.	<p>Current Findings on Previous Recommendations:</p> <p>Recommendation 1, July 2006: Continue to monitor Admission Nutrition Assessments for Assessment Type Gs to ensure that they are completed in a timely manner.</p> <p>Findings: NSH reported 88% compliance with this requirement from a review of 123 records. My review of 22 records (CS, AB, GS, LH, CH, JL, AY, TW, RB, AB, CW, SM, CN, JH, TH, FT, DO, SC, VB, MM, DK, PM) found that 20 were in compliance with this requirement.</p>

		<p>Recommendation 2, July 2006: Report scores for self-assessment tool broken down by items as well as overall scores to provide more specific and accurate data regarding strengths and problem areas.</p> <p>Findings: As above in b, under findings for recommendation #1, 2006.</p> <p>Recommendations 3 and 4, July 2006:</p> <ul style="list-style-type: none"> • Retrain appropriate staff regarding deficiencies and appropriate procedures for Admission Nutrition Assessments. • Document the above as corrective action including date(s) completed. <p>Findings: NSH submitted training rosters adequately addressing these issues The compliance with this requirement has improved since the baseline review in July 2006.</p> <p>Other findings: As consistently found in the other assessment types, issues were noted from my review and the NSH review regarding the quality and completeness of the nutritional assessments. The department continues to provide training to its staff regarding deficiencies identified through the self-assessment process.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to monitor Admission Nutrition Assessments for Assessment Type Gs to ensure that they are completed in a timely manner.
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		<ol style="list-style-type: none"> 2. Continue to retrain appropriate staff regarding deficiencies and appropriate procedures for Admission Nutrition Assessments. 3. Document the corrective actions taken. 4. Implement a system within the current monitoring system to track and follow up on nutritional assessments that were incomplete.
h	<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 recommendations:</p> <p>Recommendation 1, July 2006: Report scores for self-assessment tool broken down by items as well as overall scores to provide more specific and accurate data regarding strengths and problem areas.</p> <p>Findings: Same as above in b, under findings for recommendation #1, 2006.</p> <p>Recommendations 2 and 3, July 2006:</p> <ul style="list-style-type: none"> • Retrain appropriate staff regarding the Nutritional Status Type (NST) classifications. • Document the above as corrective action including date(s) completed. <p>Findings: NSH submitted meeting minutes and training rosters adequately addressing these recommendations. In addition, the compliance rate for this requirement was noted to have increase to 95% from the baseline review.</p> <p>Other findings: None.</p>

		<p>Compliance: Substantial compliance.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
<p>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 goals/objectives, effectiveness of interventions, changes in goals/plan, recommendations, and follow-up as needed.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, July 2006: Develop and implement tracking and monitoring systems related to the elements of Nutrition Assessment Updates.</p> <p>Findings: NSH has developed a new Nutrition Assessment update form, which specifically lists the requirements so that the dietician has to address each element. In addition, the NCMT and instruction form have been modified to reflect the specific criteria required. All forms are pending approval.</p> <p>Other findings: NSH reported 91% compliance for timeliness. However, compliance with the requirements of this cell needs to be reported once the appropriate forms have been approved.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Implement documents for tracking and monitoring system related to the elements of Nutrition Assessment Updates. 2. Continue to monitor this requirement for compliance.

j.i	Individuals will be reassessed when there is a significant change in condition.	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, July 2006:</p> <ul style="list-style-type: none"> • Develop and implement a system to ensure that individuals who have a significant change in condition will be reassessed. • Develop and implement monitoring system to ensure that these individuals are adequately reassessed and in a timely manner. <p>Findings: The facility has developed a High Risk Nutritional Referral Form that is pending approval. NSH reported 86% compliance for timeliness regarding post admission high-risk referrals. These included seven records that met this criterion. Regarding non-administrative transfer to medical/SNF, 100% compliance for timeliness was reported. From my review of seven records (DS, AM, PMA, ROK, LG, JAB, and LR), I found it very difficult to determine when the significant change in condition occurred in order to determine if the assessment was timely. NSH reported that the implementation of the above-mentioned High Risk Referral Form should eliminate this issue.</p> <p>Recommendation 3, July 2006: Provide training on components of an adequate assessment for changes in conditions.</p> <p>Findings: This will be an ongoing process as the system develops. Much of the nutritional documentation that I reviewed regarding this requirement did not indicate the change in condition that precipitated the follow-up assessment note. In addition, there were significant problems noted in the quality of the assessments that I reviewed. There does not appear to be a policy or protocol guiding the documentation criteria for changes in condition.</p>
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		<p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a system to ensure that individuals who have a significant change in condition will be reassessed in a timely manner. 2. Develop and implement monitoring system to ensure that these individuals are adequately reassessed in a timely manner. 3. Develop and implement a protocol addressing the criteria to be included in a nutrition assessment addressing a change in condition. 4. Provide training regarding #3.
j.ii	Every individual will be assessed annually.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006: Ensure that each individual is nutritionally assessed annually.</p> <p>Findings: NSH reported 97% compliance for timeliness from a review of 30 records meeting this criterion. From my review of ten records, I found that all records were in compliance with this requirement.</p> <p>Recommendation 2, July 2006: Report scores for self-assessment tool broken down by items as well as overall scores to provide more specific and accurate data regarding strengths and problem areas.</p> <p>Findings: Same as above in b, under findings for recommendation #1, 2006.</p>

		<p>Recommendations 3 and 4, July 2006:</p> <ul style="list-style-type: none"> • Retrain appropriate staff regarding deficiencies and appropriate procedures for Admission Nutrition Assessments. • Document the above as corrective action including date(s) completed. <p>Findings: NSH submitted meeting minutes and training rosters adequately addressing these recommendations.</p> <p>Other findings: Overall from my review, there continues to be issues related to the quality and completeness of the nutrition assessments. NSH is aware of these issues and are reviewing the results of the monthly NCMT with the dietary staff during their department meetings and are providing the appropriate training.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Continue to ensure that each individual is nutritionally assessed annually. 2. Continue to retrain appropriate staff regarding deficiencies and appropriate procedures for Admission/Annual Nutrition Assessments. 3. Document the above as corrective action.
6	Social History Assessments	
	Each State hospital shall ensure that each individual has a social history evaluation that, consistent with generally accepted professional standards of care:	<p>Methodology: Interviewed Ann Long, LCSW, Chief of Social Work Services. Interviewed Shari Bonds, Risk Management Coordinator. Interviewed Unit Staff.</p>

		<p>Interviewed Individuals. Reviewed 15 charts (CR, WP, FH, RH, TMR, SM, JL, SLD, MAW, DSB, BAH, PFR, RD, SGH, and RT). Reviewed Social Work Integrated 5 day Monitoring Form. Reviewed Integrated Social Work Assessment Form. Reviewed Social Work Integrated Assessment Instructional Manual. Reviewed Social Work 30-Day Psychosocial Assessment Monitoring Form. Reviewed Social Work 30-Day Psychosocial Assessment Instructional Manual. Reviewed Social Work Annual Assessment Monitoring Form. Reviewed Integrated Social Work Assessment Monitoring Form. Observed team meetings. Observed Mall activities.</p>
<p>a</p>	<p>Is, to the extent reasonably possible, accurate, current and comprehensive;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006: Include quality indicators in the Social Work monitoring instruments.</p> <p>Findings: According to Ann Long, Chief of Social Work, the department is working on finalizing the monitoring tool. The tool as it stands is too vague.</p> <p>Recommendations 2-5, July 2006:</p> <ul style="list-style-type: none"> • Implement the 30-day social history reviews. • Develop and implement monitoring of the 30-day social history evaluations. • Develop, finalize and implement statewide annual social history evaluations. • Align monitoring tools with the Evaluation Plan. <p>Findings: Twelve (80%) of the 15 charts reviewed by this monitor had the initial</p>

		<p>and 30-day social history assessments. According to Ann Long, Chief of Social Work, Chiefs of Social Work from the State hospitals and Moira Leyva from DMH have developed, at their meeting date on January 22, 2007, draft versions for all the above requirements. These drafts are not finalized.</p> <p>Other findings: The Social History Assessment tool does not have a date line for examiners to enter the date of assessment. This makes it difficult to know when the assessment was conducted and if it was conducted in a timely manner.</p> <p>Only 11 of the 15 (73%) of the charts reviewed by this monitor were conducted using the proper form. The other 27% of the assessments were conducted using old forms. The old forms do not accommodate the entries necessary to fulfill the requirements.</p> <p>The initial assessment is to be conducted within 7 days of admission. However, assessments often are conducted within one or two days of admission. According to Ms. Long, Chief of Social Work, admission of individuals' at NAPA towards the end of the week results in early assessments to meet the time criterion.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Develop quality indicators in the Social Work monitoring instruments. 2. Implement the 30-day social history reviews. 3. Develop and implement monitoring of the 30-day social history evaluations. 4. Develop, finalize and implement statewide annual social history
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		<p>evaluations.</p> <p>5. Align monitoring tools with the Evaluation Plan.</p>
b	Expressly identifies factual inconsistencies among sources, resolves or attempts to resolve inconsistencies, and explains the rationale for the resolution offered;	<p>Current findings on previous recommendations:</p> <p>Recommendation, July 2006: Ensure that social workers identify and address the inconsistencies in current assessments.</p> <p>Findings: Two (RT and RH) of the five social history evaluations (RT, RH, WP, FH, and CR) reviewed by this monitor had identified inconsistencies. The inconsistencies were not resolved. Examiners had requested for more information to resolve inconsistencies.</p> <p>Other findings: According to Ann Long, Chief of Social Work, training was conducted with staff, and repeat monitor including content is to be conducted in February, 2007.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Ensure that social workers identify and address the inconsistencies in current assessments.</p>
c	Is included in the 7-day integrated assessment and fully documented by the 30 th day of an individual's admission; and	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006: Ensure all SW Integrated assessments are completed and available to the WRPT before the 7-day WRPC.</p>

		<p>Findings: NSH's progress report showed 100% compliance. All five charts reviewed by this monitor contained timely initial, 7-day Social Work Integrated assessments. In some instances, the assessment was completed too soon (within 24 hours).</p> <p>Recommendation 2, July 2006: Ensure that all 30-day social histories are completed and available to the individual's WRPT members by the 30th day of admission.</p> <p>Findings: NSH's progress report showed a compliance of 31% in timeliness of all 30-day social history assessments. The monitor's reviews of 15 charts are in agreement with NSH's findings.</p> <p>Other findings: NSH's Social Work Department has developed and implemented monitoring instruments.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure all SW integrated assessments are completed and available to the WRPT before the 7-day WRPC. 2. Ensure that assessments are not completed too early. 3. Continue to implement the 7-day and 30-day SW assessments.
d	Reliably informs the individual's interdisciplinary team about the individual's relevant social factors and educational status.	<p>Current findings on previous recommendations:</p> <p>Recommendation, July 2006: Ensure that social histories reliably inform the individual's WRPT about the individual's relevant social factors and educational status.</p>

		<p>Findings: According to Ann Long, Chief of Social Work, the item to meet this requirement is included in the 30Day Psychosocial Monitor. The monitor is to be implemented beginning February, 2007. Charts reviewed by this monitor (TMR, SM, JL, SLD, MAW, DSB, BAH, PFR, RD, SGH, CR, WP, FH, RH, and RT) showed that social and educational factors were not always identified (WP, SGH and BAH).</p> <p>Other findings: According to Ann Long, Chief of Social Work, Psychology used to identify social and educational factors. However, the Psychology Integrated Assessment form has been changed, removing the section on Social and Educational factors.</p> <p>Compliance: Non-compliance.</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>
7	Court Assessments	
		<p>Methodology: Interviewed George Splane, Staff Psychiatrist and member of the Forensic Review Panel (FRP). Interviewed David Thomas, M.D. Acting Medical Director and member of the FRP. Interviewed Rachel Bramble, Psy.D., Standards Compliance Psychologist. Reviewed court reports that were submitted for ten individuals (SS, JM, BM, BT, JC, RH, SJ, KC, JDC and JC-2). Reviewed AD #765 -Forensic Review Process for Not Guilty by Reason of Insanity (PC 1026) and Incompetent to Stand Trial (PC 1370)</p>

		<p>Commitments. Reviewed Court Reports Monitoring Form for PC 1026. Reviewed Court Report Monitoring for PC 1026 summary data (July to December 2006). Reviewed Court Report Monitoring Form for PC 1370. Reviewed Court Report Monitoring summary data (July to December 2006). Reviewed Minutes of Forensic Panel meetings (July to December 2006).</p>
<p>a</p>	<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>
<p>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, July 2006: Ensure that the FRP reviews all PC 1026 reports and provides feedback to the WRPTs to achieve compliance.</p> <p>Findings: NSH has implemented this recommendation. The FRP reviews 100% of PC 1026 reports and provides feedback to the teams regarding needed corrections. The feed back is sent by e mail. Since the baseline evaluation, 16% of reports have required corrective feed back.</p> <p>Recommendation 2, July 2006: Address the reason(s) for any significant discrepancy between findings of the monitor and the facility's data.</p>

		<p>Findings: The facility's progress report indicates that NSH has conducted an analysis of its monitoring data from May 2006 to determine reason for the discrepancy, but no further information is provided.</p> <p>Recommendation 3, July 2006: Clarify presentation of monitoring data in terms of sample size, how sample was selected, and corresponding results.</p> <p>Findings: Using the Court Reports Monitoring Form for PC 1026, members of the FRP reviewed 100% of PC 1026 and PC 1370 reports during the period July to December 2006. The facility's data indicate a compliance rate of 88% with the requirement in this cell. This monitor reviewed five charts of individuals admitted under PC 1026. The review was conducted with members of the FRP. The review shows compliance in two charts (BT and JC), partial compliance in two (SS and BM) and non-compliance in one (JM) regarding the requirement in this cell. The facility's compliance data and this monitor's findings for items D.7. a. ii through D.7.a.ix are outlined in each corresponding cell below.</p> <p>Other findings: None.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue FRP reviews and corrective feedback regarding all PC 1026 and PC 1370 court submissions. 2. Address the reason(s) for any significant discrepancy between findings of the monitor and the facility's data. 3. Continue to monitor this requirement.
a.ii	acts of both verbal and physical aggression and property destruction during the past year of	Facility's data show compliance rate of 76% for this item. This monitor's reviews indicate compliance in the charts of SS, JM and BM and non-

	hospitalization and, if relevant, past acts of aggression and dangerous criminal behavior;	compliance in the chart of BT and JC.
a.iii	understanding of potential for danger and precursors of dangerous/criminal behavior, including instant offense;	The compliance rate reported by NSH for this item is 63%. This monitor's reviews show that the reports in most charts (SS, JM, BT and JC) do not address this criterion. One chart (BM) is in compliance.
a.iv	acceptance of mental illness and understanding of the need for treatment, both psychosocial and biological, and the need to adhere to treatment;	NSH reports a compliance rate of 80% for this item. This monitor's review show compliance in two charts (SS and JC), partial compliance in one (BM) and non-compliance in two (JM and BT).
a.v	development of relapse prevention plan (i.e., Personal Wellness Recovery Plan or Wellness Recovery Action Plan) for mental illness symptoms, including the individual's recognition of precursors and warning signs and symptoms and precursors for dangerous acts;	NSH reports a compliance rate of 65% for this item. Chart reviews by this monitor demonstrate compliance in three charts (SS, BM and BT), and non-compliance in two (JM and JC).
a.vi	willingness to achieve understanding of substance abuse issues and to develop an effective relapse prevention plan (as defined above);	The compliance rate, based on the facility's monitoring data, is 57%. This monitor's review of charts shows compliance in one chart (BM) and non-compliance in one (JM). This item is not applicable to SS, BT and JC.
a.vii	previous community releases, if the individual has had previous CONREP revocations;	The facility reports a compliance rate of 87% for this item. This monitor's reviews indicate that three charts (SS, BM and JC) comply with this criterion and one chart (JM) is in partial compliance. The item does not apply to BT.
a.viii	social support, financial resources, family conflicts, cultural marginalization, and history of sexual and emotional abuse, if applicable; and	The compliance rate reported by NSH is 63%. This monitor found noncompliance in four charts (SS, JM, BM and JC) and partial compliance in one (BT).
a.ix	relevant medical issues, all self-harm behaviors, risks for self harm and risk of harm to others, to inform the	NSH reports a compliance rate of 60% for this item. This monitor found noncompliance in three charts (SS, JM and JC) and partial compliance in

	<p>courts and the facility where the individual will be housed after discharge.</p>	<p>two (BT and BM).</p>
<p>b</p>	<p>Each State hospital shall develop and implement policies and procedures to ensure an interdisciplinary approach to the development of court submissions for individuals admitted to the hospital pursuant to Penal Code Section 1370, "incompetent to stand trial" ("IST"), based on accurate information and individualized risk assessments. Consistent with the right of an individual accused of a crime to a speedy trial, the focus of the IST hospitalization shall be the stabilization of the symptoms of mental illness so as to enable the individual to understand the legal proceedings and to assist his or her attorney in the preparation of the defense. The forensic reports should include the following:</p>	<p>Compliance: Partial.</p>
<p>b.i</p>	<p>relevant clinical description of initial presentation, if available, which caused the individual to be deemed incompetent to stand trial by the court;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, July 2006: Same as under D.7.a.i</p> <p>Findings: Same as in D.7.a.i. This monitor reviewed five charts of individuals admitted under PC 1370. The review was conducted with members of the FRP. The review shows compliance in two charts (RH and SJ) and non-compliance in three (KC, JDC and JC-2). Using the Court reports Monitoring Form for PC 1370, the facility reports a compliance rate of 88% with this item. The facility's compliance data and this monitor's findings for items D.7. b.ii through D.7.b.iv are outlined in each corresponding cell below.</p>

		<p>Other findings: None.</p> <p>Current recommendation: As above.</p>
b.ii	clinical description of the individual at the time of admission to the hospital;	The facility reports compliance rate of 76%. This monitor found compliance in four charts (RH, SJ, JDC and JC-2) and partial compliance in one (KC).
b.iii	course of hospital stay, describing any progress or lack of progress, response to treatment, current relevant mental status, and reasoning to support the recommendation; and	NSH reports compliance rates for different sub-items of this criterion. The rates are: 88% (describing any progress or lack of progress), 76% (response to treatment), 63% (current relevant mental status) and 80% (reasoning to support the recommendation). Overall compliance rate of 80% was reported. This monitor found partial compliance in all five charts reviewed.
b.iv	all self-harm behaviors and relevant medical issues, to inform the courts and the facility where the individual will be housed after discharge.	The facility has no compliance data for this item. This monitor found partial compliance in one chart (RH). Non-compliance in two (SJ and KC). The requirement is not applicable to JDC and JC-2
c	Each State hospital shall establish a Forensic Review Panel (FRP) to serve as the internal body that reviews and provides oversight of facility practices and procedures regarding the forensic status of all individuals admitted pursuant to Penal Code 1026 and 1370. The FRP shall review and approve all forensic court submissions by the Wellness and Recovery Teams and ensure that individuals receive timely and adequate assessments by the teams to evaluate changes in their psychiatric condition, behavior and/or risk factors that may warrant modifications in their forensic status and/or level of restriction	<p>Current findings on previous recommendations:</p> <p>Recommendation, July 2006: Ensure that the panel performs the primary function of reviewing all court reports for individuals admitted under penal codes 1026 and 1370. The panel must provide feedback to WRPTs to ensure compliance with all above requirements.</p> <p>Findings: As mentioned earlier, the facility has implemented this recommendation.</p>

		<p>Other findings: None.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
c.i	<p>The membership of the FRP shall include Director of Forensic Psychiatry, Facility Director or designee, Medical Director or designee, Chief of Psychology or designee, Chief of Social Services or designee, Chief of Nursing Services or designee, and Chief of Rehabilitation Services or designee. The Director of Forensic Psychiatry shall serve as the chair and shall be a board certified forensic psychiatrist. A quorum shall consist of a minimum of four FRP members or their designee.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, July 2006: Improve interdisciplinary input by including, as members, Chief of Nursing Services or designee and Chief of Rehabilitation Services or designee.</p> <p>Findings: The facility has expanded membership of the FRP to include nursing and rehabilitation directors. At this time, the membership consist of a board-certified forensic psychiatrist (Chair), five psychiatrists, a psychologist, two social workers, the chiefs of nursing and rehabilitation and the Medical Director. The panel meets weekly.</p> <p>Other findings: None.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>

E	Discharge Planning and Community Integration	
		<p>Summary of Progress:</p> <ol style="list-style-type: none"> 1. NHS has correctly recognized that discharge planning focus begins from the individual's first day of admission. 2. NSH is focused on meeting the criteria on appropriate and timely discharge and community integration of the individuals in its facility 3. NSH has adopted the WRP as an essential tool toward addressing the individual's rehabilitation needs and preparation of the individual for discharge and community integration. 4. Social workers are provided training in the discharge process.
1	<p>Taking into account the limitations of court-imposed confinement, the State shall pursue actively the appropriate discharge of individuals under the State's care at each State hospital and, subject to legal limitations on the state's control of the placement process, provide services in the most integrated, appropriate setting in which they reasonably can be accommodated, as clinically appropriate, that is consistent with each individual's needs.</p>	<p>Methodology:</p> <p>Interviewed Ann Long, LCSW, Chief of Social Work Services. Reviewed charts of five individuals (BV, AT, AV, JB, and RPC). Reviewed WRP Chart Audit Form. Reviewed WRP Chart Audit Data Summary. Reviewed documentation of individuals who met discharge criteria but are still in the hospital. Observed WRPT meetings. Observed mall activities</p>
1	<p>Each State hospital shall identify at the 7-day therapeutic and rehabilitation service planning conference, and address at all subsequent planning conferences, the particular considerations for each individual bearing on discharge, including:</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1, 2 and 3, July 2006:</p> <ul style="list-style-type: none"> • Achieve continuity of the discharge process from admission to discharge through the WRP and WRPT process. • Involve the individual in the discharge process through discussion of discharge criteria and how to meet them by attending relevant PSR Mall groups, individual therapy (as needed), and by practicing newly acquired skills in the therapeutic milieu. • Social workers must review discharge status with the WRPT

		<p>and the individual at all monthly WRP conferences involving the individual.</p> <p>Findings: NSH does not have proper audits and monitors to fully address the requirements for the elements of this cell.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Develop a plan to achieve continuity of the discharge process from admission to discharge through the WRP and WRPT process. 2. Develop a tool to monitor the involvement of the individual in the discussion of progress on meeting discharge criteria. 3. Ensure that social workers review discharge status on each discharge criteria with the WRPT and the individual at all scheduled WRP conferences involving the individual. 4. Ensure that the Present Status section of the Quarterly WRP is updated to reflect the status of each discharge criteria.
1a	<p>those factors that likely would foster successful discharge, including the individual's strengths, preferences, and personal life goals;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, July 2006:</p> <ul style="list-style-type: none"> • Ensure that the individual's strengths and preferences are utilized to achieve discharge goals. These should be linked to the interventions that impact the individual's discharge criteria. • The individual's life goals should be linked to one or more foci of hospitalization, with associated objectives and interventions.

		<p>Findings: Review of charts (BV, AT, AV, JB, and RPC) by this monitor showed that most often the individual's strengths, preferences, and personal life goals are not fully addressed in developing discharge goals. Individuals' life goals, when appropriate, are rarely a focus of hospitalization, with associated objectives and interventions. No tool has been developed.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Develop a Discharge Planning Audit tool. 2. Link the individual's life goals to one or more focus of hospitalization, with associated objectives and interventions.
<p>1b</p>	<p>the individual's level of psychosocial functioning;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006: 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: Three of the seven (42%) of the charts reviewed by this monitor included the individual's psychosocial functioning, in the present status section of the case formulation section of the WRP.</p> <p>Recommendation 2, July 2006: Implement the DMH WRP Manual in developing and updating the case formulation.</p>

		<p>Findings: According to Ann Long, Chief of Social Work, staff has undergone training in this area. Monitor has been developed and implemented.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that the level of psychosocial functioning (functional status) is included in the individual's present status section of the case formulation section of the WRP. 2. Implement the DMH WRP Manual in developing and updating the case formulation.
<p>1c</p>	<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>Recommendations 1, 2 and 3, July 2006:</p> <ol style="list-style-type: none"> 1. Ensure that discharge barriers, especially difficulties in previously unsuccessful placements, are discussed with the individual at scheduled WRPC. 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. <p>Findings: NSH does not have a system to track and monitor compliance with this requirement. The WRPs reviewed by this monitor (JS, AP, AV, and CLC) did not include skill training and supports to enable individuals to overcome barriers to a successful transitioning to an integrated environment. JS's WRP (dated December 12, 2006) had no report on the difficulties/ barriers from previous placements. There is no report of the supports and skills needed to achieve discharge goals. There is</p>

		<p>no indication of any progress or lack thereof.</p> <p>Other findings: None.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that discharge barriers, especially difficulties in previously unsuccessful placements, are discussed with the individual at scheduled WRPC. 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.
1d	the skills and supports necessary to live in the setting in which the individual will be placed.	<p>Current findings on previous recommendations:</p> <p>Recommendations 1, 2 and 3, July 2006:</p> <ol style="list-style-type: none"> 1. Assess the skills and supports that will be needed by the individual for a successful transition to the identified setting. 2. Assess skills and supports deficits the individual may have for the intended placement. 3. Include these skills and supports in the individual's WRP at the next scheduled conference. <p>Findings: NSH does not have a system to track and monitor this requirement. Only one of the charts reviewed by this monitor (BV, AT, AV, JB, and RPC) had included individual's skills and supports necessary to live in the setting in which the individual will be placed.</p>

		<p>Other findings: None.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Develop a tool to track and monitor this requirement.</p>
<p>2</p>	<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, 2 and 3, July 2006:</p> <ol style="list-style-type: none"> 1. Ensure that the individual is an active participant in the discharge planning process. 2. Implement the DMH WRP Manual on discharge process. 3. Prioritize objectives and interventions related to the discharge process. <p>Findings: NSH's progress report showed that most individuals are active participants, given their level of functioning and legal status, in their discharge planning process. This monitor observed WRPCs , interviewed individuals, and reviewed discharge goals and individuals life goals in WRPs. In a majority of cases, individuals are not as active as they can be in their discharge planning process. Individual life goals, even when appropriate, are rarely used as foci with accompanying objectives and interventions.</p> <p>Other findings: Ann Long, Chief of Social Work, indicated that staff was trained in WRP Consultation group Training on November, 15th, 2006.</p>

		<p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to train the Social Work Department on engaging the individual as an active participant in the discharge planning process. 2. Implement the requirements outlined in the DMH WRP Manual on discharge process.
<p>3</p>	<p>Each State hospital shall ensure that, consistent with generally accepted professional standards of care, each individual has a professionally developed discharge plan that is integrated within the individual's therapeutic and rehabilitation service plan, that addresses his or her particular discharge considerations, and that includes:</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation July 2006: Follow the established WRP process for discharge planning to ensure that each individual has a professionally developed discharge plan that is integrated within the individual's WRP.</p> <p>Findings: NSH does not have a system to track and monitor this requirement.</p> <p>Other findings: According to Ann Long, Chief of Psychology, Supervising Social Workers are to develop a quality monitor that will be used to monitor this requirement. She wants the monitors to be applied when a sufficient number of specific sub-sections approach compliance.</p> <p>NSH has established as its goal to focus on an individual's discharge planning from their first day of admission. However, there is lack of integration of an individual's discharge goals and plans in their therapeutic and rehabilitation service plan. Documentation still is a deficiency at NSH. There is a lack of communication and coordination between and among disciplines, programs, and therapy groups at NSH, leading to inadequate implementation of the principles and practice</p>

		<p>requirements in the DMH WRP.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Develop a tool to track and monitor this requirement.</p>
<p>3a</p>	<p>measurable interventions regarding these discharge considerations;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation July 2006: Write all interventions, including those dealing with discharge criteria, in behavioral and measurable terms as outlined in the DMH WRP Manual.</p> <p>Findings: NSH's progress report indicates poor compliance to this requirement.</p> <p>This monitor reviewed nine WRPs (RPC, AT, AL, BV, AP, HS, CLC, JS, and AV). None of the WRPs (0%) had all interventions written in behavioral and measurable terms. Intervention for RPC reads, "Nursing staff will teach Mr. R. to reduce weight." Intervention for AL reads, "Assess A's recognition of the need to use the toilet." BV has a foci for "Dental, risk for aspiration"; the objective for this foci reads, "Mr. V will brush his teeth or rinse his mouth after each meal as documented in the IDN," and the intervention includes multiple components all in one intervention (6.3.1.1).</p> <p>Other findings: None.</p> <p>Compliance: Partial.</p>

		<p>Current recommendation: Ensure that all discharge criteria and their related intervention(s) are measurable.</p>
<p>3b</p>	<p>the staff responsible for implement the interventions; and</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, July 2006: For each intervention in the Mall or for individual therapy, clearly state the name of the staff member responsible.</p> <p>Findings: NSH's progress report showed that this requirement had substantial compliance.</p> <p>This monitor reviewed nine WRPs. AT had clearly identified providers for his interventions. None of AL's interventions had identified providers. Most of the other cases did not have identified providers. Frequently, providers were identified with generic labels such as 'staff', 'in group therapy', 'psychologists', 'team', and 'art therapists' (RPC, BV and AP).</p> <p>Other findings: None.</p> <p>Compliance: Partial.</p> <p>Current recommendation: For those active treatment interventions where a discipline is specified rather than the staff members name and discipline, clearly state the name of the staff member responsible.</p>

3c	the time frames for completion of the interventions.	<p>Current findings on previous recommendations:</p> <p>Recommendation, July 2006: For each intervention in the mall or for individual therapy, clearly state the time frame for the next scheduled review. This review should be the same as the individual's scheduled WRPC.</p> <p>Findings: NSH's progress report showed that this requirement was partially met. This monitor reviewed seven WRPs. Four WRPs (AP, AV, HS, and RPC) had review dates for all active interventions. Some of the interventions for AL (3.1), CLC (6.1.1), and JS (6.4.1) did not have review dates.</p> <p>Other findings: None.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Ensure that interventions are reviewed at least monthly.</p>
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:	
4a	individuals who have met discharge criteria are discharged expeditiously, subject to the availability of suitable placements; and	<p>Current findings on previous recommendations:</p> <p>Recommendations 1, 2 and 3, July 2006:</p> <ul style="list-style-type: none"> • 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

		<p>timely discharge.</p> <ul style="list-style-type: none"> • Develop and implement a tracking and monitoring system for obtaining data on all individuals delayed from their discharge. <p>Findings: NSH does not have a tracking system to address this requirement.</p> <p>This monitor had requested for a list of individuals still at NSH after being referred for discharge. NSH produced a partial list of 40 individuals referred for discharge. The list did not indicate the date of referral for discharge or reasons for the delay in discharge.</p> <p>Other findings: NSH has outlined the following plan to meet this requirement:</p> <ul style="list-style-type: none"> • Develop a mechanism for notification by the Social Worker to the Chief, Social Work Services, when the WRPT determines the individual has met discharge criteria and is recommended for discharge. • Track discharges from this list on a monthly basis. • Develop a follow-up form to the Social Workers to be triggered at set intervals to determine cause of delay/ status of referral and recommended interventions to expedite discharge. <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Reduce the overall number of individuals still hospitalized after referral for discharge has been made. 2. Identify and resolve system factors that act as barriers to timely discharge. 3. Develop and implement a tracking and monitoring system for obtaining data on all individuals delayed from their discharge.
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<p>4b</p>	<p>individuals receive adequate assistance in transitioning to the new setting.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, July 2006:</p> <ul style="list-style-type: none"> • Develop and implement a monitoring and tracking system to address the key elements of this requirement. • Ensure and document that individuals receive adequate assistance when they transition to the new setting. <p>Findings: NSH does not have a tracking system to monitor this requirement. There is no means of knowing if individuals receive any assistance in transitioning to a new setting.</p> <p>Other findings: Ann Long, Chief of Social Work, has identified funding, ID, and Social Security as supports that can be useful for individuals in any new setting. She also thought that communication with staff in the potential new setting, and invitation to CONREP to attend discharge meetings as steps to preparing individuals to new settings.</p> <p>Compliance: No basis for rating.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a monitoring and tracking system to address this requirement. 2. Develop and implement documentation guidelines to ensure that individuals receive adequate assistance when they transition to the new setting.
<p>5</p>	<p>For all children and adolescents it serves, each State hospital shall:</p>	<p>Only MSH</p>

5a	develop and implement policies and protocols that identify individuals with lengths of stay exceeding six months; and	
5b	establish a regular review forum, which includes senior administration staff, to assess the children and adolescents identified in § V.E.1 above, to review their treatment plans, and to create an individualized action plan for each such child or adolescent that addresses the obstacles to successful discharge to the most integrated, appropriate placement as clinically and legally indicated.	

F	Specific Therapeutic and Rehabilitation Services	<p>Summary of Progress:</p> <ol style="list-style-type: none"> 1. NSH has made process improvements in current systems for reporting of Adverse Drug Reactions (ADRs) and Medication Variances. 2. NSH has increased reporting of ADRs. 3. NSH has maintained its practice of using appropriate instruments to monitor high-risk medication uses, including PRN and STAT medications, benzodiazepines, anticholinergics and polypharmacy. 4. NSH has expanded monitoring of polypharmacy to include categories of medication uses other than antipsychotic medications.
1	Psychiatric Services	<p>Methodology:</p> <p>Interviewed David Thomas, M.D. Acting Medical Director. Interviewed John Banducci, RPh, Pharmacy Director. Interviewed Pam Moe, Pharm D Assistant Pharmacy Director. Interviewed Jim Young, M.D., Staff Psychiatrist. Interviewed Victoria Cabanela, Staff Psychiatrist. Interviewed Eve Arcala, R.N. Assistant Coordinator, Nursing Services Interviewed Michelle Patterson, RN, HSS, Central Nursing Services. Interviewed six staff psychiatrists.</p> <p>Reviewed charts of 39 individuals (EEC, CAD, VLC, CAD, KFH, EA, JE, RAV, ELH, RLH, EMS, GMT, HTS, MT, LVH, LRJ, AP, LM, HK, PAM, LM, MAA, MD, WBM, RAM, MG, DAG, LM, TAB, WCB, NHB, LKL, ABP, WCB, WF, FT, KP, SS and CD).</p> <p>Reviewed draft individualized medication guidelines regarding the use of aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, divalproex, lamotrigine and serotonin-specific reuptake inhibitors.</p> <p>Reviewed list of all individuals at the facility, including current medications, diagnoses and attending physicians.</p>

		<p>Reviewed Psychiatric progress Notes (PPN) Monthly Monitoring Form-Psychopharmacology.</p> <p>Reviewed PPN Monthly Monitoring Psychopharmacology summary data (July to December 2006).</p> <p>Reviewed PRN & Stat Progress Notes Form-Psychopharmacology.</p> <p>Reviewed PRN & Stat Progress Notes Psychopharmacology Monitoring summary data (July to December 2006).</p> <p>Reviewed Benzodiazepine Data Collection Sheet.</p> <p>Reviewed Benzodiazepine summary data (July to December 2006).</p> <p>Reviewed Anticholinergic Data Collection Sheet.</p> <p>Reviewed Anticholinergic summary data (July to December 2006).</p> <p>Reviewed Polypharmacy Data Collection Sheet.</p> <p>Reviewed Polypharmacy summary data (July to December 2006).</p> <p>Reviewed New Generation Antipsychotics Data Collection Worksheet.</p> <p>Reviewed New Generation Antipsychotics summary data (July to December 2006).</p> <p>Reviewed list of individuals diagnosed with tardive dyskinesia (TD).</p> <p>Reviewed TD Monitoring Form.</p> <p>Reviewed TD Monitoring summary data (July to November 2006).</p> <p>Reviewed Policy and procedure regarding Adverse Drug Reactions (ADR).</p> <p>Reviewed revised Adverse Drug Reaction (ADR) data collection sheet.</p> <p>Reviewed revised policy and procedure regarding ADR.</p> <p>Reviewed randomly selected ADR reports (#10).</p> <p>Reviewed revised medication variance reporting (MVR) data collection sheet.</p> <p>Reviewed randomly selected medication variance reports (#10).</p> <p>Reviewed aggregated data regarding ADRs and MVR from January to December 2006.</p> <p>Reviewed P&T Committee Minutes (January 18, February 15, April 27, June 14, July 12, September 13 and November 8, 2006).</p> <p>Reviewed Substance Abuse Checklist.</p> <p>Reviewed Substance Abuse Checklist summary data (July to December</p>
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		<p>2006). Reviewed Department of Psychiatry meeting minutes (January to December 2006).</p>
<p>1a</p>	<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, July 2006: Develop individualized medication guidelines that include specific information regarding indications, contraindications, clinical and laboratory monitoring and adverse effects for all psychotropic and anticonvulsant medications in the formulary. The guidelines must be derived from current literature, relevant clinical experience and current generally accepted professional practice guidelines.</p> <p>Findings: The facility has yet to implement this recommendation. The DMH is in the process of finalizing individualized medication guidelines regarding the use of new-generation antipsychotic medications, some mood stabilizers (e.g. lamotrigine and divalproex) and some antidepressants (e.g. serotonin-specific reuptake inhibitors). The guidelines are in accord with current generally accepted professional standards.</p> <p>Recommendation 2, July 2006: Implement recommendations listed in D.1.c, D.1.d and D.1.e.</p> <p>Findings: Same as in D.1.c, D.1.d and D.1.e.</p> <p>Other findings: Using the PPN Monthly Monitoring Form- Psychopharmacology, peer psychiatrists reviewed samples from all programs that varied from 5% to 12% each month from July to December 2006. The compliance rates are identified for each cell below. This process did not utilize</p>

		<p>the new individualized guidelines.</p> <p>This monitor's findings of deficiencies listed under Psychiatric Assessments (D.1.c), Diagnosis (D.1.d) and Reassessments (D.1.f) are such that monitoring by NSH of this item is not based on meaningful criteria at this time.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement individualized medication guidelines that include specific information regarding indications, contraindications, clinical and laboratory monitoring and adverse effects for all psychotropic and anticonvulsant medications in the formulary. The guidelines must be derived from current literature, relevant clinical experience and current generally accepted professional practice guidelines. 2. Implement recommendations listed in D.1.c, D.1.d and D.1.e.
1a.i	specifically matched to current, clinically justified diagnoses or clinical symptoms;	83%.
1a.ii	prescribed in therapeutic amounts, as dictated by the needs of the individual served;	No data.
1a.iii	tailored to each individual's symptoms;	80%.
1a.iv	monitored for effectiveness against clearly identified target variables and time frames;	63%.
1a.v	monitored appropriately for side effects;	50%.
1a.vi	modified based on clinical rationales;	71%.
1a.vii	are not inhibiting individuals from meaningfully	24%.

	participating in treatment, rehabilitation, or enrichment and educational services as a result of excessive sedation; and	
1a.viii	properly documented.	No aggregated data (see facility's findings in D.1.f).
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, July 2006: Update the medical staff manual to include all requirements regarding high-risk medication uses, including PRN and/or STAT medications.</p> <p>Findings: The revised Medical Staff manual (draft) includes EP requirements.</p> <p>Recommendation 2, July 2006: Continue to monitor the use of PRN and STAT medications to ensure correction of the above deficiencies.</p> <p>Findings: The facility has continued to monitor the use of PRN and STAT medications using the PRN & Stat Progress Notes Monitoring Form-Psychopharmacology. Using this form, peer psychiatrists reviewed sample sizes that varied from 2% to 6% each month from July to December 2006. The form contains appropriate indicators. An overall compliance rate of 38% is reported for this requirement.</p> <p>Recommendation 3, July 2006: Consolidate the monitoring processes for PRN and/or STAT medications and for psychiatric reassessments (progress notes).</p> <p>Findings: The facility has yet to implement this recommendation. The recommendation is intended to facilitate and simplify the process of</p>

		<p>monitoring.</p> <p>Other findings: As mentioned in D.1.f, this monitor found is a trend of poor documentation of PRN and/or Stat medication use. The following are the main deficiencies:</p> <ol style="list-style-type: none">1. There is inadequate review of the administration of PRN and STAT medications, including the circumstances that required the administration of drugs, the type and doses of drugs administered or the individual's response to the drugs.2. PRN medications are prescribed for generic indications, typically "agitation" without specific information on the nature of behaviors that require the drug administration.3. At times, more than one drug is ordered on a PRN basis without specification of the circumstances that require the administration of each drug.4. There is no evidence of a face-to-face assessment by the psychiatrist within one hour of the administration of Stat medication.5. There is no evidence of a critical review of the use of PRN and/or STAT medications in order to modify scheduled treatment based on this use.6. PRN medications are frequently ordered when the individual's condition, as documented in psychiatric progress notes, no longer requires this intervention. <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none">1. Continue to monitor the use of PRN and STAT medications to ensure correction of the deficiencies noted by this monitor.
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		<ol style="list-style-type: none"> 2. Consolidate the monitoring processes for PRN and/or STAT medications and for psychiatric reassessments (progress notes). 3. Ensure monitoring of a sample of 20% of the target population.
<p>c</p>	<p>Each State hospital shall monitor the psychiatric use of benzodiazepines, anticholinergics, and polypharmacy to ensure clinical justification and attention to associated risks.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006: Update the Medical Staff Manual to include all requirements regarding high-risk medication uses, including benzodiazepines, anticholinergics and polypharmacy.</p> <p>Findings: The draft revision contains an adequate summary of the expectations.</p> <p>Recommendation 2, July 2006: Develop Medication Guidelines for benzodiazepines and anticholinergics. The guidelines must specify risks of use and clinical monitoring requirements to minimize these risks.</p> <p>Findings: The facility has yet to implement this recommendation.</p> <p>Recommendation 3, July 2006: Continue to use current monitoring instruments regarding the use of benzodiazepines, anticholinergics and polypharmacy. Ensure that the justification of use is consistent with current generally accepted standards.</p> <p>Findings The facility has implemented this recommendation.</p> <p>Using the Benzodiazepine Data Collection Sheet, peer psychiatrists</p>

		<p>reviewed samples that varied from 4% to 6% each month from July to December 2006. The review addressed the use of lorazepam and clonazepam. An overall compliance rate of 7% is reported. The following are the rates for specific indicators:</p> <ol style="list-style-type: none"> 1. The latest team conference has a DSM-IV diagnosis of an anxiety disorder (3%). 2. The documentation justifies the regular use of lorazepam for anxiety or other disorder (19%). 3. When benzodiazepines are used regularly, there is documentation of the risks of sedation (5%), drug dependence (4%) or cognitive decline (2%). 4. Benzodiazepines used for individuals with alcohol /drug use problems are justified in PPN documentation (9%). 5. Benzodiazepines used for individuals with cognitive disorders are justified in the progress note documentation (7%). 6. When benzodiazepines are used for more than two months continuously, there is clear documentation of the risks for sedation (2%), drug dependence (2%) or cognitive decline (2%). 7. Treatment is modified in an appropriate and timely manner to ensure proper indications and minimize risk (18%). <p>The facility used the anticholinergic Data collection to monitor the use of benztropine, diphenhydramine and trihexyphenidyl. The sample sizes varied from 4% to 7% each month from July to December 2006. The overall compliance rate is reported at 28%. The specific rates are as follows:</p> <ol style="list-style-type: none"> 1. Documentation justifies the regular use (47%). 2. Documentation includes EPS indications (49%). 3. Anticholinergic use for elderly individuals clearly documents in the PPN risks of sedation (5%), cognitive decline (5%), or gait unsteadiness/falls (5%).
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		<ol style="list-style-type: none"> 4. Anticholinergic use for more than two months continuously includes documentation of the risks of cognitive decline (7%) and other risks (8%). 5. Treatment is modified in an appropriate and timely manner (42%). <p>NSH used the Polypharmacy Data Collection Sheet to review the use of antipsychotic and antidepressant polypharmacy as well as the use of four or more psychotropic medications. In this process, peer psychiatrists reviewed samples that varied from 3% to 8% each month from July to December 2006. An overall compliance rate of 38% is reported. The following is an outline of the compliance rate for each indicator averaging the results of the three types of use:</p> <ol style="list-style-type: none"> 1. Documentation justifies intra-class polypharmacy (43%). 2. Documentation justifies inter-class polypharmacy (40%). 3. Use of intra- or inter-class is accompanied by documentation in the PPN of drug-drug interactions and their risks (12%). 4. Polypharmacy use is modified in a timely manner to ensure proper indications and minimize risks (58%). <p>Recommendation 4, July 2006: Consolidate the process of monitoring of all individual medications within the Drug Utilization Evaluation (DUE) Process.</p> <p>Findings: The facility has yet to implement this recommendation.</p> <p>Other findings: This monitor's findings of the deficiencies in D.1.f indicate that the psychiatric reassessments by and large do not provide the basis for accurate monitoring of the item.</p>
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		<p>This monitor reviewed the charts of nine individuals receiving benzodiazepines (EEC, CAD, VLC, CAD, KFH, EA, JE, RAV and ELH). The reviews show lack of documentation that justifies high risk uses, including long-term use in individuals at a variety of risks. The following are examples of these uses:</p> <ol style="list-style-type: none"> 1. Lorazepam in individuals diagnosed with polysubstance dependence (EEC, CAD, VLP, VLC, CAD, KFH and EA). 2. Lorazepam in an individual diagnosed with vascular dementia (JE); 3. Lorazepam in an individual diagnosed with dementia due to due to head injury and alcohol abuse (RAV); and 4. Clonazepam, temazepam and lorazepam (PRN) in an individual with borderline intellectual functioning (ELH). <p>Chart reviews by this monitor of individuals receiving long-term treatment with anticholinergic agents (RLH, EMS, GMT, HTS and MT) also show lack of documented justification regarding the use in individuals at risk of cognitive impairment. Examples are as follows:</p> <ol style="list-style-type: none"> 1. Benztropine (and lorazepam) in an individual with mild mental retardation (RLH); 2. Benztropine in an individual diagnosed with mild mental retardation and learning Disorder (EMS); 3. Benztropine (and clonazepam and PRN lorazepam) in an individual with borderline intellectual functioning (GMT); 4. Benztropine (and clonazepam and chlorpromazine) in an individual with cognitive disorder, NOS (HTS); and 5. Benztropine and clonazepam with pervasive developmental disorder and mild mental retardation (MT). <p>Reviewing the charts of several individuals receiving antipsychotic polypharmacy (LVH, LRJ, AP, LM and HK), this monitor found the</p>
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		<p>following examples of inadequate documentation of justified use:</p> <ol style="list-style-type: none"> 1. Clozapine, quetiapine, haloperidol and olanzapine (LVM), 2. Olanzapine, quetiapine and fluphenazine (LRJ). 3. Risperidone, haloperidol and clozapine (AP). 4. risperidone and quetiapine (LM); and 5. Olanzapine and chlorpromazine (HK). <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Develop medication guidelines for benzodiazepines and anticholinergics. The guidelines must specify risks of use and clinical monitoring requirements to minimize these risks. 2. Continue to use current monitoring instruments regarding the use of benzodiazepines, anticholinergics and polypharmacy. Ensure that the justification of use is consistent with current generally accepted standards. 3. Consolidate the process of monitoring of all individual medications within the Drug Utilization Evaluation (DUE) Process. 4. Ensure monitoring of a sample of 20% of the target population.
d	<p>Each State hospital shall ensure the monitoring of the metabolic and endocrine risks associated with the use of new generation antipsychotic medications.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006: Same as in recommendation #1 in F.1.a.</p> <p>Findings: See F.1.a.</p>

		<p>Recommendation 2, July 2006: Clarify monitoring data in terms of sample size, how sample was selected and relevant data.</p> <p>Findings: The facility has yet to improve presentation of progress data to address this requirement. In many instances in sections D.1. and F.1, this monitor had to aggregate the facility's data to determine sample sizes.</p> <p>Recommendation 3, July 2006: Same as in F.1.g.</p> <p>Findings: Same as in F.1.g.</p> <p>Other findings: The facility used the New Generation Antipsychotics Data Collection Worksheet to monitor this item. Peer psychiatrists reviewed chart samples that varied from 6% to 13% each month from July to December 2006. The following are the rates of compliance with each indicator:</p> <ol style="list-style-type: none"> 1. Use of medications is based on documentation of benefits and tolerability (61%). 2. New generation antipsychotics are not used for individuals with diagnoses of dyslipidemia (35%), diabetes (42%) or obesity (29%) without documented justification in the PPN. 3. Risperidone used for individuals with hyperprolactinemia only with documented justification (30%). 4. There is appropriate baseline and periodic monitoring of family/personal risk factors (34%), Body Mass Index (64%), waist circumference (15%), triglycerides (75%), cholesterol
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		<p>(75%), fasting blood glucose (70%), glycosylated HgbA1c (43%), menstrual cycle (15%) and breast signs (4%).</p> <ol style="list-style-type: none"> 5. There is appropriate baseline and periodic monitoring of EKG for individuals receiving ziprasidone (60%) and, as indicated, other new generation antipsychotics. (47%). 6. There is appropriate baseline and periodic monitoring for postural hypotension for individuals receiving quetiapine (47%), ziprasidone (60%), olanzapine (IM) (45%) and risperidone (50%). 7. There is appropriate baseline and periodic monitoring of blood counts (100%) and vital signs (91%) for individuals receiving clozapine. 8. Psychiatric progress notes document potential and actual risks for each medication used (22%). 9. There is evidence of timely/appropriate modification of treatment to address identified risks (45%). <p>This monitor reviewed charts of individuals receiving new generation antipsychotic medications, including olanzapine (PAM, LM, MAA and MD) clozapine (WBM, RAM and MG), ziprasidone (DAG, MAA and SDD), risperidone (LM, TAB, WCB and NHB) and quetiapine (LKL, LM and ABP). The review included individuals diagnosed with diabetes mellitus and are receiving olanzapine (MD), risperidone and quetiapine (LM), risperidone (TAB and NHB) and quetiapine (ABP), individuals diagnosed with dyslipidemia and are receiving risperidone (PAM) and olanzapine and ziprasidone (MAA), and an individual with a BMI of 44 who is receiving risperidone (WCB).</p> <p>These reviews indicate a general pattern of adequate laboratory monitoring, but inadequate documentation of the status of the individual regarding the metabolic and endocrine risks of treatment and of attempts to utilize safer medication alternatives. There is evidence of infrequent monitoring of vital signs for individuals</p>
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		<p>receiving clozapine. The reviews show adequate monitoring using EKG for individuals receiving ziprasidone.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Same as in F.1.a. 2. Same as in F.1.g.
<p>e</p>	<p>Each State hospital shall ensure regular monitoring, using a validated rating instrument (such as AIMS or DISCUS), of tardive dyskinesia (TD); a baseline assessment shall be performed for each individual at admission with subsequent monitoring of the individual every 12 months while he/she is receiving antipsychotic medication, and every 3 months if the test is positive, TD is present, or the individual has a history of TD.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006: Ensure that the Medical Staff Manual includes required criteria for monitoring of individuals with TD.</p> <p>Findings: The facility has a draft revision of the Medical Staff Rules and Regulations that addresses this requirement. Based on this revision, the facility developed a statement regarding the required frequency of AIMS.</p> <p>Recommendation 2, July 2006: Ensure that the diagnoses listed on the WRP are aligned with those listed in psychiatric documentation.</p> <p>Findings: The facility has yet to implement this recommendation.</p> <p>Recommendation 3, July 2006: Ensure that TD is recognized as one of the foci of hospitalization and that appropriate objectives and interventions are identified for treatment and/or rehabilitation.</p>

		<p>Findings: The TD statement includes the requirement to include TD as a focus of hospitalization with corresponding objectives and interventions. The statement does not address management strategies. The facility has a new tracking system to improve the identification of individuals suffering from TD. At this time, the facility requires quarterly follow up of all individuals diagnosed with TD at the movement disorders clinic. The clinic is run by a neurologist with expertise in movement disorders.</p> <p>Other findings: NSH used the Tardive Dyskinesia Monitoring form to assess compliance. Peer psychiatrist reviewed samples that a number of charts that varied from 21 to 39 each month from July to November 2006. The facility did not provide appropriate data regarding target population for this review. The monitoring indicators are aligned with the requirement. The following are compliance rates for each indicator:</p> <ol style="list-style-type: none">1. If a conventional antipsychotic is used, is there documented justification? (14%).2. Was an AIMS done on admission? (66%).3. Was an annual AIMS done at the time of the last annual physical examination? (64%).4. If this patient has TD, was a new AIMS done every three months? (6%).5. If the individual has a history of TD, was a new AIMS done every three months? (11%).6. Do monthly progress notes for the past three months indicate that antipsychotic treatment has been modified for individuals with TD, history of TD or positive AIMS test? (17%).
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		<p>This monitor reviewed the charts of four individuals diagnosed with TD (WF, FT, KP and SS) and one individual with documented history of TD (CD). The review showed non-compliance with the required monitoring (using AIMS) in all charts.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure monitoring of a 20% sample of the target population (i.e. individuals with diagnosis or history of TD). 2. Address (and correct) factors related to low compliance. 3. Ensure that the diagnoses listed on the WRP are aligned with those listed in psychiatric documentation. 4. Ensure that TD is recognized as one of the foci of hospitalization and that appropriate objectives and interventions are identified for treatment and/or rehabilitation. 5. Ensure that the TD statement addresses management strategies.
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, July 2006: Provide instruction to all clinicians regarding significance and proper methods in reporting of ADRs.</p> <p>Findings: Reportedly, the psychiatry department meetings have included instruction to the medical staff regarding this recommendation. However, the facility did not provide documentation of written guidelines to all clinical staff regarding the proper reporting and investigation and analysis of ADRs</p>

		<p>Recommendation 2, July 2006: Increase reporting of ADRs</p> <p>Findings: The facility has data to show an increase in ADR reporting since the baseline evaluation. During the period of January to December 2006, a total of 452 ADRs were reported. These ADRs included 210 reports that were related to changes in blood counts of individuals receiving clozapine (the facility has expanded the definition of ADR to include any change in blood indices that require the performance of complete blood counts as per the new FDA monitoring requirement). The reporting of 242 non-clozapine related reactions represents a significant increase in reporting compared to the previous year.</p> <p>Recommendation 3, July 2006: Revise current policy and procedure and develop guidelines to staff to improve attention to the items described above.</p> <p>Findings: The ADR policy and procedure has been revised. The revision has expanded the definition of ADR to include common and mild side effects and included new criteria for pharmacists to initiate ADR reporting.</p> <p>The facility has revised its data collection tool regarding ADRs. The revision adequately addresses some of the deficiencies noted by this monitor during the baseline evaluation. The revised tool provides information regarding the proper description of details of the reaction, the review of all medications that the individual was actually receiving at the time of the ADR and physician notification of the ADR. The revised tool has yet to address other deficiencies that were noted in the baseline report.</p>
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		<p>Recommendation 4, July 2006: Develop and implement tracking log and data analysis systems.</p> <p>Findings: The facility has partially implemented this recommendation. The facility has aggregated data regarding ADRs in the past year by time, duration, location, type, outcome and severity. The facility has yet to conduct data analysis to identify trends and patterns that require corrective/educational interventions.</p> <p>Recommendation 5, July 2006: Develop and implement an intensive case analysis procedure based on established severity/outcome thresholds. The analysis must include proper discussion of history/circumstances, preventability, contributing factors and recommendations.</p> <p>Findings: The facility has yet to implement this recommendation.</p> <p>Other findings: This monitor reviewed ADR-related data presented by NSH. The facility has made progress since the baseline evaluation, but the following deficiencies must be addressed to achieve compliance:</p> <ol style="list-style-type: none"> 1. The facility does not provide information or have written guidelines regarding the requirements for: <ol style="list-style-type: none"> a) Classification of reporting discipline; b) Additional circumstances surrounding the reaction, including how reaction was discovered, allergies, etc.; c) Information about all medications that are suspected or could be suspected of causing the reaction; d) A probability rating if more than one drug is suspected of causing the ADR;
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		<p>e) Information regarding future screening; and f) Information on the clinical review process, including the clinical review person or team, determination of need for intensive case analysis and other actions.</p> <ol style="list-style-type: none"> 2. NSH does not have a formalized system of intensive case analysis based on established ADR-related thresholds. 3. NSH does integrate data regarding ADRs in the current system of psychiatric peer review. 4. NSH does not provide analysis of individual and group practitioner trends and patterns regarding ADRs. 5. NSH has not provided educational programs to address trends in the occurrence of ADRs. <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Revise current policy and procedure and develop guidelines to staff to improve attention to the monitor's findings described above. 2. Develop and implement data analysis systems. 3. Provide educational programs to address trends in the occurrence of ADRs. 4. Develop and implement an intensive case analysis procedure based on established severity/outcome thresholds. The analysis must include proper discussion of history/circumstances, preventability, contributing factors and recommendations.
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<p>g</p>	<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, July 2006: Same as recommendation #1 in F.1.a.</p> <p>Findings: Same as in F.1.a.</p> <p>Recommendations 2, 3 and 4, July 2006:</p> <ul style="list-style-type: none"> • Develop and implement a DUE system based on established individualized medication guidelines. • Ensure systematic review of all medications, with priority give to high-risk, high-volume uses. • Determine the criteria by which the medications are evaluated, the frequency of evaluation, the indicators to be measured, the DUE data collection form, the sample size, and acceptable thresholds of compliance. • Ensure that the individualized medication guidelines are continually updated to reflect current literature, relevant clinical experience and current professional practice guidelines. <p>Findings: The facility has yet to implement these recommendations.</p> <p>Other findings: None.</p> <p>Compliance: Non-compliance.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Same as recommendation #1 in F.1.a. 2. Develop and implement a DUE system based on established
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		<p>individualized medication guidelines.</p> <ol style="list-style-type: none"> 3. Ensure systematic review of all medications, with priority give to high-risk, high-volume uses. 4. Determine the criteria by which the medications are evaluated, the frequency of evaluation, the indicators to be measured, the DUE data collection form, the sample size, and acceptable thresholds of compliance. 5. Ensure that the individualized medication guidelines are continually updated to reflect current literature, relevant clinical experience and current professional practice guidelines.
<p>h</p>	<p>Each State hospital shall ensure documentation, reporting, data analyses, and follow up remedial action regarding actual and potential medication variances ("MVR") consistent with generally accepted professional standards of care.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006: Provide instruction to all clinicians regarding significance of and proper methods in MVR.</p> <p>Findings: The facility has yet to implement this recommendation.</p> <p>Recommendation 2, July 2006: Develop a policy and procedure regarding MVR that includes a revised data collection tool. The procedure and the revised tool must address the deficiencies identified above. The current policy and procedure is not aligned with the revised data collection tool.</p> <p>Findings: The facility developed a new tool that was used to report variances from July to October 2006. The revision included change of the form's title from Medication Error Report to Medication Variance Report and removal of the identification of the staff member who was responsible for the variance. These changes were intended to ensure</p>

		<p>that reporting was a non-punitive process. Other changes included the addition of prescription, documentation, ordering/procurement, dispensing/storage and medication security variances as well as some other process improvements (e.g. severity scale). Although the changes represent improvement in the process of MVR, these changes do not provide corrections for many of the deficiencies identified by this monitor in the baseline report. The facility has plans to make further revisions, including an identification of actual vs. potential variances, variances involving specific monitoring of the individual and outcome of the variance.</p> <p>Recommendation 3, July 2006: Develop and implement tracking log and data analysis systems.</p> <p>Findings: The facility has yet to implement this recommendation based on adequate data collection methods.</p> <p>Recommendation 4, July 2006: Develop and implement an intensive case analysis procedure based on established severity/outcome thresholds. The analysis must include proper discussion of history/circumstances, preventability, contributing factors and recommendations.</p> <p>Findings: The facility has yet to implement this recommendation.</p> <p>Recommendation 5, July 2006: Ensure that MVR is a non-punitive process.</p> <p>Findings: The facility has made appropriate process change to address this recommendation.</p>
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		<p>Other findings: This monitor's review indicates that the facility needs to make further progress to address the following deficiencies:</p> <ol style="list-style-type: none"> 1. NSH does not give proper instruction to the clinical staff regarding the appropriate methods of reporting medication variances and of providing information that aid in the investigation and analysis of the variances. Specifically, the facility does not provide information or have written guidelines to staff regarding: <ol style="list-style-type: none"> a) Classification of reporting discipline; b) Proper description of details of the variance; c) Additional facts involving the variance, including how the variance was discovered, how the variance was perpetuated, relevant individual history, etc.; d) Description of the full chain of events involving the variance; e) Classification of potential and actual variances; f) All medications involved and their classification; g) The route of medication administration; h) Critical breakdown points; i) All possible outcome categories; and j) Outline and analysis of contributing factors. 2. NSH does not aggregate and analyze MVR data. 3. NSH does not have a formalized system of intensive case analysis based on established MVR-related thresholds. 4. NSH does not integrate data regarding MVR in the current system of psychiatric peer review. 5. NSH does not provide analysis of individual and group practitioner trends and patterns regarding MVR. 6. NSH has not provided educational programs to address trends in the occurrence of MVR.
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		<p>7. The current system of MVR is not integrated in any meaningful fashion in the activities of the P & T Committee, the MRC, the Department of Psychiatry or the Department of Medicine.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Provide instruction to all clinicians regarding significance of and proper methods in MVR. 2. Develop and implement a policy and procedure regarding MVR that includes a revised data collection tool. The procedure and the revised tool must address the deficiencies identified above. 3. Develop and implement tracking log and data analysis systems. 4. Provide educational programs to address trends in the occurrence of ADRs. 5. Develop and implement an intensive case analysis procedure based on established severity/outcome thresholds. The analysis must include proper discussion of history/ circumstances, preventability, contributing factors and recommendations.
i	<p>Each State hospital shall ensure tracking of individual and group practitioner trends, including data derived from monitoring of the use of PRNs, Stat medications, benzodiazepines, anticholinergics, and polypharmacy, and of ADRs, DUE, and MVR consistent with generally accepted professional standards of care.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006: Same as in F.1.a. through F.1.h.</p> <p>Findings: Same as in F.1.a through F.1.h.</p> <p>Recommendation 2, July 2006: Improve IT resources to the pharmacy to facilitate the development</p>

		<p>of databases regarding medication use.</p> <p>Findings: The facility has yet to implement this recommendation.</p> <p>Other findings: None.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Same as in F.1.a through F.1.h. 2. Improve IT resources to the pharmacy to facilitate the development of databases regarding medication use.
<p>j</p>	<p>Each State hospital shall ensure feedback to the practitioner and educational/corrective actions in response to identified trends consistent with generally accepted professional standards of care.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, July 2006: Same as above.</p> <p>Findings: Same as above.</p> <p>Other findings: None.</p> <p>Compliance: Non-compliance.</p> <p>Current recommendations: Same as above.</p>

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 recommendations:</p> <p>Recommendation, July 2006: Same as above.</p> <p>Findings: Same as above.</p> <p>Other findings: None.</p> <p>Compliance: Non-compliance.</p> <p>Current recommendations: Same as above.</p>
l	<p>Each State hospital shall ensure that all physicians and clinicians are verifiably competent, consistent with generally accepted professional standards of care, in appropriate medication management, interdisciplinary team functioning, and the integration of behavioral and pharmacological treatments.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006: 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, D1.f. and F.1.a through F.1.h.</p> <p>Recommendation 2, July 2006: Develop and implement a formalized supervisory system for the psychiatry department to ensure clinical and administrative support to staff, proper oversight and development, implementation and coordination of monitoring, educational and peer review systems. Specifically, the facility should consider creating a dedicated position for Chief of Psychiatry and positions for a lead psychiatrist for each of the programs.</p>

		<p>Findings: The Acting Medical Director states that the facility has yet to implement this recommendation</p> <p>Other findings: None.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Same as in D.1.b., D.1.c., D.1.f.viii. and F.1.a. through F.1.h. 2. Develop and implement a formalized supervisory system for the psychiatry department to ensure clinical and administrative support to staff, proper oversight and development, implementation and coordination of monitoring, educational and peer review systems. Specifically, the facility should consider creating a dedicated position for Chief of Psychiatry and positions for a lead psychiatrist for each of the programs.
m	Each State hospital shall review and ensure the appropriateness and safety of the medication treatment, consistent with generally accepted professional standards of care, for:	<p>Compliance: Partial.</p>
m.i	all individuals prescribed continuous anticholinergic treatment for more than two months;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006: Same as in F.1.c.</p> <p>Findings: Same as in F.1.c.</p>

		<p>Recommendation 2, July 2006: Ensure that this practice is triggered for TRC review and follow-through.</p> <p>Findings: The facility has yet to implement this recommendation.</p> <p>Other findings: Same as in F.1.c.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Same as in F.1.c. 2. Ensure that this practice is triggered for TRC review and follow through.
m.ii	all elderly individuals and individuals with cognitive disorders who are prescribed continuous anticholinergic treatment regardless of duration of treatment;	Same as above.
m.iii	all individuals prescribed benzodiazepines as a scheduled modality for more than two months;	Same as above.
m.iv	all individuals prescribed benzodiazepines with diagnoses of substance abuse or cognitive impairments, regardless of duration of treatment; and	Same as above.
m.v	all individuals with a diagnosis or evidencing symptoms of tardive dyskinesia.	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, July 2006:</p> <ul style="list-style-type: none"> • Same as in F.1.e. • Revise the current monitoring mechanism to ensure the proper identification and management of TD as well as proper frequency of clinical assessments. <p>Findings: Same as in F.1.e.</p>

		<p>Other findings: Same as in F.1.e.</p> <p>Current recommendations: As in F.1.e.</p>
m.vi	all individuals diagnosed with dyslipidemia, and/or obesity, and/or diabetes mellitus who are prescribed new generation antipsychotic medications	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006: Same as in F.1.g.</p> <p>Findings: Same as in F.1.g.</p> <p>Recommendation 2, July 2006: Develop and implement DUE monitoring system based on individualized medication guideline.</p> <p>Findings: The facility has yet to implement this recommendation.</p> <p>Other findings: Same as in F.1.g.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Same as in F.1.g. 2. Develop and implement DUE monitoring system based on individualized medication guideline.

<p>n</p>	<p>Each State hospital shall ensure that the medication management of individuals with substance abuse disorders is provided consistent with generally accepted professional standards of care.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1, 2 and 3, July 2006:</p> <ul style="list-style-type: none"> • Ensure that the monitoring instrument addresses the requirement. • Same as in F.1.m.iii. • Ensure that medication management for these individuals is triggered for review by the TRC and follow-through. <p>Findings: The facility has yet to implement these recommendations. The findings in C.2.o, F.1.c and F.1.m.iii. are applicable to this requirement.</p> <p>Other findings: Same as in C.2.o and F.1.c.</p> <p>Compliance: Partial.</p> <p>Current recommendations: Same as in C.2.o, F.1.c and F.1.m.iii.</p>
<p>o</p>	<p>Metropolitan State Hospital shall provide a minimum of 16 hours per year of instruction, through conferences, seminars, lectures and /or videotapes concerning psychopharmacology. Such instruction may be provided either onsite or through attendance at conferences elsewhere.</p>	<p>Only MSH</p>
<p>2 Psychological Services</p>		
	<p>Each State hospital shall provide adequate and appropriate psychological supports and services that are derived from</p>	<p>Methodology:</p>

	<p>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>Interviewed Jim Jones, Ph.D., Acting Chief Psychologist. Interviewed Jessica Michaelson, Psy.D., Psychologist, PBS Team 3. Interviewed Barbara Ann Bachmeier, Psy.D., Psychologist, DCAT. Interviewed Wendy Hatcher, Psy.D., Psychologist, PBS Team4. Interviewed William Foreman, Ph.D., Psychologist, PBS, Team 1. Interviewed Anthony Rabin, Ph.D., Mall Director. Interviewed Patricia White, Ph.D., PBS psychologist. Interviewed Kathleen Patterson, Ph.D., Senior Supervising Psychologist. Interviewed Ann Hoff, Ph.D., Senior Supervising Psychologist. Interviewed Nicole Aviles-Galberth, Ph.D., BY CHOICE Coordinator. Interviewed many individuals served by NSH. Interviewed unit staff Reviewed charts of 25 individuals (BS, LJ, MT, HS, CC, AV, JS, AP, AL, RPC, AT, BV, MC, CS, MT, GB, TP, CLC, JS, AL, PA, SH, AT, RPQ, and PR). Reviewed Memberships of PBS Teams. Reviewed PBS Team Assignments. Reviewed AD for Psychology Services. Reviewed NSH Psychology Department Manuals. Reviewed PBS Manual. Reviewed APA Ethics Standards of Practice. Reviewed Mall Curriculum. Reviewed Psychology Protocols and Assessment Tools. Reviewed BCC treatment plans. Reviewed DMH audit forms. Reviewed WRP audit forms. Reviewed BY CHOICE Manual Reviewed NSH Psychology Department Organizational Chart. Reviewed individuals x program x unit needing behavioral interventions. Reviewed list of individuals on PBS plans. Reviewed personnel CVs. Reviewed personnel certification and licensure documents. Reviewed PBS monitoring form.</p>
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		<p>Reviewed PBS-BCC checklist. Observed virtual Mall sessions. Observed unit Mall sessions. Observed WRPT conferences. Visited BY CHOICE stores.</p>
<p>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>Recommendations 1, 2 and 3, July 2006:</p> <ul style="list-style-type: none"> • Revise the statewide PBS manual to include clear guidelines on the referral process (i.e., what triggers a referral, who is responsible for making the referral and what is expected once a referral is made, timelines). • Include in the PBS manual clear guidelines on how structural and functional assessments are to be performed. • Identify in the manual specific evidence-based tools to use for each type of assessment. <p>Findings: According to Jim Jones, Acting Chief of Psychology, the revisions to the PBS manual are not complete.</p> <p>Recommendation 4, July 2006: Use the terms of behavior guidelines and PBS plans instead of Type A and Type B plans, which are not meaningful to staff or the individuals.</p> <p>Findings: Plans developed in the last 3 months use the correct terminology. The NSH PBS AD #851 has been approved, and currently being aligned with revisions of Special Order.</p> <p>Recommendation 5, July 2006: Recruit additional PBS team.</p>

		<p>Findings: NSH has four fully functioning PBS teams and one DCAT team. There is one DCAT team that consists of a psychologist, RN, PT, and Social Worker.</p> <p>Recommendation 6, July 2006: Ensure that all PBS psychologists use the PBS model as currently identified in the literature.</p> <p>Findings: Five assessments and three PBS plans were reviewed. None of the assessments or plans were fully aligned with the PBS model and practices.</p> <p>Recommendation 7, July 2006: Provide Positive Behavior Supports training to all PBS team members. The PBS Psychologist should provide training to the RNs, PTs and data analysts. Specifically, train these members on the reliable use of evidence-based tools (QABF, FAI, ABC Observations, Maladaptive Behavior Record, scatterplots, etc.).</p> <p>Findings: NSH has not completed training of PBS staff on evidence-based tools.</p> <p>Recommendation 8, July 2006: Standardize the referral system and the format for developing PBS structural and functional assessments across all facilities.</p> <p>Findings: A referral system has not been standardized. A format for Structural Assessments and Functional Assessments has not been developed statewide.</p>
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		<p>Other findings:</p> <p>In interviews with PBS psychologists and a review of their referral databases it was evident that each PBS psychologist manages their referrals differently. In instances where the PBS teams have reassigned cases, the receiving PBS team is not clear as to what should be done with the referral. For example, in several cases the individual had a PBS plan with the first team and the new team is not tracking a plan and is uncertain as to whether or not there should still be a plan.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Finalize Special Order #129.01. 2. Finalize the statewide PBS Manual. 3. Continue to use Behavior Guidelines and PBS plans as the terms for identifying Behavior Supports. 4. Continue to recruit additional PBS team members. 5. Ensure that all PBS psychologists use the PBS model as currently identified in the literature. 6. Ensure that the PBS Psychologists provide training to the RNs, PTs and data analysts in data collection methods and on the reliable use of evidence-based tools. 7. Develop a standardized referral system across all facilities.
<p>a.i</p>	<p>the development and use of positive behavior support plans, including methods of monitoring program interventions and the effectiveness of the interventions, providing staff training regarding program implementation, and, as appropriate, revising or terminating the program; and</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006: Ensure that all PBS staff members receive systematic training in all aspects of the PBS plans, including the relationship between PBS and recovery principles.</p> <p>Findings:</p>

		<p>NSH's PBS team members have started a series of trainings on PBS models and practices with the Chief CRIPA consultant.</p> <p>Recommendation 2, July 2006: Conduct treatment implementation fidelity checks regularly.</p> <p>Findings: NSH does not consistently and systematically conduct treatment implementation fidelity checks. None of the PBS plans reviewed (CC, AL, PA) used fidelity checks that meet generally accepted professional standards.</p> <p>Recommendation 3, July 2006: Senior Psychologists should be assigned to review Type A plans and Crisis Intervention plans for content and appropriateness.</p> <p>Findings: Two Senior Supervising Psychologists have been hired, Kathleen Patterson, Ph.D., and Ann Hoff, Ph.D. They have not reviewed all Behavior Guidelines (previously Type A), PBS plans and Crisis Intervention Plans to monitor for appropriate referrals to PBS and effectiveness of Behavior Guidelines and PBS plans.</p> <p>In this Court Monitors review of the Behavior Guidelines and three PBS plans (CC, AL, PA) none showed evidence of changes based on lack of progress or improvement. For example, many WRPs had Behavior Guidelines in place that were not well developed (even punitive in some cases). The WRPT psychologist did not have outcome data that indicated improvement on the objective and did not then make a referral to PBS.</p> <p>Recommendations 4 and 5, July 2006:</p> <ul style="list-style-type: none"> • PBS team leaders need to develop a systematic way of
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		<p>evaluating treatment outcomes and reporting those outcomes.</p> <ul style="list-style-type: none"> • Revision of treatment plans should be directly related to the outcome data and reported at all scheduled WRPC of the individual. <p>Findings: Not developed.</p> <p>Recommendations 6, 7, 8, 9 and 10, July 2006:</p> <ul style="list-style-type: none"> • PBS teams and WRPTs need to follow the PBS-BCC checklist for all referrals to the BCC. • The PBS teams, WRPTs and the BCC require further training to fully understand their roles, agenda at the BCC and tracking of referrals made to the BCC. • Ensure that all PBS team leaders receive training in the development of structural assessment, functional assessment and functional analysis, and the development and implementation of PBS plans. • Develop a training protocol for all PBS plans to ensure that all staff who will be responsible for implementing the plan are consistently and appropriately trained prior to implementation of the plan (i.e., behavioral rehearsals, demonstrations, role plays, modeling). • Ensure that all RNs, PTs and data analysts on the PBS teams receive guidelines for using evidence-based tools for referrals, training on evidence-based tools for data collection and that a team leader performs reliability checks in this area. <p>Findings: In a review of the referrals to the PBS teams, this monitor found that 0% of referrals to the PBS teams followed the PBS-BCC checklist as it was designed. In addition, an interview with the Jim Jones, Acting Chief of Psychology and BCC co-chair, and a review of BCC minutes</p>
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		<p>indicated that the PBS-BCC checklist is not used to indicate appropriate and timely referrals to the BCC.</p> <p>PBS team, WRPT, and BCC members have not received training from the hospital to fully understand their roles and the process to follow when making referrals. In addition, the PBS team members have not been trained by the PBS psychologists on data collection methods and no reliability checks have been performed.</p> <p>The Fidelity of Implementation checklist has been developed, but is not being properly used. When the checklist is used, strategies are not clearly delineated rendering the data useless.</p> <p>Recommendation 11, July 2006: Integrate a response to triggers in the referral process.</p> <p>Findings: The automated triggers system is not yet in place. PBS teams do not have a process in place for responding to trigger related referrals.</p> <p>Recommendation 12, July 2006: Ensure that team psychologists and PBS psychologists are trained in the WRP process. The DMH WRP manual outlines the requirements for including PBS programs in the Objectives and Interventions of an individual's WRP.</p> <p>Findings: NSH's progress reports states that PBS team leaders have attended the WPR consultation groups run by the TEC as well as starting a series of trainings with the Chief CRIPA consultant. In interviews with the PBS teams it was evident that the PBS teams do not fully understand their role in the WRP process. In chart reviews for the three PBS plans (CC, AL, PA) 0% of the plans were accurately addressed in the</p>
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		<p>Present Status section and in the Objectives and Interventions of the individual's WRP.</p> <p>Other findings: This Court Monitor reviewed two Functional Assessments (CC, AL), three Structural Assessments (RW, SH, HS) and three PBS plans (CC, AL, PA) and identified the following patterns:</p> <ol style="list-style-type: none"> 1. The individual's Wellness and Recovery Plan (WRP) Team is involved in the assessment and intervention process—40% in compliance. 2. Broad goals of intervention were determined—20% in compliance, 60% in partial compliance and 20% not in compliance. 3. At least one specific behavior of concern was defined in clear, observable and measurable terms—80% showed full compliance, and 20% partial compliance. 4. Baseline estimate of the maladaptive behavior was established in terms of objective measure—40% showed full compliance, 20% partial compliance and 40% not in compliance. 5. Pertinent records were reviewed—40% in full compliance, 40% in partial compliance and 20% not in compliance. 6. Structural assessments (e.g., ecological, sleep, medication effects, mall attendance, etc) were conducted, as needed, to determine broader variables affecting the individual's behavior—80% in partial compliance and 20% not in compliance. 7. Functional assessment interviews were conducted with people (e.g., individual, parents and family members, therapists and care staff, teachers) who often interact with the individual within different settings and activities—60% in full compliance, 20% in partial compliance and 20% not in compliance. 8. Direct observations were conducted across relevant circumstances (e.g., multiple settings, over time) and by more
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		<p>than one observer, as appropriate—80% in partial and 20% not in compliance.</p> <ol style="list-style-type: none"> 9. Other assessment tools (e.g., rating scales, checklists) were used to produce objective information regarding events proceeding and following the behavior of concern, as well as ecological and motivational variables that may be affecting the individual's behavior--20% in complete compliance, 40% in partial compliance, 40% not in compliance. 10. Patterns were identified from the data collected that included (1) circumstances in which the behavior was most and least (e.g. when, where, and with whom) and (2) specific functions the behavior appeared to serve the individual (i.e. what the individual gets or avoids by engaging in the behaviors of concern)--40% partial compliance and 60% not in compliance. 11. Broader variables (e.g., activity patterns, curriculum) that may be affecting the individual's behavior were identified--40% partial compliance and 60% not in compliance. 12. Patterns were summarized into written hypotheses based on structural and/or functional assessments. These statements were clear, concise, and based on data—20% in partial compliance and 80% not in compliance. 13. Intervention strategies were clearly linked to the hypotheses derived from the structural and/or functional assessments—40% in partial compliance, 60% not in compliance. 14. The individual's PBS Team designed a positive behavior support plan (PBS plan) collaboratively with the individual's WRPT that includes: Description of the behavior, patterns identified through the structural and functional assessments and goals of intervention—100% in partial compliance. 15. Modifications to the social, environmental or cultural milieu that may prevent the behavior and/or increase the likelihood of alternative appropriate behavior(s)—100% in partial compliance. 16. Specific behaviors (skills) to be taught and/or reinforced that
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		<p>will: (i) achieve the same function as the maladaptive behavior, and (ii) allow the individual to cope more effectively with his/her circumstances—33% full compliance, 67% in partial compliance.</p> <p>17. Strategies for managing consequences so that reinforcement is maximized for positive behavior and (ii) minimized for behavior of concern, without the use of aversive or punishment contingencies—33% in full compliance, 67% in partial compliance.</p> <p>18. The PBS plan is clearly specified in the Objective and Intervention sections of the individual's WRP. The PBS plan itself need not be included in the individual's WRP—33% in full compliance, 67% in partial compliance.</p> <p>19. If necessary to insure safety and rapid de-escalation of the individual's maladaptive behavior, crisis management procedures and criteria for their use and termination were determined and documented—67% in partial compliance, 33% n/a.</p> <p>20. Everyone working with the individual on a regular basis is familiar with the PBS plan and implements its strategies with high degree of fidelity (>90%) — 100% not in compliance.</p> <p>21. Implementation of the PBS plan is monitored to insure that strategies are used consistently across all intervention settings—100% not in compliance.</p> <p>22. Objective information is collected to evaluate the effectiveness of the PBS plan. This information includes decreases in maladaptive behavior—33 % in full compliance, 67%, partial compliance.</p> <p>23. Increases in replacement skills and/or alternative behaviors-- 33% full compliance, 67% in partial compliance.</p> <p>24. Achievement of broader goals—33% full compliance, 33% partial compliance, 33% not in compliance.</p> <p>25. Durability of behavior change—100% not in compliance.</p> <p>26. The individual's WRPT reviews, at scheduled Wellness and</p>
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		<p>Recovery Plan Conferences, the individual's progress and a PBS Team member or the WRPT psychologist makes necessary adjustments to the PBS plan, as needed—100% partial compliance.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue with training of all PBS team staff. 2. Ensure that Fidelity Implementation checks delineate the specific steps of the PBS plan. 3. Conduct the Fidelity checks prior to implementation of the plan. 4. Ensure that staff who will be responsible for implementing the PBS plans are certified. 5. Ensure that Senior Psychologists review all Guidelines, PBS plans and Crisis Intervention plans. 6. PBS team leaders need to develop a systematic way of evaluating treatment outcomes and reporting those outcomes to the WRP. 7. Ensure that outcome data is updated in the Present Status Section of the case formulation and the PBS plan is identified in the intervention section of the WRP. 8. Ensure that revision of WRPs with PBS plans as an intervention is revised based on the outcome data of the PBS plan. 9. The PBS teams, WRPTs and the BCC require further training to fully understand their roles, agenda at the BCC and tracking of referrals made to the BCC. 10. Ensure that all PBS team leaders receive training in the development of structural assessment, functional assessment and functional analysis, and the development and implementation of PBS plans.
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		<ol style="list-style-type: none"> 11. Ensure that all RNs, PTs and data analysts on the PBS teams receive guidelines for using evidence-based tools for referrals, training on evidence-based tools for data collection and that a team leader performs reliability checks in this area. 12. Integrate a response to triggers in the referral process to PBS. 13. Ensure that team psychologists and PBS psychologists are trained in the WRP process. The DMH WRP manual outlines the requirements for including PBS programs in the Objectives and Interventions of an individual's WRP.
<p>a.ii</p>	<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, July 2006: Fully implement the BY CHOICE program.</p> <p>Findings: The BY CHOICE program is not implemented system wide.</p> <p>Recommendation 2, July 2006: Train all staff in correctly implementing the BY CHOICE program.</p> <p>Findings: NSH's progress report shows that all staff and individuals in NSH have received training. However, training records indicate that Program Four staff have not been fully trained in the BY CHOICE Program.</p> <p>Recommendation 3, July 2006: Implement the program as per the manual.</p> <p>Findings: There is no automated inventory tracking system. NSH progress report indicates that training was conducted per the Manual. However,</p>

		<p>interviews with staff and observations of WRPCs revealed that BY CHOICE is not properly implemented across staff and Programs.</p> <p>Recommendation 4, July 2006: Ensure that the program has additional resources, including computers and software that will assist in running the system smoothly.</p> <p>Findings: The BY CHOICE program is short staffed.</p> <p>Recommendations 5 and 6, July 2006:</p> <ul style="list-style-type: none"> • Assure that the individuals have the final choice in allocating points per cycle, ranging from 0 to 100 per cycle. • BY CHOICE point allocation should be determined by the individual at the individual's WRPC, with facilitation by the staff. <p>Findings: In all WRPC's attended by this Court Monitor the psychologist did not review the BY CHOICE points with the individual and the team as outlined in the BY CHOICE manual. In some instances, the WRP showed documentation that was a remnant from the previous WRPC (i.e. " BY CHOICE points and allocation reviewed and no need for changes.") or was not fully covered in the review process (i.e. "BY CHOICE" points are fine".).</p> <p>Recommendation 7, July 2006: Report BY CHOICE point allocation in the Present Status section of the individual's case formation and update at every scheduled WRPC.</p> <p>Findings: BY CHOICE point allocation is not consistently documented in the Present Status section of the individuals WRP case formulation.</p>
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		<p>Only (55%) of the nine WRPs (HS, CC, AV, JS, AP, AL, RPC, AT, and BV) reviewed by this monitor had entries on BY CHOICE in the individual's Present Status sections of their WRPs. Of these, only one (AV) updated the Present Status as outlined in the DMH WRP Manual.</p> <p>Other findings: A visit to the BY CHOICE stores by this monitor showed that the staff in the stores were well trained. They did not have any difficulty explaining the process in the stores. The stores were well-organized. Individuals interviewed by this monitor liked the BY CHOICE program; however, their main complaint was that the prices for many of the items are high.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Fully implement the BY CHOICE program. 2. Train all staff in correctly implementing the BY CHOICE program. 3. Implement the program as per the manual. 4. Ensure that the program has additional resources, including computers and software that will assist in running the system smoothly. 5. BY CHOICE point allocation should be determined by the individual at the individual's WRPC, with facilitation by the staff. 6. Document BY CHOICE point allocation in the Present Status section of the individual's case formation and update at every scheduled WRPC as per the DMH WRP Manual.
b	Each State Hospital shall ensure that the Chief of Psychology has the clinical and administrative responsibility for the	Current findings on previous recommendations:

	<p>Positive Behavior Supports Team and the By CHOICE incentive program.</p>	<p>Recommendations 1 and 2, July 2006:</p> <ul style="list-style-type: none"> • Use the Special Order as the NSH AD. • Implement the AD. <p>Findings: Dr. Jim Jones, Acting Chief of Psychology, does not have both the clinical and administrative responsibility of the Positive Supports Teams and the BY CHOICE incentive program.</p> <p>Other findings: Partial.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Use the Special Order as the NSH AD. 2. Implement the AD.
<p>c</p>	<p>Each State Hospital shall ensure that:</p>	<p>Compliance: Partial.</p>
<p>c.i</p>	<p>behavioral assessments include structural and functional assessments and, as necessary, functional analysis;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006: Train all PBS team members in functional assessment, data collection, data analysis, graphing, plan implementation and data interpretation.</p> <p>Findings: To date, NSH has not provided training specific to these assessments and analysis. However, the PBS team members have started a series of trainings with the Chief CRIPA consultant, on PBS models and practices.</p>

		<p>Recommendation 2, July 2006: Develop a system for identifying and tracking individuals in the hospital who are in need of behavioral interventions.</p> <p>Findings: No system is in place.</p> <p>Recommendation 3, July 2006: Use the PBS-BCC checklist for all consultations.</p> <p>Findings: All BCC referrals (for the years 2006 and 2007) reviewed by this monitor had a PBS-BCC checklist (MC, BS, AL, CS, BS, MT, GB, and TP). However, the checklist was not appropriately used to trigger a referral to either PBS for assessment or to the BCC for review.</p> <p>Recommendation 4, July 2006: Senior Psychologists should be utilized to monitor the appropriateness of Behavior Guidelines, Crisis Intervention Plans and the need for a referral to PBS teams when an assessment or analysis is indicated.</p> <p>Findings: Two Senior Supervising Psychologists have been hired, Kathleen Patterson, Ph.D., and Ann Hoff, Ph.D. They have not reviewed all Behavior Guidelines (previously Type A), PBS plans and Crisis Intervention Plans to monitor for appropriate referrals to PBS and the need for a structural or functional assessment or a functional analysis.</p> <p>Other findings: NSH's review of Behavioral Guidelines and Crisis Intervention found that the plans contained use of PRNs and/or emergency interventions. Unit psychologists do not demonstrate sufficient knowledge in</p>
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		<p>developing Behavior Guidelines and do not understand would indicate the need for an assessment or analysis by the PBS teams.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Train all PBS team members in structural and functional assessment, functional analysis, data collection, data analysis, graphing, plan implementation and data interpretation. 2. Develop a system for identifying and tracking individuals in the hospital who are in need of behavioral interventions. 3. Utilize Senior Psychologists to monitor the appropriateness of Behavior Guidelines, Crisis Intervention Plans and the need for a referral to PBS teams when an assessment or analysis is indicated.
<p>c.ii</p>	<p>hypotheses of the maladaptive behavior are based on structural and functional assessments;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation July 2006: Ensure that hypotheses of the maladaptive behavior are based on structural and functional assessments and clearly stated in the PBS documentation.</p> <p>Findings: The hypothesis for maladaptive behavior (CC, AL, RW, SH, HS, PA) reviewed by this monitor were derived from structural and functional assessments. However, the assessment process did not develop hypothesis that were based on reliable data and that documented a clear pathway to change.</p> <p>Other findings: None.</p>

		<p>Compliance: Partial.</p> <p>Current recommendation: Ensure that hypotheses of the maladaptive behavior are based on reliable data.</p>
<p>c.iii</p>	<p>There is documentation of previous behavioral interventions and their effects;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation July 2006: Document previous behavioral interventions.</p> <p>Findings: Integrated Psychology Assessments and Focused Assessment templates have been modified to include this information. However, the PBS teams and WRPTs do not ensure that Behavior Guidelines and PBS plans that have been successful are then documented in the Previous Response to Treatment Section of the case formulation.</p> <p>One (CLC) out of the ten charts reviewed (CLC, JS, AL, VB, AV, PA, SH, AT, RPQ, and PR) by this monitor had discussed previous behavioral interventions.</p> <p>Other findings: None.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Document previous behavioral interventions.</p>

<p>c.iv</p>	<p>behavioral interventions, which shall include positive behavior support plans, are based on a positive behavior supports model and do not include the use of aversive or punishment contingencies;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, July 2006: Ensure that all behavioral interventions are based on a positive behavior supports model and do not include the use of aversive or punishment contingencies.</p> <p>Findings: Interviews with the PBS Psychologist and Jim Jones, Acting Chief of Psychology and review of Behavior Guidelines, PBS Plans and crisis plans revealed that some Behavior Guidelines and crisis management plans use aversive procedures including response cost and loss of ground privileges. All three PBS plans reviewed by this monitor used did not include aversive or punishment contingencies.</p> <p>Other findings: None.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Ensure that all behavioral interventions are based on a positive behavior supports model and do not include the use of aversive or punishment contingencies.</p>
<p>c.v</p>	<p>behavioral interventions are consistently implemented across all settings, including school settings;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, July 2006: Ensure that all behavioral interventions are consistently implemented across all settings, including mall, vocational and education settings.</p>

		<p>Findings: Behavior interventions are not consistently implemented across all settings. None of the staff interviewed at the Mall could speak to the specific strategies outlined in the Behavior Guidelines or PBS plan of the individuals they were working with. Although some staff were aware of the existence of Behavior Guidelines or a PBS plan, Mall and unit staff could not produce copies of the interventions when asked by this monitor.</p> <p>Other findings: None.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Ensure that all behavioral interventions are consistently implemented across all settings, including mall, vocational and education settings.</p>
<p>c.vi</p>	<p>triggers for instituting individualized behavioral interventions are specified and utilized, and that these triggers include excessive use of seclusion, restraint, or psychiatric PRN and Stat medication for behavior control;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation July 2006: The hospital should have a system for using their trigger data to obtain PBS consultation for appropriate individuals.</p> <p>Findings: Out of 25 charts of individuals (BS, LJ, MT, HS, CC, AV, JS, AP, AL, RPC, AT, BV, MC, CS, MT, GB, TP, CLC, JS, AL, PA, SH, AT, RPQ, and PR) that had one or more key indicators activated in the last 3 months, only five WRPs showed evidence of the WRPT addressing the trigger with either an appropriately aligned psychosocial treatment intervention, a behavior guideline or a referral to PBS. None of the charts reviewed had clinical justification for not addressing the key</p>

		<p>indicators.</p> <p>There are very few PBS assessments and plans in place. Given the high number of key indicators (individuals' in seclusion and restraints, individual's on enhanced observations, crisis intervention, PRN, and STAT medication, low group attendance) a greater number of PBS referrals would be expected.</p> <p>Other findings: None.</p> <p>Compliance: Non-compliance</p> <p>Current recommendation: The hospital should have a system for using their trigger data to initiate a Behavior Guideline or obtain PBS consultation.</p>
<p>c.vii</p>	<p>positive behavior support teams and team psychologists integrate their therapies with other treatment modalities, including drug therapy;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations July 2006: Integrate all behavioral interventions with other treatment modalities, including drug therapy.</p> <p>Findings: NSH's progress report showed that only 59% of the charts reviewed met this requirement. However, a review of the charts of those individual's with a PBS plan did not demonstrate consideration or integration of other treatment modalities. One structural assessment did appropriately consider drug therapy in its recommendations.</p> <p>Other findings: None.</p>

		<p>Compliance: Partial.</p> <p>Current recommendation: Integrate all behavioral interventions with other treatment modalities, including drug therapy.</p>
<p>c.viii</p>	<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 recommendations:</p> <p>Recommendation, July 2006: Specify PBS plans in the objectives and interventions sections of the individual's WRP Plan as outlined in the DMH PBS Manual.</p> <p>Findings: NSH's progress report showed that only 29% of charts reviewed met this requirement. However, a review of the WRP of the three individuals (CC, AL, PA) with a PBS plan showed only partial compliance with this item. For example, the PBS plan may have been documented in the interventions, but was not clearly or appropriately linked to the objective.</p> <p>Other findings: None.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Specify PBS plans in the objectives and interventions sections of the individual's WRP Plan as outlined in the DMH PBS Manual.</p>

<p>c.ix</p>	<p>all positive behavior support plans are updated as indicated by outcome data and reported at least quarterly in the Present Status section of the case formulation in the individual's Wellness and Recovery Plan</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, July 2006: 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: NSH's progress report showed that 23% of the sample met this criterion. However, in chart reviews for the three PBS plans (CC, AL, PA) 0% of the plans were accurately addressed in the Present Status section of case formulation. When PBS was mentioned in the Present Status it was not properly documented and the data presented was not sufficient to inform and guide the WRPT and PBS team in updating the PBS plan.</p> <p>Other findings: This monitor observed a meeting with a PBS team and BN's WRPT. This was an example of the weekly meeting called specifically for PBS consultation. The WRPTs and the PBS teams do not utilize the monthly and quarterly WRPCs as the time to review and update cases. The meeting could have been better structured. It ended without a clear plan for the next 30 days.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. 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. 2. Ensure that PBS teams are a part of the regularly scheduled monthly and quarterly WRPC's for the individuals and that they
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		are not a separate weekly meeting.
c.x	all staff has received competency-based training on implementing the specific behavioral interventions for which they are responsible, and performance improvement measures are in place for monitoring the implementation of such interventions.	<p>Current findings on previous recommendations:</p> <p>Recommendation, July 2006: Provide competency-based training to appropriate staff on implementing specific behavioral interventions for which they are responsible, and have performance improvement measures in place for monitoring the implementation of such interventions.</p> <p>Findings: PBS team members have been providing training to unit staff on implementing behavioral interventions. The PBS teams are not properly using The Fidelity of Implementation checklist to gain competency.</p> <p>Other findings: None.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Provide competency-based training to appropriate staff on implementing specific behavioral interventions for which they are responsible, and have performance improvement measures in place for monitoring the implementation of such interventions.</p>
c.xi	all positive behavior support team members shall have as their primary responsibility the provision of behavioral interventions;	<p>Current findings on previous recommendations:</p> <p>Recommendation, July 2006: Ensure that all PBS team members provide PBS services fulltime until the needs of all individuals requiring behavioral interventions are met.</p>

		<p>Findings: This monitor interviewed Jim Jones, Acting Chief of Psychology, and the PBS team members. PBS team members have as their primary duty PBS services, and are not required to provide non-PBS services during their regular work week.</p> <p>Other findings: None.</p> <p>Compliance: Full compliance.</p> <p>Current recommendation: Maintain current service provision.</p>
<p>c.xii</p>	<p>the By CHOICE point allocation is updated monthly in the individual's Wellness and Recovery Plan.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, July 2006: Ensure that BY CHOICE point allocation is updated monthly in the individual's Wellness and Recovery Plan.</p> <p>Findings: BY CHOICE point allocation is not updated monthly in the individual's Wellness and Recovery Plan. Only five out of nine charts reviewed by this monitor had BY CHOICE mentioned in the Present Status section of the individuals WRPs.</p> <p>Other findings: None.</p> <p>Compliance: Partial.</p>

		<p>Current recommendation: Ensure that BY CHOICE point allocation is updated monthly in the individual's Wellness and Recovery Plan.</p>
<p>d</p>	<p>Each State hospital shall ensure that it has at least one developmental and cognitive abilities team (DCAT; consisting of 1 clinical psychologist, 1 registered nurse, 1 social worker, 1 psychiatric technician, and 1 data analyst (who may be a behavior specialist) who have a demonstrated competence, consistent with generally accepted professional standards of care, in assessing individuals with cognitive disorders/challenges; developing therapeutic interventions (including positive behavior supports); advising therapy and rehabilitation providers on the implementation of interventions at the cognitive level of the individuals; and managing discharge processes for individuals with developmental disabilities and cognitive disorders/challenges,. This team shall assume some of the functions of the positive behavior support teams if the individuals they serve also need positive behavioral supports.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, July 2006: Develop and implement a DCAT.</p> <p>Findings: NSH has a DCAT team; however the team is short a data analyst. DCAT has a new team leader and has not yet fully implemented DCAT services.</p> <p>Other findings: The DCAT consults hospital-wide on diagnosis, treatment considerations, behavioral interventions and discharge concerns. DCAT had identified individuals in need of DCAT services. According to this list there is a large number of individuals at NSH are in need of cognitive retraining and related services.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that the DCAT has a full team as required by EP. 2. Ensure that the DCAT team is available for consultation to other staff to assist with planning individual's therapeutic activities at the cognitive functioning level of the individuals.

e	<p>Each State Hospital shall develop and implement a Behavioral Consultation Committee (BCC), chaired by the Chief of Psychology, and co-chaired by the Chief of Psychiatry, to review the Wellness and Recovery Plan and maladaptive behavior(s) of the individuals who have not made timely progress on positive behavior support plans. The Chief of Psychology is responsible for the functions of this committee, together with members of the positive behavior support team (in functions of the committee that relate to individuals under the care of those team members). The committee membership shall include all clinical discipline heads, including the medical director, as well as the clinical administrator of the facility.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006: The Chief of Psychology should chair this committee as required by the EP.</p> <p>Findings: Jim Jones, Acting Chief of Psychology is the co-chair. This is not in line with EP.</p> <p>Recommendation 2, July 2006: Use the PBS-BCC checklist to define the sequence of steps for referrals to the BCC.</p> <p>Findings: Jim Jones, Acting Chief of Psychology and Co-chair of the BCC was interviewed and the BCC minutes were reviewed. Although the PBS and BCC are starting to use the PBS-BCC checklist it is not being used as designed at this time.</p> <p>Recommendation 3, July 2006: Ensure that all standing members of the BCC attend every meeting.</p> <p>Findings: A review of NSH's Behavioral Consultation Committee Meetings Attendance Record, for the 2006 and 2007, showed a poor record of attendance by member of the Behavioral Consultation Committee. Between January 2006 and January 2007, a total of 10 BCC meetings were conducted. Attendance at these meetings ranged between a low of 14% on January, 2007, and a high of only 68% on February 2006.</p> <p>Other findings: None.</p>
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		<p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. The Chief of Psychology must chair this committee as required by the EP. 2. Use the PBS-BCC checklist to define the sequence of steps for referrals to the BCC. 3. Ensure that all standing members of the BCC attend every meeting.
f	<p>Each State Hospital shall ensure that it has sufficient neuropsychological services for the provision of adequate neuropsychological assessment of individuals with persistent mental illness.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006: Ensure that WRPTs, especially psychologists, make referrals that are appropriate for neuropsychological assessments.</p> <p>Findings: According to NSH's progress report, a Senior Psychologist Supervisor monitors referrals and ensures that referrals receive attention and response appropriate to their clinical need. This monitor reviewed the list of Neuropsychological Assessments referred and completed between July 2006 and December 2006. This list contains a total of only 36 referrals. This number is an under-representation of individuals with need for neuropsychological evaluations and services, given the number of individuals at NSH with neurological deficits. Four neuropsychological evaluations are on hold due to lack of interpreters.</p> <p>Recommendation 2, July 2006: Ensure that neuropsychologists provide cognitive remediation and cognitive retraining groups in the PSR Mall.</p>

		<p>Findings: Neuropsychologists at NSH do not currently provide cognitive remediation and cognitive retraining groups in the PSR Mall.</p> <p>Other findings: Two neuropsychologists have been hired.</p> <p>Recommendation 3, July 2006: Increase the number of neuropsychologists to meet the anticipated demand for neuropsychological services.</p> <p>Findings: According to Jim Jones, Acting Chief of Psychology, NSH has approved the hiring of additional fulltime neuropsychologists.</p> <p>Other findings: None.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that WRPTs, especially psychologists, make referrals that are appropriate for neuropsychological assessments. 2. Ensure that neuropsychologists provide cognitive remediation and cognitive retraining groups in the PSR Mall. 3. Increase the number of neuropsychologists to meet the anticipated demand for neuropsychological services.
g	All clinical psychologists with privileges at any State Hospital shall have the authority to write orders for the implementation of positive behavior support plans, consultation for educational or other testing, and positive	<p>Current findings on previous recommendations:</p> <p>Recommendation, July 2006: The hospital and/or State must provide psychologists the authority to</p>

	<p>behavior support plan updates.</p>	<p>write orders as specified in the Enhancement Plan.</p> <p>Findings: Psychologists at NSH now can write orders. NSH Administrative Directive #850, Section under Treatment and Services Provided by Psychologists includes "writing orders for the implementation of positive behavior support plans and plan updates, educational or other psychological testing, enhanced observation, suicide precautions, escort status, and non-medical consultations at the Hospital."</p> <p>Other findings: None.</p> <p>Compliance: Full compliance.</p> <p>Current recommendation: Continue current practice.</p>
3	Nursing Services	
	<p>Each State hospital shall provide adequate and appropriate nursing care and services consistent with generally accepted professional standards of care to individuals who require such services.</p>	<p>Methodology: Interviewed Ann Rust, MSN, Nursing Quality Improvement Coordinator. Interviewed Eve Arcala, RN, Assistant Coordinator of Nursing Services. Interviewed Larry Turner, RN, HSS. Interviewed Natalie Allen, Psychiatric Nursing Education Director. Interviewed Nickey Jones, RN, Coordinator of Nursing Services. Interviewed Charlene Paulson, Assistant Coordinator of Nursing Services. Interviewed Michelle Patterson, RN, HSS. Interviewed Marsha Jacobson, DMH Legal. Reviewed Statewide Admission Nursing Assessment Monitoring Form.</p>

		<p>Reviewed Quality Control Summary of Initial Nursing Assessment data, (October to December 2006). Reviewed STAT PRN Control Sheet data, November 2006 to January 2007. Reviewed policy #1131-PRN/STAT Medication Use for Physical and Psychiatric Symptoms Management. Reviewed new hire roster. Reviewed policy #108.5-Documentation Nightly Audits. Reviewed policy #108.7-Documentation RAND Card System. Reviewed policy #113-Care of the Individual with Impaired Mobility. Reviewed Nursing training roster. Reviewed New Hire Validation Tracking System. Reviewed memo dated November 22, 2006 regarding confirmation of plan for new hire employee competency validation. Reviewed Night Shift (NOC) Audit. Reviewed staff rosters for Positive Behavioral Support (PBS) training. Reviewed NSH Nursing Education Program for medication class and mandatory psychotropic medication class. Reviewed curriculum for Medication Administration annual class. Interviewed Candida Asuncion Supervising RN for skilled nursing unit. Reviewed Noc Audit tool. Toured units A4, T18, A3. Attended shift report for unit T-11.</p>
a	<p>Each State hospital shall develop and implement policies and protocols regarding the administration of medication, including pro re nata ("PRN") and "Stat" medication (i.e., emergency use of psychoactive medication), consistent with generally accepted professional standards of care, to ensure:</p>	<p>Compliance: Partial.</p>
a.i	<p>safe administration of PRN medications and Stat medications;</p>	<p>Current findings on previous recommendations: Recommendation, July 2006: Continue to develop and implement policies and procedures that ensure</p>

		<p>the safe administration of PRN medications and STAT medications.</p> <p>Findings: The facility reported that policy #1131-PRN/STAT Medication Use for Physical and Psychiatric Symptom Management was revised and implemented on October 15, 2006 in alignment with the EP. In addition, nursing education has included training on PRN and STAT medication for orientation and on an ongoing basis.</p> <p>Other findings: None.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Continue to develop, revise, implement, and provide training regarding policies and procedures that ensure the safe administration of PRN medications and STAT medications.</p>
a.ii	documentation of the circumstances requiring PRN and Stat administration of medications;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006s: Provide training to staff regarding the use of alternative therapeutic strategies to assist individuals to deal with emotions.</p> <p>Findings: NSH reported that training was completed in November regarding adequate documentation criteria for PRN and STAT medication.</p> <p>Recommendation 2, July 2006: Ensure staff documents the attempts to use these strategies prior to PRN and/or Stat medication administration.</p>

		<p>Findings: NSH reported that in November, 2006, they began to use the Night Shift (NOC) Audit to monitor documentation of staff attempts of alternative strategies before PRN and/or STAT medications are given. NSH plans to provide ongoing training to staff regarding this recommendation.</p> <p>Recommendation 3, July 2006: Clarify and specify criteria regarding what should be included in the progress notes for item b.c on the NSH: PRN & STAT Progress Notes Monitoring Form to ensure accurate data.</p> <p>Findings: NSH reported that progress note training regarding this recommendation was provided in November 2006. In addition, the DMH Statewide 24-hour Noc Audit will be revised to include these specific criteria.</p> <p>Other findings: The data presented from NSH from November 2006 to January 2007 indicated a 72% compliance with documenting the circumstances requiring a STAT medication and 16% compliance for STAT medication documentation. From my review of 15 records of individuals who had received PRN and/or STAT medications, I found that there continued to be significant problems regarding the documentation of circumstances requiring these medications in all records. Similarly to my baseline review in July 2006, I found that the progress notes for PRN medications indicated that the individuals asked for the medication for "anxiety" or "aggression". There was no documentation indicating that the staff explored the cause of these symptoms or offered alternative interventions.</p>
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		<p>From my review of the documentation for STAT medications, I found clearer documentation regarding the circumstances requiring the STAT medication. However, there were no alternative interventions documented prior to the time the individual was becoming agitated. Clearly, ongoing training is needed in this area.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to provide training to staff regarding the use of alternative therapeutic strategies to assist individuals to deal with emotions. 2. Ensure that staff documents the attempts to use these strategies prior to PRN and/or Stat medication administration.
<p>a.iii</p>	<p>documentation of the individual's response to PRN and Stat medication.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, July 2006:</p> <ul style="list-style-type: none"> • Provide staff training regarding the documentation of specific indicators describing an individual's response to PRN and STAT medications. • Clarify and specify criteria regarding what should be included in the progress notes for item b.d on the NSH: PRN & STAT Progress Notes Monitoring Form to ensure accurate data. <p>Findings: As above in F.3. a.ii.</p> <p>Other findings: The data presented by NSH indicated 48% compliance for PRN and 69% compliance for STAT medications with this requirement. My findings were similar to those of NSH.</p>

		<p>Compliance: Partial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
<p>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>Recommendations 1, 2 and 3, July 2006:</p> <ul style="list-style-type: none"> • Complete the revision of the necessary report forms and monitoring tools. • Revise policies and procedures regarding medications variances to include failure to properly sign MTR and Controlled Medication Log as a reportable medication variance. • Provide training to staff regarding the above. <p>Findings: NSH reported that the Statewide monitoring tools have been revised to reflect this requirement. Policies #108.5, 1101, and 1102 were revised to include this requirement. In addition, staff training was conducted to familiarize staff with changes in policies and criteria for reporting medication variances.</p> <p>Other findings: The data presented by NSH regarding this requirement incomplete and cannot be interpreted.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure data regarding this requirement is reliable and

		<p>complete. 2. Continue to monitor this requirement.</p>
<p>c</p>	<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, July 2006: Provide ongoing training regarding the WRP and the Wellness and Recovery Model.</p> <p>Findings: NSH has initiated ongoing training regarding the WRP and the Wellness and Recovery Model by the program trainers and in evening workshops every Wednesday.</p> <p>Recommendation 2, July 2006: Ensure that interventions are written in observable, behavioral, and/or measurable terms.</p> <p>Findings: NSH reported it has provided training regarding how to write observable, behavioral, and measurable interventions.</p> <p>Recommendation 3, July 2006: Develop and implement proactive interventions related to the individuals needs.</p> <p>Findings: Nursing reported that staff has been trained on the revised policy #101-Basic Nursing Process in January 2007.</p> <p>Recommendation 4, July 2006: Revise appropriate monitoring and tracking instruments to ensure accurate data.</p>

Findings:
 NSH has developed a monitoring audit form addressing this requirement. It has not yet been fully implemented.

Recommendation 5, July 2006:
 Revise policies and procedures to reflect the key elements in this requirement.

Findings:
 NSH reported that policy #101.5-Nursing Care Planning has been revised reflecting this requirement.

Other findings:
 NSH presented the following data for November, December 2006 and January 2007:

	Nov 06	Dec 06	Jan 07
Nursing interventions are proactive	51%	52%	46%
Nursing interventions are aligned with other disciplines	23%	32%	26%
Interventions are written in observable, behavioral, and measurable terms	26%	30%	34%
All nursing interventions are in the WRP	47%	38%	43%

From my review of the nursing interventions contained in the WRPs, my findings of compliance were significantly lower than NSH's regarding being proactive. From my interviews with members of the nursing staff, it became apparent that nursing spends little time with the

		<p>individuals. Nursing candidly reported that they have little time to spend with individuals and do not get to know their individuals in any detail. This issue has significantly contributed to the lack of individualized interventions found in the WRPs.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to provide ongoing training regarding the WRP and the Wellness and Recovery Model. 2. Ensure nursing staff are provided training regarding therapeutic communication and interventions. 3. Initiate a system to ensure that therapeutic interactions are expected as part of staffs' duties and performance. 4. Continue to monitor that interventions are written in observable, behavioral, and/or measurable terms. 5. Develop and implement proactive interventions related to the individuals needs. 6. Continue to revise policies and procedures to reflect the elements in this requirement.
d	<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, July 2006: Provide ongoing training regarding recovery-focused interactions with individuals.</p> <p>Findings: NSH has initiated ongoing training regarding the WRP and the Wellness and Recovery Model by the program trainers and in evening workshops every Wednesday.</p>

Recommendation 2, July 2006:

Provide positive reinforcement to staff familiar with the goals, objectives, and interactions of individuals.

Findings:

Although this recommendation has not been fully addressed, NSH reported that they have been reviewing a number of ways to reinforce staff members who are familiar with their individuals. During my site visit, I discussed the option of including this issue on performance evaluations to stress the value of actually knowing and being familiar with the individuals. In addition, nursing has to reinforce its staff when nurses are out on the units interacting with the individuals rather than staying in the nursing stations, as is the current practice.

Other findings:

NSH reported the following data for November, December, 2006 and January 2007:

	Nov 06	Dec 06	Jan 07
Staff knowledge of individuals' goals	33%	48%	41%
Staff able to state one objective	44%	48%	34%
Staff able to state mall service intervention	39%	36%	28%
Staff able to state therapeutic milieu intervention	36%	36%	28%

Clearly, there needs to be an emphasis placed on staff developing therapeutic relationships with the individuals in order to facilitate the Wellness and Recovery principles.

		<p>Compliance: Partial</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to provide ongoing training regarding Recovery focused interactions with individuals. 2. Ensure nursing staff are provided training regarding therapeutic communication and interventions. 3. Initiate a system to ensure that therapeutic interactions are expected as part of staffs' duties and performance. 4. Develop strategies that provide positive reinforcement to staff familiar with the goals, objectives, and interactions of individuals.
e	<p>Each State hospital shall ensure that nursing staff timely monitor, document and report the status of symptoms, target variables, health, and mental health status, of individuals in a manner that enables interdisciplinary teams to assess each individual's status, and response to interventions, and to modify, as appropriate, individuals' therapeutic and rehabilitation service plans. Each State Hospital shall ensure that all nursing shift changes include a review of changes in status of individuals on the unit.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006: Develop and implement systems to generate individualized, clinical, objective data.</p> <p>Findings: NSH reported that they modified a nursing policy regarding the use of RAND cards (Cardex), however it met with opposition from the program directors and has not been implemented.</p> <p>Recommendation 2, July 2006: Develop and implement specific criteria for reporting for shift reports.</p> <p>Findings: At the time of this review, there had been no system implemented to guide what information should be routinely passed on at shift report.</p>

		<p>Although the shift report I observed on unit T included very individualized information, there was no set criteria regarding what information should be routinely passed on to the oncoming shift.</p> <p>Recommendation 3, July 2006: Develop and implement monitoring and tracking instruments to measure the key elements of this requirement.</p> <p>Findings: NSH has developed a nursing services shift change monitoring form. However, criteria for shift change report has to be develop and implemented.</p> <p>Recommendation 4, July 2006: Develop and implement individualized interventions for patients who are at risk for choking and/or aspiration.</p> <p>Findings: NSH reported that Physical and Nutritional Management Plans (PNMP) have been developed for two individuals on unit A4. In addition, a nursing policy and procedure for dysphagia was developed and implemented on October 25, 2006. A PNMP team has been formed and is in the process of conducting assessments on the high-risk individuals on unit A4.</p> <p>From my review, nursing has not initiated proactive interventions for individuals who have been identified as being high-risk for aspiration. Interventions such as listening to lung sounds before and after meals, obtaining oxygen saturations, and taking daily vital signs daily have not been incorporated into WRPs for these high -risk individuals. While the dysphagia system is being developed, these proactive interventions would supply the PNMP teams with clinical objective data by which to measure the effectiveness of the team's interventions.</p>
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		<p>Recommendation 5, July 2006: Develop and implement a monitoring and tracking system to ensure that the above interventions are consistently initiated.</p> <p>Findings: The facility has yet to address this recommendation.</p> <p>Recommendation 6, July 2006: Obtain prethickener packets for individuals requiring thickened fluids to ensure the consistency of fluids is consistent.</p> <p>Findings: The Dietetics Department has secured the appropriate prethickener for individuals requiring thickened fluids.</p> <p>Other findings: As noted from my baseline review July 2006, there continues to be a significant lack of clinical objective data available to review in the records to determine if an individual's symptoms, target variables, and health and mental status are better or worse. The lack of this data hampers the timely detection of changes in status and modifications to interventions and the WRP.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement systems to generate individualized, clinical, objective data. 2. Implement specific criteria for reporting for shift reports. 3. Implement monitoring and tracking instruments to measure this requirement.
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		<ol style="list-style-type: none"> 4. Continue to develop and implement individualized interventions for patients who are at risk for choking and/or aspiration. 5. Develop and implement a monitoring and tracking system to ensure that the above interventions are consistently initiated.
f	Each State hospital shall develop and implement a system to monitor nursing staff while administering medication to ensure that:	Compliance: Partial.
f.i	nursing staff are knowledgeable regarding each individual's prescribed medications;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006: Increase the number of Medication Pass and Treatment Administration Reviews to at least 20% per program per quarter.</p> <p>Findings: NSH reported that beginning December 1, 2006, each Health Service Supervisor monitored two medications passes and treatment administration reviews every month for both AM and PM shifts, and NOC shift is monitored once a month.</p> <p>Recommendation 2, July 2006: Provide ongoing training for staff regarding medications.</p> <p>Findings: Training was provided regarding medication administration in October 2006. A schedule needs to be developed and implemented to ensure that this training is ongoing.</p> <p>Other findings: NSH has significantly increased the Medication Pass and Treatment Administration Reviews from five that were conducted from January to July 2006 to 97 from November to January. The results indicated that there was an overall 53% compliance in staff demonstrating</p>

		<p>knowledge of individuals' prescribed medications.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to increase the number of Medication Pass and Treatment Administration Reviews to at least 20% per program per quarter. 2. Provide ongoing training for staff regarding medications. 3. Continue to monitor this requirement.
<p>f.ii</p>	<p>education is provided to individuals during medication administration;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, July 2006:</p> <ul style="list-style-type: none"> • Increase the number of Medication Pass and Treatment Administration Reviews to at least 20% per program per quarter. • Provide ongoing training for staff regarding medications. <p>Findings: As above in F.3.f.i</p> <p>Other findings: The results from the Medication Pass and Treatment Administration Reviews indicated that there was only 70% compliance with providing education during medication administration. This is a 10% increase from the baseline results in July 2006.</p> <p>Compliance: Partial.</p>

		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to increase the number of Medication Pass and Treatment Administration Reviews to at least 20% per program per quarter. 2. Provide ongoing training for staff regarding medications. 3. Continue to monitor this requirement. 																				
<p>f.iii</p>	<p>nursing staff are following the appropriate medication administration protocol; and</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, July 2006:</p> <ul style="list-style-type: none"> • Increase the number of Medication Pass and Treatment Administration Reviews to at least 20% per program per quarter. • Provide ongoing training for staff regarding medication administration procedures. <p>Findings: As above in F.3.f.i.</p> <p>Other findings: NSH provided the following compliance data regarding this requirement:</p> <table border="1" data-bbox="1045 1044 1795 1385"> <thead> <tr> <th>Protocol</th> <th>Nov 06</th> <th>Dec 06</th> <th>Jan 07</th> </tr> </thead> <tbody> <tr> <td>Principle of asepsis</td> <td>94%</td> <td>90%</td> <td>93%</td> </tr> <tr> <td>Prepares no more than one hour ahead</td> <td>100%</td> <td>96%</td> <td>93%</td> </tr> <tr> <td>Appropriately identifies individuals</td> <td>97%</td> <td>100%</td> <td>79%</td> </tr> <tr> <td>Checks allergies</td> <td>97%</td> <td>81%</td> <td>64%</td> </tr> </tbody> </table>	Protocol	Nov 06	Dec 06	Jan 07	Principle of asepsis	94%	90%	93%	Prepares no more than one hour ahead	100%	96%	93%	Appropriately identifies individuals	97%	100%	79%	Checks allergies	97%	81%	64%
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f.iv	medication administration is documented in accordance with the appropriate medication administration protocol.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006: Include medication administration documentation requirements on the Medication Pass and Treatment Administration Reviews.</p> <p>Findings: NSH have included medication administration documentation requirements on the monitoring tool.</p> <p>Recommendations 2 and 3, July 2006:</p> <ul style="list-style-type: none"> • Provide ongoing training for staff regarding medication administration procedures. • Increase the number of Medication Pass and Treatment Administration Reviews to at least 20% per program per quarter. 												

		<p>Findings: As above in f.i.</p> <p>Other findings: NSH submitted that following compliance data regarding this requirement:</p> <table border="1" data-bbox="1045 524 1856 789"> <thead> <tr> <th>Documentation</th> <th>Nov 06</th> <th>Dec 06</th> <th>Jan 07</th> </tr> </thead> <tbody> <tr> <td>Signed controlled med log</td> <td>89%</td> <td>90%</td> <td>89%</td> </tr> <tr> <td>Signs MTR immediately after administration of meds</td> <td>97%</td> <td>92%</td> <td>93%</td> </tr> <tr> <td>Documents when med not taken</td> <td>92%</td> <td>100%</td> <td>100%</td> </tr> </tbody> </table> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to increase the number of Medication Pass and Treatment Administration Reviews to at least 20% per program per quarter. 2. Provide ongoing training for staff regarding medications. 3. Continue to monitor this requirement. 	Documentation	Nov 06	Dec 06	Jan 07	Signed controlled med log	89%	90%	89%	Signs MTR immediately after administration of meds	97%	92%	93%	Documents when med not taken	92%	100%	100%
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Signs MTR immediately after administration of meds	97%	92%	93%															
Documents when med not taken	92%	100%	100%															
g	Each State hospital shall ensure that individuals remain in a "bed-bound" status only for clinically justified reasons.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006: Develop and implement a system to ensure that clinical justification is documented in the medical records for individuals who are in a "bed-bound" status.</p>																

		<p>Findings: NSH has developed policies addressing this requirement, which were approved in October 06. Full implementation of these policies has not yet been initiated.</p> <p>Recommendation 2, July 2006: Initiate interventions in WRP to integrate bed-bound individuals into milieu activities both in and out of their rooms.</p> <p>Findings: NSH reported that all bed-bound individuals have been identified and this information has been disseminated to the Mall Coordinator. NSH reported that by the end of January, the treatment teams would be initiating interventions in the WRP for bed-bound individuals.</p> <p>Other findings: During my tour of unit A4, I was informed that there were a number of individuals who had to remain bed-bound because their wheelchairs were sent for maintenance. I was told that in some cases, individuals remained bed-bound for up to five days because the staff did not have access to their wheelchairs. The staff also reported that at times they would rotate the use of an individual's wheelchair to other individuals so that not any one person would have to be bed-bound for a long time.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Implement a system to ensure that clinical justification is documented in the medical records for individuals who are in a
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		<p>"bed-bound" status.</p> <ol style="list-style-type: none"> 2. Initiate interventions in WRP to integrate bed-bound individuals into milieu activities both in and out of their rooms. 3. Develop and implement a system to ensure that no individual is rendered bed-bound due to the lack of needed adaptive equipment.
<p>h</p>	<p>Each State hospital shall ensure that, before they work directly with individuals, all nursing and psychiatric technicians have successfully completed competency-based training regarding:</p>	
<p>h.i</p>	<p>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>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006: Evaluate the need to extend the nursing preceptorship.</p> <p>Findings: NSH evaluated the nursing preceptorship program and extended it to 6 days.</p> <p>Recommendation 2, July 2006: Develop and implement a reliable system to monitor and track staff who have not completed orientation classes and annual mandatory training.</p> <p>Findings: NSH has initiated a temporary tracking system available on the group I drive until a permanent system can be developed and implemented.</p> <p>Recommendation 3, July 2006: Assign responsibility for follow-up for attendance at orientation classes and other required training.</p>

		<p>Findings: An agreement was reached between nursing education and the program department heads for the monitoring, reporting, and follow-up of employee training. This system has recently been implemented.</p> <p>Recommendation 4, July 2006: Ensure completion of classes and skill demonstration prior to competency validation.</p> <p>Findings: As above for recommendation # 2.</p> <p>Other findings: None.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a permanent system to monitor and track staff who have not completed orientation classes and annual mandatory training. 2. Continue to monitor this requirement.
<p>h.ii</p>	<p>the provision of a therapeutic milieu on the units and proactive, positive interventions to prevent and de-escalate crises; and</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006: Implement additional training as recommended.</p> <p>Findings: NSH submitted documents indicating that all staff has been trained in Alternative Dispute Resolution (ADR).</p>

		<p>Recommendation 2, July 2006: Develop and implement a reliable system to monitor and track staff attendance at training classes.</p> <p>Findings: A temporary tracking system is in place in nursing education. However, they reported that they have tracking data but are unable to print out a compliance report. Without this information, the current system is not reliable and needs to be modified.</p> <p>Other findings: None.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to implement additional training as recommended. 2. Develop and implement a reliable system to monitor and track staff attendance at training classes.
<p>h.iii</p>	<p>positive behavior support principles.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006: Ensure that PBS team is available to conduct training.</p> <p>Findings: NSH has made PBS training part of the orientation training.</p> <p>Recommendation 2, July 2006: Develop and implement a reliable system to monitor and track staff attendance at training classes.</p>

		<p>Findings: As above for recommendation #2.</p> <p>Other findings: None.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to monitor this requirement. 2. Develop and implement a reliable system to monitor and track staff attendance at training classes.
i	<p>Each State hospital shall ensure that, prior to assuming their duties and on a regular basis thereafter, all staff responsible for the administration of medication has successfully completed competency-based training on the completion of the MTR and the controlled medication log.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006: Develop and implement monitoring tools that address the key required elements.</p> <p>Findings: NSH has developed a tool to address this requirement. However, it has not been implanted as of yet.</p> <p>Recommendation 2, July 2006: Initiate Psychotropic Medication class as mandatory.</p> <p>Findings: NSH has initiated a mandatory psychotropic medication class during nursing orientation.</p> <p>Recommendation 3, July 2006: Require remediation classes for staff with unsatisfactory performance</p>

		<p>on Medication Pass audits.</p> <p>Findings: NSH has implemented the use of medication pass focus class or annual training class for remediation.</p> <p>Recommendation 4, July 2006: Develop and implement an annual Medication Administration competency-based class.</p> <p>Findings: As above under findings for recommendation #2.</p> <p>Other findings: None.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Implement monitoring tools that address this requirement. 2. Monitor the elements of this requirement.
4	Rehabilitation Therapy Services	
	<p>Each State hospital shall provide adequate, appropriate, and timely rehabilitation therapy services to each individual in need of such services, consistent with generally accepted professional standards of care.</p>	<p>Methodology: Interviewed Karen Zanetell, Chief of Rehabilitation Services. Interviewed Nancy Rooney, SLP, Dysphagia Certified. Interviewed Rich Pike, PT, GCS. Interviewed Karen Breckenridge, PT. Interviewed Eve Arcala, RN, Assistant Coordinator of Nursing Services. Observed individuals on unit A4. Interviewed Candida Asuncion, SRN for unit A4.</p>

		<p>Reviewed Memo of Summary of actions related to Dysphagia, wheelchairs, and supervision of rehabilitative and restorative nursing services dated 1/26/07.</p> <p>Reviewed Competency Validation for Mobility Enhancement documentation.</p> <p>Reviewed training and development rosters for positioning, transfer training, range of motion, and dealing with Huntington's.</p> <p>Reviewed DMH Monitoring Plan Wellness Recovery Plan Charting Auditing data.</p> <p>Reviewed Physical Nutrition and Management Plan Team (PNMP) members' list and Roles and Functions.</p> <p>Reviewed NSH PNMP Meeting Minutes for January 3, 18, and 24, 2007.</p> <p>Observed the adaptive equipment used by individuals on unit A4.</p>
a	<p>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>	<p>Compliance: Partial.</p>
a.i	<p>the provision of direct services by rehabilitation therapy services staff; and</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, July 2006: Revise policies and procedures to include principles and language of the Wellness and Recovery Model.</p> <p>Findings: The Rehabilitation Therapy Professional Practice Group Operations Manual has been revised to meet this requirement. Speech Dysphagia policies and procedures are being formulated to develop a manual. In addition, the Physical Therapy policies are in the process of being updated to incorporate Wellness and Recovery language.</p> <p>Compliance: Partial.</p>

		<p>Other findings: As the system for Dysphagia continues to be developed and implemented, policies and procedures will need to be developed, revised, and implemented as well.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue the process of developing, revising, and updating policies addressing this requirement. 2. Develop and implement policies and procedures related to Dysphagia to include principles and language of the Wellness and Recovery Model.
<p>a.ii</p>	<p>the oversight by rehabilitation therapists of individualized physical therapy programs implemented by nursing staff.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006: Develop and implement a system to provide regular oversight by rehabilitation therapists to nursing staff implementing individualized physical therapy programs.</p> <p>Findings: The facility is in process of developing new training curricula to augment the existing ones. Physical therapy has initiated closer supervision of the Mobility Enhancement Team (MET) by making monthly rounds with the MET and reviewing selected cases. Nursing staff is given training during this time as well. A nursing that will be in charge of monitoring the MET staff has recently received training in basic restorative and nursing concepts by Physical Therapy. This training included issues such as range of motion, transfers, ambulation progression, and positioning. Documentation was provided to verify this training was completed. Advanced training for this nursing will be provided in the near future.</p>

		<p>Recommendation 2, July 2006: Develop and implement a monitoring system to ensure that oversight by rehabilitation therapists of individualized physical programs implemented by nursing staff is occurring.</p> <p>Findings: The facility has yet to fully address this requirement. As noted during the baseline review, there is no formal oversight provided by the rehabilitation therapists of individualized physical therapy programs that are implemented by nursing staff. However, the Rehabilitation Therapy Department has begun the process of collaboration and integration with other disciplines, including nursing. The facility reported that as the individuals' needs are assessed and identified, a system would be developed to address this requirement.</p> <p>Other findings: As the facility identifies individuals' needs related to rehabilitation therapy, it is evident that the current staffing levels of rehabilitation therapy are inadequate. The facility needs to secure the appropriate number of specialty therapies to ensure the needs of the individuals are met.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to develop and implement a system to provide regular oversight by rehabilitation therapists to nursing staff implementing individualized physical therapy programs. 2. Develop and implement a monitoring system to ensure that oversight by rehabilitation therapists of individualized physical programs implemented by nursing staff is occurring. 3. Ensure that there are an adequate number of specialty
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		therapies to meet the needs of the individuals.
b	Each State hospital shall provide competency-based training to nursing staff, as appropriate, on the use and care of adaptive equipment, transferring, and positioning, as well as the need to promote individuals' independence.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006: Develop and implement a system to provide and document competency-based training on the key elements of this requirement.</p> <p>Findings: As noted above in F.4. a.ii, the nurse supervising the MET staff has received competency-based training from the Physical Therapist. The initiation of this system is at the infancy stage and will need to be continually addressed to meet the elements of this requirement.</p> <p>Recommendation 2, July 2006: Develop and implement a monitoring system to ensure that competency-base training is provided for the key elements of this requirement.</p> <p>Findings: The facility reported that hospital-wide training for Dysphagia would be conducted this month (February 2007). In addition, this training will be provided in orientation and in Nursing Educations. Again, this system will need to be continually addressed to meet the requirements of the EP.</p> <p>Other findings: None.</p> <p>Compliance: Partial.</p>

		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to develop and implement a system to provide and document competency-based training regarding this requirement. 2. Continue to develop and implement a monitoring system to ensure that competency-base training is provided for all the elements of this requirement.
c	<p>Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, July 2006: Develop and implement a system to monitor the key elements of this requirement.</p> <p>Findings: There continues to be no monitoring system in place to ensure compliance with requirement. NSH submitted data only reflecting the timeliness of the WRPs rather than the Rehabilitation Therapy Assessment. From my interviews, the assessment is in the final stages of development pending review from the specialty therapies, OT, PT, and Speech. The tool submitted from NSH, the DMH Monitoring Plan Wellness Recovery Plan Chart Auditing Form does not address the elements of this requirement.</p> <p>Compliance: Partial.</p> <p>Other findings: None.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Implement the Rehabilitation Therapy Assessment after review, revisions, and approval from the appropriate disciplines.

		<p>2. Develop and implement a system to monitor the elements of this requirement.</p>
<p>d</p>	<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, July 2006: Develop and implement a system to monitor the key elements of this requirement.</p> <p>Findings: The facility has begun the process of taking inventory hospital-wide on the wheelchairs to determine needed repairs or replacement. In addition, five individuals on unit A4 have been assessed for equipment needs. The state's consultant is scheduled to assist the teams in determining appropriate measures for wheelchairs and additional adaptive equipment.</p> <p>Other findings: Currently, the facility does not have access to a vendor or wheelchair specialist to fabricate and maintain needed equipment. In addition, the supervising registered nurse on unit 4A reported that communication with General Services regarding the ordering of equipment is inadequate. The nurse indicated that General Services planned to order approximately 50 sling-back wheelchairs for the unit. However, most individuals on this unit have not been assessed by the appropriate clinicians to determine their adaptive equipment needs. Ordering these wheelchairs without the direction of the clinicians would result in spending a significant amount of money for equipment that would most likely be contrary to the needs to the individuals and ultimately useless.</p> <p>Compliance: Partial.</p>

		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to develop and implement a system to monitor this requirement. 2. Secure the needed vendors/specialists to ensure that appropriate and adequate equipment are provided to individuals. 3. Develop and implement a reliable and streamlined system for ordering adaptive equipment that is based on the recommendations of the appropriate clinical disciplines.
5	Nutrition Services	
	<p>Each State hospital shall provide the individuals it serves, particularly those experiencing weight-related problems, adequate and appropriate dietary services consistent with generally accepted professional standards of care.</p>	<p>Methodology: Interviewed Wen Pao, Clinical Dietician. Reviewed the updated Statewide Nutrition Care Monitoring Tool (NCMT.) Reviewed Nursing Policy 111, Dysphagia. Reviewed Dysphagia/Choking Screening. Reviewed Physical and Nutritional Management Plans for JM and JC. Reviewed training rosters for "It's Tough to Swallow: Nutrition and Dining for Dysphagia," "Comprehensive Dysphagia Management Training," "Wellness and Recovery Plan Training", and "PNMP Training 24-hour Dysphagia Care Plan". Reviewed the PNMP Monitoring form. Reviewed Mealtime Competency-Based Training Checklist form. Reviewed NSH Enteral Tube Feeding procedure. Reviewed the F5 Monitoring Tool. Reviewed Nursing Policy 130, Nutrition Assessment Referral for High Risk Individuals. Reviewed training material for "Nutrition Assessment & Incorporation into the Wellness & Recovery Plan". Reviewed Dysphagia Protocol flow chart. Reviewed updated Dietetic Department policy regarding Dysphagia. Reviewed Dysphagia/Choking Precaution List</p>

		<p>Reviewed Enteral Feeding List Reviewed list of individuals admitted directly into the medical-surgical unit. Reviewed list of individuals directly admitted into the skilled nursing facility. Reviewed list of individuals who were new admissions with identified nutrition triggers.</p>
<p>a</p>	<p>Each State hospital shall modify policies and procedures to require that the therapeutic and rehabilitation service plans of individuals who experience weight problems and/or related health concerns include adequate strategies and methodologies to address the identified problems and that such strategies and methodologies are implemented in a timely manner, monitored appropriately, and revised, as warranted, consistent with generally accepted professional standards of care.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006: Develop and implement a system to monitor the key elements of this requirement.</p> <p>Findings: The Nutrition statewide task force has developed an initial draft of a monitoring tool. The tool adequately addresses issues related to dysphagia and weight problems.</p> <p>Recommendation 2, July 2006: Retrain staff regarding medical conditions to be listed in the WRP.</p> <p>Findings: NSH submitted training rosters indicating that training was conducted on September 19, 2006 for the Dietetics Department staff.</p> <p>Recommendation 3, July 2006: Develop and implement creative mall activities addressing weight and health issues.</p> <p>Findings: At the time of this review, NSH had developed a Nutrition and Mental Health mall class. In addition, Nutrition classes were being conducted</p>

		<p>on the admission units; A9 and T3. Nutrition education materials have also been developed to aid other disciplines in presenting nutrition information at the mall. Also, a dysphagia poster has been developed and implemented for use on unit T18, the geriatric unit.</p> <p>Other findings: NSH has initiated the dieticians attending the WRPs for units A9 and T3 for individuals who have focus 6 issues to provide input to the teams.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that all elements of this requirement are addressed in the monitoring system. 2. Continue to develop and implement creative mall activities addressing weight and health issues.
<p>b</p>	<p>Each State hospital shall ensure that one or more treatment team members demonstrate competence in the dietary and nutritional issues affecting the individuals they serve and the development and implementation of strategies and methodologies to address such issues.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, July 2006:</p> <ul style="list-style-type: none"> • Develop and implement a competency-based curriculum to ensure that team members demonstrate competence in the dietary and nutritional issues and the development and implementation of strategies and methodologies to address such issues, • Develop and implement a system to monitor the key elements of this requirement. <p>Findings: NSH has developed a draft competency-based curriculum to be used for new employee orientation. It is entitled Nutrition Assessment and</p>

		<p>Incorporation into the Wellness and Recovery Plan and is very comprehensive. The post-test for this curriculum is currently being developed.</p> <p>Other findings: None.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Finalize post-test and implement the competency-based nutrition curriculum to ensure that team members demonstrate competence in the dietary and nutritional issues and the development and implementation of strategies and methodologies to address such issues. 2. Develop and implement a system to monitor the elements of this requirement.
<p>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 recommendations:</p> <p>Recommendation 1, July 2006: Secure the assistance of a consultant who specializes in dysphagia to ensure the key elements of this requirement are met.</p> <p>Findings: The State has secured the services of Bailey and Associates, who specialize in dysphagia and mobility issues. These consultants provided an initial training at MSH and then came on-site to NSH December 11-14, 2006 regarding Physical and Nutritional Management. In response to the consultants' recommendations, NSH established a Physical and Nutritional Management Plan team (PNMP).</p>

		<p>The PNMP consists of the speech therapist that is the clinical team leader, 2 PTs, 2 RN supervisors, a Health Services Supervisor, a dietician, a unit supervisor, a physician and dentist consultant from the facility, a respiratory therapist, an OT, and a psychology consultant from the facility. Currently the PNMP team meets weekly. A schedule for ongoing training and consultation by Bailey and Associates is in the process of being developed.</p> <p>Recommendation 2, July 2006: Revise policies and procedures in accordance with generally accepted standards of practice regarding risk of aspiration/dysphagia.</p> <p>Findings: NSH has developed a draft for dysphagia protocol flowchart. They are currently revising the Dietetics Department Procedure Manual regarding Dysphagia as well as the nursing policy #111, dysphagia. As this system continues to expand, additional policies and procedures will need to be developed and/or revised.</p> <p>Recommendation 3, July 2006: Develop and implement 24-hour, individualized, dysphagia care plans with the assistance of a consultant with expertise in this area.</p> <p>Findings: The PNMP team has begun comprehensive assessments on the individuals who have been determined to be at Level 1, the highest risk for aspiration. NSH is currently in the very early stages of assessing individuals and developing 24-hour, individualized Dysphagia care plans in conjunction with the state's consultants.</p> <p>Recommendation 4, July 2006: Provide competency-based training to staff regarding risk of aspiration/dysphagia.</p>
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		<p>Findings: NSH has begun to conduct competency-based training regarding the risk of aspiration/dysphagia. The training "It's Tough to Swallow: Nutrition and Dysphagia" was conducted on September 20, 2006. In addition, "Comprehensive Dysphagia Management" was conducted on November 6, 2006. A facility-wide training is scheduled for February 2007 regarding the "Basics of Physical and Nutrition Management".</p> <p>Recommendation 5, July 2006: Provide competency-based training on individualized, 24-hour dysphagia care plans to staff working with individuals at risk of aspiration/dysphagia.</p> <p>Findings: Although 24-hour Dysphagia Care Plan Training has been conducted for the Dietetic staff, competency-based training for individuals 24-hour Dysphagia care plans have not been initiated as of yet. The assessment process by the PNMP team has only recently begun.</p> <p>Recommendation 6, July 2006: Develop and implement a monitoring system of the key elements of this requirement.</p> <p>Findings: The facility has not yet addressed this recommendation.</p> <p>Other findings: None.</p> <p>Compliance: Partial.</p>
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		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to revise policies and procedures in accordance with generally accepted standards of practice regarding risk of aspiration/dysphagia. 2. Continue to develop and implement 24-hour, individualized, dysphagia care plans with the assistance of a consultant with expertise in this area. 3. Continue to provide competency-based training to staff regarding risk of aspiration/dysphagia. 4. Provide competency-based training on individualized, 24-hour dysphagia care plans to staff working with individuals at risk of aspiration/dysphagia. 5. Develop and implement a monitoring system for the elements of this requirement.
<p>d</p>	<p>Each State hospital shall ensure that staff with responsibilities for assessments and interventions regarding aspiration and dysphagia has successfully completed competency-based training commensurate with their responsibilities.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006: Secure a consultant with expertise in aspiration/dysphagia to assist in developing and implementing competency-based training for this key element of the requirement.</p> <p>Findings: As above in F.5.c.</p> <p>Recommendation 2, July 2006: Develop and implement a monitoring system to ensure the key elements of this requirement.</p> <p>Findings: Although NSH has developed a competency-based training checklist,</p>

		<p>this system has not yet been fully developed as required by the EP.</p> <p>Other findings: None.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Develop and implement a monitoring system to ensure the key elements of this requirement.</p>
<p>e</p>	<p>Each State hospital shall develop and implement policies and procedures requiring treatment of the underlying causes for tube feeding placement, and ongoing assessment of the individuals for whom these treatment options are utilized, to determine the feasibility of returning them to oral intake status.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006: Revise policies and procedures to reflect key elements of this requirement.</p> <p>Findings: Thus far NSH has revised its Dietetics Department Procedure Manual regarding tube feeding.</p> <p>Recommendation 2, July 2006: Develop and implement a system to monitor all the key elements of this requirement.</p> <p>Findings: NSH has developed a draft of a monitoring tool to address the elements of this requirement. It has not yet been implemented.</p> <p>Other findings: None.</p>

		<p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to revise policies and procedures to reflect the elements of this requirement. 2. Finalize and implement a system to monitor all elements of this requirement.
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: Interviewed John Bandiucci, Pharmacy Director Interviewed Pamela Moe, Assistant Pharmacy Director</p>
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, July 2006: Develop and implement a system to monitor the key elements of this requirement.</p> <p>Findings: The facility has developed a system for this requirement. However, due to pharmacy vacancies, it has not been implemented. The department reported a loss of 8 pharmacists in the past few months. They have been able to hire four (4) contract pharmacists, but they continue to have significant vacant positions, which have impacted their ability to progress with the EP. The Pharmacy Director reported that at this time they have been only able to provide basic services.</p> <p>Recommendation 2, July 2006: Develop, update and/or revise and implement policies and procedures to address key elements of this requirement.</p>

		<p>Findings: The policy for Level 1 drug-drug interactions is in place. However, other policies and procedures addressing this requirement have not been developed and/or implemented as of yet. This deficiency was attributed to the critically low pharmacy staffing issues.</p> <p>Recommendation 3, July 2006: Establish appropriate database to monitor key elements of this requirement.</p> <p>Findings: Pharmacy monitoring software has been purchased and will be implemented when the Pharmacy Director believes the department has stabilized from the staffing issues.</p> <p>Other findings: From my interview with the Pharmacy Director and Assistant Director, it was reported that a number of pharmacy requirements/duties have been stopped due to the loss of pharmacy staff. Some of these include:</p> <ol style="list-style-type: none"> 1. A decrease in nursing education classes conducted by pharmacists; 2. Pharmacy and Therapeutic Committee meetings have not been conducted since November 2006; 3. The smoking cessation class that was conducted by a pharmacist has been discontinued; 4. Pharmacists are unable to conduct monthly medication regimen reviews. Nurses are conducting these reviews 2 months out of every quarter; 5. Patient education groups have been canceled; and 6. Drug utilization reviews have not been consistently conducted.
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		<p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. The State must address issues related to recruitment and retention of staff needed to execute the EP. 2. Implement a system to monitor this requirement. 3. Continue to develop, update and/or revise and implement policies and procedures to address the elements of this requirement. 4. Implement the use of a database to monitor the elements of this requirement.
<p>b</p>	<p>Physicians to consider pharmacists' recommendations, and for any recommendations not followed, document in the individual's medical record an adequate clinical justification.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1, 2, 3 and 4, July 2006:</p> <ul style="list-style-type: none"> • Develop and implement a system to address this required element. • Develop and implement policies and procedures regarding this requirement. • Develop and implement a system to monitor the key elements of this requirement. • Establish appropriate database to monitor key elements of this requirement. <p>Findings: The facility has yet to address this requirement.</p> <p>Compliance: Non-compliance.</p> <p>Other findings: Given the combination of the critical staffing shortage, the use of</p>

		<p>contract pharmacists who are not familiar with the physicians and have not yet established a rapport with them, and the lack of an established system to address this requirement, it is basically impossible to determine how this requirement is currently being addressed. The facility reported that informal systems such as telephone calls and messages left on answering machines are being utilized. However, there appears to be no consistent documentation system to ensure that this communication is occurring as required.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a system to address this required element. 2. Develop and implement policies and procedures regarding this requirement. 3. Develop and implement a system to monitor the elements of this requirement. 4. Establish appropriate database to monitor the elements of this requirement. 5. The State must address issues related to recruitment and retention of need staff to execute the EP.
7	General Medical Services	
		<p>Methodology: Interviewed Scott Anderson, M.D, PhD. Chief of Medical Ancillary Services. Interviewed Dally Matteucci, Interim Executive director Interviewed William Kocsis, M.D., staff physician. Interviewed Hong-Shen Yeh, M.D. staff physician. Interviewed Rodolfo Pineda, M.D., staff physician Reviewed charts of five individuals (JJP, JAM, GBL, JC and ED). Reviewed NSH revised Physician Duty Statement. Reviewed NSH statement regarding performance improvement/peer review monitoring of transfers to a higher level of care.</p>

		<p>Reviewed Medical Quality Management Monitor-Outside Transfer. Reviewed Outside Transfers Monitoring summary data (September to December 2006). Reviewed Quality of Care Monitoring Instrument-Diabetes Mellitus. Reviewed Diabetes Mellitus Monitoring summary data (September to December 2006). Reviewed Quality of Care Monitoring Instrument- Asthma/COPD. Reviewed Asthma/COPD Monitoring summary data (September to December 2006). Reviewed Admission and Annual Medical Evaluation Form. Reviewed Admission and Annual Medical Evaluation summary data (September 2006). Reviewed Department of Medicine meeting minutes (June 28, July 26, August 23 and September 27, 2006) Reviewed List of individuals requiring hospitalization, E.R. care and/or medical emergency response.</p>
<p>a</p>	<p>Each State hospital shall provide adequate, appropriate, and timely preventive, routine, specialized, and emergency medical care to all individuals in need of such services, consistent with generally accepted professional standards of care. Each State hospital shall ensure that individuals with medical problems are promptly identified, assessed, diagnosed, treated, monitored and, as monitoring indicates is necessary, reassessed, diagnosed, and treated, consistent with generally accepted professional standards of care.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006: Develop and implement policy and procedure to codify facility's standards and expectations regarding the areas outlined above.</p> <p>Findings: The facility has revised the Physician Duty Statement to address the recommendation. The revision adequately addresses the monitor's recommendation regarding the assessment and documentation of medical risk factors that are relevant to the individual in a manner that facilitates and integrates interdisciplinary interventions needed to reduce the risks. However, the revised document does not address other important areas that were listed as part of the monitor's findings in the baseline evaluation (see other findings below).</p>

		<p>Recommendation 2, July 2006: Ensure that monitoring instruments are aligned with the policy and procedure and that the data address not only timeliness and completeness of medical assessments but also quality of assessments and management interventions.</p> <p>Findings: The revised Physician's Duty Statement (described above) does not provide the basis for implementation of the recommendation regarding alignment of practice with facility's policy.</p> <p>Since the baseline evaluation, the facility has implemented monitoring instruments regarding the management of Diabetes Mellitus and Asthma & COPD. The facility also used the Medical Quality Management Monitor, including Outside Transfers to assess the appropriateness of care for individuals who are transferred to outside facilities. This instrument does not specify other types of transfers that are being monitored. The three instruments contain appropriate quality indicators for their respective areas. However, the Outside Transfers monitor doe not include specific parameters regarding timely recognition of the medical condition and timely evaluation of the individual.</p> <p>Using these tools, peer physicians reviewed 100% samples of individuals referred to the Diabetes and Asthma/COPD clinics as well as outside transfers to medical facilities. The facility reports overall compliance rates of 57% (Diabetes Mellitus), 45% (Asthma/COPD) and 47% (Outside Transfers). The data regarding outside transfers show inconsistencies in the compliance rates regarding the timely evaluation of the individual (10%) and the timely recognition of the medical condition (97%).</p> <p>In addition to these data, the facility used the Admission and Annual</p>
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		<p>Medical Evaluation Monitor to assess its overall compliance with this requirement of the EP. In this process, peer physicians reviewed 16 charts in September 2006. Based on these reviews, the facility reports the following compliance data:</p> <ol style="list-style-type: none"> 1. Timeliness of the admission medical assessment (81%); 2. Ordering of appropriate laboratory tests upon admission (100%); 3. Appropriate referrals of individuals for specialty care upon admission, when applicable (58%); 4. Timeliness of the annual history and physical examination (100%); 5. Ordering of annual laboratory tests (100%); and 6. Referrals of individuals for specialty care during hospitalization (100%). <p>Recommendation 3, July 2006: Ensure easy access by physicians to the laboratory information system, radiology data/reports, chart notes and consultation reports.</p> <p>The facility has taken steps to improve IT support, and obtained budget approval for a digital radiology system.</p> <p>Recommendation 4, July 2006: Address physicians' concerns regarding the status of equipment and environmental conditions at the consultation clinics to ensure proper functioning of these clinics.</p> <p>Findings: The facility has yet to implement this recommendation. A feasibility study has been conducted and a plan to improve the complex where the clinics are located has been approved. An architectural review and plan development are pending.</p>
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Recommendation 5, July 2006:

Same as in F.1.c.i

Findings:

Same as in F.1.c.i.

Other findings:

Since the baseline evaluation, the facility has recruited one board-certified family practice physician, one staff physician became half-time and five physicians departed through retirement and employment elsewhere. The facility has a new consulting endocrinologist.

The department currently has five vacancies. As a result of this shortage, the facility now provides rotating coverage on Program 4 and some physicians were transferred from the internal medical clinic to provide unit coverage.

This monitor reviewed charts of six individuals that required transfer to a local emergency room and/or hospitalization at an outside facility. The review focused on the timeliness and quality of the medical evaluation of the change in the individual's physical status and the timeliness and appropriateness of the transfer. The following table outlines the individuals' initials, the reason for the transfer, the date/ and time of the medical evaluation upon the transfer and the date and time of actual transfer.

Individual's initials	Reason for transfer	Date/time of medical evaluation	Date/time of transfer
JJP	End-stage liver disease, anemia	12/13/06 10:23	12/14/06 11:30

Individual's initials	Reason for transfer	Date/time of medical evaluation	Date/time of transfer
JAM	Acute abdomen	07/24/06 08:50	07/24/06 Unspecified time
GBL	Pneumonia	11/09/06 19:10	11/09/06 19:37
JC	Hypotension and bradycardia	09/01/06 16:24	09/01/06 Unspecified time
ED	Hand infection	10/21/06 09:15	10/21/06 Unspecified time

The review shows substantial compliance with plan requirements in four cases (JAM, GBL, JC and ED). The review of JJP demonstrates inadequate documentation of the status of the individual regarding the absence of signs suggesting active bleeding. The charts of JAM, JC and ED do not include clear documentation of the actual transfer time.

At this time, NSH does not have a policy and procedure that outlines standards and expectations regarding the following areas:

1. Timeliness and documentation requirements of initial assessments;
2. Timeliness and documentation requirements regarding medical attention to changes in the status of individuals;
3. Requirements for preventive health screening of individuals;
4. Proper physician-nurse communications and physician response with timeframes that reflect the urgency of the condition;
5. Emergency medical response, including drill practice;

		<ul style="list-style-type: none"> 6. Communication of needed data to consultants; 7. Timely review and filing of consultation and laboratory reports; 8. Follow-up on consultant's recommendations; 9. Parameters for physician participation in the WRP process to improve integration of medical and mental health care; and 10. Proper documentation of changes in the medical status of individuals in the WRP. <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ul style="list-style-type: none"> 1. Develop and implement a policy/procedure and/or duty statement that includes the facility's expectations regarding all the areas (1 through 10) listed above. 2. Continue to monitor the management of Diabetes Mellitus, Asthma/COPD and Outside transfers. Clarify the types of transfers that are being monitored, include specific parameters for timeliness and address inconsistent findings in that monitor. 3. Develop and implement other monitors to address quality of care as pertinent to the facility's population. 4. Monitor at least 20% sample of all admission medical examinations and ensure that monitoring addresses completeness and quality of examination and appropriate follow up regarding deferral of items and refusal of examination.
b	Each State hospital shall develop and implement protocols and procedures, consistent with generally accepted professional standards of care, that:	<p>Compliance: Partial.</p>
b.i	require the timely provision of initial and ongoing assessments relating to medical care, including but not	<p>Current findings on previous recommendations:</p>

	<p>limited to, vision care, dental care, and laboratory and consultation services;</p>	<p>Recommendation July 2006: As above.</p> <p>Findings: As above.</p> <p>Other findings: At this time, the facility does not monitor the timeliness and quality of consultation services.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. As above. 2. Monitor the timeliness and quality of consultation referrals.
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, July 2006: As above.</p> <p>Findings: As above.</p> <p>Other findings: None.</p> <p>Current recommendation: As above.</p>
b.iii	<p>define the duties and responsibilities of primary care (non-psychiatric) physicians;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, July 2006: Ensure that the duty statement outlines the performance standards and expectations as above.</p>

		<p>Findings: As above.</p> <p>Other findings: None.</p> <p>Current recommendation: As above.</p>
b.iv	ensure a system of after-hours coverage by primary care physicians with formal psychiatric training (i.e., privileging and proctorship) and psychiatric backup support after hours; and	<p>Current findings on previous recommendations:</p> <p>Recommendation, July 2006: Continue current practice.</p> <p>Findings: The facility has maintained an adequate system for after-hours coverage by psychiatrists and primary care physicians.</p> <p>Other findings: None.</p> <p>Current recommendation: Continue current practice.</p>
b.v	endeavor to obtain, on a consistent and timely basis, an individual's medical records after the individual is treated in another medical facility.	<p>Current findings on previous recommendations:</p> <p>Recommendation, July 2006: Continue current practice and increase efforts to ensure consistency in the availability of needed records.</p> <p>Findings: NSH has maintained current mechanisms of communications with</p>

		<p>Queen of the Valley Hospital to ensue continuity of care issues and address identified barriers. The facility does not monitor this item at this time.</p> <p>Other findings: None.</p> <p>Current recommendation: Monitor the timeliness and completeness of needed records.</p>
<p>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, July 2006: Develop and implement monitoring and tracking instruments to ensure that the foci of hospitalization address current assessed medical needs and that foci, objectives and interventions are modified in a timely basis to address the changes in the physical status of the individuals.</p> <p>Findings: The facility has yet to implement this recommendation.</p> <p>Recommendation 2, July 2006: Improve integration of medical staff into the interdisciplinary functions of the WRP.</p> <p>Findings: The facility did not present a progress report related to this recommendation.</p> <p>Other findings: This monitor's chart reviews indicate that, in general, the foci of hospitalization, objectives and interventions are not modified to</p>

		<p>reflect changes in the physical status of individuals. As mentioned earlier, this deficiency is also noted in the services provided to individuals suffering from cognitive disorders, substance abuse and seizure disorders.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement monitoring and tracking instruments to ensure that the foci of hospitalization address current assessed medical needs and that foci, objectives and interventions are modified in a timely basis to address the changes in the physical status of the individuals. 2. Improve integration of medical staff into the interdisciplinary functions of the WRP.
<p>d</p>	<p>Each State Hospital shall monitor, on a continuous basis, outcome indicators to identify trends and patterns in the individual's health status, assess the performance of medical systems, and provide corrective follow-up measures to improve outcomes.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006: Develop and implement a formalized physician peer review system that utilizes indicators aligned with the standards and expectations outlined in F.7.a.</p> <p>Findings: As mentioned earlier, the facility has implemented peer review monitors focused on the management of Diabetes Mellitus, Asthma/COPD and Outside Transfers and the timeliness and completeness of Admission and Annual Medical Evaluations. The facility is yet to develop other monitors and to identify practitioner trends and patterns for performance improvement. The findings in F.7.a are applicable to this recommendation.</p>

		<p>Recommendations 2, 3, 4 and 5, July 2006:</p> <ul style="list-style-type: none"> • Collect data on the medical triggers identified in the Key Indicators. The facility may establish additional indicators of outcome to the individuals and the medical systems of care. • Identify trends and patterns based on clinical and process outcomes. • Provide corrective actions to address problematic trends and patterns. • Expedite efforts to automate data systems to facilitate data collection and analysis. <p>Findings: The facility did not present progress report on these recommendations. At this time, NSH does not have a formalized system that identifies practitioner trends and patterns and that addresses health care outcomes for the individuals and process outcomes for the medical service.</p> <p>Other findings: None.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Same as in F.7.a. 2. Develop and implement a formalized physician peer review system that utilizes indicators aligned with the standards and expectations outlined in F.7.a. 3. Collect data on the medical triggers identified in the Key Indicators. The facility may establish additional indicators of outcome to the individuals and the medical systems of care. 4. Identify trends and patterns based on clinical and process
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		<p>outcomes.</p> <ol style="list-style-type: none"> 5. Provide corrective actions to address problematic trends and patterns. 6. Expedite efforts to automate data systems to facilitate data collection and analysis.
8	Infection Control	
	Each State hospital shall develop and implement infection control policies and procedures to prevent the spread of infections or communicable diseases, consistent with generally accepted professional standards of care.	<p>Methodology: Interviewed Bob Kolker, RN Public Health Nurse II. Reviewed Infection Control Office Procedures. Reviewed Initial Drafts of Infection Control Monitoring Tools. Reviewed Monthly Key Indicator list.</p>
a	Each State hospital shall establish an effective infection control program that:	<p>Compliance: Partial.</p>
a.i	actively collects data regarding infections and communicable diseases;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006: Develop and implement a system to monitor the key elements of this requirement.</p> <p>Findings: The facility has made little to no progress on this recommendation. A statewide committee has recently met to begin the development of instruments addressing the requirements of the EP.</p> <p>Recommendation 2, July 2006: Develop and implement a system for consistent unit reporting of appropriate information.</p> <p>Findings: A tool was developed and implemented, however, it appears to only</p>

		<p>address if a request for information was sent to the units. It does not address nor measure the consistency of units reporting appropriate information to the Department.</p> <p>Recommendation 3, July 2006: Develop and implement a system to ensure that community labs and x-rays are forwarded to the public health department.</p> <p>Findings: The tool developed by the facility does not adequately address this recommendation.</p> <p>Recommendation 4, July 2006: Develop and implement systems to monitor and track unit reporting and accessibility of community labs and x-rays.</p> <p>Findings: The facility has yet to address this recommendation.</p> <p>Other findings: NSH Public Health Department collects and analyzes a multitude of data regarding infection control issues. They need to focus on developing and implementing a system that monitors the requirements of the EP. In addition, I noted that there was no information on the Monthly Key Indicator list regarding individuals diagnosed with Hepatitis C and with MRSA. This information should be available and obtained from the NSH Public Health Department.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a system to monitor the elements of
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		<p>this requirement.</p> <ol style="list-style-type: none"> 2. Develop and implement a system for consistent unit reporting of appropriate information. 3. Develop and implement a system to ensure that community labs and x-rays are forwarded to the public health department. 4. Develop and implement systems to monitor and track unit reporting and accessibility of community labs and x-rays. 5. Provide the appropriate information for the Monthly Key Indicators.
<p>a.ii</p>	<p>assesses these data for trends;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006: Develop and implement a system to monitor the key elements of this requirement.</p> <p>Findings: As above in a.i.</p> <p>Recommendation 2, July 2006: Develop and implement a system to document identified trends, interventions/corrective actions, and follow-up.</p> <p>Findings: The facility has yet to address this recommendation.</p> <p>Other findings: None.</p> <p>Compliance: Noncompliance.</p>

		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a system to monitor the elements of this requirement. 2. Develop and implement a system to document identified trends, interventions/corrective actions, and follow-up.
a.iii	initiates inquiries regarding problematic trends;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006: Develop and implement a system to monitor the key elements of this requirement.</p> <p>Findings: As above in a.i.</p> <p>Recommendation 2, July 2006: Develop and implement a system to document identified trends, interventions/corrective actions, and follow-up.</p> <p>Findings: The facility has yet to address this recommendation.</p> <p>Compliance: Noncompliance.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a system to monitor the elements of this requirement. 2. Develop and implement a system to document identified trends, interventions/corrective actions, and follow-up.
a.iv	identifies necessary corrective action;	As above.

a.v	monitors to ensure that appropriate remedies are achieved; and	As above.
a.vi	integrates this information into each State hospital's quality assurance review.	As above.
9	Dental Services	
	Each State hospital shall provide individuals with adequate, appropriate and timely routine and emergency dental care and treatment, consistent with generally accepted professional standards of care.	<p>Methodology: Interviewed Craig B. Story, Chief Dentist. Reviewed NSH Standards and Compliance Annual Audit form. Reviewed Dental Admission Exam Monitoring form. Reviewed memos dated February 27, September 22, September 27, September 28 and December 22, 2006 regarding critical staffing issues and adjustment of clinical services in response to staffing shortages. Reviewed Dental Daily Monitoring form. Reviewed Dental Service Clinic Manual. Reviewed NSH Dental Policies and Procedures. Reviewed NSH Dental Extraction Monitoring form and data. Reviewed NSH General Anesthesia/Hospital Dentistry Monitoring tool and data. Reviewed Dental Cancellations Monitoring tool and data. Reviewed Proactive Dental Alert Monitoring tool. Reviewed Refusal of Offered Dental Services Monitoring tool. Reviewed minutes of Clinical Management Team dated October 25, 2006.</p>
a	Each State hospital shall retain or contract with an adequate number of qualified dentists to provide timely and appropriate dental care and treatment to all individuals it serves;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006: Develop and implement a system to monitor the key elements of this requirement.</p>

		<p>Findings: NSH has developed an audit to track annual and admission dental exams. However, refusals for these appointments are not reported separately thus making the data unreliable.</p> <p>Recommendation 2, July 2006: Evaluate the need for an additional dentist, dental assistant, dental hygienist, a PTA, and a clerical staff position to cover 1200 patients.</p> <p>Findings: NSH submitted documentation indicating that they have been trying to recruit an additional dentist, dental assistant, dental hygienist, a psychiatric technician assistant (PTA), and a clerical staff position. Thus far, none of these positions have been filled.</p> <p>Other findings: The data presented by NSH does not accurately indicate the elements of this requirement. Refusals need to be reported separately to better represent this requirement.</p> <p>In addition, NSH reported that it has cut its efforts of providing preventive and restorative dental care and services to the individuals due to staff shortages in the dental department. Admission and annual assessments and emergencies are basically the only services they are currently providing.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Separate refusals in the dental assessment data. 2. Continue to monitor this requirement. 3. Ensure that the dental department has an adequate number of
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		staff to deliver appropriate services.
b	Each State hospital shall develop and implement policies and procedures that require:	Compliance: Partial.
b.i	comprehensive and timely provision of dental services;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006: Develop and implement a system and a data base to monitor the key elements of this requirement.</p> <p>Findings: The dental department has implemented some monitoring forms to address this requirement.</p> <p>Recommendation 2, July 2006: Revise Dental Manual.</p> <p>Findings: The Dental Manual has been revised in alignment with the EP.</p> <p>Recommendation 3, July 2006: Finalize and implement Dental Department policies and procedures.</p> <p>Findings: As above under findings for recommendation #2.</p> <p>Other findings: The data submitted from NSH does not accurately reflect this requirement. Data regarding refusals were not separated in the data. In addition, there is no data indicating reasons why exams were not completed.</p>

		<p>Compliance: Partial.</p> <p>Current recommendation: Continue to develop and implement a system and a database to monitor this requirement.</p>
b.ii	documentation of dental services, including but not limited to, findings, descriptions of any treatment provided, and the plans of care:	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006: Develop and implement a system to monitor the key elements of this requirement.</p> <p>Findings: NSH has developed and implemented a daily monitoring form to address this requirement. However, data for findings and treatment plans needs to be collected and reported separately.</p> <p>Recommendation 2, July 2006: Consider placing patient dental records in medical records or on a facility computerized system for staff to have accessibility to this health care information.</p> <p>Findings: NSH has developed a system to temporarily address this recommendation until a computerized system can be developed and implemented.</p> <p>Recommendation 3, July 2006: Implement revised Patient Dental Record.</p> <p>Findings: NSH has implemented the revised Patient Dental Record.</p>

		<p>Other findings: NSH submitted the following compliance data:</p> <table border="1" data-bbox="1045 375 1927 570"> <thead> <tr> <th>Criteria</th> <th>Oct 06</th> <th>Nov 06</th> <th>Dec 06</th> </tr> </thead> <tbody> <tr> <td>Treatment provided</td> <td>100%</td> <td>80%</td> <td>95%</td> </tr> <tr> <td>Treatment planning</td> <td>97%</td> <td>98%</td> <td>97%</td> </tr> <tr> <td>Restorative care</td> <td>35%</td> <td>31%</td> <td>10%</td> </tr> <tr> <td>Preventive care</td> <td>26%</td> <td>47%</td> <td>5%</td> </tr> </tbody> </table> <p>As mentioned above in A, NSH has been unable to provide restorative and preventative care due to staffing issues in the dental department.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that each element of this requirement is monitored individually and reported as such in the data. 2. Continue to develop a system to include individuals' dental records in medical records or on a facility-computerized system for staff to have accessibility to this health care information. 3. Facility must address staffing issues to ensure adequate dental services are provided. 	Criteria	Oct 06	Nov 06	Dec 06	Treatment provided	100%	80%	95%	Treatment planning	97%	98%	97%	Restorative care	35%	31%	10%	Preventive care	26%	47%	5%
Criteria	Oct 06	Nov 06	Dec 06																			
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b.iii	use of preventive and restorative care whenever possible; and	<p>Findings:</p> <p>Recommendation 1, July 2006: Develop and implement a system to monitor the key elements of this requirement.</p>																				

		<p>Findings: NSH has developed and implemented a daily monitoring form to address this requirement. However, data for findings and treatment plans needs to be collected and reported separately</p> <p>Recommendation 2, July 2006: Evaluate staffing needs as outlined in recommendation #2,a. in providing adequate preventative and restorative dental care.</p> <p>Findings: As above in A, under findings for recommendation #2.</p> <p>Recommendation 3, July 2006: Develop and implement database to monitor and track care and use of general anesthesia.</p> <p>Findings: NHS as developed and implemented the <i>General Anesthesia Hospital Dentistry Monitoring Tool</i>.</p> <p>Other findings: NSH data regarding percentages of individuals receiving preventative and restorative care were noted above. A total of 4 individuals had general anesthesia during the months of September-December 2006. NSH reported 100% compliance that <i>GA</i> was used appropriately.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Collect and report data separately for the elements of this requirement. 2. Continue to monitor this requirement.
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		<p>3. Facility must address staffing issues to ensure adequate dental services are provided.</p>																												
<p>b.iv</p>	<p>tooth extractions be used as a treatment of last resort, which, when performed, shall be justified in a manner subject to clinical review.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, July 2006: Develop and implement a system to monitor the key elements of this requirement.</p> <p>Findings: NSH has developed and implemented a Dental Extraction tracking system. However, the monitoring tool does not include criteria by which to measure the clinical justification for the extraction.</p> <p>Other findings: NSH reported the following compliance data for extractions:</p> <table border="1" data-bbox="1045 821 1873 1084"> <thead> <tr> <th>Criteria</th> <th>July 06</th> <th>Aug 06</th> <th>Sept 06</th> <th>Oct 06</th> <th>Nov 06</th> <th>Dec 06</th> </tr> </thead> <tbody> <tr> <td>Clinical justification</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> </tr> <tr> <td>Last resort</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> </tr> <tr> <td>n =</td> <td>1</td> <td>9</td> <td>14</td> <td>11</td> <td>18</td> <td>16</td> </tr> </tbody> </table> <p>Compliance: Full compliance.</p> <p>Current recommendation: Continue monitoring this requirement.</p>	Criteria	July 06	Aug 06	Sept 06	Oct 06	Nov 06	Dec 06	Clinical justification	100%	100%	100%	100%	100%	100%	Last resort	100%	100%	100%	100%	100%	100%	n =	1	9	14	11	18	16
Criteria	July 06	Aug 06	Sept 06	Oct 06	Nov 06	Dec 06																								
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Last resort	100%	100%	100%	100%	100%	100%																								
n =	1	9	14	11	18	16																								
<p>c</p>	<p>Each State hospital shall ensure that dentists demonstrate, in a documented fashion, an accurate understanding of</p>	<p>Current findings on previous recommendations:</p>																												

	<p>individuals' physical health, medications, allergies, and current dental status and complaints.</p>	<p>Recommendation, July 2006: Develop and implement a system to monitor the key elements of this requirement.</p> <p>Findings: NSH developed and implemented the Dental Clinic daily monitoring tool to meet this requirement. However, the tool does not separate data for dental status and complaints. Otherwise, the tool addresses the elements of this requirement.</p> <p>Other findings: NSH submitted the following compliance data for this requirement:</p> <table border="1" data-bbox="1045 672 1795 902"> <thead> <tr> <th>Criteria</th> <th>Nov 06</th> <th>Dec 06</th> </tr> </thead> <tbody> <tr> <td>Physical health</td> <td>100%</td> <td>100%</td> </tr> <tr> <td>Medications</td> <td>100%</td> <td>100%</td> </tr> <tr> <td>Allergies</td> <td>100%</td> <td>100%</td> </tr> <tr> <td>Dental status and complaints</td> <td>98%</td> <td>97%</td> </tr> <tr> <td>n =</td> <td>49</td> <td>39</td> </tr> </tbody> </table> <p>Compliance: Full compliance.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	Criteria	Nov 06	Dec 06	Physical health	100%	100%	Medications	100%	100%	Allergies	100%	100%	Dental status and complaints	98%	97%	n =	49	39
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n =	49	39																		
d	<p>Each State hospital shall ensure that transportation and staffing issues do not preclude individuals from attending dental appointments, and individuals' refusals are addressed to facilitate compliance.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, July 2006: Develop and implement a system to monitor the key elements of this requirement.</p>																		

		<p>Findings: NSH has developed and implemented the Dental clinic Cancellation monitor tool to meet this requirement.</p> <p>Other findings: NSH submitted the following compliance data regarding reasons for missed dental appointments:</p> <table border="1" data-bbox="1045 488 1906 716"> <thead> <tr> <th>Criteria</th> <th>July 06</th> <th>Aug 06</th> <th>Sept 06</th> <th>Oct 06</th> <th>Nov 06</th> </tr> </thead> <tbody> <tr> <td>Staffing issues</td> <td>7%</td> <td>4%</td> <td>0%</td> <td>5%</td> <td>6%</td> </tr> <tr> <td>Transportation issues</td> <td>0%</td> <td>0%</td> <td>0%</td> <td>0%</td> <td>0%</td> </tr> <tr> <td>n =</td> <td>137</td> <td>118</td> <td>103</td> <td>83</td> <td>128</td> </tr> </tbody> </table> <p>Compliance: Partial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	Criteria	July 06	Aug 06	Sept 06	Oct 06	Nov 06	Staffing issues	7%	4%	0%	5%	6%	Transportation issues	0%	0%	0%	0%	0%	n =	137	118	103	83	128
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e	Each State hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to overcome individual's refusals to participate in dental appointments.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006: Develop and implement a system to monitor the key elements of this requirement.</p> <p>Findings: NSH has recently developed a Dental Refusal Notification system. However, it has not yet been fully implemented.</p> <p>Recommendation 2, July 2006: Develop and implement a facility-wide system to facilitate</p>																								

		<p>communication with Dental and the Wellness and Recovery teams regarding individualized strategies to address refusals of dental appointments and treatments</p> <p>Findings: NSH plans to implement a system where the dental office will work with the clinical administrator to ensure that WRPTs respond with a copy of the focus/objectives/interventions developed to address this requirement. This system has not been yet fully implemented.</p> <p>Other findings: The Dental Department has already developed an Intervention Request form and Individual's Refusal of Dental Treatment form to activate desensitization for the individual. Thus far, no data has been collected.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Implement a system to monitor this requirement. 2. Continue to develop and implement a facility-wide system to facilitate communication with Dental and the Wellness and Recovery teams regarding individualized strategies to address refusals of dental appointments and treatments
10	Special Education	
	Each State hospital shall provide the school-age and other residents, as required by law, who qualify for special education ("students"), individualized educational programs that are reasonably calculated to enable these students to receive educational benefits, as defined by applicable law.	Only MSH
a	Each State hospital shall develop and implement uniform	

	systems for assessing students' individual educational needs and monitoring their individual progress.	
b	Each State hospital shall ensure that all Individual Education Plans ("IEPs") are developed and implemented consistent with the Individuals with Disabilities Education Act, 20 U.S.C. § 1400 <u>et seq.</u> (2002) ("IDEA").	
c	Each State hospital shall ensure that teachers providing instruction to students at each State hospital have completed competency-based training regarding teaching and academic instruction, behavioral interventions, monitoring of academic and behavioral progress and incident management and reporting.	
d	Each State hospital shall ensure that students receive instruction and behavioral supports appropriate to their learning abilities and needs, consistent with generally accepted professional standards of care.	
e	Each State hospital shall provide appropriate literacy instruction, consistent with generally accepted professional standards of care, for students who show deficits in one or more common areas of reading (e.g., decoding or comprehending).	
f	Each State hospital shall on admission and as statutorily required thereafter, assess each student's capacity to participate, with appropriate supports and services, in an integrated, non-institutional, education environment, and provide access to an integrated education environment for those students who can participate in one with appropriate supports and services.	
g	Each State hospital shall ensure that all students receive their education in the least restrictive setting pursuant to the requirements of the IDEA, consistent with their legal and clinical status.	

<p>G</p>	<p>Documentation</p>		
		<p>Summary of Progress:</p> <ol style="list-style-type: none"> 1. NSH is progressing in its implementation of the Wellness and Recovery Model. Although significant work has yet to be done, NSH is making heartfelt efforts to move the process in a positive direction in the face of a severe staffing shortage. 2. The DMH WRP manual includes criteria for the proper documentation of the main components of the new model. 3. The facility continues to conduct a thorough self-assessment of their current system and has implemented significant changes to move the systems toward compliance. 	
	<p>Each State hospital shall ensure that an individual's records accurately reflect the individual's response to all treatment, rehabilitation and enrichment activities identified in the individual's therapeutic and rehabilitation service plan, including for children and adolescents, their education plan, consistent with generally accepted professional standards of care. Each State hospital shall develop and implement policies and procedures setting forth clear standards regarding the content and timeliness of progress notes, transfer notes, school progress notes, and discharge notes, including, but not limited to, an expectation that such records include meaningful, accurate, and coherent assessments of the individual's progress relating to treatment plans and treatment goals, and that clinically relevant information remains readily accessible.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1, 2 and 3, July 2006:</p> <ul style="list-style-type: none"> • Revise, update, and implement policies and procedures related to documentation to include specific criteria required. • Develop and implement a system to monitor and track the quality of documentation addressing the required elements in the Plan. • Provide ongoing training regarding documentation requirements. <p>Findings:</p> <p>As mentioned in sections C.1 and C.2, the facility has developed and implemented appropriate WRP monitoring instruments. Many of the instruments that are utilized to monitor disciplinary assessments are aligned with requirements of the EP, but some instruments require modification as recommended in corresponding cells in sections D and F. The previously mentioned findings of deficiencies in the documentation of admission and integrated assessments (D.1. through D.7) and the main components of integrated therapeutic and rehabilitation services (C.2.b through C.2.i) and specific therapeutic and rehabilitation services (F.1 through F.7) indicate that the</p>	

		<p>documentation of these systems remains generally inadequate.</p> <p>Other findings: None.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none">1. Revise, update, and implement policies and procedures related to documentation to include specific criteria required.2. Ensure that all monitoring instruments regarding disciplinary assessments are aligned with requirements of the EP3. Provide ongoing training regarding documentation requirements.
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H	Restraints, Seclusion, and PRN and Stat Medication	
		<p>Summary of Progress:</p> <ol style="list-style-type: none"> 1. NSH has initiated many of the needed revisions in its policies and procedures regarding seclusion, restraints, PRN and /STAT medications. 2. Monitoring systems continue to be implemented to ensure that proper procedures are being implemented. 3. The staff and administration at NSH are committed to decreasing the use of seclusion/restraints and PRN and STAT medications. 4. NSH is committed to the Wellness and Recovery Model to guide its provision of services to individuals with serious mental illness. 5. NSH continues to identify and address many its deficits through the process of self-assessment.
	<p>Each State hospital shall ensure that restraints, seclusion, psychiatric PRN medications, and Stat medications are used consistent with generally accepted professional standards of care.</p>	<p>Methodology:</p> <p>Interviewed Nickey Jones, Coordinator of Nursing Services. Interviewed Eve Arcala, RN, Assistant Coordinator of Nursing Services. Interviewed Cindy Black, LCSW, CPHQ, Standards and Compliance Director. Interviewed David Thomas, MD, Acting Medical Director. Interviewed Ann Rust, MSN, Nursing QI Coordinator. Interviewed Amarpreet Singh, MD, Chief of Medical Services. Reviewed Initial Safety Restraint Assessment form. Reviewed NSH Medical Staff Rules and Regulations #203, Administration of PRN Medication. Reviewed records for the following individuals (GB, EL, LK, ES, NF, JB, HS, VH, JW, LR, MW, JL, RT, CP, AH, JC, LH, CR, TR, LS and JW). Reviewed the Seclusion and Restraints Reduction Oversight Committee agenda dated February 13, 2007. Reviewed statewide Medication Administration Monitoring form.</p>

		<p>Reviewed Prevention and Management of Assaultive Behavior (PMAB) curriculum and post-test. Reviewed NSH Standards and Compliance Department Nursing Quality Improvement Seclusion and Restraint Review raw data. Reviewed DMH Monitoring Plan Outcome data for November-December 06. Reviewed Safety Restraints Reduction Monitoring form. Reviewed Side Rail Usage list</p>
<p>1</p>	<p>Each State hospital shall revise, as appropriate, and implement policies and procedures regarding the use of seclusion, restraints, psychiatric PRN medications, and Stat Medications consistent with generally accepted professional standards of care. In particular, the policies and procedures shall expressly prohibit the use of prone restraints, prone containment and prone transportation and shall list the types of restraints that are acceptable for use.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, July 2006: Revise, implement, and retrain staff on policies and procedures addressing the use of seclusion, restraints, psychiatric PRN medications, and STAT medication in accordance with generally, accepted standards of practice.</p> <p>Findings: NSH is in process of revising its policies to come into alignment with the EP. No specific data was submitted regarding which policies were already revised and which ones were still in process.</p> <p>Other findings: None.</p> <p>Compliance: Partial.</p> <p>Current recommendations: Continue to revise implement, and retrain staff regarding policies and procedures addressing the use of seclusion, restraints, psychiatric PRN medications, and STAT medication in accordance with generally, accepted standards of practice.</p>

2	Each State hospital shall ensure that restraints and seclusion:	<p>Compliance: Partial.</p>
a	are used in a documented manner and only when individuals pose an imminent danger to self or others and after a hierarchy of less restrictive measures has been considered in a clinically justifiable manner or exhausted;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006: Develop and implement a system to monitor the key elements of this requirement.</p> <p>Findings: NSH reported that this recommendation was not completed due to pending revision of policy to document a hierarchy of interventions.</p> <p>Recommendations 2, 3 and 4, July 2006:</p> <ul style="list-style-type: none"> • Revise policies and procedures to include implementing seclusion and restraints only after a hierarchy of less restrictive measures has been considered in a clinically justifiable manner or exhausted with supporting documentation to be in the medical records. • Retrain staff regarding new policies and procedures regarding the use of seclusion and restraint. • Revise forms used to document use of seclusion and restraint to include documentation of less restrictive measures used prior to restrictive procedures being implemented. <p>Findings: NSH reported these recommendations have not yet been completed due to the pending revision of policy to document a hierarchy of interventions. It has been place on the agenda for approval at the Seclusion and Restraint Reduction Oversight Committee for February. NSH did report that additional hours in Prevention and Management of Assaultive Behavior were added to the training schedule.</p>

		<p>Other findings: From my review of 15 individuals (GB, EL, LK, ES, NF, JB, HS, VH, JW, LR, MW, JL, RT, CP and AH) who were placed in seclusion and/or restraints, there was no indication from the documentation that less restrictive measures were tried prior to the use of restraints and/or seclusion.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to develop and implement a system to monitor the elements of this requirement. 2. Continue to revise policies and procedures to include implementing seclusion and restraints only after a hierarchy of less restrictive measures has been considered in a clinically justifiable manner or exhausted with supporting documentation to be in the medical records. 3. Retrain staff regarding new policies and procedures regarding the use of seclusion and restraint. 4. Revise forms used to document use of seclusion and restraint to include documentation of less restrictive measures used prior to restrictive procedures being implemented.
<p>b</p>	<p>are not used in the absence of, or as an alternative to, active treatment, as punishment, or for the convenience of staff;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006: Develop and implement a system to monitor the key elements of this requirement.</p> <p>Findings: There was no data provided by NSH addressing this recommendation.</p>

		<p>From my review of the raw data collected regarding seclusion and restraints, I found no system in place monitoring the elements of this requirement.</p> <p>Recommendation 2, July 2006: Provide ongoing training for staff regarding therapeutic interactions and interventions.</p> <p>Findings: NSH reported that training has been implemented and expanded to address this recommendation.</p> <p>Recommendation 3, July 2006: Increase the number of therapeutic mall activities to provide adequate treatment options to individuals.</p> <p>Findings: NSH did not submit data addressing this recommendation.</p> <p>Other findings: From my review of a number of individuals on unit A4, I noted that many of them were being placed in "soft tie" restraints. However, I could not find documentation indicating that these restraints were being taken off at appropriate intervals and that the individuals' circulation and range of motion were being addressed. In an interview, the RN Supervisor of the unit stated that it has not been the practice to release the individual from these "soft tie" restraints as NSH's policy dictates. This finding needs to be addressed, corrected and monitored as outline in the EP regarding the use of restraints.</p> <p>Compliance: Partial.</p>
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		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a system to monitor the key elements of this requirement. 2. Continue to provide ongoing training for staff regarding therapeutic interactions and interventions. 3. Increase the number of therapeutic mall activities to provide adequate treatment options to individuals. 4. Develop and implement a system to address the use of "soft tie" restraints to ensure that policies and procedures are being followed.
c	are not used as part of a behavioral intervention; and	<p>Current findings on previous recommendations:</p> <p>Recommendation, July 2006: Continue ongoing monitoring to ensure compliance with this key element.</p> <p>Findings: NSH did not submit any data regarding this requirement. However, the records that I reviewed indicated that seclusion and/or restraints were not included as a behavioral intervention in the WRPs.</p> <p>Other findings: None.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Continue ongoing monitoring to ensure compliance with this requirement.</p>
d	are terminated as soon as the individual is no longer an	<p>Current findings on previous recommendations:</p>

	<p>imminent danger to self or others.</p>	<p>Recommendation 1, July 2006: Continue ongoing monitoring to ensure compliance with this key element.</p> <p>Findings: NSH data indicted that 90% of records reviewed demonstrated that seclusion/restraints were terminated as soon as the individual was no longer an imminent danger to self or others and that 68% of those that were not released had documentation justifying the rationale.</p> <p>Recommendation 2, July 2006: Develop and implement monitoring system to identify specific problematic trends related to this key element to ensure effective plans of corrections.</p> <p>Findings: NSH reported that software was recently purchased that will address this recommendation. The system has not yet been implemented.</p> <p>Other findings: None.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue ongoing monitoring to ensure compliance with this requirement. 2. Implement monitoring system to identify specific problematic trends related to this requirement to ensure effective plans of corrections.
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3	<p>Each State hospital shall comply with 42 C.F.R. § 483.360(f), requiring assessments by a physician or licensed clinical professional of any individual placed in seclusion or restraints within one hour. Each State hospital shall also ensure that any individual placed in seclusion or restraints is continuously monitored by a staff person who has successfully completed competency-based training on the administration of seclusion and restraints.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, July 2006: Develop and implement a system to monitor and ensure compliance the key elements of this requirement.</p> <p>Findings: NSH reported that the monitoring system for seclusion and restraints has been completed. Software for management of aggregated data is being configured and has not yet been implemented. Completion of competency-based training is now being tracked.</p> <p>NSH data indicated 100% compliance with individuals being seen within an hour by a physician or RN while in seclusion/restraints. My review supports NSH's data.</p> <p>There was no data submitted by NSH regarding continuous monitoring by competency-based trained staff.</p> <p>Other findings: None.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Implement a system to monitor and ensure compliance all the elements of this requirement.</p>
4	<p>Each State hospital shall ensure the accuracy of data regarding the use of restraints, seclusion, psychiatric PRN medications, or Stat medications.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, July 2006: Develop and implement an automated system to ensure accuracy of</p>

		<p>data regarding the use of restraints, seclusion, psychiatric PRN medications, or STAT medications.</p> <p>Findings: NSH reported that the system is currently being implemented but has not produced data as of yet.</p> <p>Other findings: From my interviews, it was reported that there has been an increase in prescribing PRN medications in order to compensate for the staffing shortages in psychiatry. Many psychiatrists have taken this measure to ensure that the medication of choice is used in the case of an emergency rather than having another psychiatrist or MOD order a STAT medication for an individual they may not be familiar with. This practice will significantly skew the data regarding PRN and STAT medications.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to implement an automated system to ensure accuracy of data regarding the use of restraints, seclusion, psychiatric PRN medications, or STAT medications. 2. Address the issue of an increase in prescribing PRNs rather than STAT medications regarding the requirements of the EP.
5	<p>Each State hospital shall revise, as appropriate, and implement policies and procedures to require the review within three business days of individuals' therapeutic and rehabilitation service plans for any individuals placed in seclusion or restraints more than three times in any four-week period, and modification of therapeutic and</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, July 2006:</p> <ul style="list-style-type: none"> • Revise appropriate policies and procedures to ensure compliance with this requirement. • Develop and implement a monitoring system to ensure that

	<p>rehabilitation service plans, as appropriate.</p>	<p>there is a review within three business days of individuals' therapeutic and rehabilitation service plans for any individuals placed in seclusion or restraints more than three times in any four-week period, and modification of therapeutic and rehabilitation service plans, as appropriate.</p> <p>Findings: NSH reported that the triggers are being used to address this recommendation and that the WRP manual requires an update of aggression foci. However, this system has not been implemented as of yet.</p> <p>Other findings: There is no monitoring system in place to ensure that there is a review within three business days of individuals' therapeutic and rehabilitation service plans for any individuals placed in seclusion or restraints more than three times in any four-week period, and modification of therapeutic and rehabilitation service plans, as appropriate.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Revise appropriate policies and procedures to ensure compliance with this requirement. 2. Develop and implement a monitoring system to ensure that there is a review within three business days of individuals' therapeutic and rehabilitation service plans for any individuals placed in seclusion or restraints more than three times in any four-week period, and modification of therapeutic and rehabilitation service plans, as appropriate.
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6	Each State hospital shall develop and implement policies and procedures consistent with generally accepted professional standards of care governing the use of psychiatric PRN medication and Stat medication, requiring that:	Compliance: Partial.
a	such medications are used in a manner that is clinically justified and are not used as a substitute for adequate treatment of the underlying cause of the individual's distress.	<p>Findings on previous recommendations:</p> <p>Recommendations 1, 2 and 3, July 2006:</p> <ul style="list-style-type: none"> • Same as in C.1.b • Develop and implement policy/procedure to outline facility's standards regarding PRN/STAT medication use. • Develop and implement triggers for review by TRC and follow through. <p>Findings: The findings in F.1.b indicate that the use of PRN and STAT medication does not conform to the requirements of the EP. At this time, NSH does not have a formalized system to ensure appropriate use.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Same as in F.1.b 2. Develop and implement triggers for review by TRC and follow through.
b	PRN medications, other than for analgesia, are prescribed for specified and individualized behaviors.	Same as above.
c	PRN medications are appropriately time limited.	Same as above.
d	nursing staff assess the individual within one hour of the administration of the psychiatric PRN medication and Stat medication and documents the individual's response.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006: Revise appropriate policies and procedures to ensure compliance with this requirement.</p>

		<p>Findings: NSH submitted the revised nursing policy 1131: PRN/STAT Medication Use For Physical And Psychiatric Symptom Management, which is in alignment with the EP.</p> <p>Recommendation 2, July 2006: Develop and implement a monitoring system to ensure that 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> <p>Findings: NSH has implemented an audit tool addressing this recommendation.</p> <p>Recommendation 3, July 2006: Provide staff training regarding policies/procedure changes and the documentation of specific indicators describing an individual's response to PRN and STAT medications.</p> <p>Findings: The HSSs are training staff weekly and will continue until all staff is fully trained. Training roster sheets provided by nursing supports this action.</p> <p>Recommendation 4, July 2006: Clarify and specify criteria regarding what should be included in the progress notes for item b.d on the NSH: PRN & STAT Progress Notes Monitoring Form to ensure accurate data.</p> <p>Findings: NSH reported that the monitoring form has been developed and implemented.</p>
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		<p>Other findings: From my review of the NSH monitoring tools, I found that none specifically addressed that 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. I found data indicating the individual's response to PRN and STAT medications, but not specifically within the one-hour time frame as noted in the EP.</p> <p>From my review of the records, I did not find consistent documentation of an assessment of individuals within one hour of the administration of the psychiatric PRN and STAT medications.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Implement a monitoring system to ensure that 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. 2. Continue to provide staff training regarding policies/procedure changes and the documentation of specific indicators describing an individual's response to PRN and STAT medications. 3. Continue to monitor this requirement.
e	A psychiatrist conducts a face-to-face assessment of the individual within 24 hours of the administration of a Stat medication. The assessment shall address reason for Stat administration, individual's response, and, as appropriate, adjustment of current treatment and/or diagnosis.	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, July 2006:</p> <ul style="list-style-type: none"> • Develop and implement a monitoring instrument to address this requirement. • Same as in recommendation #2 in H.6.a.

		<p>Findings: NSH has yet to adequately address these recommendations. See findings under F.1.b. and H.6.a.</p> <p>Compliance: Partial.</p> <p>Current recommendations: Same as in F.1.b and H.6.a.</p>
7	<p>Each State hospital shall ensure that all staff whose responsibilities include the implementation or assessment of seclusion, restraints, psychiatric PRN medications, or Stat medications successfully complete competency-based training regarding implementation of all such policies and the use of less restrictive interventions.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006: Improve and update training database to ensure compliance with this requirement.</p> <p>Findings: NSH has initiated a temporary training tracking system available on the group I drive until a permanent system can be developed and implemented.</p> <p>Recommendation 2, July 2006: Develop and implement competency-based training on the key elements of this requirement.</p> <p>Findings: NSH has initiated competency-based training to address the requirement of the EP. A system has been set up to retrain those who initially do not pass the training.</p> <p>Other findings: None.</p>

		<p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Implement a permanent training database to ensure compliance with this requirement. 2. Continue to develop and implement competency-based training regarding the elements of this requirement.
8	Each State hospital shall:	<p>Compliance: Partial.</p>
a	develop and implement a plan to reduce the use of side rails as restraints in a systematic and gradual way to ensure individuals' safety; and	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006: Develop and implement a system to monitor the key elements of this requirement.</p> <p>Findings: NSH has begun to meet weekly to address this requirement. A Monitoring form has been developed, but not implemented as of yet.</p> <p>Recommendation 2, July 2006: Evaluate, obtain, and maintain appropriate equipment needs for those individuals that warrant the use of side rails.</p> <p>Findings: This recommendation was not addressed by NSH as of yet. The need for high-low beds has not been fully addressed.</p> <p>Recommendation 3, July 2006: Develop, implement, and regularly review individualized plans for the</p>

		<p>reduction of side rails.</p> <p>Findings: Weekly reviews have been implemented. However, no data regarding this requirement has been generated thus far.</p> <p>Other findings: NSH has not submitted any data thus far regarding the progress of reduction in the use of side rails.</p> <p>From my review of the records of six individuals (JC, LH, CR, TR, LS and JW), I found no indication that individuals had a plan in place to reduce the use of side rails.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Implement a system to monitor this requirement. 2. Evaluate, obtain, and maintain appropriate equipment needs for those individuals that warrant the use of side rails. 3. Continue to develop, implement, and regularly review individualized plans for the reduction of side rails.
b	<p>ensure that, as to individuals who need side rails, their therapeutic and rehabilitation service plans expressly address the use of side rails, including identification of the medical symptoms that warrant the use of side rails, methods to address the underlying causes of such medical symptoms, and strategies to reduce the use of side rails, if appropriate.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006: Develop and implement a system to monitor the key elements of this requirement.</p> <p>Findings: NSH developed the Safety Restraints Reduction monitoring form that addresses the elements of this requirement. It has not yet been</p>

		<p>implemented.</p> <p>Recommendation 2, July 2006: Provide training to appropriate staff regarding individuals who need side rails, including identification of the medical symptoms that warrant the use of side rails, methods to address the underlying causes of such medical symptoms, and strategies to reduce the use of side rails, if appropriate.</p> <p>Findings: NSH does not yet have a system in place addressing this requirement.</p> <p>Other findings: None.</p> <p>Current recommendations:</p> <ol style="list-style-type: none">1. Implement a system to monitor the elements of this requirement.2. Provide training to appropriate staff regarding individuals who need side rails, their therapeutic and rehabilitation service plans expressly address the use of side rails, including identification of the medical symptoms that warrant the use of side rails, methods to address the underlying causes of such medical symptoms, and strategies to reduce the use of side rails, if appropriate.
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I	Protection From Harm	
	<p>Each State hospital shall provide the individuals it serves with a safe and humane environment and ensure that these individuals are protected from harm.</p>	<p>Summary of Progress:</p> <ol style="list-style-type: none"> 1. The hospital has revised policies and procedures that require the reporting of incidents and that provide protections to persons who report incidents. The hospital has a database maintained by Standards Compliance for serious incident data. The database has the capacity to produce reports on many of the variables (type, location, level of injury) required by the Enhancement Plan. Presently this system produces a monthly report on aggression; it is not used to produce other incident data reports on a regular basis. Thus, there is no tracking of patterns and trends and no identification of high-risk individuals and situations. 2. The hospital police also keep a database. Work needs to be done regularly to reconcile the hospital police database and the Standards Compliance database. The hospital police have agreed to send a copy of their data each month to Standards Compliance for this purpose. 3. Key indicator data is being collected in various databases and by hand on the units. However, there are no guidelines that identify the measures that are expected to be taken when an individual reaches a trigger. Thus, the numbers collected on key indicator data are presently serving a very limited purpose. Further, there is no mechanism in place to identify for the units the names of the individuals who have hit a trigger and mechanism to receive back from the unit information on the clinical response. Finally, there is no system in place that will allow Standards Compliance to review implementation of the measures on a sample basis. 4. The hospital has identified and corrected many suicide and self-harm hazards. It has undertaken semi-annual environmental inspections of each unit, which include attention to the personal care needs of individuals.

		<ol style="list-style-type: none"> 5. The hospital's present system for reviewing deaths cannot be relied upon to produce a report that addresses with sufficient vigor all relevant considerations. 6. A complete investigation file has not yet been compiled that includes all recommendations made and implemented. Working back through several investigations it was possible to find the corrective actions that had been implemented, but there is no single repository for this information. 7. The Cooperating Advisory Council meets monthly and reports that Administration is responsive to their concerns and responds in a timely manner. The Council conducts a survey each month on one unit.
1	Incident Management	
	<p>Each State hospital shall develop and implement across all settings, including school settings, an integrated incident management system that is consistent with generally accepted professional standards of care.</p>	<p>Methodology: Interviewed C. Black, Standards Compliance Director. Interviewed D. Hauscarriague, Senior Special Investigator. Interviewed D. Grundman, Special Investigator. Interviewed R. Eggers, Assoc. Mental Health Specialist in Standards Compliance. Interviewed D. Gardiner, Assoc. Mental Health Specialist in Standards Compliance. Interviewed D. Percy, Human Resource Manager. Interviewed J. M. Adams, Training Officer II. Interviewed L. Dean, Police Services Consultant. Interviewed S. Kessler, Patient Rights Advocate. Reviewed 12 Special Investigator (SI) investigations and 10 criminal Investigations. Reviewed hospital data on staff orientation training in abuse/neglect. Reviewed mandatory reporting acknowledgements in ten employee personnel files. Reviewed ADs #437 and #435. Reviewed hospital police and Standards Compliance incident logs. Observed changes made to Personnel Database.</p>

		Reviewed 23 Headquarter Reportable Incident Briefing Forms.
a	Each State hospital shall review, revise, as appropriate, and implement incident management policies, procedures and practices that are consistent with generally accepted professional standards of care. Such policies, procedures and practices shall require:	Compliance: Partial.
a.i	that each State hospital not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of individuals;	Current findings on previous recommendations: Recommendation, July 2006: Insert into ADs #435 and #437 (and wherever else appropriate) a strong statement that the hospital will not tolerate abuse or neglect. Findings: The hospital has implemented the recommendation. AD 435 was modified effective January 11, 2007 to include the following language. "No employee shall engage in, aid in the commission of, or willfully fail to report any type of abuse...." It further states that the hospital will ensure that individuals are protected from harm, and will not tolerate any form of individual abuse and/or neglect. AD #437 was also modified effective January 11, 2007 to include the same language indicating that the hospital will not tolerate individual abuse and/or neglect. It also contains the following language. "Several federal and California laws and regulations require all staff to report known or suspected instances of elder or dependent adult/child abuse. All instances of suspected or alleged abuse, abandonment, isolation and neglect shall be reported immediately." Other findings: None.

		<p>Current recommendation: Ensure that New Employee Orientation training and annual refresher abuse/neglect training includes a review of ADs #435 and #437.</p>
<p>a.ii</p>	<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 recommendations:</p> <p>Recommendation July 2006: Continue current practice.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. NSH has the policy framework to support the identification of incidents and their investigation. AD #437 provides definitions and reporting instructions for allegations of abuse and neglect. AD 435 provides the same framework for the identification, reporting and investigation of criminal acts and employee misconduct. 2. DMH is continuing work on the definitions of some sexual incidents. 3. With the maintenance of two incident databases—the SIR database and the hospital police database, some discrepancies in the data still exists related to categories and definitions of incident types. <p>Other findings: None.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Hospital police will share their incident log each month with the Standards Compliance Office. Standards Compliance will review the data and communicate with the hospital police about any discrepancies. Appropriate corrections will be made. 2. Continue work on incident definitions.

<p>a.iii</p>	<p>mechanisms to ensure that, when serious incidents such as allegations of abuse, neglect, and/or serious injury occur, staff take immediate and appropriate action to protect the individuals involved, including removing alleged perpetrators from direct contact with the involved individuals pending the outcome of the facility's investigation;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006: Revise ADs to include the instruction to attend to the safety of the individual first, including removing the alleged perpetrator from contact.</p> <p>Findings: The hospital has implemented this recommendation. AD #437 has been modified to include language that states: The protection of the individual's safety, physical and mental well-being shall be paramount. Protections include staff reassignment, placement of staff on administrative leave, individual room reassignment, unit transfers, etc.</p> <p>Recommendation 2, July 2006: Ensure information about attending to the safety of the individual first is included on all Special Investigation Reports alleging staff misconduct causing physical or psychological harm.</p> <p>Findings: A memo was sent to all Program Directors at the hospital on September 5, 2006 directing them to document on all SIRs the actions taken to ensure the safety of the victim and any other individuals at risk.</p> <p>Recommendation 3, July 2006: Include a copy of the Special Investigation Report in all investigation files. This will allow the facility to ensure proper actions were taken initially.</p> <p>Findings: A copy of the SIR was present in some, but not all of the investigation files reviewed. This is consistent with the hospital data which</p>
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		<p>indicated the 23% of the 44 relevant investigation files (July-December 2006) did not contain an SIR.</p> <p>Recommendation 4, July 2006: Add a cell to the Investigation Compliance Monitoring Form that checks for the presence of the SIR in the investigation case file.</p> <p>Findings: The hospital implemented this recommendation and has added this cell to the Investigation Compliance Monitoring Form. This information is also contained in the Hospital Police's Investigations data report. AD #437 was amended to include the requirement that all investigative files shall contain available copies of generated Special Incident Reports.</p> <p>Other findings: The Hospital Police Investigation data report (produced monthly) indicates that in the period from September 06 through December 06 eight cases that appear to require an SIR given their type did not have an SIR. It may be that upon further review the cases did not contain an allegation for which an SIR is required.</p> <p>Current recommendation: Provide a copy of the Hospital Police Investigation data report each month to Standards Compliance to enable that department to match the data against its database in order to be sure that all situations that require an SIR have one completed and logged into the Standards Compliance database.</p>
<p>a.iv</p>	<p>adequate competency-based training for all staff on recognizing and reporting potential signs and symptoms of abuse or neglect, including the precursors that may lead to abuse;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006: Add a meaningful competency component to the A/N orientation</p>

		<p>training.</p> <p>Findings: The present Elder and Dependent Adult Abuse Reporting post-test adequately tests competency with nine multiple-choice questions, two of which present scenarios involving events that might occur on a unit. One open-ended question asks the respondent to identify three possible indicators of abuse.</p> <p>Recommendation 2, July 2006: Ensure training clarifies the definition and common examples of neglect and the reporting responsibilities for neglect, as well as abuse.</p> <p>Findings: The training provides time for the discussion of real-life incidents that might occur on a unit. Similar scenarios are also presented in the post-test.</p> <p>Recommendation 3, July 2006: Within one year, ensure formal competency-based training regarding abuse and neglect is provided to staff annually.</p> <p>Findings: The hospital initiated annual abuse/neglect training for all staff on January 1, 2007 to be provided during the employee's birth month. This recommendation was implemented before the due date.</p> <p>Other findings:</p> <ol style="list-style-type: none"> 1. DMH, through the work of a police consultant, has developed a uniform training curriculum for incident management from recognition through investigation. The curriculum was designed for police officers. A number of the PowerPoint slides on the orientation abuse/neglect training contain legal definitions and
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		<p>complex sentences. Trainers must ensure that all staff in the class understands the content.</p> <p>2. In response to my request, the facility produced a report of the 107 staff members who had not received abuse/neglect reporting training during orientation. Later, a review of the actual training records of the first ten persons on the list indicated that seven had actually received abuse/neglect training, indicating the list was not accurate. With the initiation of annual abuse/neglect training, the demand for accurate training data will increase if the program is to be successful.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Include in the training not only hospital police but all staff members who may be investigating incidents and those who may be supervising and reviewing the investigations. This would include, but not be limited to, Program Directors, Hospital Administrators, Executive Directors and Central Office staff involved in incident management. 2. Provide "Train the Trainer" training for staff providing the abuse/neglect training at orientation and at the annual refresher to ensure they understand the content and can explain it when necessary in simple, straight-forward language. 3. Develop a database capable of identifying with accuracy staff persons who have missed specific trainings. 4. Develop a system whereby staff members and their supervisors are notified when a staff member has missed training and which ensures that the training is attended in a timely manner.
a.v	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	Current findings on previous recommendations:

	<p>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>Recommendation 1, July 2006: Increase the frequency of training and ensure, through testing, understanding of the material.</p> <p>Findings: The hospital began to require annual abuse training for all staff on January 1, 2007. This training will last for 90 minutes. New staff orientation training on abuse and neglect has been lengthened to two hours.</p> <p>Recommendation 2, July 2006: Add a check box to the personnel database for "delayed reporting" and design a report inquiry. Include "delayed reporting" under "charges" in the same database.</p> <p>Findings: This recommendation has been implemented.</p> <p>Other findings: A review of the personnel records of 10 staff members indicated that all had signed the statement indicating understanding of their responsibilities as mandated reporters of abuse and neglect.</p> <p>Current recommendation: Employ a system that accurately tracks attendance at training and advises employees and supervisors to ensure attendance.</p>
<p>a.vi</p>	<p>mechanisms to inform individuals and their conservators how to identify and report suspected abuse or neglect;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, July 2006:</p> <ul style="list-style-type: none"> • Develop and use a sign off sheet where private conservators indicate they have been advised of the rights of the individuals in care and have received a copy of the "How to File a

		<p>Complaint" procedures</p> <ul style="list-style-type: none"> • Add a cell on the Admission and Annual Audit form to indicate that the conservator has been made aware of the rights of individuals served and how to file a complaint. <p>Findings: These recommendations have not been implemented. Public conservators of individuals in Program 4 were provided a copy of the Protection and Advocacy, Inc. booklet that includes a statement of individuals' rights and procedures for filing a complaint.</p> <p>Recommendation 3, July 2006: Augment the rights information given to individuals and conservators that includes information on how to recognize abuse and neglect, asserts the right to be free from retaliation for reporting and explains procedures for reporting retaliation. Use easy-to-understand language. Provide this information in the individual's language of choice.</p> <p>Findings: The Protection and Advocacy, Inc. booklet that is given to individuals upon admission has not been modified or augmented to include the right to protection against retaliation for reporting incidents and does not include procedures for reporting retaliation.</p> <p>Other findings: Individuals are supposed to receive notice of their rights and sign an acknowledgement that this has occurred when they are admitted to the hospital and annually thereafter. A review of the records of 12 individuals on the units inspected revealed 42% were not current:</p>
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		<table border="1" data-bbox="1045 228 1766 727"> <thead> <tr> <th data-bbox="1045 228 1346 269">Individual's Initials</th> <th data-bbox="1346 228 1766 269">Date of Most Recent Signing</th> </tr> </thead> <tbody> <tr> <td data-bbox="1045 269 1346 305">HM</td> <td data-bbox="1346 269 1766 305">12/31/03</td> </tr> <tr> <td data-bbox="1045 305 1346 341">AG</td> <td data-bbox="1346 305 1766 341">4/26/03</td> </tr> <tr> <td data-bbox="1045 341 1346 376">NK</td> <td data-bbox="1346 341 1766 376">3/11/06</td> </tr> <tr> <td data-bbox="1045 376 1346 412">DA</td> <td data-bbox="1346 376 1766 412">5/31/06</td> </tr> <tr> <td data-bbox="1045 412 1346 448">CH</td> <td data-bbox="1346 412 1766 448">11/02/06</td> </tr> <tr> <td data-bbox="1045 448 1346 483">TF</td> <td data-bbox="1346 448 1766 483">11/30/06</td> </tr> <tr> <td data-bbox="1045 483 1346 519">MD</td> <td data-bbox="1346 483 1766 519">1/04/07</td> </tr> <tr> <td data-bbox="1045 519 1346 555">JY</td> <td data-bbox="1346 519 1766 555">1/03/04</td> </tr> <tr> <td data-bbox="1045 555 1346 591">AC</td> <td data-bbox="1346 555 1766 591">5/26/06</td> </tr> <tr> <td data-bbox="1045 591 1346 626">RJ</td> <td data-bbox="1346 591 1766 626">9/6/04</td> </tr> <tr> <td data-bbox="1045 626 1346 662">LG</td> <td data-bbox="1346 626 1766 662">2/10/02</td> </tr> <tr> <td data-bbox="1045 662 1346 698">MW</td> <td data-bbox="1346 662 1766 698">8/31/06</td> </tr> </tbody> </table> <p data-bbox="1045 773 1381 797">Current recommendations:</p> <ol data-bbox="1094 808 1927 1170" style="list-style-type: none"> <li data-bbox="1094 808 1927 911">1. Develop a clinical record monitoring system that identifies those individuals who have not signed the rights acknowledgement at the time of their annual review. <li data-bbox="1094 919 1927 1057">2. Develop and use a sign off sheet where private conservators indicate they have been advised of the rights of the individuals in care and have received a copy of the "How to File a Complaint" procedures <li data-bbox="1094 1065 1927 1170">3. Add a cell on the Admission and Annual Audit form to indicate that the conservator has been made aware of the rights of individuals served and how to file a complaint. 	Individual's Initials	Date of Most Recent Signing	HM	12/31/03	AG	4/26/03	NK	3/11/06	DA	5/31/06	CH	11/02/06	TF	11/30/06	MD	1/04/07	JY	1/03/04	AC	5/26/06	RJ	9/6/04	LG	2/10/02	MW	8/31/06
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a.vii	posting in each living unit and day program site a brief and easily understood statement of individuals' rights, including information about how to pursue such rights and how to report violations of such rights;	<p data-bbox="1045 1219 1644 1243">Current findings on previous recommendations:</p> <p data-bbox="1045 1292 1409 1317">Recommendation, July 2006</p> <p data-bbox="1045 1325 1371 1349">Continue current practice.</p>																										

		<p>Findings: The facility remains in compliance with this cell. All units I visited had rights posters on the walls.</p> <p>Other findings: None.</p> <p>Current recommendation: Continue current practice.</p>															
a.viii	procedures for referring, as appropriate, allegations of abuse or neglect to law enforcement; and	<p>Current findings on previous recommendations:</p> <p>Recommendation, July 2006: Continue current practice.</p> <p>Findings: The hospital has policies in place and a flow chart indicating the circumstances and the method by which hospital police report criminal matters to the District Attorney's office.</p> <p>A review of ten criminal investigation cases revealed that in each, the investigator provided a rationale for sending or not sending the case forward to the District Attorney. This determination was reviewed by a supervising officer. With the exception of one case, as shown below, the determination whether to forward the case to the DA was made in a timely manner.</p> <table border="1" data-bbox="1045 1192 1797 1421"> <thead> <tr> <th>Individual</th> <th>Incident Date</th> <th>DA notification determination date</th> </tr> </thead> <tbody> <tr> <td>MT</td> <td>10/18/06</td> <td>10/31/06</td> </tr> <tr> <td>WP</td> <td>10/22/06</td> <td>12/27/06</td> </tr> <tr> <td>OH</td> <td>11/20/06</td> <td>11/28/06</td> </tr> <tr> <td>WZ</td> <td>11/06/06</td> <td>11/06/06</td> </tr> </tbody> </table>	Individual	Incident Date	DA notification determination date	MT	10/18/06	10/31/06	WP	10/22/06	12/27/06	OH	11/20/06	11/28/06	WZ	11/06/06	11/06/06
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a.ix	<p data-bbox="296 688 1020 976">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 data-bbox="1045 688 1644 716">Current findings on previous recommendations:</p> <p data-bbox="1045 761 1402 789">Recommendation July 2006:</p> <p data-bbox="1045 797 1898 938">Establish a protocol within AD entitled "Prohibition from Retaliation for Persons Who Report Illegal Acts" whereby any entity receiving a complaint of retaliation will inform the Director of Human Resources who will keep a log of these complaints.</p> <p data-bbox="1045 984 1157 1011">Findings:</p> <p data-bbox="1045 1019 1925 1414">NSH has implemented this recommendation. AD #355 "Prohibition From Retaliation Against Persons Who Report Illegal Acts", effective August 24, 2006, states that no manager, supervisor, or employee shall take retaliatory action against another employee or other listed parties for reporting improper governmental activity. It also states that employees who believe they are being subjected to retaliatory measures should file a written complaint with the Executive Director within 30 days. The Executive Director will assign a staff member to conduct a management inquiry into the allegation and prepare a written report within 30 days of the assignment. The Personnel Dept. will be responsible for maintaining an audit log of all complaints filed and the</p>												

		<p>outcomes. This fulfills the intent of the recommendation.</p> <p>Other findings: None.</p> <p>Current recommendation: Ensure that AD 355 is reviewed during abuse/neglect orientation and annual training.</p>
b	<p>Each State hospital shall review, revise, as appropriate, and implement policies and procedures to ensure the timely and thorough performance of investigations, consistent with generally accepted professional standards of care. Such policies and procedures shall:</p>	<p>Compliance: Partial.</p>
b.i	<p>require investigations of all deaths, as well as allegations of abuse, neglect, serious injury, and theft. 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, July 2006: Route all Special Incidents and Headquarter Reportable Special Incidents through the Standards Compliance Office for tracking.</p> <p>Findings: The facility has implemented this recommendation. All SIRs are reported first to the Standards Compliance Office, where they are logged into the SIR database.</p> <p>Recommendation 2, July 2006: Give "read only" rights to this database to Hospital Police and Special Investigators. The Hospital Police may maintain a separate data collection system if it chooses.</p> <p>Findings: The hospital continues to maintain two databases related to incidents,</p>

		<p>and these databases sometimes contain inconsistent information. The Hospital Police maintain the Sergeant's log that logs in all criminal cases and a log of all cases that are reviewed for forwarding to the District Attorney's Office. The Office of the Special Investigator maintains a database of abuse/neglect allegations, and the Standards Compliance Department maintains the SIR database.</p> <p>Recommendation 3, July 2006: Write a procedure that ensures that all allegations related to abuse, neglect, serious injury or theft that are made to the PRA are put into a Special Incident Report form and entered into the Standards Compliance Database.</p> <p>Findings: The procedure described above has not been written.</p> <p>Recommendation 4, July 2006: Ensure the PRA is advised in writing of the determination at the close of an investigation, so that she can advise the complainant.</p> <p>Findings: According to the PRA, no system has been implemented which ensures that she is advised of the determinations in cases that originated in the PRA Office.</p> <p>Recommendation 5, July 2006: Create a complete case file at the close of an investigation. This will include the Special Investigator's report, the SIR and all SIR Briefing forms and communication between the Program Director and the Clinical Administrator.</p> <p>Findings: The investigation files reviewed did not include the SIR Briefing form</p>
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for Headquarter Reportable Incidents and did not contain communication between the Program Director and the Clinical Administrator. Since corrective measures would be documented in these forms and communications, the absence of these materials makes the file incomplete, as one cannot be sure if corrective measures were identified and implemented.

Recommendation 6, July 2006:

Train Program Directors to complete SIR Briefing forms and communications with the Hospital Clinical Administrators, at the close of an investigation, identifying all corrective actions in succinct, bulleted or numbered form. It may be helpful to redesign the form.

Findings:

Review of 23 SIR Briefing Forms covering October and November 2006 indicated that documentation of corrective actions had improved on 19 of the forms. The Briefing Form for the November 25, 2006 incident involving CW was considered inadequate because it provided no corrective measures directed toward the aggressor. Similarly the briefing form for the 9/19/06 incident involving EF was considered inadequate because the cause of the SIB was not identified and not addressed. In a separate form, there is no information regarding actions taken involving the staff member alleged to have been verbally abusive to RK on 10/06/06. Finally, in another form, the actions taken against a physician who called an individual an "idiot" (witnessed by staff) in the October 4, 2006 incident involving ZH were wholly inadequate.

Recommendation 7, July 2006:

Identify the best way to compile information on corrective measures, so that it is useful for identifying patterns and which also facilitates checks on implementation, in anticipation of creating a database.

		<p>Findings: The hospital has not yet begun to compile information on corrective measures related to incidents.</p> <p>Recommendation 8, July 2006: Ensure that, in determining how best to investigate serious injuries, the input of medical professionals is sought when the circumstances of an injury require it. See, however, "Other findings" below.</p> <p>Findings: AD #437 Abuse/Neglect and Reporting Requirements, effective January 11, 2007, states that investigators may seek the input of medical professionals when investigating the circumstances of a serious injury.</p> <p>Recommendation 9, July 2006: Change the format of the Mortality Review minutes to identify specifically actions taken to improve care. Consider the use of a table that identifies the case, the deficiency or "opportunity to improve care," the specific actions implemented and the date.</p> <p>Findings: The format of the Mortality Review minutes identifies deficiencies and opportunities to improve care.</p> <p>Other findings: The deaths of several individuals raised questions about the way in which they were reviewed. Specifically, the Mortality Review Committee identified deficiencies in care that one could argue required more aggressive action than was suggested or implemented. Because these were clinical matters, the SI investigation did not uncover them all:</p>
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		<ul style="list-style-type: none">• As an example, no pain assessments or orders for pain medication were provided to the decedent (case #06-08 as identified in the Mortality Review Committee minutes) in the month preceding his/her death. Additionally, intake and output documentation was incomplete. These were cited in the Mortality Review Committee minutes as problems. There is no indication that anyone is asking the question whether the care provided (or not provided) to the decedent was neglectful.• Similarly, the decedent (#05-17) also had no pain assessments completed as he was dying of cancer.• In another death (# 06-10), the Mortality Review Committee minutes state that the physician's several-hour delay in responding "was of a concern and possibly a factor in the patient's death." The note diminishes the responsibility of the physician, citing the lack of a clear written description of the responsibilities of the Noon/Day MOD. Again, there is no indication that anyone is looking at the actions of the physician in light of the professional responsibility or definitions of neglect. In addition, although the minutes recommend a letter of concern to the involved physician, this has not been done.• In the case (# 06-04) of RM, who had died several hours before being found dead in bed in the morning, the direct support staff were disciplined (salary reductions and change of assignments) for failure to complete bed checks and/or for false documentation that the dead individual was breathing and smoking in the courtyard. Although the autopsy showed potentially toxic serum levels of olanzapine and in May the Mortality Review Committee minutes state "the high level, if valid, may have caused a cardiac dysrhythmia and been the immediate cause of death, the committee reaffirmed its prior conclusion that the category of death was cardiac." There is no mention of the need for training/mentoring for this physician and no questions were raised about the supervision of
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		<p>this physician at the time of the death or in the future.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that investigation files are complete. This includes Headquarters briefing forms. 2. Open discussions with the PRA to identify a system to provide feedback at the close of those investigations that originated in the PRA Office. This system should likewise ensure that all allegations received through the PRA Office are filed on an SIR and SOC 341, as appropriate. 3. Critically review abuse/neglect allegations to ensure that all staff members are subject to the same level of corrective actions regardless of rank. 4. Identify and implement a death review process that measures the actions of staff, regardless of rank, against professional standards, performance expectations, and dependent adult abuse and neglect definitions.
<p>b.ii</p>	<p>ensure that only the State Hospital staff who have successfully completed competency-based training on the conduct of investigations be allowed to conduct investigations of allegations of petty theft and all other unusual incidents;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006: Ensure all staff persons reviewing incident reports and conducting investigations, particularly Program Directors, have had investigation training.</p> <p>Findings: The California Department of Mental Health, through the work of a Police Consultant has just completed a statewide training curriculum that includes training on incident investigation. If provided to Program Directors and clinical and administrative staff who may be reviewing investigations, it will address concerns about their ability to conduct, supervise and review investigations. It is anticipated that this training will be provided within the next six months.</p>

		<p>Recommendation 2, July 2006: Ensure the training has a test of competency.</p> <p>Findings: The new training curriculum contains competency tests in each teaching module.</p> <p>Other findings: Competent training for hospital police, Program Directors and persons reviewing investigations remains an area of need.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Approve the curriculum. 2. Mandate that Program Directors and any other staff who will be investigating, supervising or reviewing incident investigations be trained in this curriculum.
<p>b.iii</p>	<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, July 2006: Continue current practice.</p> <p>Findings: The hospital continues to be in compliance with the requirements of this cell. Several of the investigation files I reviewed had photos of injuries or property that had been destroyed. Several also had evidence logs.</p> <p>Other findings: None.</p>

		<p>Current recommendation: Continue current practice.</p>
b.iv	<p>investigations required by paragraph I.1.b.i, (above) require the development and implementation of standardized procedures and protocols for the conduct of investigations that are consistent with generally accepted professional standards. Such procedures and protocols shall require that:</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, July 2006: Review the Long Term Care Services State Hospital Special Investigations Manual to identify revisions that may be necessary to bring it into compliance with the Enhancement Plan.</p> <p>Findings: According to the Senior Special Investigator, this manual has been updated to include the requirements of the Enhancement Plan.</p> <p>Other findings: None.</p> <p>Current recommendation: Continue the review of investigations by hospital police supervisors and continue to require the supervisor's signature indicating that the investigation meets professional standards.</p>
b.iv.1	<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, July 2006: Track the date the Special Investigator receives notice of the incident (and put this date on the investigation report as well) and the date the first investigation steps are taken, to identify the source of the problem and take appropriate corrective actions.</p> <p>Findings: The more recent Special Investigation reports include the date on which the allegation was referred to the Special Investigations Unit,</p>

		<p>as well as the date the incident was reported. One is then able to determine if there was a delay in notifying the SI unit. The date of each interview is provided, thus enabling the reader to determine if the investigation began expeditiously. While it is possible to use this data to determine why investigations are not meeting this criterion, the hospital has not used the information for this purpose.</p> <p>Other findings: The hospital's aggregate data indicates varying degrees of success in meeting the requirement to begin an investigation within 24 hours as indicated below.</p> <table border="1" data-bbox="1045 672 1740 941"> <thead> <tr> <th>Month</th> <th>Sample Size</th> <th>% in compliance</th> </tr> </thead> <tbody> <tr> <td>July</td> <td>2</td> <td>50</td> </tr> <tr> <td>August</td> <td>18</td> <td>67</td> </tr> <tr> <td>September</td> <td>15</td> <td>87</td> </tr> <tr> <td>October</td> <td>9</td> <td>89</td> </tr> <tr> <td>November</td> <td>7</td> <td>57</td> </tr> <tr> <td>December</td> <td>2</td> <td>50</td> </tr> </tbody> </table> <p>It is also relevant that presently there are only two Special Investigators. Three more investigators are expected to be hired shortly.</p> <p>Current recommendation: Hire and train the new Special Investigators as quickly as possible.</p>	Month	Sample Size	% in compliance	July	2	50	August	18	67	September	15	87	October	9	89	November	7	57	December	2	50
Month	Sample Size	% in compliance																					
July	2	50																					
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December	2	50																					
<p>b.iv.2</p>	<p>investigations be completed within 30 business days of the incident being reported, except that investigations where material evidence is unavailable to the investigator, despite best efforts, may be completed within 5 business days of its availability;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, July 2006: Identify the factors that are contributing to the tardy initiation and lateness of completion of the Special Investigations.</p>																					

		<p>Findings: The hospital has made significant progress in completing investigations within the 30-business day time limit. In its self-assessment of 53 Special Investigations covering July-December 2006, 45 investigations (85%) were completed within the time limit. In my review of 11 Special Investigator investigations all but one was completed within the time limit. The investigation that did not meet the deadline did not involve individuals, but rather involved two staff. [September 26, 2006 incident involving EM and ND closed on November 30, 2006.]</p> <p>Other findings: None.</p> <p>Current recommendation: Continue to triage investigations as long as the Office of Special Investigator is not fully staffed.</p>
<p>b.iv.3</p>	<p>each investigation result in a written report, including a summary of the investigation, findings and, as appropriate, recommendations for corrective action. The report's contents shall be sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly and separately:</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation July 2006: Same as b.i.</p> <p>Findings: NSH has adopted a standard format for SI investigation reports that includes a summary of the investigation and findings. This format has resulted in reports that are easier to follow, present information in logical order and provide an explicit rationale for determinations. The investigation reports do not include recommendations for corrective actions, but do state that the report is being forwarded to the Executive Director, Clinical Administrator, Hospital Administrator, Program Office and Standards Compliance for further review and disposition.</p>

		<p>Other findings: Some programmatic corrective actions are identified on the SIR, which is often included in the investigation file. Other corrective actions are documented on the Headquarters Briefing forms. These documents are not included in the investigation file. Thus, there is no single depository where one can identify all corrective actions taken in response to an incident. Thus, it will be very difficult for Standards Compliance to monitor implementation of these measures until this is addressed.</p> <p>Current recommendation: Construct a uniform investigation file that captures all of the corrective actions taken in response to an incident.</p>
<p>b.iv.3(i)</p>	<p>each allegation of wrongdoing investigated;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, July 2006: Continue current practice.</p> <p>Findings: The investigation reports reviewed during this tour, like those reviewed during the baseline review, clearly identify the allegation of wrongdoing under investigation.</p> <p>Other findings: None.</p> <p>Current recommendation: Continue current practice.</p>

b.iv.3(ii)	the name(s) of all witnesses;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006: List witnesses (by name and title) at the beginning of the investigation report, where the allegation, alleged perpetrator and victim are identified.</p> <p>Findings: The hospital has implemented this recommendation. The new investigation report format includes the identification of witnesses on the title page.</p> <p>Recommendation 2, July 2006: Consider during supervisory review of investigations whether the report indicates any efforts/questioning to identify other possible witnesses, including staff on duty and individuals served.</p> <p>Findings: Witnesses that are identified by the individual or by staff members involved in the incident are interviewed. There are instances where investigators should be searching out witnesses who have not been identified in the SIR. These have not been identified during the supervisory review.</p> <p>Other findings: The investigation report concerning the October 6, 2006 incident involving RK, one witness (an individual) who alleged that RK was the victim of verbal abuse on a daily basis told investigators that there were no other witnesses. Investigators took this information as accurate and made no efforts to identify additional witnesses. Similarly, in the October 25, 2006 incident involving TH that included an allegation that TH and a staff member were having a sexual relationship, the investigator did not interview other individuals living</p>
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		<p>on the unit, but relied on the Program Director's report that no one else witnessed the alleged liaison between TH and the staff member.</p> <p>Current recommendation: Consider other individuals and staff, beyond those identified on the incident report, who may have heard or seen an incident. Document attempts to find these persons and interview them.</p>
b.iv.3(iii)	the name(s) of all alleged victims and perpetrators;	<p>Current findings on previous recommendations:</p> <p>Recommendation, July 2006: Continue current practice.</p> <p>Findings: As in the baseline review, all investigation reports reviewed identified the names of the alleged victims and perpetrators.</p> <p>Other findings: None.</p> <p>Current recommendation: Continue current practice.</p>
b.iv.3(iv)	the names of all persons interviewed during the investigation;	<p>Current findings on previous recommendations:</p> <p>Recommendation, July 2006: Include a list of all persons interviewed (with title/position) at the beginning for the investigation report with the other identifying information.</p> <p>Findings: Using the new format, the names of all persons interviewed appear on the face sheet.</p>

		<p>Other findings: In the October 6, 2006 incident involving RK, one person was interviewed in the hall. Unless there are extenuating circumstances, hallways and other public areas should not be used for interviews.</p> <p>Current recommendation: Be cognizant of the location of interviews both while conducting the investigation and in reviewing completed investigations to ensure privacy wherever possible.</p>
b.iv.3(v)	a summary of each interview;	<p>Current findings on previous recommendations:</p> <p>Recommendation, July 2006: Provide a fuller interview summary, indicating questions asked and the response.</p> <p>Finding: Interview summaries are more comprehensive when compared to the baseline review findings. Incident dated December 17, 2006 involving PN provides a good example of multiple interviews that are adequately summarized. These interviews address the location of each staff member when the alleged physical and verbal abuse occurred.</p> <p>Other findings: None.</p> <p>Current recommendation: Continue current practice.</p>
b.iv.3(vi)	a list of all documents reviewed during the investigation;	<p>Current findings on previous recommendations:</p>

		<p>Recommendation 1, July 2006: Photocopy the relevant portions of all documents reviewed and include these in the investigation file.</p> <p>Findings: Several of the investigations reviewed contained photocopies of pictures taken during the investigation. In other instances, the investigator cited specific information from a document, e.g. information regarding an individual's recent incident history, as in the investigation of the December 15, 2006 incident involving PA and review of an individual's clinical chart during the investigation of the October 30, 2006 incident involving GC.</p> <p>Recommendation 2, July 2006: List all documents reviewed with the other identifying information at the beginning of the report.</p> <p>Findings: NSH has implemented this recommendation. Documents reviewed are listed on the face sheet of the investigation summary.</p> <p>Other findings: None.</p> <p>Current recommendation: Continue current practice.</p>
b.iv.3(vii)	all sources of evidence considered, including previous investigations and their results, involving the alleged victim(s) and perpetrator(s);	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, July 2006:</p> <ul style="list-style-type: none"> • Document in the investigation that the incident history of the victim and the alleged perpetrator was reviewed and indicate the finding from this search.

		<ul style="list-style-type: none"> • See also the recommendations in b.i., which would facilitate the retrieval of this historical information. <p>Findings: The recommendations are not being implemented consistently. None of the investigations reviewed referenced the staff member's incident history. An individual's incident history was referenced in one report as noted in b.iv.3(vi).</p> <p>Other findings: None.</p> <p>Current recommendation: Document in the investigation that the incident history of the victim and the alleged perpetrator was reviewed and indicate the findings from this search.</p>
b.iv.3(viii))	the investigator's findings, including findings related to the substantiation of the allegations as well as findings about staff's adherence to programmatic requirements; and	<p>Current findings on previous recommendations:</p> <p>Recommendation, July 2006: Begin development of an integrated incident investigation system as described in b.i.</p> <p>Findings: As indicated in the preceding cells, the conduct and reporting of investigations has improved.</p> <p>Other findings: Problems remain in substantiation determinations and in determinations related to adherence to programmatic requirements. For example, in the November 4, 2006 incident involving EL, his injuries and the statements of staff witnesses indicated that EL was struck in the face by a staff member. The staff member said his</p>

		<p>actions were “not malicious or intentional—just a reaction” (to being hit in the shins by EL). The SI concluded that criminal charges would likely not be filed because “there was no willful cause by [the employee] to inflict pain/suffering upon a dependent adult.” The investigator sustained a “violation of employee ethics.” There was clearly sufficient evidence to sustain a charge of dependent adult abuse, and the investigation should have clearly stated this and made this determination. [The employee was terminated on February 1, 2007.]</p> <p>Current recommendation: Use DMH definitions in writing rationales for determinations. Apply the facts of the case to the definitions.</p>
<p>b.iv.3(ix)</p>	<p>the investigator’s reasons for his/her conclusions, including a summary indicating how potentially conflicting evidence was reconciled; and</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006: Include in the investigation reports a rationale for determinations that expressly weighs potentially conflicting evidence.</p> <p>Findings: In the investigations reviewed, there were few instances of credible conflicting information. Interviewing more people near the incident could have clarified some information. This would have been the case in the October 25, 2006 incident involving TH.</p> <p>Recommendation 2, July 2006: Conclude that an investigation is “undetermined” when the investigator cannot produce a convincing rationale for a determination of substantiated or unfounded.</p> <p>Findings: The Special Investigators defined their terms for determinations as</p>

		<p>follows: Sustained = preponderance standard met; not sustained = preponderance not met; unfounded = matter did not occur. There is no need to introduce the term "undetermined."</p> <p>Other findings: None.</p> <p>Current recommendation: Ensure that investigation reports explicitly discuss conflicting information and how it is being reconciled or, if reconciliation is not possible, why one set of facts is believed credible and another is not.</p>
<p>b.iv.4</p>	<p>staff supervising investigations review the written report, together with any other relevant documentation, to ensure that the investigation is thorough and complete and that the report is accurate, complete, and coherent. Any deficiencies or areas of further inquiry in the investigation and/or report shall be addressed promptly. As necessary, staff responsible for investigations shall be provided with additional training and/or technical assistance to ensure the completion of investigations and investigation reports consistent with generally accepted professional standards of care.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, July 2006: Review again the requirements of the Enhancement Plan with a more critical eye to compliance.</p> <p>Findings: As reported, the investigations have improved. Areas that need improvement and that supervising staff need to direct attention to include:</p> <ul style="list-style-type: none"> • Ensure that any rationale for a determination regarding abuse accurately quotes the DMH definition. Specifically, be aware that the definitions do not include "malicious intent". • Be aware of the need to look for possible additional witnesses to an incident. • Include the incident history of staff members, as well as individuals. • In one SI investigation reviewed the roles of the individuals involved were confused in the investigation report (10/6/06 incident involving PB and RK). Observe for this in the

		<p>supervisor's review.</p> <p>Other findings: None.</p> <p>Current recommendation: Look carefully for these types of problems and correct them and any others before investigation reports are finalized.</p>
<p>c</p>	<p>Each State Hospital shall ensure that whenever disciplinary or programmatic action is necessary to correct a situation or prevent reoccurrence, each State hospital shall implement such action promptly and thoroughly, and track and document such actions and the corresponding outcomes.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, July 2006: Continue current practice.</p> <p>Findings: From a limited review of incidents, it appears the hospital is taking appropriate disciplinary action in incidents involving psych technicians. It is unclear whether ADs related to abuse and neglect are being even-handedly applied to physicians.</p> <p>Other findings:</p> <ol style="list-style-type: none"> 1. A review of the disciplinary actions related to the incidents reviewed revealed that with the exceptions cited below related to the actions against physicians, they were appropriate. One staff member was terminated for physical abuse of an individual; a staff member received a counseling memo and required to attend additional training for taking a picture of individuals; a third staff member was issued a counseling memo for losing her keys, necessitating a search of the unit; and a fourth staff member was issued an unofficial letter of reprimand for delayed reporting. In contrast, the psychiatrist who called an individual an "idiot" to his face was asked only to "sign a training roster" indicating she had received a copy of

		<p>AD #437 (Abuse Reporting) because the Program Director determined there was no "malicious intent." See also b.i.</p> <p>2. As reported previously, some programmatic changes are reported on SIRs and additional ones are sometimes reported on the Headquarters Briefing Forms. There is no single repository for this information where a supervisor/administrator could read all measures taken and be assured that all corrective measures had been identified.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Undertake a review of the physician's actions cited above and determine if the response taken (or the lack of action taken) is consistent with the disciplinary actions in similar incidents that did not involve physicians. 2. Consider the advisability of putting in writing minimum disciplinary measures to be taken for specific violations involving abuse and neglect to ensure even-handedness. 3. Compile a complete investigation file.
d	Each State hospital shall have a system to allow the tracking and trending of investigation results. Trends shall be tracked by at least the following categories:	<p>Compliance: Partial.</p>
d.i	type of incident;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006: Determine the source of the problem. If the problem is that Standards Compliance is not receiving all abuse SIR reports and investigations, designate Standards Compliance as the first stop for the SIR.</p>

		<p>Findings: All SIR reports are going to Standards Compliance. There may be incidents reported on SOC 341 that are not being put on SIR forms. Because SOC 341 forms are not sent to Standards Compliance, when this happens they are not included in the SC incident database.</p> <p>Recommendation 2, July 2006: When the problem is corrected, begin to run reports on closed cases on the variables that the database can presently track. These include type of incident, location, date and time, alleged victim and alleged perpetrator.</p> <p>Findings: The hospital is not producing incident data reports as required.</p> <p>Other findings: The hospital is producing a monthly report of incidents of peer-to-peer and individual-to-staff aggression that includes historical data back to January 2005 and rates per 1000 patient days by program. Program 4 leads the hospital in peer-to-peer and individual -to-staff aggression across all months. This data indicates that hospital-wide the number of unique incidents approached or exceeded 100 each month from June 06 through October 06. The number was lower at 82 and 81 respectively in November and December.</p> <p>The hospital is not producing a report on other types of incidents. This means the hospital is not identifying those individuals who are most vulnerable—those who are seriously or repeatedly hurt—and those persons who are doing the hurting. For example, the data indicates that there are 14 individuals who had three or more episodes of aggression in one or more of the months in the period September through December 2006. The Program should be advised of the identity of these individuals and their victims, so that the behavior can</p>
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		<p>be addressed.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Create a timeline for the development of an integrated incident management system. 2. Begin producing monthly reports on incidents by type and level of injury initially. 3. Ensure that the reports identify persons being hurt and persons doing the hurting, particularly those whose names appear repeatedly. 4. Distribute these reports to those persons who can initiate a clinical and/or administrative response and monitor its effectiveness.
d.ii	staff involved and staff present;	<p>Current findings on previous recommendations:</p> <p>Recommendation, July 2006: Continue to work on the capacity to generate useful reports on a regular basis.</p> <p>Finding: This recommendation remains in effect. See d.i. for specific suggestions.</p> <p>Other findings: None.</p> <p>Current recommendation: Continue to work on the capacity to generate useful reports on a regular basis.</p>
d.iii	individuals directly and indirectly involved;	<p>Current findings on previous recommendations:</p>

		<p>Recommendation, July 2006: Continue to work on the capacity to generate useful reports on a regular basis.</p> <p>Finding: This recommendation remains in effect.</p> <p>Other findings: None.</p> <p>Current recommendation: As above.</p>
d.iv	location of incident;	<p>Current findings on previous recommendations:</p> <p>Recommendation, July 2006: Continue current practice.</p> <p>Finding: The SIR log identifies incident location, but the hospital is not using this information to identify patterns related to location.</p> <p>Other findings: None.</p> <p>Current recommendation: As above.</p>
d.v	date and time of incident;	<p>Current findings on previous recommendations:</p> <p>Recommendation, July 2006: Continue current practice.</p>

		<p>Finding: The SIR log identifies date and time of an incident, but the hospital is not using this information to identify high-risk days and times.</p> <p>Other findings: None.</p> <p>Current recommendation: As above.</p>
d.vi	cause(s) of incident; and	<p>Current findings on previous recommendations:</p> <p>Recommendation, July 2006: Identify a list of common causes of incidents to form the basis of a drop-down menu. The terminology used should be determined in collaboration with the hospital police and be consistent with the Aggression Reduction Training.</p> <p>Findings: This cell in the Enhancement Plan is causing problems. In an effort to come into compliance, the hospital police have included a field on their database called "cause". They are making reasonable determinations as to the cause of an incident in some cases, e.g. false report. In other instances the cause listed is only a guess, e.g. retaliation for the reporting of an earlier event, with little or no supporting evidence. Identifying the root causes of an incident takes considerable analysis and is generally done on very serious incidents--these include, but are not limited to, incidents involving serious injury, serious suicide or homicide attempts, sexual offending behavior, and death cases.</p> <p>Other findings: None.</p>

		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Commit to doing a thorough causal analysis that concludes in a written report of the analyses and conclusions for very serious incidents. 2. Consider permitting "cause" to be labeled "unknown" for those incidents that are not serious (as defined above) and where the cause is not apparent.
d.vii	outcome of investigation.	<p>Current findings on previous recommendations:</p> <p>Recommendation, July 2006: Continue current practice.</p> <p>Findings: The database kept by the hospital police identifies the determination (outcome) of the investigations, as does the SIR log. This information is not yet provided to the hospital in report form on a regular basis.</p> <p>Other findings: None.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Develop a report form that included essential basic information, type of incident, location and date and disposition as a first step in supplying the hospital with regular incident data. 2. Provide the names of alleged victims and perpetrators in incidents involving serious injury, death, abuse and neglect in a separate report that also includes type and date, so that the hospital can begin to identify repeat victims and aggressors.
e	Each State hospital shall ensure that before permitting a staff person to work directly with any individual, each State	<p>Current findings on previous recommendations:</p>

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.

Recommendation, July 2006:

No recommendation—based on limited information.

Other findings:

A review of the personnel files of 10 employees revealed that all had had drug screening and criminal background checks completed. As per current policy, checks were completed before hiring for those staff members most recently hired. Specific results include:

Initials	Date of Hire	Drug Screen	Criminal Check
ST	10/8/03	9/25/03	8/21/03
WM	11/1/06	9/29/06	9/15/06
ER	11/1/06	NA*	8/28/06
TM	11/8/06	10/23/06	10/13/06
TM	11/1/06	NA*	8/12/06
JM	11/1/06	9/26/06	9/18/06
NN	8/2/05	6/21/05	4/22/05
BS	5/10/04	12/21/04	4/6/04
ET	8/7/02	6/27/02	5/30/02
FL	11/8/06	10/10/06	9/11/06

NA* These staff members were transferring to NSH from another State facility. In these circumstances, according to the Human Resources Manager, a new drug screening is not required.

Compliance:

Substantial.

Current recommendation:

Continue current practice.

2	Performance Improvement	
	<p>Each State hospital shall develop, revise as appropriate, and implement performance improvement mechanisms that enable it to comply fully with this Plan, to detect timely and adequately problems with the provision of protections, treatment, rehabilitation, services and supports, and to ensure that appropriate corrective steps are implemented. Each State hospital shall establish a risk management process to improve the identification of individuals at risk and the provision of timely interventions and other corrective actions commensurate with the level of risk. The performance improvement mechanisms shall be consistent with generally accepted professional standards of care and shall include:</p>	<p>Methodology: Interviewed C. Black, Director of Standards Compliance. Interviewed R. Eggers, Office of Standards Compliance. Reviewed Key Indicator Data. Attended Cooperating Advisory Council. Conducted private interviews with 12 individuals.</p>
a	<p>Mechanisms for the proper and timely identification of high-risk situations of an immediate nature as well as long-term systemic problems. These mechanisms shall include, but not be limited to:</p>	<p>Compliance: Partial.</p>
a.i	<p>data collection tools and centralized databases to capture and provide information on various categories of high-risk situations;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, July 2006: Be mindful that the purpose of the collection of this information is to identify persons and situations that place individuals at risk of harm. Communicate the names of persons who reach key indicators triggers to the units and to the Hospital Clinical Director so that they can take action.</p> <p>Findings: The recommendation above has not yet been implemented.</p> <p>Other findings:</p> <ol style="list-style-type: none"> 1. A review of key indicators (abuse and neglect, suicide

		<p>attempts, and deaths) revealed that the numbers presented matched the information in the database from which it was derived. This is an improvement over the baseline. The trigger data, however, continues to serve a limited purpose. It does not identify persons who have hit a trigger, and there are no written expectations regarding what should occur when an individual hits a particular trigger.</p> <ol style="list-style-type: none"> 2. The WaRMSS "Quick Hits" system for automation of trigger data is scheduled to be available to each of the hospitals early in March 2007. <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Identify for hospital administrators and Program Directors the individuals who are hitting triggers in a timely manner. 2. Identify and promulgate expectations regarding the treatment response when an individual hits a trigger. This may include a list of possible actions to take, but the list should be specific to each Key Indicator. 3. Develop a system for receiving feedback from the units on the measures taken. 4. Develop a system for monitoring (on a sample basis) implementation of these measures.
a.ii	establishment of triggers and thresholds that address different levels of risk, as set forth in Appendix A; and	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006: Review the existing ADs related to the Key Indicators. Revise these as necessary to reflect the appropriate additional attention to be provided to an individual who has reached a trigger.</p> <p>Findings: This recommendation has not been implanted.</p>

		<p>Recommendation 2, July 2006: Establish a system whereby the unit is notified when an individual has reached trigger criteria and the unit responds in writing with corrective actions and target and/or completion dates.</p> <p>Findings: This recommendation has not been implemented.</p> <p>Recommendation 3, July 2006: Determine the best way to augment the present database to include corrective measures and dates of completion. May want to consider a drop-down menu for standard responses (as identified in the ADs), using some of the same actions presently listed in the Special Incident database (under Actions and Clinical Response) and adding additional ones, as well as space for a narrative for more individualized responses.</p> <p>Findings: This recommendation has not been implemented.</p> <p>Other findings: As noted, work on making the key indicator data useful in reducing an individual's risk of harm is just beginning and much work is yet to be done.</p> <p>Current recommendations:</p> <ol style="list-style-type: none">1. See a.i.2. Continue the work of reviewing and revising ADs that deal with Key Indicators.
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a.iii	identification of systemic trends and patterns of high risk situations.	<p>Current findings on previous recommendations:</p> <p>Recommendation, July 2006: See recommendations suggested earlier in this report.</p> <p>Findings: NSH has not taken action to present trends and patterns that identify high-risk individuals and situations.</p> <p>Other findings: None</p> <p>Current recommendations: Use the SIR database to produce reports that identify high-risk individuals (repeat victims and repeat perpetrators) and high-risk situations (location, time, shift, weekend vs. weekdays, etc.) Distribute widely the information that does not include individuals' names. Distribute reports with individuals' names to the appropriate clinicians and administrators who can effect change. Monitor on a selective basis the implementation and effectiveness of corrective actions.</p>
b	Mechanisms for timely interventions and other corrective actions by teams and disciplines to prevent or minimize risk of harm to individuals. These mechanisms shall include, but not be limited to:	<p>Compliance: Partial.</p>
b.i	a hierarchy of interventions by clinical teams that correspond to triggers and thresholds;	<p>Current findings on previous recommendations:</p> <p>Recommendation July 2006: See I.2.a.ii.</p> <p>Finding The hospital has not developed a hierarchy of responses to be enacted</p>

		<p>when an individual reaches a trigger.</p> <p>Other findings: None.</p> <p>Current recommendation: Continue work on the developing a system for identifying persons who hit a trigger, for developing a menu of possible responses and a method for the return of information regarding the implementation of the response to Standards Compliance.</p>
b.ii	<p>timely corrective actions by teams and/or disciplines to address systemic trends and patterns;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006: Review individuals' records, logs, and other documentation looking for under-reporting.</p> <p>Findings: This recommendation has not been implemented.</p> <p>Recommendation 2, July 2006: Establish a system of unannounced, frequent visits on the units by administrators.</p> <p>Findings: There have been no visits to the units by administrators for this purpose (looking for under-reporting of incidents).</p> <p>Recommendation 3, July 2006: Interview individuals served using a standard interview format, review the information gathered for patterns, and follow-up on issues raised, as reflected in individuals' responses to questions related to their safety.</p>

		<p>Findings: The Cooperating Council conducts a survey each month on one unit. Data from the November and December 2006 surveys on T-5 and T-17 are reported in cells related to First Amendment Rights and Due Process. The hospital has not indicated what steps it is taking to address the problems that are identified in the survey results.</p> <p>Other findings: None</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Enlarge the sample of individuals interviewed and use follow-up questions to identify the source of the problem. For example, if individuals are signing the form indicating they were advised of their rights, but are also indicating on the survey that they were not taught their rights, is the problem that they do not understand the form and it is not explained? 2. Identify and implement measures to address the survey items that are of the most concern. 3. Initiate reviews of logs and charts and interviews on the units to detect under-reporting of incidents.
<p>b.iii</p>	<p>formalized systems for the notification of teams and needed disciplines to support appropriate interventions and other corrective actions;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, July 2006: Same as in I.2.a.ii.</p> <p>Findings: As reported elsewhere, there is no system for notifying programs and disciplines of the individuals and situations that are identified in the trigger information that need their attention.</p>

		<p>Other findings: None</p> <p>Current recommendation: Begin work on a system for notifying programs and disciplines of individuals and situations that require their attention because triggers have been hit as recommended in a.i.</p>
b.iv	<p>formalized systems for feedback from teams and disciplines to the standards compliance department regarding completed actions; and</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, July 2006 Same as above.</p> <p>Findings: The hospital does not have in place a system for feedback from units and disciplines to Standards Compliance re: actions completed in response to Key Indicators.</p> <p>Other findings: None</p> <p>Current recommendation: Continue work on the development of a feedback loop. Perhaps initially a simple check-off sheet where the unit indicates from a menu of possible actions the one taken returned to Standards Compliance could be an initial step before a full data system is available.</p>
b.v	<p>monitoring and oversight systems to support timely implementation of interventions and corrective actions and appropriate follow up.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, July 2006: Same as in I.2.a.ii.</p>

		<p>Findings: Presently the hospital is not providing monitoring and oversight of the implementation of corrective measures.</p> <p>Other findings: None.</p> <p>Current recommendation: See b.iv.</p>
<p>c</p>	<p>Utilize, on an ongoing basis, appropriate performance improvement mechanisms to assess and address the facility's compliance with its identified service goals.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1, 2 and 3, July 2006:</p> <ul style="list-style-type: none"> • Identify how the self-assessment and the accompanying tools are to be used moving forward. • Make any changes to the instruments as needed. • Broaden the reviews to include staff that is not directly responsible for the issue under review to ensure objectivity. <p>Findings: In general, the self-assessment has been helpful in identifying work that needs to be done. Recommendations for modifying the tools are included throughout this report.</p> <p>Thus far, no evidence has been presented that indicates that the hospital is using staff not directly responsible for the issue under review to validate the data presented.</p> <p>Other findings: The performance expectations or internal controls identified within a department or discipline are best reviewed on a regular basis by at least two persons working independently. When the department is satisfied with its process, the data should be checked on a sample</p>

		<p>basis by someone not directly involved with the issue under review.</p> <p>Current recommendations:</p> <ol style="list-style-type: none">1. Continue work in improving the self-assessment tools as suggested in this report.2. Begin to validate the data using staff members not directly involved with the issue.
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3	Environmental Conditions	
	<p>Each State hospital shall develop and implement a system to review regularly all units and areas of the hospital to which individuals being served have access to identify any potential environmental safety hazards and to develop and implement a plan to remedy any identified issues, consistent with generally accepted professional standards of care. Such a system shall require that:</p>	<p>Methodology: Conducted environmental inspections of six units. Interviewed D. Matteucci, Interim Executive Director Interviewed A. Rust, RN Interviewed E. Arcale, RN Interviewed L. Turner, RN Interviewed M. McQueeney, Interim Hospital Administrator and former Chief of Plant Operations.</p>
a	<p>Potential suicide hazards are identified and prioritized for systematic corrective action, and such action is implemented on a priority basis as promptly as feasible;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, July 2006: Continue current practice.</p> <p>Findings: The facility completed a review of environmental suicide and self-injury hazards that rated hazards by seriousness. The hospital has eliminated many of these hazards and has made capital requests to finance others. Measures already implemented include, but are not limited to, removal of internal window bars and latches, replacement of shower heads, covers over sink plumbing, modifications in toilet stall supports and in cages for smoke detectors, and installation of personal alarm system in the courtyards.</p> <p>During this monitor's tour of the units I did not see any obvious suicide hazards and did see the changes described above. All individuals I questioned said they had an adequate and accessible supply of personal hygiene items.</p> <p>Other findings: An individual told a story of how he was wounded by a peer who broke off a portion of the plastic holder for paper toilet seat covers. It is</p>

		<p>not clear how common this is, but it warrants review.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Determine whether the plastic holders for toilet seat covers constitute a hazard. 2. Continue work on identifying and correcting suicide and self-injury hazards. 3. Ask individuals to identify uncorrected hazards—perhaps using the Cooperating Advisory Council survey.
<p>b</p>	<p>All areas of the hospital that are occupied by individuals being served have adequate temperature control and deviations shall be promptly corrected;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006: Supply each unit with a digital thermometer and collect information on common area and bedroom area temperatures when the outdoor temperature reaches health-endangering range. Hospital to determine that specific temperature.</p> <p>Findings: In the two units where this monitor asked to see the digital thermometer, staff was not able to produce them.</p> <p>Recommendations 2, 3 and 4, July 2006:</p> <ul style="list-style-type: none"> • Specify and circulate instructions to staff on how to respond to extremely warm temperatures. • Determine circumstances under which standard procedures may be waived in extreme situations. • Identify criteria for identifying individuals particularly at high risk during extremely hot weather and the appropriate interventions.

		<p>Findings: These three recommendations have been implemented.</p> <p>A Nursing Policy Guideline, effective September 15, 2006, addresses heat-related illnesses. A second, effective September 27, 2006 and titled Maintenance of Hydration, requires that when temperatures outside or within the unit reach 81 degrees or higher, the Fire Department will notify Central Nursing Services and the Dietetics Department. Some of the measures that will occur include: food service will provide extra fluids, fans will be placed in corridors, and the Unit Supervisor will record an hourly temperature in one activity area and one bedroom; outdoor activities (when temperatures are greater than 85 degrees) that require excessive energy or may cause a fluid balance deficit may be waived.</p> <p>The policy guidelines also identify persons who are particularly at risk and how to protect them.</p> <p>Recommendation 5, July 2006: Enforce procedures for the unannounced review of environmental conditions monthly.</p> <p>Findings: The hospital provided no evidence that unannounced environmental reviews are conducted monthly. The inspection form used during the twice yearly inspection of each unit requires the inspector to indicate whether monthly unit environmental rounds are performed, but no data was provided related to this criterion.</p> <p>Recommendation 6, July 2006: Establish a short check-list to ensure the availability of necessary supplies and acceptable unit conditions at the change of shift.</p>
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		<p>Findings:</p> <p>The hospital has developed a form that identifies the inventory (quantity) of personal hygiene items that may be maintained on a unit and serves as a form for ordering more. While this is likely a helpful form and procedure, it does not satisfy the intent of this recommendation, which was to provide a non-burdensome method to ensure that a unit is in good condition when it is turned over to the next shift.</p> <p>The inspection form used twice-weekly on all units requires the inspector to indicate if there is documentation that personal living space is monitored daily by staff. No data was provided regarding this requirement.</p> <p>Other findings:</p> <p>An inspection of six units revealed that generally common areas were clean, as were most bathrooms. However, several bedrooms had garbage and dirty clothes in them, leaving a bad odor (Units T-13 and T-1). A bathroom on A-9 was particularly dirty with toilet paper stuck to the wall and what looked like blood or feces on the ceiling of one toilet stalls. This monitor did not inspect T-6 and T-7 but walked through them, and was struck by the strong body odor smell upon entering (as was the escort).</p> <p>In several of the units toured, some individuals were wearing dirty clothes (fresh food stains) and needed to take a shower. Three Unit Supervisors or Shift Leaders indicated during the tour of their units that they require their units to do a general clean-up once a week.</p> <p>Compliance:</p> <p>Partial.</p>
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		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Enforce procedures for the unannounced review of environmental conditions monthly by program administrators and aggregate the resulting data. 2. Establish a short checklist to ensure the availability of necessary supplies and acceptable unit conditions at the change of shift. This should ensure quick identification of problems like those in the bathroom of A-9 cited above. 3. Focus attention on the personal hygiene of individuals who needs assistance/guidance as an integral part of wellness and recovery.
c	<p>Each State hospital reviews, revises, as appropriate, and implements procedures and practices so that individuals who are incontinent are assisted to change in a timely manner;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, July 2006: Maintain a list of individuals with problems with incontinence on each unit with check and change information, so that for those individuals where bladder control might be regained, there is data to determine if progress is being made.</p> <p>Findings: The hospital generated a list of 89 individuals with problems with incontinence. A review of the clinical records of five individuals randomly selected from that list indicated that incontinence was addressed in three (RM, JH and TE) and not addressed in two (TR and JB).</p> <p>This finding is not inconsistent with the hospital data for the two months in which it was collected (July and December 2006) that shows that 31% of the 35 individuals in the sample had incontinence identified in the WRP or as an open problem with a nursing care plan.</p>

		<p>Other findings: The Incontinent Care Flow Sheet and the hospital monitoring tool address most relevant areas, but not all.</p> <p>Compliance: Partial</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Add "skin checks" to the "action codes" on the incontinent flow sheet. 2. Add two additional issues to the hospital monitoring tool: <ul style="list-style-type: none"> • Bowel and Bladder sheet completed every 2 hours • Skin checks completed. 3. Include incontinence care in the WRP for those individuals for whom it is a problem.
d	<p>Each State hospital thoroughly reviews and revises, as appropriate, its policy and practice regarding sexual contact among individuals served at the hospital. Each State hospital shall establish clear guidelines regarding staff response to reports of sexual contact and monitor staff response to incidents. Each State hospital documents comprehensively therapeutic interventions in the individual's charts in response to instances of sexual contact; and</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, July 2006:</p> <ol style="list-style-type: none"> 1. Continue honest discussion on how to accommodate consenting couples, including in the dialogue individuals served who are part of the Cooperating Council. 2. Consider a mall "training" option for consenting couples on accommodations for intimate relationships, how to say "no" to specific acts, etc. <p>Findings: The Interim Executive Director reported that rather than deal with this issue on a hospital-by-hospital basis, DMH has decided to address sexual expression among individuals in care with guidance from Central Office.</p> <p>NSH continues to provide condoms to individuals.</p>

		<p>The minutes of the July Cooperative Advisory Council meeting indicate public sexual activity on the grounds was raised as a problem without satisfactory resolution, indicating guidance is needed.</p> <p>Other findings:</p> <ol style="list-style-type: none"> 1. The hospital's monitoring tool completed for eight incidents of sexual contact indicates that the hospital is most successful in documenting the incident and making the necessary notifications. It is most deficient in notifying the psychiatrist so that he/she can evaluate the individual for appropriate psychological care, WRPT evaluation of the need for additional actions and the provision of sex education. 2. AD #774 Sexuality and Safety of Individuals includes statements of sexual activity and non-sexual touching that is permissible. It also requires staff to intervene in incidents involving unsafe sex practices and/or where the sexual activity is "otherwise physically or psychologically injurious to any of the participants." It leaves unanswered the question of if, and where, mutually consenting individuals may engage in sexual activity using safe sex practices. <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Focus attention on the clinical team's response to incidents of sexual activity. 2. DMH should continue work on clear and comprehensive guidelines regarding sexual activity among individuals in care.
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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 recommendations:</p> <p>Recommendation 1, July 2006: Add training providing basic information on mental illness.</p> <p>Findings: This recommendation has been implemented. Mental Illness 101 has been added to the training for non-clinical mall providers.</p> <p>Recommendation 2, July 2006: Create a separate personnel category for non-level of care staff who provide mall services in order to be able to track their training records.</p> <p>Findings: This recommendation will be addressed in the new staff training database that will be available shortly.</p> <p>Recommendation 3, July 2006: Ensure critical trainings have a test of competency.</p> <p>Findings: This recommendation has been implemented.</p> <p>Other findings: None.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Continue current practice.</p>
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J	First Amendment and Due Process	
		<p>Summary of Progress:</p> <ol style="list-style-type: none"> 1. NSH has a functioning Cooperating Advisory Council (CAC) that meets monthly and that reports that the administration is responsive to their requests for information and to their concerns. The minutes of the CAC indicate that administrators accept invitations to be guests at the meetings to hear concerns and answer questions. 2. In interviews, individuals did not indicate that they had problems communicating with legal advisors or family when asked the direct question by this monitor. Individuals did say that the phone cards sold in the canteen were expensive.
	<p>Each State hospital unconditionally permits individuals to exercise their constitutional rights of free speech, including the right to petition the government for redress of grievances without State monitoring, and provides them due process.</p>	<p>Methodology: Attended the Cooperating Advisory Council Meeting on January 31, 2007. Interviewed 16 individuals during unit tours.</p>
		<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2006: Include on the Environmental Monitoring form an item to look for mail on the unit, with a goal of determining if mail is not being distributed in a timely fashion or not leaving the unit in a timely fashion.</p> <p>Findings: This recommendation was not implemented.</p> <p>Recommendation 2, July 2006: Include on the individual interview form questions about the mail, communication with the PRA and privacy during phone calls.</p>

Findings:

This recommendation has been implemented.

The results of the Individual Council Survey, conducted monthly on one unit, conducted on Units T-5 (November) and T-17 (December) indicate that in total 19 of the 23 individuals responding indicated they received their mail in a timely manner and unopened (83%)

Other findings:

1. The aggregate data presented by the hospital for the surveys cited above contains errors. Aggregate data for selected items from the T-5 and T-17 surveys cited above, based only on the number of individuals who actually responded, i.e. did not choose an NA response, taken from the raw data is as follows:

Question	# Responding	# Yes/ %Yes
Feel safe?	23	19/78
Envir. clean; have hygiene supplies?	25	21/84
Services address current & discharge needs?	19	14/74
Family, attorneys, etc. encouraged to participate?	24	19/79
Taught about medications?	24	21/88
Can communicate freely w/family, attorneys, etc.?	24	21/88
Grievance procedures work?	18	12/67
Taught about A/N and rights?	24	13/54

Question	# Responding	# Yes/ %Yes
Offered info/assistance in preparing writs?	15	8/53

2. During the CAC meeting this monitor attended and during private interviews, several major issues surfaced as requiring attention. Again, these were reported to this monitor:
- The use of Tagalog by staff members, including nurses, hospital police and physicians, in front of individuals who do not understand the language. Almost unanimously, individuals attending the CAC meeting agreed this was a problem. This practice reported that it makes them angry, suspicious, and feel demeaned.
 - The use of drugs in the hospital brought in by staff was cited by individuals most often as the reason that they do not feel safe. Individuals also cited the practice of individuals selling or trading medications prescribed for them. Individuals said they could get anything they wished from heroin to Ativan.
 - The perception that discharge criteria do not remain fixed, so that when an individual attains discharge criteria, someone on the team decides there is something else he/she must do.
 - The adverse effect that numerous staff resignations and changes have on individuals. Individuals reported that with staff changes they feel that they have to start all over again, showing new clinicians who they are and how far they have come. Individuals also cited the loss of or reduction in 1:1 time with psychiatrists, psychologists and social workers.

		<p>Compliance: Partial.</p> <p>Current recommendation: Address these issues with the Cooperative Advisory Council, explaining what the hospital is doing and plans to do in response.</p>
MES 022807		