

REPORT 1
PATTON STATE HOSPITAL BASELINE EVALUATION

December 4-8, 2006

THE HUMAN POTENTIAL CONSULTING GROUP
ALEXANDRIA, VIRGINIA

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 Patton State Hospital (PSH) from December 4 to 8, 2006 to evaluate the facility's compliance with the Enhancement Plan (EP). The evaluators' objective was to develop a detailed baseline assessment of the status of compliance with all action steps of the EP.

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

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

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

B. Methodology

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

C. Findings

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

1. Key Indicator Data

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

- a) The key indicator data provide a global assessment of the clinical and process outcomes at the facility and should not be seen as just another requirement of the EP. In their totality, the key indicator data provide an index of the facility's performance.
- b) The data collection and aggregation is currently consolidated under the Director of Standards Compliance, who has provided effective leadership in this regard.
- c) At present, the key indicators vary in their completeness, consistency and reliability. The following are examples of some deficiencies that must be corrected before the data can be used to drive changes in processes at the facility and/or improve the functional status of the individuals:
 - i. The reliability of the data is an issue that must be addressed by the facility (e.g., data related to individuals' non-adherence to their Wellness and Recovery Plans, some physical health indicators and the use of PRN and Stat medications).
 - ii. There is a need to accelerate efforts to automate data collection systems to improve consistency and timeliness in the gathering, aggregation and presentation of data across all facilities. In particular, the WRP data must be computerized and properly linked to the MAPP program. In addition, the facility needs to ensure consistency of the MAPP program in recognizing all active treatment interventions on the individual's schedule.
 - iii. There is underreporting of medication variances. The data are based on a collection tool that fails to address many required elements and staff is not well-educated regarding importance and appropriate methods of reporting.

2. Monitoring and mentoring

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

- a) The facility's self-assessment data generally had integrity, were reasonably well organized and the data presented were relevant to requirements of the EP.

- b) Many of the facility's monitoring tools are well aligned with the requirements of the EP. Examples include the tools related to WRP Process Observations and WRP Chart Audits, the tools to assess psychiatric assessments and reassessments, inter-unit transfer assessments, court assessments, nutrition assessments and some aspects of medical service delivery.
- c) Not all the tools are accompanied by instructions and operational definitions that can standardize the use within and across the facilities.
- d) Many of the self-assessment data relevant to medical services did not include the standards used to determine compliance.
- d) The ratings were mixed. Some ratings closely matched those of the Court Monitor's expert consultants (e.g., many indicators of psychiatric assessments, reassessments, court assessments and nutrition assessments). However, other ratings significantly differed from findings of the Court Monitor's expert consultants.
- e) In many cases, the sample size monitored was far too small to be meaningful and the method of selection unstated. The sample size must be representative of the total population or subpopulations that are being assessed.
- f) With few exceptions, section leaders and staff presenting the data to the Court Monitor's team were well-informed about their data.
- g) In some cases, the data analyses were substandard and the interpretation of the data was inadequate.
- h) There was minimal indication that the data were used to enhance clinical practice.
- i) There is no reliability data on internal monitoring. Approximately 20% of the data collected should be assessed for reliability.
- j) Monitoring is not always undertaken by staff that is trained to competency in the process of monitoring. The frequent change in the core of monitors is a systems deficit that must be corrected.
- k) All monitoring tools must be standardized for use statewide.
- l) Given the amount of monitoring that is required, the tools and data collection must be automated.

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

3. Self-Evaluation

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

- a) In the process of verifying the validity and reliability of the data, the Court Monitor and expert consultants require that the facilities readily and clearly demonstrate methods of data collection, where the data are documented and information about timeliness, completeness and quality of the documentation.
- b) 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.
- c) The matrix model used by the facility highlights the administrative leadership of the Program Directors, but the EP requires the clinical chiefs to be held accountable for the clinical outcomes. Thus, the clinical chiefs appear to have the responsibility but not the authority to implement and produce the outcomes expected by the EP.

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 individuals' quality of life.
 - 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.
 - v. The DMH-approved monitoring system has the potential to demonstrate the effectiveness of the recovery-oriented psychiatric rehabilitation of the individuals served in the DMH forensic hospitals.

- vi. The training provided regarding the recovery model is excellent, but it has not yet reached the level of care staff in a manner that can significantly improve the functioning and lives of the individuals. In some cases, the individuals being served appear to have a better understanding of what recovery means than the staff providing the services.
- vii. In general, the Court Monitor's team found strong administrative leadership at PSH.
- viii. The Medical Staff has made positive changes under the current leadership of the Department of Psychiatry and the Medical Staff. However, the current lack of senior psychiatrists has impeded further efforts to implement the EP. Other barriers include support staff shortage, lack of office space and the backlog at the transcription service. Medical Staff can make an enormous difference in implementing requirements of the EP and these barriers must be addressed and corrected.
- ix. The Court Monitor's team found generally good collaboration between psychiatrists and psychologists at the facility. This can greatly facilitate proper implementation of the EP.
- x. The current charting system requires major overhaul in order to ensure proper implementation of the EP. The charts must be reorganized in a manner that facilitates access by clinicians to needed data, especially in an emergency. The current system is archaic, overly redundant and the physical structure of the charts precludes review of needed data. Lack of automation is a major barrier.

b) Function of current and planned implementation:

- i. Although there is an excellent manual of WRP, the implementation of the principles and practice requirements outlined in this manual is, in general, inadequate. The content of the WRPs is deficient in almost all the key components, including case formulation, foci of hospitalization, objectives and interventions.
- ii. Many staff members are not familiar with the actual requirements of the EP and therefore have little knowledge of the key changes that they need to make.
- iii. Although some professionals and direct care professionals have embraced the new model, some key providers have not yet learned the model or accepted its potential to achieve the desired outcomes.
- iv. Staff is not fully conversant with the recovery model, concepts of psychiatric rehabilitation, and the PBS and BY CHOICE systems. Most of the interdisciplinary providers are not yet trained to competency regarding the principles and practice of the new model. In some cases, individuals being served appear to have better understanding of the recovery model than the providers of care.
- v. Functional outcomes of the current structural changes are yet to be identified and implemented to guide further implementation.
- vi. Like at other hospitals, the recovery model has yet to be ingrained in the culture of service delivery. In general, staff appears to utilize the format of the new system to transfer the same content of the old system.

- vii. This hospital has yet to implement a system to ensure linkage between interventions provided at the PSR Mall and objectives outlined in the WRP. At present, there is a disconnection between the Mall activities and the WRP and between the Mall Manual and actual group interventions.

5. Staffing

The PSH staffing table below shows the staffing pattern at the hospital as of September 30, 2006. These data were provided by the California DMH. The table shows that there is a major shortage of staff in several key areas: staff psychiatrists, senior psychiatrists, senior psychologists, pharmacists, social workers and rehabilitation therapists.

Identified Clinical Positions	Budgeted Positions (06/07 FY)	Filled	Vacancies
Assistant Chief Education CPS	1.00	1.00	0.00
Assistant Coordinator, Nursing Services	5.00	5.00	0.00
Assistant Director, Dietetics	4.00	4.00	0.00
Audiologist I	1.00	1.00	0.00
Chief Dentist	1.00	1.00	0.00
Chief Physician and Surgeon	1.00	1.00	0.00
Chief, Central Program Services	1.00	0.00	1.00
Clinical Dietician/Pre-Reg. Clin. Dietician	9.00	8.00	1.00
Clinical Laboratory Technologist	1.00	1.00	0.00
Coordinator, Nursing Services	1.00	1.00	0.00
Coordinator, Volunteer Services	1.00	1.00	0.00
Dental Assistant	4.00	4.00	0.00
Dentist	2.00	2.00	0.00
Dietetic Technician	4.00	3.00	1.00
E.E.G., Technician	0.00	0.00	0.00
Hospital Worker	0.00	0.00	0.00
Health Record Technician	10.40	4.00	6.40
Health Services Specialist	24.00	22.00	2.00
Institution Artist Facilitator	0.00	0.00	0.00

Identified Clinical Positions	Budgeted Positions (06/07 FY)	Filled	Vacancies
Licensed Vocational Nurse	83.00	83.00	0.00
Medical technical Assistant	0.00	0.00	0.00
Nurse Instructor	5.00	4.00	1.00
Nurse Practitioner	3.00	3.00	0.00
Nursing Coordinator	11.00	11.00	0.00
Office Technician	36.00	25.00	11.00
Pathologist	0.00	0.00	0.00
Pharmacist I	13.00	8.50	4.50
Pharmacist II	1.00	1.00	0.00
Pharmacy Services Manager	1.00	1.00	0.00
Pharmacy Technician	11.00	10.60	0.40
Physician & Surgeon	20.00	18.90	1.10
Podiatrist	1.00	1.00	0.00
Pre-Licensed Pharmacist	0.00	0.00	0.00
Pre-licensed Psychiatric Technician	13.00	13.00	0.00
Program Assistant	8.00	6.00	2.00
Program consultant (RT, PSW, Psych)	2.00	2.00	0.00
Program Director	8.00	8.00	0.00
Psychiatric Social Worker	99.70	91.75	7.95
Psychiatric Nursing Education Director	1.00	1.00	0.00
Psychiatric Technician	611.50	611.50	0.00
Psychiatric Technical Trainee	0.00	0.00	0.00
Psychiatric Technician Assistant	44.10	39.00	5.10
Psychiatric Technician Instructor	1.00	1.00	0.00
Psychologist-HF, (Safety)	48.60	46.00	2.60
Public Health Nurse II/I	2.00	2.00	0.00
Radiologic Technologist	1.00	1.00	0.00
Registered Nurse	290.70	290.70	0.00
Reg Nurse Pre-Registered	0.00	0.00	0.00

Identified Clinical Positions	Budgeted Positions (06/07 FY)	Filled	Vacancies
Rehabilitation Therapist	72.30	59.25	13.05
Special Investigator	2.00	2.00	0.00
Speech Pathologist I	1.00	1.00	0.00
Sr. Psychiatrist	3.00	0.00	3.00
Sr. Psychologist	6.70	0.00	6.70
Sr Psych Tech (Safety)	74.00	74.00	0.00
Sr Radiologic Technologist (Specialist)	1.00	1.00	0.00
Sr. Voc. Rehab Counselor/Voc. Rehab. Counselor	2.00	2.00	0.00
Staff Psychiatrist	85.80	66.00	19.80
Supervising Registered Nurse	7.00	7.00	0.00
Teacher-Adult Educ. /Vocational Instructor	14.90	11.00	3.90
Teaching Assistant	1.00	0.00	1.00
Unit Supervisor	28.00	27.00	1.00
Vocational Services Instructor	1.00	1.00	1.00

In addition, PSH has data to indicate that in order to meet requirements of the EP (regarding WRP staff to individual ratios), the facility needs to recruit many additional staff on the admissions and long-term units. At this time, only two long-term teams (on one unit) are in compliance with this requirement. In order to meet requirements of the EP, the additional numbers required from each discipline are identified in the table below:

Discipline	Admissions units	Other units
Psychiatrist	3	4
Psychologist	6	28
Social Worker	1	2
Rehabilitation Therapist	1	18

At this time, staffing shortage is the central and overriding issue that impedes proper implementation of the EP at PSH and most of the other hospitals. This shortage is detrimental to the clinical care of individuals served in DMH forensic hospitals. The situation is more dire now than it was at the time of the initial investigations by the DOJ and the facilities appear to have reached

a crisis point. PSH has attempted many ways of recruiting and retaining staff, but has not been successful in filling their vacancies. The recent actions of the Court Receiver at the California Department of Corrections and Rehabilitation (CDCR), especially the pay raises in the specialties of psychiatry, psychology, nursing and pharmacy, have obviously had a negative impact on recruitment and retention of DMH staff. DMH must seriously consider contracting with a staffing and consulting company with national experience in recruiting professional clinical staff.

D. Monitor's Evaluation of Compliance

The status of compliance is assessed considering the following factors:

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

E. Next Steps

1. The Court Monitor's team is scheduled to tour NSH January 29 to February 2, 2007 for a follow-up evaluation.
2. All compliance reports should be reviewed and utilized, as applicable, by all facilities to guide implementation efforts regardless of the schedule of facility-specific assessments.

Section	Enhancement Tasks	Monitoring Instruments Source Documents	What the Court Monitor will be looking for
A	Definitions		
1	Effective Date		
	The Effective Date will be considered the first day of the month following the date of execution of the agreement by all parties. Unless otherwise specified, implementation of each provision of this Plan shall begin no later than 12 months after the Effective Date.		
2	Consistent with <i>Generally Accepted Professional Standards of Care</i>		
	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. PSH is transitioning from a traditional medical, psychiatric, and forensic model of care to a person-centered wellness and recovery system. 2. PSH has a Wellness and Recovery Plan (WRP) manual that codifies state-of-the-art elements in recovery-oriented services for individuals with serious mental illnesses. 3. PSH provides services within an interdisciplinary team model. 4. PSH has a substance abuse program that is guided by the generally accepted trans-theoretical model of care and the skills training for people with schizophrenia model. 5. Many of the providers at PSH are dedicated and caring professionals who are making a sincere effort to provide services within the new system. 6. PSH has implemented the new template for the Wellness and Recovery Plan (WRP) in all of its programs. 7. PSH has initiated a new model of providing services to individuals through the Psychosocial Rehabilitation (PSR) Mall. This model represents current professionally accepted standards in psychosocial rehabilitation of individuals with serious mental illnesses in hospital settings. 8. PSH has developed and implemented a variety of monitoring instruments, including both process observations and chart audits, to assess its compliance with the EP. Most of the monitoring instruments are aligned with requirements of the EP. 9. PSH has completed a reasonably thorough and well-organized self-assessment process based on current monitoring instruments. The process has heightened staff's awareness of the EP and its expectations. <p>PSH made successful efforts to train many staff to use the new monitoring instruments.</p>

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: Interviewed Raafat Girgis, M.D., Chief of Medical Staff. Interviewed Wadsworth Murad, M.D., Acting Chief of Psychiatry. Interviewed Jean Barawad, Assistant Deputy Director. Interviewed Randy Bohlmann, Nursing Coordinator, Standards Compliance. Interviewed Garilyn Richardson, Standards Compliance Director. Observed WRP team meetings for monthly review of AA. and DP. Observed WRP team meetings for 7-Day/14-Day review of LH, FF and JW. Observed WRP team meeting for quarterly review of JRM. Reviewed the DMH WRP Manual (Draft July 7, 2006). Reviewed A.D. #15.42 Wellness & Recovery Plan. Reviewed DMH Psychosocial Rehabilitation Malls Manual. Reviewed DMH BY CHOICE Manual. Reviewed AD #15.38 BY CHOICE System. Reviewed DMH SO #130.01 The BY CHOICE Incentive System. Reviewed DMH PBS Manual. Reviewed DMH SO #129 PBS. Reviewed AD #15.09 PBS Program. Reviewed DMH WRP Observation Monitoring Form. Reviewed WRP Observation Monitoring Form Instructions. Reviewed Observation Monitoring Summary Data (August to October 2006). Reviewed DMH Chart Audit Form. Reviewed Chart Audit Monitoring Summary Data (May to October 2006). Reviewed PSH WRP Team Attendance/Nursing Participation Audit. Reviewed Team Attendance Summary Data August to October 2006. Reviewed Audit for Timeliness and Completeness of Documentation Form. Reviewed Audit for Timeliness and Completeness of Documentation</p>

		<p>Monitoring Summary Data (September and October 2006). Reviewed WRP Phase I Training Post Test. Reviewed facility's data regarding core membership of the WRP teams.</p>
a	<p>Have as its primary objective the provision of individualized, integrated therapeutic and rehabilitation services that optimize the individual's recovery and ability to sustain himself/herself in the most integrated, appropriate setting based on the individual's strengths and functional and legal status and support the individual's ability to exercise his/her liberty interests, including the interests of self determination and independence.</p>	<p>Findings: PSH utilizes the draft DMH WRP manual. The manual (section 3. Assessments, 3.2 Integrated Assessments, 3.4 Strengths, 3.5 stages and Readiness of Change) contains state-of-the-art principles and practice requirements in recovery-oriented services that meet the requirements in this section.</p> <p>The facility has a variety of Manuals, Administrative Directives and DMH Special Orders that relate to components of this requirement but do not adequately address the requirement. These include A.D.#15.42 - Wellness & Recovery Plan, Psychosocial rehabilitation Mall Manual, BY CHOICE Manual, SO #130 BY CHOICE, PBS Manual, SO #15.09 PBS, and AD #15.09 PBS Program.</p> <p>PSH does not have a monitoring tool or a mechanism to assess its compliance with this requirement.</p> <p>This monitor's observations of WRP team meetings (see C.1.b. through C.1.f) and review of charts (see C.2) indicate that, in general, the process and content of Wellness Recovery Planning at PSH 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>Recommendations: 1. Finalize, approve and implement the DMH WRP manual.</p>

		<ol style="list-style-type: none"> 2. Ensure that all ADs, SOs and Manuals that address Wellness and Recovery Planning are aligned with the DMH WRP manual. 3. Provide documentation that WRP team members have been trained to competency. 4. Continue and strengthen current training program. In addition, the facility needs to ensure that each program has a dedicated trainer, to build the competency of program trainers and to increase training sessions for all members of the WRP teams. 5. Provide monitoring data that address this requirement. 6. Streamline and refine current WRP monitoring instruments to reflect the specific recommendations in each of sections C.1.b through C.1.g below. The monitoring instruments should contain operational criteria that address the specific requirements in each section. 7. Standardize the WRP monitoring instruments and sampling methods across State facilities. 8. Ensure that monitoring data are based on adequate monthly samples of at least 20% of team meetings and charts. This recommendation is relevant to all applicable items in Sections C.1. and C.2. 9. Ensure a stable core of process observers and chart auditors who have been trained to competency by the State consultants.
b	Be led by a clinical professional who is involved in the care of the individual.	<p>Findings: At PSH, the attending psychiatrists are designated as the team leaders and coverage is provided by other professionals, usually another psychiatrist in the same program, during the absence of the designated leaders.</p> <p>DMH Wellness and Recovery Plan Manual (page 5) describes the functions and responsibilities of the Team Leader. In reviewing the</p>

		<p>DMH WRP manual, this monitor observed that the sequence of tasks identified in the manual regarding the team members' responsibilities does not include the responsibility of the leader to ensure that members: a) communicate results of the assessments prior to the planning process; b) understand the parameters for meaningful participation by the individual in the WRP meeting; and b) update the present status section of the case formulation. The DMH WRP manual includes team responsibilities at 7-Day, 14-Day, monthly, quarterly and annual conferences. The responsibilities at the 14-Day and monthly reviews do not include discussion of Positive Behavior Support (PBS), data regarding monitoring instruments (MOSES) and the individual's current medical status.</p> <p>PSH has a Performance Profile for its psychiatrists that include interdisciplinary team leadership. The document does not include objective criteria to evaluate this function.</p> <p>The facility used the DMH WRP Process Observation Form (7-Day/14-Day) to assess compliance with this item. Six auditors, all nursing staff, were trained by the State consultants and inter-rater reliability checks were conducted by the consultants. The auditors observed WRP Conferences (7-Day/14-Day). The sample was randomly selected to represent all team leaders. During the months of August to September 2006, 60 WRP conferences were observed. The data show 6% compliance with the monitoring indicator that "the team leader synthesized the assessments prior to the WRP and provided an overview of the assessments findings."</p> <p>In addition, the unit supervisors or designees attended 100% of all WRP conferences and completed the PSH WRP Team Attendance/Nursing Participation Audit. This audit assessed participation by all core members of the WRPs, including the psychiatrists. The audits were completed for the months of August</p>
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		<p>to October 2006. The compliance rates, by discipline, were: 86% (Individual), 92% (Psychiatrist), 63% (Psychologist), 80% (Social Worker), 79 (Rehabilitation Therapist), 63% (Registered Nurse) and 60% (Psychiatric Technician).</p> <p>The facility identified that the attendance rates for Registered Nurses/Psychiatric Technicians were overestimated because the team coordinators were counted as core members.</p> <p>The facility does not monitor actual participation by psychiatrists or the covering professionals as team leaders.</p> <p>The team meetings that this monitor attended included participation by psychiatrists as team leaders in all cases. However, the team meetings demonstrate that the team leaders do not perform their primary function of ensuring a structure that allows members to: a) provide, combine and coordinate their efforts; b) address all relevant planning issues during the meeting time; and c) obtain meaningful input from the individuals. The teams spent most of the meeting times in conducting a series of disciplinary assessments rather than actual planning of services. The individuals' participation was mostly limited to answering questions during these assessments.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none">1. Monitor both presence and proper participation by the team leaders in all WRP meetings.2. Develop and implement a peer mentoring system to ensure competency in team leadership skills.3. Develop a Department of Psychiatry Manual that includes specific requirements regarding WRP leadership. The
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		<p>requirements must be aligned with the WRP team responsibilities that are outlined in the DMH WRP manual.</p> <ol style="list-style-type: none"> 4. The DMH WRP manual should address the leader's responsibility to ensure that members provide concise presentation of the results of their assessments prior to the discussion of objectives and interventions. 5. The DMH WRP manual should specify the leader's responsibility to ensure appropriate parameters for participation by the individual in their treatment, rehabilitation and enrichment activities. 6. The DMH WRP manual should address the leader's responsibility to ensure that the present status section of the case formulation is updated during the WRP team meetings and that other sections in the formulation are consequently updated as clinically indicated. 7. The DMH WRP manual should combine tables 5.1 and 5.2 regarding team responsibilities during WRP reviews to include the same expectations regarding discussion of PBS data, MOSES data and the individual's current medical condition.
c	Function in an interdisciplinary fashion.	<p>Findings:</p> <p>The DMH WRP Manual (section 5.2, WRP Team Responsibilities at 7-Day, 14-Day, quarterly, monthly and annual reviews) outlines the responsibilities of each team member. This outline contains the key requirements that enable an effective interdisciplinary process.</p> <p>The facility reports a compliance rate of 17% with this requirement (an average of compliance with all items on the form).</p> <p>This monitor's findings under C.1.a are also applicable to this section. These findings corroborate the facility's low compliance rates.</p>

		<p>Compliance: Partial.</p> <p>Recommendations: Same as C.1.a. and C.1.b.</p>
d	<p>Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary, and appropriate psychiatric and medical care.</p>	<p>Findings: As mentioned above, the DMH WRP Manual outlines the responsibilities of each team member in a manner that enables an effective interdisciplinary process. AD # 15.42 item 6.2 states that the unit psychiatrist, as team leader, has the final responsibility for the WRP.</p> <p>At this time, the physicians' privileging and re-privileging processes do not include the provision of competent, necessary, and appropriate psychiatric and medical care as required in the EP.</p> <p>As mentioned earlier, the facility monitors the psychiatrists' attendance in the WRP conferences (92% compliance).</p> <p>The team meetings attended by this monitor indicate a pattern of deficiency regarding the team leaders assuming the primary responsibility for the individual's therapeutic and rehabilitation services. Findings regarding the performance of team leaders in the provision of competent psychiatric and medical care are detailed in Sections D and F below.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Same as in C.1.a, b and c. 2. Conduct surveys to assess the views of team members

		<p>regarding the functions of their designated leaders.</p> <ol style="list-style-type: none"> 3. Develop and implement a Physician Performance Profile that includes indicators that ensure provision of competent, necessary, and appropriate psychiatric and medical care as required in the EP.
e	<p>Ensure that each member of the team participates appropriately in competently and knowledgeably assessing the individual on an ongoing basis and in developing, monitoring, and, as necessary, revising the therapeutic and rehabilitation services.</p>	<p>Findings: The facility used the DMH WRP Process Observation Forms (7-Day/14-Day, Monthly and Quarterly conferences) and found overall compliance rate of 8% with this requirement. The sample sizes varied (60 of 7-Day/14-Day, 62 of Monthly and 217 of Quarterly conferences were observed). The following monitoring indicators were used:</p> <ol style="list-style-type: none"> 1. A team member gives a summary report of the individual's progress on each treatment objective and progress in meeting discharge criteria (compliance rate 8%). 2. The team revised or added new treatment objectives and/or interventions as appropriate (6%). 3. The team evaluated the need for additional assessments and when an assessment was indicated a team member took responsibility for scheduling and coordination of the assessment by the next review (25%). 4. The treatment team asked the individual for input in the evaluation of progress in meeting each treatment objective. Each objective was reviewed with the individual in light of target dates, data for the intervention or need for new interventions (3%). <p>The facility also used the WRP Chart Audits to assess compliance with this requirement. Seven nursing auditors, including one who is bilingual, reviewed 788 charts over a six-month period (May to October 2006). The facility found 38% compliance with the indicator</p>

		<p>stating that the WRP is evaluated and revised as necessary in response to instances of severe maladaptive behavior, use of seclusion or restraint, PRN medications, or other outcome triggers</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Same as in C.1.a. through C.1.d. 2. Same as in D.1.a. through D.1.e. 3. Improve clinical oversight to ensure competency in the processes of assessments, reassessments, interdisciplinary team functions and proper development and timely and proper updates of case formulations, foci of hospitalization, objectives and interventions. 4. Address and correct discrepant findings between Process Observation and Chart Audits.
f	<p>Ensure that assessment results and, as clinically relevant, consultation results, are communicated to the team members, along with the implications of those results for diagnosis, therapy and rehabilitation by no later than the next review.</p>	<p>Findings: PSH has observation monitoring data (7-Day/14-Day and Quarterly conferences). The following is an outline of indicators and compliance rates:</p> <p>7-Day/14-Day conference: Assessments were presented by each discipline and were brief and non-redundant: 12%.</p> <p>The team evaluated the need for additional assessments and when an assessment was indicated, a team member took responsibility for scheduling and coordination of the assessment by the next review: 11%.</p>

		<p>Quarterly conference: Treatment team updated present status of the case formulation and diagnosis, based on current assessment, process reviews and the individual's thoughts and concerns about treatment: 23%.</p> <p>Observations of the team meetings attended by this monitor indicate general deficiency in the key requirements of presenting results of the assessments and analyzing those results to assess implications for diagnosis, treatment and/or rehabilitation of individuals.</p> <p>Compliance: Partial.</p> <p>Recommendations: Same as in C.1.a through C.1.e.</p>
g	<p>Be responsible for the scheduling and coordination of assessments and team meetings, the drafting of integrated treatment plans, and the scheduling and coordination of necessary progress reviews.</p>	<p>Findings: The DMH WRP manual (3. Assessment, 3.1 Admission Assessment, 3.2 Integrated Assessment, 3.3 Clinically Indicated Assessment, 3.6 Assessment Schedule, 4. WRP Schedule and 4.3 WRP Conferences) includes practice requirements regarding the key elements in this step.</p> <p>Using the above-mentioned Process Observation method, the facility assessed its compliance. Most of the monitoring indicators used were not appropriate to this requirement. The following is a listing of the type of conference and corresponding compliance rates and monitoring indicators that are relevant to this requirement:</p> <ol style="list-style-type: none"> 1. The team identified a treatment plan recorder who is responsible for drafting the integrated assessment plan: 82% (14-Day conference). 2. The team evaluated the need for additional assessments and

		<p>when an assessment was indicated, a team member took the responsibility for scheduling and coordination of the assessments by the next WRP review: 25% (Quarterly conference).</p> <p>In addition, the facility conducted the following Chart Audits:</p> <ol style="list-style-type: none"> 1. WRP Chart Audit: The audit shows 0% compliance with the requirement that the team reviewed and revised the WRP per schedule. 2. Audit for Timeliness and Completeness of Documentation. This audit focused on the completeness all disciplinary assessments on the admissions units per required time frames during September and October 2006. Based on a sample size that varied from 18 to 29 charts, the facility reports overall compliance rate of 46%. <p>Compliance: Partial.</p> <p>Recommendations: Address the deficiency in the implementation of this requirement and ensure compliance.</p>
h	<p>Consist of a stable core of members, including at least the individual served; the treating psychiatrist, treating psychologist, treating rehabilitation therapist, the treating social worker; registered nurse and psychiatric technician who know the individual best; and one of the individual's teachers (for school-age individuals), and, as appropriate, the individual's family, guardian, advocates, attorneys, and the pharmacist and other staff.</p>	<p>Findings: The DMH WRP manual (2. Brief Definitions, 2.3 The WRP Team, 5. WRP Team Member Responsibilities) contains needed information regarding this requirement.</p> <p>The facility has a database that includes information regarding the core membership of all teams in the facility. As mentioned in C.1.i below, the facility acknowledges non-compliance with the EP requirement due to staffing shortages.</p>

		<p>Refer to C.1.b for the Facility's data regarding attendance by core members in the WRP team conferences:</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Address and correct the deficiencies regarding core memberships of the WRP teams. 2. Address and correct the deficiencies regarding attendance by core members. 3. Continue to monitor the core membership of the WRP teams and the attendance by core members in the team conferences.
i	<p>Not include any core treatment team members with a case load exceeding 1:15 in admission teams (new admissions of 90 days or less) and, on average, 1:25 in all other teams at any point in time.</p>	<p>Findings: PSH reports poor compliance with this requirement in the majority of its WRP teams. In order to meet plan requirements on the admission units, the facility needs to recruit three psychiatrists, six psychologists, one registered nurse, one social worker, one rehabilitation therapist and two psychiatric technicians.</p> <p>On the other units, the facility needs to recruit the following members:</p> <p>Psychiatrist=4 Psychologist=28 Social Worker=2 Rehabilitation Therapist=18</p> <p>At this time, only two long-term teams (on unit 36) are in compliance with the requirement.</p>

		<p>Compliance: Non-compliance.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure consistent compliance with this requirement. 2. Same as in recommendation #3 under C.1.h.
j	<p>Not include staff that is not verifiably competent in the development and implementation of interdisciplinary wellness and recovery plans.</p>	<p>Findings: PSH does not have an adequate database regarding attendance by different disciplines in the WRP training. The facility has yet to implement the post-test regarding the didactic first phase of WRP training. The facility has yet to develop mechanisms to ensure competencies in phases II and III of this training.</p> <p>This monitor's observations of team meetings reveal that most team leaders and members are not yet fully trained to meet this requirement.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Same as in C. 1.a through C.1.f. 2. Implement the WRP Phase I post-test to include the WRP process expectations. 3. Develop and implement mechanisms to ensure that all WRP team members are competent in all phases of WRP training.

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: Observed WRP team meetings for Monthly 7-Day/14-Day WRP reviews of AA, and DP. Observed WRP team meetings for 7-Day/14-Day WRP reviews of LH, FF and JW. Observed WRP conferences for PC and MS. Observed WRP team meeting for Quarterly WRP review of JRM. Reviewed charts of 94 individuals (LL, MS, BRA, HG, BSL, PS, MAT, PH, EV, TMH, LDG, JJD, LEJ, JB, JMJ, LBS, JLW, TLE, SM, JD, DLW, CB, PMA, LLL, APG, MM, VH, RC, WWM, MWG, JJF, JRC, CC, MDL, MJ, CS, MB, AA, AB, AJ, AL, AT, BB, BM, CB, CH, CM, CS, DB, DC, DG, DJ, DS, EC, EH, EL, FC, GA, GB, GE, GF, GG, GJ, HA, HH, IR, JC, JE, JF, JG, JJ, KD, KR, LE, LR, MG, MH, MK, MS, MW, PA, PC, PD, PK, PM, RJ, RR, RS, SB, SG, SH, ST, TS, and WC). Interviewed Cynthia Siples, Program Director, Comprehensive Addiction Recovery Education (CARE) services. Interviewed Fred Wolfner, Program Director, Enhancement Services. Interviewed Andre Bryant, Psychiatric Technician, CARE services. Interviewed Ruth Hild, Rehabilitation Therapist, CARE services. Interviewed Melanie Byde, Ph.D., Psychologist, Acting Mall Director. Interviewed Garilyn Richardson, RN, Standards Compliance. Interviewed Joseph Malancharuvil, Ph.D., ABPP, Clinical Administrator. Interviewed Brian Correll, Psychiatric Technician. Interviewed Carson Chambers, Ph.D., Psychologist. Interviewed Steven Berman, Ph.D., Psychologist. Interviewed Ming Liu, Ph.D., Psychologist. Interviewed Edward Hayes, SPT, Acting Unit Supervisor. Interviewed Sylvia Glover, RN. Interviewed Gelen Dangiapo, RN. Interviewed Individuals (ST and GA). Reviewed A.D. #15.42 Wellness & Recovery Plan. Reviewed DMH Psychosocial Rehabilitation Malls Manual.</p>

		<p>Reviewed DMH BY CHOICE Manual.</p> <p>Reviewed AD #15.38 BY CHOICE System.</p> <p>Reviewed SO #130.01 The BY CHOICE Incentive System.</p> <p>Reviewed DMH PBS Manual.</p> <p>Reviewed DMH SO #129 PBS.</p> <p>Reviewed AD #15.09 PBS Program.</p> <p>Reviewed Group Treatment for Substance Abuse: A Stages-of-Change Therapy Manual by Mary Velasquez, Gaylyn Gaddy Maurer, Cathy Crouch and Carlo C. DiClemente.</p> <p>Reviewed Overcoming Addictions, Skills Training for People with Schizophrenia by Lisa Roberts, Andrew Shaner and Thad A. Eckman.</p> <p>Reviewed PSH's Manual regarding Treating Substance Use Disorders, A Transtheoretical Model, Precontemplative and Contemplative Stages of Change.</p> <p>Reviewed Considering Sobriety, Preparation Stage Manual.</p> <p>Reviewed Recovery in Action, Action Stage Substance Abuse Education Manual.</p> <p>Reviewed DMH WRP Manual (Draft July 7, 2006).</p> <p>Reviewed WRP Process Observation Monitoring Form.</p> <p>Reviewed WRP Process Observation Monitoring Form Instructions.</p> <p>Reviewed WRP Observation Monitoring Summary Data (August to September 2006).</p> <p>Reviewed WRP Chart Audit Form.</p> <p>Reviewed WRP Chart Audit Monitoring Summary Data (September to October 2006).</p> <p>Reviewed Quarterly Case Formulation Monitoring Form.</p> <p>Reviewed Case Formulation Monitoring Instructions.</p> <p>Reviewed Case Formulation Monitoring Data Summary (September and October 2006).</p> <p>Reviewed WRP Mall Alignment Protocol Score Sheet.</p> <p>Reviewed WRP Mall Alignment Protocol Data Summary (May to October 2006).</p> <p>Reviewed DMH Draft Policy regarding Screening for Substance</p>
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		<p>Abuse.</p> <p>Reviewed PSR Mall Manual.</p> <p>Reviewed PSR Mall Schedule.</p> <p>Reviewed PSR Mall Curricula.</p> <p>Reviewed PSR Resource Catalog.</p> <p>Reviewed PSH Discharge Analysis Log.</p> <p>Reviewed Technical and Procedural Manual for Developmental and Cognitive Abilities Teams (DCAT).</p> <p>Reviewed DCAT Referral List.</p> <p>Reviewed Psychology Staff Assignment List.</p> <p>Reviewed Psychosocial Rehabilitation Malls Manual.</p> <p>Reviewed the PSH, MHDS Manual.</p> <p>Reviewed the Manual Resource Binder.</p> <p>Reviewed the BY CHOICE Program Manual.</p> <p>Reviewed the DMH Clinical Indicator List</p> <p>Reviewed the DMH Wellness and Recovery Plan Manual.</p> <p>Reviewed WRP Chart Audit Form.</p> <p>Reviewed the Technical and Procedural Manual for Positive Behavior Support Plans.</p> <p>Reviewed the Staff Development Training, Manual TCR Binder.</p> <p>Reviewed BY CHOICE fidelity check.</p> <p>Reviewed Completed PBS and BCC Checklists.</p> <p>Reviewed Psychosocial Active Treatment List.</p> <p>Reviewed DMH WRP Manual.</p> <p>Reviewed Chart Audit Forms.</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>Observed Mall Groups (Me and My Mental Illness, Recovery Enhancement group, Mens Issues, Applied Life Skills, Art Strategies for Anger Management, Cognitive Skills Building, Transition Skills for CONREP, Health and Wellness, Collaborative Recovery).</p> <p>Observed BY CHOICE activities.</p>
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<p>a</p>	<p>Individuals have substantive input into the therapeutic and rehabilitation service planning process, including but not limited to input as to mall groups and therapies appropriate to their WRP.</p>	<p>Findings: PSH has completed its transition to the new formats of the WRP model.</p> <p>The facility used the previously described WRP Process Observation Form (7-Day/ 14-Day, Monthly and Quarterly) to assess compliance with this requirement. The following is an outline of the compliance rates and monitoring indicators that are relevant to the requirement:</p> <p>7-Day/14-Day WRP conference (overall compliance 12%):</p> <ol style="list-style-type: none"> 1. The team reviewed with the individual BYCHOICE point preferences and allocation: 5%. 2. The team updated the person's life goals and valued role functions based on discussion prior to the conference and, when appropriate, link them to treatment, rehabilitation and enrichment goals (19%). 3. The team asked the individual what are the most important treatment outcomes he/she hopes to achieve during this admission (12%); 4. The treatment team discussed with the individual his/her cultural preferences and concerns that may impact treatment (7%). 5. The treatment team asked the individual about the involvement of family and others in relation to treatment (15%). <p>Monthly WRP conference (overall compliance 15%):</p> <ol style="list-style-type: none"> 1. The individual was asked about his/her experiences of treatment and effectiveness (26%); 2. The treatment team asked the individual for input in the evaluation of progress in meeting each treatment objective.
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		<p>Each objective was reviewed in light of target dates, data from interventions or need for new interventions (0%).</p> <ol style="list-style-type: none"> 3. The team reviewed with the individual BYCHOICE points, preferences and allocation (2%). 4. The team discussed with the individual his/her satisfaction with the treatment and services (20%). 5. If indicated, the treatment team updated present status of the case formulation and diagnosis based on current assessments, progress reviews and the individual's thoughts and concerns about treatment (28%). <p>Quarterly WRP conference (overall compliance 15%):</p> <ol style="list-style-type: none"> 1. Treatment team discussed with the individual changes in the case formulation and diagnosis (15%). 2. The team reviewed with the individual BY CHOICE points, preferences and allocation (22%). 3. The team discussed with the individual his/her satisfaction with the treatment and services (36%). 4. The team discussed with the individual his/her cultural preferences and concerns that may impact treatment (9%). 5. The treatment team asked the individual for input in the evaluation or progress in meeting each treatment objective. Each objective was reviewed with the individual in light of target dates, data from interventions, or need for new interventions (3%). 6. Individuals have substantive input into the therapeutic and rehabilitation planning process as evidence by a choice of groups, BY CHOICE points' preferences and allocation, formulation of objectives and behavioral expectations to meet discharge criteria and a choice in type of therapy offered (5%).
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		<p>In addition, the eighteen audits from nursing services randomly selected two individuals from each unit and surveyed their views regarding this requirement. The following is an outline of questions asked and percentages of affirmative answers:</p> <ol style="list-style-type: none"> 1. Does your Wellness and Recovery Team ask you about Life Goals and include your input into your Wellness and Recovery Plan? (69%). 2. Do you have the opportunity to provide input into or to choose the mall groups, individual or group therapy and enrichment activities that are assigned to you in your WRP? (66%). 3. Do you know the objectives you are working on in your Wellness and Recovery Plan? (62%). 4. Does your Wellness and Recovery Team ask for your input in evaluating the progress you have made in meeting each objective in your WRP? (54%). <p>As mentioned in section C.1, this monitor's observations of the WRP team meetings indicate that, in general, the teams do not obtain meaningful input from the individuals in the process of review and revisions of the plans. The main deficiency is that the individual's input is obtained in the context of performing/completing disciplinary assessments rather than interdisciplinary planning of the services necessary to meet the individual's assessed needs. This monitor observed that several team members rely on the WRP meetings to conduct their assessments. The assessments must be completed prior to the WRP meetings. Delaying these assessments until meeting time impedes planning of services and also results in unacceptable delays in determining the current status of the individual regarding a variety of risk factors and in the institution of timely interventions to reduce the risk.</p> <p>In some cases, the individuals were given choices among PSR groups.</p>
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		<p>However, the PSR groups were selected from standard group offerings and were not matched to the individual's needs. The match between what the individuals needed and the choices offered were tenuous. At times, objectives and discharge criteria were developed without input from individuals whose functional status permitted such input. In general, the WRP teams were not following the instructions in the DMH WRP Manual.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Same as in C.1.a through C.1.f. 2. Ensure that self-assessment data address all requirements of the EP using both process observation and chart audit tools, as appropriate. 3. Continue and strengthen WRP training that focuses on the process of engaging the individual in providing substantive input.
b	Therapeutic and rehabilitation service planning provides timely attention to the needs of each individual, in particular:	<p>Compliance: Partial.</p>
b.i	initial therapeutic and rehabilitation service plans (Admission-Wellness and Recovery Plan ("A-WRP")) are completed within 24 hours of admission;	<p>Findings: PSH has yet to implement this requirement. The facility's monitoring data, based on chart audits, show 0% compliance.</p> <p>This monitor's findings corroborated the facility's data. All charts reviewed by this monitor showed non-compliance.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Implement requirement regarding timeliness of the initial WRP. 2. Continue chart audits to assess compliance.

b.ii	<p>master therapeutic and rehabilitation service plans ("Wellness and Recovery Plan" (WRP)) are completed within 7 days of admission; and</p>	<p>Findings: The facility has chart audit data to assess compliance with this requirement. The data that show 0% compliance with this requirement.</p> <p>This monitor reviewed 11 charts and found non-compliance in all cases (LL, MS, BRA, HG, BSL, PS, MAT, PH, EV, TMH and LDG).</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Implement requirement regarding timeliness of the master WRP. 2. Continue chart audits to assess compliance.
b.iii	<p>therapeutic and rehabilitation service plan reviews are performed every 14 days during the first 60 days of hospitalization and every 30 days thereafter. The third monthly review is a quarterly review and the 12th monthly review is the annual review.</p>	<p>Findings: At this time, the WRP teams perform the master WRP at 14 days from admission. The WRP is then reviewed upon 30 day and 60 day from admission and quarterly thereafter. The facility has yet to implement a schedule that fully complies with this requirement of the EP. The facility does not have monitoring data to assess its compliance with the requirement.</p> <p>This monitor's review of the above-mentioned 11 charts revealed compliance with this requirement in only two charts (TMH and BSL), with the remaining cases ranging from partial to non-compliance.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Same as above. 2. Ensure monitoring of bi-weekly, quarterly and monthly WRPs.

c	<p>Treatment rehabilitation and enrichment services are goal-directed, individualized, and informed by a thorough knowledge of the individual's psychiatric, medical, and psychosocial history and previous response to such services;</p>	<p>Findings: The DMH WRP manual (7.3. Case Formulation, 7.5 Discharge Criteria, 7.6 Focus of Hospitalization, 7.7 Objectives and 7.8 Interventions) adequately addresses this requirement.</p> <p>The facility has the following data from the Quarterly WRP Process Observation Form (overall compliance 18%):</p> <ol style="list-style-type: none"> 1. The team updated and continued to develop a case formulation. (13%) 2. Treatment team updated Present Status of the case formulation and diagnosis based on current assessments, process reviews and the individual's thoughts and concerns about treatment. (23%) <p>PSH has the following monitoring data based on the WRP Chart Audit (overall compliance 22%):</p> <ol style="list-style-type: none"> 1. MWRP (My Wellness Recovery Plan) includes case formulation developed in the 6-p format (pertinent history; predisposing, precipitating and perpetuating factors; previous treatment history, and present status). (26%) 2. MWRP includes individual's life goals. (81%) 3. The individual's strengths are used in the interventions to assist individual to achieve objective. (4%) 4. There is a therapeutic milieu intervention for each active objective. (12%). <p>This monitor reviewed the charts of five individuals suffering from seizure disorders and receiving older generation anticonvulsant medications (JJD, LEJ, JB, JMJ and LBS). In all these individuals, the seizure disorder was identified on the WRP as a focus for treatment with corresponding objectives and interventions. However,</p>
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		<p>none of these individuals was assessed regarding the possible negative impact of treatment on the cognitive, behavioral and life quality of the individual. This deficiency was noted even in individuals who suffered from documented cognitive impairment (e.g., JB).</p> <p>This monitor also reviewed charts of nine individuals suffering from a variety of cognitive disorders (JB, JLW, TLE, SM, JD, DLW, EV, CB and PMA). This review revealed the following pattern of deficiencies:</p> <ol style="list-style-type: none"> 1. There is mismatch between the Integrated Psychiatric Assessment and the WRP regarding the status of a diagnosis of Cognitive Disorder, NOS due to Head Trauma (PMA). 2. The WRPs fail to include the cognitive dysfunction as a focus (JB and EV) or to include objectives and interventions for treatment and/or rehabilitation when the condition is identified as a focus (JD and CB). 3. There is no documentation that interventions appropriate to the type and extent of cognitive impairment were provided when the foci of hospitalization and objectives include the cognitive disorder (JLW, TLE, SM and DLW). 4. In general, when interventions are included, there is no documentation of the individual's progress in treatment and its implication for further treatment and rehabilitation. <p>The above examples indicate that the WRPs currently performed at PSH generally fail to comply with this requirement.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop a new monitoring tool to assess the overall quality of the integrated elements in the WRP in order to adequately
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		<p>address this requirement. The review must be done only by clinicians.</p> <p>2. Continue and strengthen training of WRP teams to ensure that:</p> <p>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</p> <p>b) Foci of hospitalization addresses all identified needs of the individual in the above domains.</p> <p>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.</p> <p>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.</p> <p>5. Develop and implement audit items to ensure that seizure disorders, if present, are documented as a focus and that individualized and appropriate objectives and interventions are provided. The documentation needs to address the interface between seizure disorders (and its treatment), psychiatric status (and its treatment) and psychosocial functioning of the individual.</p>
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:	Compliance: Partial.
d.i	be derived from analyses of the information gathered from interdisciplinary assessments, including diagnosis	Findings: The facility used the Quarterly Case Formulation Monitoring Form to

	<p>and differential diagnosis;</p>	<p>assess compliance with this requirement. Eleven auditors from nursing services were trained by the Standards Compliance Director regarding the use of this form. The auditors reviewed 112 charts (September and October 2006) and found the following compliance rates:</p> <ol style="list-style-type: none"> 1. Is the information (i.e., pertinent history, predisposing, precipitating, perpetuating factors, previous treatment and present status) aligned with the assessments? (46%). 2. Is the case formulation interdisciplinary (i.e., does the information reflect participation by all relevant disciplines? (11%). <p>The facility used the WRP Process Observation Form (7-Day/14-Day) (60 observations during August to September 2006) and found 27% compliance with the requirement that the team developed a case formulation (during the conference). The facility's quarterly observation data indicate 13% compliance.</p> <p>Chart reviews by this monitor corroborate the facility's low compliance rates. In general, the case formulations are not based on careful analysis of the information in the assessments. Almost all the charts reviewed demonstrate a pattern of significant deficiencies in the quality/content and completeness of case formulations. The key deficiencies include:</p> <ol style="list-style-type: none"> 1. The case formulations are not consistently completed in the 6-p format. 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.
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		<ol style="list-style-type: none"> 4. There is inadequate linkage between the material in the case formulations and other key components of the WRP (e.g., foci of hospitalization, life goals, objectives and interventions). 5. The information in the case formulations does not provide the basis for proper delineation of diagnosis and development and finalization of a differential diagnosis. <p>These deficiencies are such that the current case formulations performed at PSH generally fail to address the requirement in this step. This finding is also applicable to C.2.d.ii through C.2.d.i.v.</p> <p>PSH used the Quarterly Case Formulation Monitoring Form to assess compliance with the required elements of this section. The monitoring should be undertaken on a monthly basis because quarterly is too infrequent to provide the necessary data on which to base the needed mentoring of the WRPT members. The review must be done only by clinicians.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Continue and strengthen training of the WRP teams to ensure that the case formulation adequately addresses the requirements in C.2.d. 2. Undertake case formulation monitoring on a monthly basis. 3. Ensure that case formulation monitoring is done only by clinicians.
d.ii	include a review of: pertinent history; predisposing, precipitating and perpetuating factors; previous treatment history, and present status;	<p>Findings:</p> <p>The facility used the Quarterly Case Formulation Monitoring Form and found overall compliance rate of 5%. The following is a breakdown of the compliance rate for each component:</p> <ol style="list-style-type: none"> 1. Pertinent history: 7%. 2. Predisposing factors 6%;

		<ol style="list-style-type: none"> 3. Precipitating factors: 2%; 4. Perpetuating factors: 6%; 5. Previous treatment history: 6%; and 6. Present status: 5%. <p>PSH reports the following process observation Data:</p> <ol style="list-style-type: none"> 1. The team developed a case formulation (during the 7-Day/14-Day conference) (27%). 2. The team updated and continued to develop a case formulation (during the quarterly conference) (13%). 3. Treatment team updated Present Status of the case formulation and diagnosis based on current assessments, process reviews and the individual's thoughts and concerns about treatment (23%). <p>The facility also has data based on the WRP Chart Audit Form. The Data indicate approximately 26% compliance with the requirement that the WRP includes case formulation developed in the above-listed six-p format (during the 7-Day/14-Day conference).</p> <p>Recommendations: Same as above.</p>
d.iii	consider biomedical, psychosocial, and psychoeducational factors, as clinically appropriate, for each category in § [III.B.4.b] above	<p>Findings: PSH used the quarterly Case Formulation Monitoring Form and found overall rate of 17% based on compliance with all the indicators on this form. The indicators are aligned with this requirement.</p> <p>The facility reports WRP process observation and chart audit data that do not address the requirement.</p> <p>Recommendations: Same as above.</p>

d.iv	consider such factors as age, gender, culture, treatment adherence, and medication issues that may affect the outcomes of treatment and rehabilitation interventions;	<p>Findings: Using the Quarterly Case Formulation Monitoring Form, the facility reports 10% compliance with the following indicator:</p> <p>Does the case formulation include a review and analysis of important clinical factors across multiple domains (medical, psychiatric, behavioral, functional status, and quality of life)?</p> <p>The facility has data based on the WRP Chart Audit. The following are the compliance rates:</p> <ol style="list-style-type: none"> 1. The case formulation is culturally informed (2%). 2. MWRP includes the individual's life goals (81%). <p>Recommendations: Same as above.</p>
d.v	support the diagnosis by diagnostic formulation, differential diagnosis and Diagnostics and Statistical Manual DSM-IV-TR (or the most current edition) checklists; and	<p>Findings: PSH used the Psychiatric Evaluation Monitoring Form to assess compliance with this requirement. However, the indicators used are more relevant to psychiatric assessments than to case formulation.</p> <p>In addition, the facility has data based on the Quarterly Case Formulation Monitoring Form. The following are the compliance rates:</p> <ol style="list-style-type: none"> 1. Does the case formulation document completion of the DSM-IV checklist? (6%). 2. Does the completed DSM-IV-TR checklist support the given diagnosis? (6%). <p>Recommendations: Same as above.</p>

d.vi	enable the interdisciplinary team to reach sound determinations about each individual's treatment, rehabilitation, enrichment and wellness needs, the type of setting to which the individual should be discharged, and the changes that will be necessary to achieve discharge.	<p>Findings: The facility used the Quarterly Case Formulation Form and reports overall compliance rate of 28%. The following are the compliance rates for each indicator:</p> <ol style="list-style-type: none"> 1. Does the Present Status section of the case formulation adequately summarize the needs of the individual in the three domains: treatment, rehabilitation, and enrichment? (11%) 2. Does the case formulation identify required changes in individual and systems to optimize treatment, rehabilitation and enrichment outcomes? (11%) 3. Does the case formulation predict the discharge setting? (46%) 4. Is there evidence of proper analysis of information? (49%) 5. Is there proper linkage within different sections of the formulation? (46%) 6. Does the case formulation account for strengths of the individual and the system? (5%) <p>PSH also used other chart audit indicators and reports the following data:</p> <p>There is at least one objective and intervention for each focus of hospitalization. (18%)</p> <p>Recommendations: Same as in C.2.c, C.2.f, C.2.g and C.2.o.</p>
e	The therapeutic and rehabilitation service plan specifies the individual's focus of hospitalization (goals), assessed needs (objectives), and how the staff will assist the individual to achieve his or her goals/objectives (interventions);	<p>Findings: PSH has data based on the WRP Chart Audit. The facility reports overall compliance rate of 38% with the following indicators:</p> <ol style="list-style-type: none"> 1. MWRP includes clear, observable, measurable and behaviorally

		<p>worded objectives written in terms of what the individual will do.</p> <ol style="list-style-type: none"> 2. Individual's strengths are used in the interventions to assist individual to achieve objective. 3. MWRP includes names of specific staff responsible for intervention frequency and duration. <p>The facility used Nursing Interventions Monitoring Form. In this process, 11 auditors from nursing services reviewed 237 records during September to October 2006. The indicators are focused on the integration of nursing interventions into the WRP. The auditors report an overall compliance rate of 38%.</p> <p>Chart reviews by this monitor indicate that, in almost all cases, the foci of hospitalization are incomplete, usually limited to one or two areas; are identified in generic terms; and do not offer meaningful targets for treatment, rehabilitation and enrichment of the individuals. Deficiencies are noted in the following areas:</p> <ol style="list-style-type: none"> 1. Identification of foci of hospitalization that address individuals' special needs (see monitor's findings in C.2.c and C.2.o). 2. Proper formulation and execution of objectives and interventions (see the monitor's findings in C.2.f.i through C.2.f.vii). 3. Appropriate revision of foci and objectives (see the monitor's finding in C.2.g). <p>Compliance: Partial.</p> <p>Recommendations: Same as in C.2.c, C.2.f, C.2.g and C.2.o.</p>
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f	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:	Compliance: Partial.
f.i	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>Findings: Using the WRP Process Observation Form, the facility found 0% compliance (7-Day/14-Day and Quarterly conferences) with the requirement that the individual's strengths were utilized in the interventions for each objective. The facility found 4% compliance (Quarterly conferences) with the requirement that the individual knew what he/she is to do for each objective.</p> <p>This monitor reviewed seven charts (LLL, APG, MM, VH, RC, WWM and MWG) to assess compliance. This review demonstrated inconsistent practice, with failure to meet the requirement in three cases (APG, RC and WWM), partial compliance in two (LLL and MWG) and compliance in two (MM and VH).</p> <p>The facility should also review charts for the required elements.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Continue and strengthen training of WRP teams to ensure that objectives and interventions are implemented in accordance with the requirements in the DMH WRP manual. 2. Add chart reviews to the monitoring process. The review must be done only by clinicians.
f.ii	ensure that the objectives/ interventions address treatment (e.g., for a disease or disorder),	Findings: The facility has data based on the WRP Chart Audit Form. The data

	rehabilitation (e.g., skills/supports, motivation and readiness), and enrichment (e.g., quality of life activities);	<p>do not address this requirement.</p> <p>Reviews of eight charts by this monitor demonstrate non-compliance with the requirement in five cases (LLL, MM, APG, VH, RC, WWM and MWG) and partial compliance in one (JJF).</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Same as in C.2.f.i. 2. Same as in C.2.e.
f.iii	write the objectives in behavioral, observable, and/or measurable terms;	<p>Findings:</p> <p>The facility has WRP Chart Audit data that show 14% compliance (MWRP includes clear, observable and behaviorally worded objectives written in terms of what the individual will do). The facility also has WRP Process Observation data (7-Day/14-Day conference) that show 5% compliance (the team developed objectives for each focus of hospitalization that are behaviorally defined, observable and measurable).</p> <p>Review of seven charts by this monitor show non-compliance in three cases (LLL, VH, WWM) and partial compliance in four (MM, APG, RC, MWG).</p> <p>Recommendations:</p> <p>Same as in C.2.f.i</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>Findings:</p> <p>The facility has monitoring data based on the WRP Chart Audit Form, showing 35% compliance (objectives are linked to individual's stages of change, if appropriate).</p> <p>Chart reviews by this monitor show poor compliance due to failure to identify any stages of change or to include an adequate outline of the</p>

		<p>stages. Non-compliance is noted in four charts (VH, RC, WWM and MWG) and partial compliance in three (LLL, MM and APG).</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Same as in C.2.f.i. 2. Same as in C.2.e.
f.v	<p>ensure that there are interventions that relate to each objective, specifying who will do what, within what time frame, to assist the individual to meet his/her needs as specified in the objective;</p>	<p>Findings:</p> <p>Based on the WRP Chart Audit Form, the facility reports the following compliance data:</p> <p>MWRP includes names of specific staff responsible for implementing interventions, frequency and duration: 10%.</p> <p>Case reviews by this monitor show overall inadequate implementation of this requirement, with compliance in three cases (LLL, APG and RC), partial compliance in two (MM and MWG) and non-compliance in two (VH and WWM).</p> <p>Recommendations:</p> <p>Same as in C.2.f.i</p>
f.vi	<p>implement interventions appropriately throughout the individual's day, with a minimum of 20 hours of active treatment per week. Individual or group therapy included in the individual's WRP shall be provided as part of the 20 hours of active treatment per week;</p>	<p>Findings:</p> <p>PSH reports a compliance rate of 10% (based on the WRP Chart Audit Form) with the requirement that the interventions include at least 20 hours of planned mall groups or individual therapy linked to the objective. The facility recognizes that this auditing mechanism does not reflect the current schedule of the individuals. PSH has implemented corrective measure in mall schedules to address this deficiency.</p> <p>PSH used the MAPP (My Activity and Participation Plan) database and developed a tracking system of hours of active treatment in the mall</p>

(scheduled and attended). The data show the hours of activities scheduled, the actual activities provided and the number of hours attended by the individuals. The facility reports that, during one week in October, the Hope Mall had 5,375 scheduled, 2,927 hours provided and 2,637 hours attended by Individuals; the Pathways Mall had 21,827 hours scheduled, 15,669 hours provided and 14,241 hours attended by Individuals; the Inspiration Mall had 6,142 hours scheduled, 3,709 hours provided and 2,278 hours attended by Individuals.

Chart reviews by this monitor (LLL, VH, RC, JRC, CC and WWM) demonstrate inadequate implementation of this requirement. The table below illustrates several examples. In this table, the hours identified in the WRPs reflect different time frames and configuration of activities than those identified in the MAPP. The system of mall cycles is the main reason for this disconnect due to discontinuity in group activities from cycle to cycle. The facility is currently transitioning to a new system of mall activities to ensure better continuity of group activities, thus improving the alignment of the information. The examples below illustrate that individuals do not receive the required hours of active treatment and that the WRPs do not include adequate schedules to comply with the required active treatment hours.

Individual's Initials	Hours Scheduled (WRP)	Hours Scheduled (MAPP)	Average Hours Attended (MAPP)
LLL	20.00	20.00	9.00
VH	Unspecified	20.00	10.00
RC	5.50	20.00	11.00
JRC	20.00	20.00	9.00
WWM	Unspecified	18.50	12.00
CC	7.50	20.00	8.00

		<p>Recommendations:</p> <ol style="list-style-type: none"> 1. Assess and address the factors related to inadequate scheduling by the WRP teams and/or participation by individuals to ensure compliance with the requirement. 2. Monitor hours of active treatment scheduled and attended, using an adequate statewide system for data processing.
f.vii	<p>maximize, consistent with the individual's treatment needs and legal status, opportunities for treatment, programming, schooling, and other activities in the most appropriate integrated, non-institutional settings, as clinically appropriate; and</p>	<p>Findings: At this time, this item is not applicable. The facility director reports that civilly committed individuals are prohibited, by legal order, from participation in community activities.</p> <p>Recommendations: Assess and correct factors related to lack of programs.</p>
f.viii	<p>ensure that each therapeutic and rehabilitation service plan integrates and coordinates all services, supports, and treatments provided by or through each State hospital for the individual in a manner specifically responsive to the plan's therapeutic and rehabilitation goals. This requirement includes but is not limited to ensuring that individuals are assigned to mall groups that link directly to the objectives in the individual's WRP and needs.</p>	<p>Findings: Using the same Chart Audit process described earlier, the facility reports overall compliance rate of 37% based on this instrument. However, the facility recognizes that the data are seriously limited due to mismatch between groups identified in the WRP and the mall curriculum (see C.1.f.vi).</p> <p>All chart reviews conducted by this monitor demonstrate lack of documentation that supports linkage between Mall activities and objectives outlined in the WRP. As mentioned in C.2.f.iv, the WRPs' documentation of scheduled active treatment hours is inconsistent with the information derived from the MAPP system.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a mechanism to ensure proper linkage between type and objectives of Mall activities and objectives outlined in the WRP as well as documentation of this linkage.

		2. Implement electronic progress note documentation 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:	Compliance: Partial.
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>Findings: The DMH WRP manual does not include specific parameters for review and revision of the foci, objectives and interventions.</p> <p>PSH reports the following relevant data based on the WRP Process Observation Form:</p> <ol style="list-style-type: none"> 1. Each objective was reviewed in light of target dates, data from interventions, or need for new interventions (Monthly Conference: 0%, Quarterly Conference: 3%). 2. The team revised or added new foci of hospitalization, treatment objectives and/or interventions as appropriate (Monthly Conference: 24%, Quarterly Conference: 6%). <p>As reported in C.2.e, this monitor found significant deficiencies in the formulation of foci of hospitalization. In addition, charts were reviewed by this monitor to assess compliance with this requirement. Most of the charts reviewed (e.g., LLL, MM, APG, VH, WWM and MWG) demonstrated failure to revise the foci and/or objectives/interventions to reflect the individuals' changing needs.</p> <p>The facility should also review charts for the required elements.</p>

		<p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that the DMH WRP manual contains specific requirements for review and revision of foci, objectives and interventions to address changes in the individual's status. 2. Continue and strengthen training to WRP teams to ensure that foci and objectives are reviewed and revised and that new interventions are developed and implemented as clinically needed. 3. Add chart reviews to the monitoring process. The review must be done only by clinicians.
g.ii	<p>review the focus of hospitalization, needs, objectives, and interventions more frequently if there are changes in the individual's functional status or risk factors (i.e., behavioral, medical, and/or psychiatric risk factors);</p>	<p>Findings:</p> <p>The facility has Process Observation data based on the following indicator: If there has been a suicide threat, behavior or report by others since last WRP then the findings of the completed suicide assessment and treatment implications were discussed. This indicator only partially addresses the requirement. The facility's compliance rates are as follows:</p> <p>7-Day/14-Day Conference: 0%. Monthly Conference: 5%. Quarterly Conference: 2%.</p> <p>The facility has Chart Audit data showing 38% compliance with the following indicator: MWRP is evaluated and revised as necessary in response to instances of severe maladaptive behavior, use of seclusion or restraint, PRN medication or other outcome triggers (e.g., Body Mass Index, AWOL, suicide attempt, etc). This indicator is more aligned with the requirement.</p> <p>This monitor reviewed the charts of five individuals that experienced restrictive interventions in the past year. This review indicated non-compliance in four charts (MWG, MDL, MJ and CS) and partial</p>

		<p>compliance in one (MB).</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Same as above. 2. Ensure that monitoring instruments address the frequency of reviews as indicated in this requirement. 3. Ensure that monitoring includes individuals whose functional status has improved. 4. Add chart reviews to the monitoring process. The review must be done only by clinicians.
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>Findings:</p> <p>The facility has data showing the following compliance rates:</p> <p>Monthly Conference: A team member gives a summary report of the individual's progress on each treatment objective and progress in meeting discharge criteria. (8%)</p> <p>Quarterly Conference: Discussion relates treatment progress to meeting discharge goals with identification of potential clinical and non-clinical barriers to discharge goals. (12%)</p> <p>Chart Audit: Discharge criteria are individualized and written in behavioral, observable and measurable terms that the individual will be able to read/understand easily. (14%)</p> <p>Chart reviews by this monitor (APG, VH, RC, WWM and MWG) indicate a general trend of deficiencies in the following areas:</p> <ol style="list-style-type: none"> 1. Team discussion of the individual's progress toward discharge;

		<ol style="list-style-type: none"> 2. Update of the present status section of the case formulation regarding the individual's progress; and 3. Revision of the interventions if no sufficient progress has been made toward discharge. <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Continue and strengthen training to WRP teams to ensure consistent implementation of this requirement. 2. Ensure that the monitoring tool addresses the documentation of the results (of the team's review or progress) in the present status section of the case formulation and appropriate revisions of the WRP if no progress has been made (as required by the DMH WRP Manual). 3. Add chart reviews to the monitoring process. The review must be done only by clinicians.
g.iv	base progress reviews and revision recommendations on data collected as specified in the therapeutic and rehabilitation service plan.	<p>Findings: The facility reports the following compliance data that are relevant to the requirement:</p> <p>Monthly Conference: If indicated, the treatment team updated present status section of the case formulation and diagnosis based on current assessments, progress reviews and the individual's thoughts and concerns about treatment. (28%)</p> <p>Quarterly Conference: A team member gives a summary report of the individual's progress on each treatment objective and progress in meeting discharge criteria. (2%)</p> <p>Chart reviews by this monitor demonstrate failure to conduct data-based reviews in the WRP in all cases (LLL, MM, APG, WWM and</p>

		<p>MWG).</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Same as in C.2.g.i. 2. Same as recommendation #3 in C.2.f.viii.
h	<p>Individuals in need of positive behavior supports in school or other settings receive such supports consistent with generally accepted professional standards of care.</p>	<p>Findings:</p> <p>PSH has three Positive Behavior Support (PBS) teams, but the third team is currently without a PBS psychologist and a registered nurse. The facility does not have a Developmental and Cognitive Abilities team (DCAT) team.</p> <p>The existing PBS team members are partially trained in the principles of PBS and Recovery, but highly motivated to fulfill their role and responsibilities.</p> <p>Not all individuals in PSH who need PBS receive the needed service.</p> <p>The PBS assessment plans reviewed by this monitor varied in quality and did not meet criteria for PBS plans. However, recent PBS plans (e.g., FS, November 2, 2006) show great improvement over the older PBS plans (e.g., CC, February 11, 2005). The PBS teams would be advised to follow a PBS plan format that combines a behavior drill with the PBS plan.</p> <p>PBS teams still do not have the authority to write orders for the implementation of PBS plans.</p> <p>In general, PBS plans are not always implemented consistently and appropriately by all involved staff across shifts and settings, as clinically indicated. PBS teams generally end up implementing the PBS plans in the units, instead of teaching, training, assisting, and then fading out. This is not how the PBS teams are expected to function.</p>

		<p>In a number of units, the PBS teams and the WRP teams do not collaborate well. Thus, the WRP teams either fail to refer individual cases to PBS teams when indicated, or fail to implement the PBS plans when one is designed by the PBS teams. The WRP and PBS teams do not work collaboratively on an ongoing basis until a case is "formally" referred to PBS. The two teams operate in a multidisciplinary rather than interdisciplinary fashion.</p> <p>Documentation of change in maladaptive and collateral social behaviors as a function of interventions is insufficient.</p> <p>It is important to recognize that PBS is most effective when used as a preventive strategy rather than an intervention strategy.</p> <p>PSH's Positive Behavioral Support Staff Development Report (i.e., training records) indicated 76% compliance. The following breakdown was presented:</p> <p>Number of staff required to attend PBS training: 1308. Number of staff who attended: 996. Number of staff who failed to attend: 312.</p> <p>PSH's self-evaluation showed that between June, 2006 and October, 2006, a total of 23 PBS referrals did not result in subsequent assessment and/or intervention plans. This requirement only had a compliance rate of 33%.</p> <p>The Statewide PBS Integrity Checklist has not been implemented at PSH.</p> <p>Compliance: Partial.</p>
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		<p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that PSH has the required number of PBS teams. 2. Ensure that all PBS team members receive further training in PBS by the Chief CRIPA Consultant. 3. Ensure that PBS psychologists have the authority to write orders for the implementation of PBS plans. 4. Ensure that all staff implement PBS plans and collect reliable and valid outcome data. 5. Provide competency-based training to all staff in PBS procedures 6. Ensure that all individuals who have severe maladaptive learned behaviors not amenable to change under unit Behavioral Guidelines are referred to the PBS teams for structural and functional analysis, and interventions. 7. Ensure that WRP team members know when they should refer individuals to the PBS teams. 8. Ensure that PBS teams know when they should refer cases to BCC and document their practice on the PBS-BCC Checklist. 9. Monitor the implementation of the PBS plans and insure that the plans are used consistently across intervention settings. 10. Collect objective information to evaluate the effectiveness of the PBS plans, including change in behaviors, stability of behavior change, change in co-varying behaviors, achievement of broader goals, and durability of behavior change. 11. Review the individual's progress on the PBS plans and make necessary changes, as indicated by the data and feedback from unit staff. 12. Ensure that recommendations through the PBS plans take into consideration the conditions and limitations imposed by the unit environment. 13. Develop an appropriate tool to monitor this task. 14. Ensure that there is full administrative support for PBS teams.
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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>Findings: PSH's psychosocial rehabilitation services are deficient in many respects. Staff reports, feedback from individuals, chart reviews, observation of WRP team conferences and observation of Mall activities showed that this requirement is not fully met. The following deficiencies were identified:</p> <ol style="list-style-type: none"> 1. Individuals' strengths, needs, and cognitive level are not always considered when assigning individuals to psychosocial rehabilitation services in the mall. 2. A number of the individuals' self-reports showed that they did not have a good understanding of the reasons for the activities they are assigned to. 3. Individuals are not always asked about their group activities, interest, preference, and/or progress during their WRP team conferences. 4. Completed PSR Mall Facilitator Monthly Progress Note was not evident in the individuals' charts. 5. A number of staff reported that individuals are forced to attend group activities even when the individuals did not like the group they are asked to attend. <p>This task is weak across the various links in the process, beginning with assessments that fail to address the individuals' rehabilitation needs; WRPs that do not fully explore the individuals' needs, preference, and strengths; and the limited variety of treatment, rehabilitation and enrichment groups available to the individuals.</p> <p>PSH has established a Recovery Enhancement Group. This group, comprised of volunteer psychologists, meets individuals who refuse to attend assigned groups. The psychologists talk to the individuals and</p>

		<p>encourage them to attend their Mall groups. Staff reported that this group has been very successful in helping individuals return to their groups. There is no evidence that any systematic method of behavior change including Motivational Interviewing, Narrative Restructuring Therapy and Cognitive-Behavioral interventions are used by the group to change the individuals' attitudes to participate in their assigned group and individual therapies.</p> <p>PSH's self-evaluation showed only 5% to 15% compliance with the various elements for this requirement.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that all discipline-specific assessments include a section that states the implications of the assessment for rehabilitation activities. 2. WRP teams should integrate relevant information from discipline-specific assessments and prioritize the individual's assessed needs 3. Ensure that group leaders are consistent and enduring for specific mall groups. 4. Use the PSH established Recovery Enhanced Group to assist individuals in attending their designated activities. 5. Expand the number of mall groups and individual therapies to accommodate the assessed needs and interests of individuals. 6. Use systematic methods of behavior change including Motivational Interviewing, Narrative Restructuring Therapy and Cognitive-Behavioral interventions to change the individuals' attitudes to participate in their assigned group and individual therapies.
i.ii	Has documented objectives, measurable outcomes, and standardized methodology	<p>Findings: The Psychosocial Rehabilitation Mall Manual addresses this requirement with course outlines and sequence of steps to conduct</p>

		<p>group activities. Methodology is not standardized across groups. Review of course material and interviews with group facilitators showed that outcome measurements and tracking of individual's progress/change is very poor. Documentation using the DHM Monthly Mall Progress notes is not utilized. Mall progress notes are not available to the individual's WRP teams. Unit staff is not aware of the individual's group performance goals for assistance and reinforcement.</p> <p>Chart review of CH shows poor implementation of this requirement.</p> <p>PSH's self-evaluation evidenced compliance rates ranging between 20% and 37% for the various elements in this cell.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that each individual has documented objectives. 2. Ensure that the learning outcomes are stated in measurable terms. 3. Ensure that each objective is directly linked to a relevant focus of hospitalization and discharge criteria. 4. Ensure that the courses offered have observable outcomes with evaluation measures built in.
i.iii	Is aligned with the individual's objectives that are identified in the individual's Wellness and Recovery Plan	<p>Findings:</p> <p>This monitor reviewed 20 charts (CH, MK, DJ, DS, AJ, RJ, GA, ST, GB, AL, JG, HH, GF, EL, WC, CS, GJ, MW, BB, and MH) and matched the objectives found in their WRPs with their weekly activity schedules. The psychosocial rehabilitation services of four of these individuals (i.e., 20% sample) were clearly aligned with the objectives identified in their WRP plan. As for the rest, this monitor had difficulty determining specificity of the services against the objectives because of the following deficiencies:</p> <ol style="list-style-type: none"> 1. Objectives often were not staged properly.

		<ol style="list-style-type: none"> 2. Objectives usually had the same target dates. 3. Outcomes were not written in measurable terms. 4. Methods to measure progress were unstated. 5. Objectives did not always have corresponding interventions. <p>PSH's self-evaluation showed compliance rates of 20%-37% for the various elements in this requirement.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that WRP teams write objectives in behavioral, observable, and/or measurable terms. 2. Ensure that all therapies and rehabilitation services provided are aligned with the assessed needs of the individuals. 3. When assigning individuals to Mall groups, the WRP team members should be familiar with the contents of the group they recommend so that the groups are aligned with the individuals needs. 4. Ensure that group facilitators follow the Mall curricula and course content. 5. Ensure that individuals' progress is tracked (using the PSR Mall Facilitator Monthly Progress Note) and their participation at different levels and different groups are adjusted accordingly.
i.iv	utilizes the individual's strengths, preferences, and interests;	<p>Findings:</p> <p>Assessments rarely identify strengths of individuals that the WRP teams can use to establish specific services for individuals.</p> <p>WRP conferences often do not explore the individuals' strengths, preferences, and/or interests to address the individuals' assessed needs.</p> <p>PSH's self-evaluation showed compliance rates between 4% and 10%</p>

		<p>with this requirement.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that the individual's strengths, preferences, and interests are clearly specified in the interventions in the individual's WRP in accordance with the DMH WRP manual. 2. Ensure that the group facilitators and individual therapists know and use the individual's strengths, preferences and interests when delivering rehabilitation services.
i.v	<p>focuses on the individual's vulnerabilities to mental illness, substance abuse, and readmission due to relapse, where appropriate;</p>	<p>Findings:</p> <p>This monitor's review of WRPs showed that the case formulations lack completeness in their discussion of predisposing and precipitating factors, and do not focus on the individual's vulnerabilities to mental illness and substance abuse, and/or readmission due to relapse.</p> <p>Chart reviews revealed uneven quality. Case formulation using the 6-p format had very little analysis, and did not follow the content guidelines established in the DMH WRP Manual. For example, GB had an Axis 1 diagnosis of Polysubstance Dependence, yet a short statement that "Mr.B. has used marijuana, cocaine, and alcohol", was the only mention under Pertinent History and Precipitating Factor section regarding GB's substance abuse behavior.</p> <p>PSH's self-evaluation evidenced compliance rates ranging between 3% and 35% for all elements for this requirement.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Undertake clinical case formulation as a team rather than by assigning the task to a team member or to non-team members. 2. Include the individual's vulnerabilities in the case formulation under predisposing, precipitating, and perpetuating factors. 3. Update the present status to reflect the current status of

		<p>these vulnerabilities.</p> <ol style="list-style-type: none"> 4. Develop and implement a training curriculum to ensure proper implementation of the staged model of substance abuse by WRP teams. 5. Provide appropriate psychosocial rehabilitation services to individuals to preempt relapse.
i.vi	<p>is provided in a manner consistent with each individual's cognitive strengths and limitations;</p>	<p>Findings: Mall groups are not assigned by cognitive levels. Group facilitators, especially "stand-ins" and substitutes, do not know the individuals' cognitive strengths and limitations.</p> <p>Individuals in the Mall groups observed by the Monitor presented with a wide range of cognitive levels.</p> <p>PSH identified 291 individuals with cognitive challenges and 299 individuals with neurocognitive deficits who would benefit from a DCAT Team. These individuals need to attend Mall groups that are aligned with their cognitive strengths and limitations.</p> <p>PSH's self-evaluation showed 20% compliance with this requirement.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. PSR Mall groups should address the assessed cognitive levels of the individuals participating in the group. 2. Psychologists should assess all individuals suspected of cognitive disorders, mental retardation and developmental disabilities and other conditions that may adversely impact an individual's cognitive status. 3. Ensure that individuals with cognitive and neurocognitive challenges are evaluated by a DCAT team and assigned to mall groups that meet their cognitive strengths and limitations.

i.vii	Provides progress reports for review by the Wellness and Recovery Team as part of the Wellness and Recovery Plan review process	<p>Findings: None of the charts reviewed by this monitor contained Mall progress notes. Information from staff indicated that the DMH PSR Mall Monthly Progress note has not been implemented.</p> <p>PSH's self-evaluation showed 0% compliance with this requirement.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that WRP teams receive timely progress notes on individuals' participation in their psychosocial rehabilitation services. 2. Automate this system. 3. Use the data from the PSR Mall Facilitator Monthly Progress Note in the WRP review process.
i.viii	is provided five days a week, for a minimum of four hours a day (i.e., two hours in the morning and two hours in the afternoon each weekday), for each individual or two hours a day when the individual is in school, except days falling on state holidays;	<p>Findings: PSH has a very motivated and committed Mall Director. The PSR Mall structure is in place for all individuals in the facility. Mall activities are planned and scheduled for five day a week (Monday through Friday), two hours in the AM and two hours in the PM (four hours/day, 20 hours/week). The PM mall group activities are not organized and structured as in the AM.</p> <p>While the number of planned hours on paper is four hours/day, the actual number of hours offered per day is less. There is a discrepancy between hours scheduled, hours offered, and hours of participation by individuals.</p> <p>Analysis of active participation list for six individuals (CM, MK, DJ, CH, RJ and JG) showed the following:</p> <p>CM: Days analyzed 16, mean hours of activity offered 3.75 hours/day, and mean hours of participation by CM was 1.8 hours/day.</p>

MK: Days analyzed 11, mean hours of activity offered was 3.5 hours/day, and mean hours of participation by MK was 1.4 hours/day.

DJ: Days analyzed 17, mean hours of activity offered was 3.2 hours, and mean hours of participation by DJ was 1.4 hours/day.

CH: Days analyzed 16, mean hours/day offered 3.3 hours/day, mean hours of participation by CH was 0.7 hours/day.

RJ: Days analyzed 17, mean hours/day activity was offered 3.4 hours/day, and mean hours of participation by RJ was 0.8 hours.

JG: Days analyzed 17, mean hours of activity offered 3.3 hours/day, and mean hours of participation by JG was 2.1 hours/day.

There appears to be a systematic error in the computation of the time, in the active participation list reviewed by this monitor. The minutes to hours conversion was incorrect (Note that the time for the data presented above was corrected.) This process needs to be automated to eliminate computational errors. If it is automated, the software/spreadsheet/macros need revision.

The Mall Director has put in place a number of initiatives. She has created individual folders for each group. The folders are labeled with identification, names of facilitators, times of meetings, and names of groups. She has planned to use motivational stickers for the groups as they improve in their functioning.

PSH also has established, unique to PSH, a Recovery Encouragement Group. Psychology staff has volunteered to staff this group to talk with individuals who refuse to attend their groups and encourage them to attend their groups.

		<p>This monitor observed group facilitators and co-facilitators check for and attend to individuals who failed to attend their groups.</p> <p>All groups observed by this monitor had at least a facilitator and a co-facilitator. The following deficiencies were noted by this monitor:</p> <ol style="list-style-type: none">1. Malls hours are not always provided as scheduled.2. Assignment of individuals to groups using their needs and interest, and discharge criteria is poor.3. A number of groups do not have curricula.4. PSH frequently uses 'rotating' facilitators making it near impossible for both individuals and staff to familiarize with each other, as well as provide continuity of care.5. Stand-in facilitators are not well informed or prepared for the day's activities.6. Mall progress notes are not written regularly and made available to the WRP team in a timely manner.7. The scheduling of activities and their content do not always relate directly to the individual's WRP plan objectives.8. Afternoon Mall group activities/content are considered more as a "filler" as opposed to structured therapeutic/educational activity.9. None of the disciplines fulfill their mandated hours of service, and the required number of hours of mall facilitation by the disciplines is too low.10. A number of groups are conducted adjacent to each other with open walkways and doors. The noise and traffic from one room to the other was disruptive and distracting to individuals. This situation is disruptive to both the individuals and the facilitators. <p>A number of staff complained that individuals are forced to attend</p>
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Mall groups even when they do not want to. "Forced treatment" should be considered a system failure. It is an indication that staff has failed to engage the individual in the treatment process. An individual's motivation to attend scheduled activities can be better handled through education, WRP conferences, and the Recovery Encouragement team; as well as by ensuring that the individual has a strong role in the choice of groups, and by offering activities of sufficient variety and quantity to accommodate the interests and preferences of individuals. Improved linkage between the various system processes including assessments, WRP conferences, group types, curriculum, and delivery methods can contribute to a better match between the individual's strengths and preferences and assignments.

According to the data provided by PSH, the number of hours of Mall services scheduled and provided by each discipline is not aligned with what is needed. For example, the scheduled and actual hours of Mall services provided by disciplines are as follows:

Discipline	Hours scheduled/week	Hours provided/week
Dietitian	0.9	0.9
Social Work	4.7	3.0
LVN	1.4	1.3
PhD	3.6	1.9
RN	1.9	1.4
RT	5.0	3.8
PT	1.9	1.3
Psychiatrist	1.8	0.8

As noted in MSH Report 1 (p. 56), the following is what is expected per week by each of the core disciplines: psychology (6 -8 hrs); Social Work (10 - 12 hrs); RT (12 -15 hrs); RN (10 - 15 hrs); PT (10 - 15 hrs);

		<p>and psychiatry (5 - 8 hrs). Furthermore, it was noted that "these are minimum hours and do not include individual therapy hours—which should be undertaken in addition to these hours."</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Provide PSR Mall groups as required by the EP. 2. Mandate that all staff other than those who attend to emergency medical needs of individuals provide services at the PSR Mall during scheduled mall hours. This includes clinical, administrative and support staff. 3. All Mall sessions must be 50 minutes in length. Sessions less in duration do not contribute to an individual's active treatment hours. 4. Ensure that individuals participate in their scheduled hours. 5. Provide groups as needed by the individuals and written in the individuals' WRPs. 6. Add new groups as the needs are identified in new/ revised WRPs.
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>Findings:</p> <p>PSH does not have a skill nursing unit and did not have any bed-bound individuals for observation during the week of this evaluation. At present, PSH does not have a program/plan to deal with individuals who are bed-bound, if any are admitted in future.</p> <p>This monitor toured Unit 11. There were a few individuals in wheelchairs in this unit. Interview of these individuals and the staff in that unit indicated that the unit staff assisted the individuals to perform various activities. The individuals did not report any concerns or complaints regarding their ability to participate in mall-type activities.</p>

		<p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that bed-bound individuals are included in the planning and implementation of appropriate activities commensurate with their cognitive status, medical, health, and physical limitations. 2. Ensure that therapy for individuals who are unable to ambulate or be transferred can be provided in any physical location within the hospital as long as the services are structured and consistent with scheduled Mall activities.
i.x	routinely takes place as scheduled;	<p>Findings:</p> <p>Mall activities are not always held consistently as planned.</p> <p>PSH's self assessment data showed high rate of cancellations of Mall groups. The number of cancellations and reasons given for those cancellations are as follows:</p> <ol style="list-style-type: none"> 1. Prolonged transition time (53 groups); 2. Non-availability of staff (16 groups); 3. Building construction (43 groups); 4. Lack of alarm system (43 groups); 5. Room was not set-up (1 group); and 6. Security reasons (8 groups). <p>At least two groups scheduled for observation by this monitor were cancelled.</p> <p>In one group, individuals were waiting for nearly 10 minutes before a "substitute" facilitator was available. In another group, there were two facilitators who did not know each other's names, let alone names of individuals attending their group; and in another group, the name of the group and the location was different than what was in the Mall Schedule.</p>

		<p>Recommendations:</p> <ol style="list-style-type: none"> 1. Implement a more focused Mall program that is regularly scheduled, implemented, and provided within the individual's cognitive, medical, physical and functional status. 2. Ensure that Mall groups and individual therapies are cancelled rarely, if ever. 3. Ensure that all disciplines facilitate a specified minimum number of hours of mall groups. 4. Ensure that administrators and support staff facilitate a minimum of one mall group per week.
i.xi	includes, in the evenings and weekends, additional activities that enhance the individual's quality of life; and	<p>Findings:</p> <p>Formal enrichment activities are not offered on the evenings and weekends.</p> <p>PSH does not track and monitor enrichment/ Psychosocial Therapeutic Services offered during evenings and weekends.</p> <p>Evening and weekend enrichment activities are minimal, and per staff report used more as a "time filler" with no formal therapeutic activities. There is no proper documentation on weekend recreational or enrichment activities.</p> <p>Staff was unable to differentiate enrichment from treatment activities offered during weekends.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop a list of all enrichment activities available along with staff names competent in facilitating the activities in accordance with generally accepted professional standards of care. 2. Plan and organize these activities such that there is minimal interruption, individuals are reinforced to participate

		<p>regularly in these activities, and as much as possible eliminate competing activities that act as a barrier for individuals to participate in such activities.</p> <ol style="list-style-type: none"> 3. Increase the number of hours of enrichment activities per individual provided in the evenings and weekends. 4. Ensure that there is uniformity in the methodology and process of how the groups are organized and managed.
i.xii	is consistently reinforced by staff on the therapeutic milieu, including living units.	<p>Findings: Observation of the milieu showed some evidence of positive affirmations about recovery posted around the units.</p> <p>Most group facilitators of the Mall groups observed by this monitor showed a high level of enthusiasm and frequently reinforced individuals in their groups. However, the situation was different in the units. A number of unit staff was unable to clearly describe how their activities related to the individual's treatment objectives.</p> <p>There was no consistent, observable evidence that staff provides reinforcement and achieve active treatment objectives across groups and settings in the therapeutic milieu.</p> <p>PSH self-assessment showed that this requirement was met only 12% of the time.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. All WRPs should have therapeutic milieu interventions clearly specified in the intervention sections. 2. Ensure that unit staff reinforces individuals appropriately during Mall group activities as well in the units.
j	Adequate, individualized group exercise and recreational options are provided, consistent with generally accepted	<p>Findings: Document review and interview of staff and individuals revealed that</p>

	<p>professional standards of care.</p>	<p>group exercises and recreational activities are provided but not in sufficient quantity to meet the needs of all individuals. PSH has a large segment of its population with high BMI's that would benefit from vigorous recreational options.</p> <p>PSH self-assessment data for the month of September, 2006, on individuals who triggered the BMI Key Indicator, showed that at least 290 individuals failed to receive any structured exercise or recreational activities.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Establish group exercise and recreational activities for all individuals. 2. Provide training to Mall facilitators to conduct the activities appropriately. 3. Track and review participation of individuals in scheduled group exercise and recreational activities. 4. Implement corrective action if participation is low.
k	<p>Individuals who have an assessed need for family therapy services receive such services in their primary language, as feasible, consistent with generally accepted professional standards of care and that these services, and their effectiveness for addressing the indicated problem, are comprehensively documented in each individual's chart.</p>	<p>Findings: PSH does not monitor this requirement. PSH has no formal system in place to assess and provide family therapy services for individuals who may need or desire such services.</p> <p>PSH's self-evaluation data showed that ten individuals living in the Spanish speaking unit are currently receiving family therapy services. One individual in Unit 35 with assessed need for family therapy service has yet to receive the service, and another is not receiving family therapy services owing to language barrier. None of the WRP conferences observed by this monitor discussed family therapy needs</p>

		<p>of the individual.</p> <p>The Director of Social Work services reported that social workers address this on an individual basis, but no documentation was provided attesting to its occurrence.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Conduct a needs assessment for family therapy with individuals and/or their families. 2. Use individual discharge plan goals as a way to identify families that may need family therapy to help them assist and support their family members upon discharge. 3. Review pre-admission reports and services/treatments provided to identify the need for family therapy services. 4. Ensure that family therapy needs are fulfilled.
I	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.	
m	The children and adolescents it serves receive, consistent with generally accepted professional standards of care:	PSH does not serve this population.
m.i	Therapy relating to traumatic family and other traumatic experiences, as clinically indicated; and	Not applicable.
m.ii	reasonable, clinically appropriate opportunities to involve their families in treatment and treatment decisions.	Not applicable.

n	Policies and procedures are developed and implemented consistent with generally accepted professional standards of care to ensure appropriate screening for substance abuse, as clinically indicated.	<p>Findings: California DMH has developed a draft policy regarding Screening for Substance Abuse. The policy provides guidelines and responsibilities for the appropriate screening of all individuals as clinically indicated. The procedures do not address one of the two main purposes of the policy, that is to ensure that screening and assessment of substance abuse is available and used to provide therapeutic and rehabilitation services that are consistent with generally accepted professional standards of care.</p> <p>At this time, PSH does not have policies and procedures that address this requirement.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Revise the DMH draft policy regarding Screening for Substance Abuse to address all purposes of the policy. 2. Finalize and implement the policy and procedure.
o	Individuals who require treatment for substance abuse are provided appropriate therapeutic and rehabilitation services consistent with generally accepted professional standards of care.	<p>Findings: PSH has Chart Audit data based on the use of a monitoring indicator that does not adequately addresses this requirement.</p> <p>Several staff members across all disciplines maintain some form of substance abuse credentials or training, but there are no formalized processes to assess the validity of the credentials, establish a privileging system and develop mechanisms for competency evaluation.</p> <p>PSH has a Comprehensive Addiction Recovery Education (CARE) program, which is part of Enhancement Services. The program is provided by a team consisting of four social workers, two</p>

		<p>rehabilitation therapists, two registered nurses, three psychiatric technicians and a physician. Staff interviews with this monitor indicate that the program does not have clearly designated administrative leadership of day-to-day operations, but clinical direction is provided by Robert Adams, a physician who is board-certified by the American Society of Addiction Medicine (ASAM). The team provides services to all individuals in need. The services are guided by the transtheoretical model as outlined in the Group Treatment for Substance Abuse: A Stages-of-Change Therapy Manual by Mary Velasquez, Gaylyn Gaddy Maurer, Cathy Crouch, and Carlo C. DiClemente. This is an excellent, evidence-based manual that comports with current generally accepted standards of care in the field. In addition, the team utilizes the Skills Training for People with Schizophrenia model, which is outlined in Overcoming Addictions by Lisa Roberts, Andrew Shaner and Thad A. Eckman.</p> <p>PSH is in the process of evaluating the Substance Abuse Treatment Curricula developed by ASH and NSH, and has developed its own curriculum regarding the stages of preparation and action. PSH has yet to finalize a complete curriculum that addresses all stages of change, including maintenance and to develop parameters for training and competency evaluation of WRP teams and of service providers.</p> <p>In a personal interview with this monitor, the CARE team identified the following barriers to service delivery:</p> <ol style="list-style-type: none">1. Limited Involvement by the CARE team in the WRP conferences: This has resulted in Lag time between the WRP Conference and initiation of services, which has delayed services for some individuals;2. Transportation of individuals located on a separate compound of the campus: This has compromised services for elderly individuals, individuals on the admission units, medically fragile
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		<p>individuals, Spanish speaking individuals and individuals with hearing impairment;</p> <ol style="list-style-type: none"> 3. Providing services to individuals under PC 1370s, who have short length of hospital stay; and 4. Training of WRT members regarding proper identification of the individual's stages of change. <p>The clinical administrator is currently developing strategies to address these challenges.</p> <p>Chart reviews by this monitor (LLL, MM, APG, WWM, RC and VH) indicate that the facility has adequate practice in the following areas:</p> <ol style="list-style-type: none"> 1. Recognizes substance abuse as a diagnosis on the WRPs; 2. Inclusion of substance abuse as a focus for hospitalization when the diagnosis is made; and 3. Development of substance abuse-related objectives or interventions when the diagnosis of substance abuse is identified as a focus for hospitalization. <p>However, the same reviews demonstrate the following pattern of deficiencies:</p> <ol style="list-style-type: none"> 1. Substance abuse is not adequately addressed in the formulation of discharge criteria (VH). 2. There is no evidence of recovery-based interventions due to either failure to identify stages of change for the individual (e.g., MM) or inappropriate identification of those stages (APG, VH, RC, WWM). 3. There is no evidence of recovery-based interventions that are linked to stages of change (MM, APG, VH and WWM). <p>Furthermore, in the majority of charts reviewed by this monitor, the</p>
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		<p>case formulations do not address the factors that precipitate or predispose, or perpetuate relapse and readmission and the WRPs do not address the interventions needed to overcome these factors.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Designate administrative and clinical leadership to the CARE team. 2. Develop and implement a monitoring instrument to assess compliance with this requirement. 3. Standardize the substance abuse auditing mechanisms across all State facilities. 4. Finalize the NSH training curriculum to ensure proper implementation of the trans-theoretical model of substance abuse by all WRP teams across all State facilities. 5. The substance recovery program should develop and utilize clinical outcomes for individuals and process outcomes for the program. 6. Ensure that all individuals receive substance abuse services based on their assessed needs.
p	<p>Group facilitators and therapists providing therapeutic and rehabilitation services (in groups or individual therapy) are verifiably competent regarding selection and implementation of appropriate approaches and interventions to address therapeutic and rehabilitation services objectives, are verifiably competent in monitoring individuals' responses to therapy and rehabilitation, and receive regular, competent supervision.</p>	<p>Findings: Staff interview and document review showed the following:</p> <ol style="list-style-type: none"> 1. PSH has not implemented the PSR Mall Course Facilitator Checklist. 2. PSH does not have a group facilitator course with a competency post-test. 3. PSH does not have a good system to evaluate provider competency.

		<p>PSH's self-evaluation showed 0% compliance to the Mall Facilitator Monitoring Form.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Monitor the competency of group facilitators and therapists in providing rehabilitation services. 2. Ensure that providers have the appropriate education, training, and experience appropriate to the scope and complexity of services
q	<p>Group facilitators and therapists providing therapeutic and rehabilitation services in the field of substance abuse should be certified substance abuse counselors.</p>	<p>Findings:</p> <p>There is no specific competency requirement in the credentialing/privileging process. All psychiatry staff is deemed to have credentials/privileges in substance abuse group and individual therapy. PSH has two psychiatrists that are board-certified in substance abuse. There is no other staff in psychiatry, psychology, and social work that holds substance abuse credentials.</p> <p>Compliance:</p> <p>Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that all group facilitators complete the substance abuse training curriculum. 2. Clarify and streamline staff competency criteria to ensure their alignment with the current training curriculum. 3. Ensure that training includes all of the five stages of change. 4. Establish a review system to evaluate the quality of services provided by these trained facilitators. 5. Ensure that providers serving individuals at the pre-contemplation stage are trained to competency and meet Substance Abuse counseling competency.

r	<p>Transportation and staffing issues do not preclude individuals from attending appointments.</p>	<p>Findings: Review of the list for missed appointments by this monitor showed that at least 30% of appointments was not kept, and in most cases reasons for missed appointments were not documented.</p> <p>PSH self-assessment on missed appointments was similar to the monitor's findings. In September; 2006, a total of 1600 appointments were scheduled, of which 509 (31%) were audited. Of these, 355 (70%) of the appointments were kept, and 154 (30%) were not kept. There was a high rate of reschedules and no shows. In most cases reasons for missed appointments were not given.</p> <p>PSH does not have an automated system to track missed appointments.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Establish an automated system to track cancellation of scheduled appointments 2. Ensure that all appointments are completed.
s	<p>Adequate oversight to treatment, rehabilitation and enrichment groups is provided to ensure that individuals are assigned to groups that are appropriate to their assessed needs, that groups are provided consistently and with appropriate frequency, and that issues particularly relevant for this population, including the use of psychotropic medications and substance abuse, are appropriately addressed, consistent with generally accepted professional standards of care.</p>	<p>Findings: Individuals' preferences, and strengths and needs are not always considered when assigning individuals to groups. Furthermore, individuals' cognitive levels are not taken into consideration for group assignments.</p> <p>Interview with staff showed that treatment, rehabilitation and enrichment groups are not fully in compliance with EP to ensure that individuals receive appropriate services.</p>

		<p>Using the Mall Alignment Checklist Monitoring Form, PSH self-evaluation showed 37% compliance with this requirement.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that individuals' cognitive levels, needs, and strengths are utilized when considering groups assignments. 2. Ensure that providers and facilitators are knowledgeable, competent, and motivated to translate course content to meet individuals' needs. 3. Ensure that progress notes are written in a timely fashion and made available to the individual's WRP team. 4. Develop and implement monitoring systems that address all the required elements.
†	<p>Treatment, rehabilitation and enrichment services are monitored appropriately against rational, operationally-defined target variables and revised as appropriate in light of significant developments, and the individual's progress, or lack thereof;</p>	<p>Findings: Individuals' treatment, rehabilitation and enrichment services are not monitored appropriately against rational, operationally defined target variables and revised as appropriate in light of significant developments and monthly progress.</p> <p>None of the WRP conferences attended or WRPs reviewed by this monitor fulfilled this criterion completely. There were no data to document individual's progress or lack thereof. For example, MH's WRP (dated November 28, 2006); in the Previous Treatment and Response section the statement about his group participation reads "He <u>appears</u> to attend <u>most</u> of the groups that he has selected to go to, but with <u>unclear</u> participation." The words "appears", "most" and "unclear" are not objective or data-based. It is not possible to know what level of progress, if any, the individual made during the evaluation period.</p>

		<p>Three of MH's WRPs (March 10, August 22 and November 22, 2006) had the same paragraphs in the Previous Treatment and Response section. There was no update of treatment responses between WRP team conferences.</p> <p>Enrichment activities, especially during the evenings and weekends, are not appropriately monitored or documented.</p> <p>PSH self assessment showed only 30% compliance with this requirement.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement monitoring tools to ensure the process outcomes of treatment and/or rehabilitation services. 2. Develop and implement monitoring tools to ensure that mall activities are properly linked to the foci, objectives and interventions specified in the WRP. 3. Implement and monitor PSR Mall Facilitator Monthly Progress Note. 4. Ensure that WRP teams review PSR Mall Facilitator Monthly Progress Note and document individual progress or lack thereof; and discuss the findings with the individual.
u	<p>Individuals are educated regarding the purposes of their treatment, rehabilitation and enrichment services. They will be provided a copy of their WRP when appropriate based on clinical judgment.</p>	<p>Findings: PSH provides this education in group format. The facility has a system for tracking group attendance by the individuals but does not have self-assessment data. The facility has yet to develop and implement a system to track individuals' participation in these groups. The facility has data showing that, during the month of October</p>

		<p>2006, 452 individual were involved in at least one Wellness and Recovery Action Plan group (the month of October).</p> <p>At this time, PSH provides 67 groups that provide this education. The following is a breakdown of the number of groups provided by each discipline:</p> <p>Psychology: 9 Social Work: 30 Rehabilitation Therapy: 14; Nursing: 14.</p> <p>There is no system in place that monitors when an individual has received a copy of his/her treatment plan.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that the Mall group curriculum includes and identifies groups that offer education about the purpose of treatment, rehabilitation and enrichment activities. 2. Develop and implement a monitoring tool to address this requirement, including groups offered and provided and individuals' attendance and participation. 3. Ensure that individuals are provided a copy of their WRP based on clinical judgment.
v	<p>Staff educates individuals about their medications, the expected results, and the potential common and/or serious side effects of medications, and staff regularly asks individuals about common and/or serious side effects they may experience.</p>	<p>Findings: The DMH WRP does not include guidelines for WRP Teams to assist individuals in making choices based on need and available services. All programs are currently offering medication management groups in the mall. There are currently active medication management groups held</p>

		<p>in the facility.</p> <p>At this time, PSH provides 46 groups:</p> <ul style="list-style-type: none"> • Psychiatry: 37; • Nursing (RN): 9 <p>The facility reports that 589 individuals are enrolled in one or more medication education groups. PSH has a system for tracking group attendance by the individuals but does not have self-assessment data.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. The DMH WRP manual needs to include guidelines to WRP teams regarding the assessment of individuals' needs regarding this requirement and to assist individuals in making choices based on both need and available services. 2. Ensure that the Mall group curriculum includes and identifies groups that offer medication education. 3. Develop and implement a monitoring tool to address this requirement, including groups offered and provided and individuals' attendance and participation.
w	<p>Interdisciplinary teams review, assess, and develop positive clinical strategies to overcome individual's barriers to participation in therapeutic and rehabilitation services.</p>	<p>Findings: The previously mentioned disconnect between the information in the WRPs and the MAPP system seriously limits the facility's self-assessment data regarding individuals' participation in active treatment. At this time, the WRP teams do not have a methodology to assess individuals' barriers to participation. In addition, the WRP teams do not provide individuals with clinical strategies to help them achieve readiness to engage in group activities.</p>

		<p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none">1. Ensure that the DMH WRP manual includes guidelines to WRP teams regarding assessment methodology and strategies, including cognitive interventions, to facilitate individuals' participation.2. Ensure alignment of information in the WRPs and the MAPP system regarding current schedules of active treatment and individuals' participation.3. Assess barriers to individuals' participation in their WRPs and provide strategies 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. PSH has transitioned to a new format of integrated assessment. When fully implemented, the format provides comprehensive assessments of the individual's needs and serves as the basis for meaningful recovery model of service planning. 2. In general, the admission medical assessments, initial psychiatric assessments, integrated assessment, psychiatric reassessments and the transfer assessments are completed in a timely manner. 3. PSH has developed and implemented a variety of monitoring instruments that are aligned with the requirements in the EP. 4. The facility's monitoring data reflect the integrity of the self-assessment process (e.g., psychiatric assessments, reassessments and transfer assessments).
1	Psychiatric Assessments and Diagnoses	
	<p>Each State hospital shall provide all of the individuals it serves with routine and emergency psychiatric assessments and reassessments consistent with generally accepted professional standards of care; and,</p>	<p>Methodology: Interviewed Wadsworth Murad, M.D., Acting Chief of Psychiatry. Interviewed Raafat Girgis, M.D., Chief of Medical Staff. Interviewed Dennis Green, Staff Service Analyst, Medical Staff Coordinator. Linda Waldorf, Medical Staff Secretary. Interviewed Katherine Ryn Smith, RN Auditor Interviewed five Staff Psychiatrists. Reviewed charts of 28 individuals (LL, MS, BRA, HG, BSL, PS, MAT, TMH, LDG, CSL, AL, KAB, VGF, RA, JG, RR, LRN, CDS, RJ, EYB, BLC, JCB, GCD, FB, BP, CB and SMC).</p>

		<p>Reviewed a roster of all psychiatrists at PSH and their board certification status.</p> <p>Reviewed PSH Staff Psychiatrist Application Packet.</p> <p>Reviewed PSH Medical Staff Office Procedures Appointment and Privileging.</p> <p>Reviewed PSH form regarding Reappointment/Reprivileging of Medical Staff.</p> <p>Reviewed PSH Medical Staff Reappointment/Reprivileging Profile.</p> <p>Reviewed written questionnaire used by the interviewing panel for psychiatry applicants.</p> <p>Reviewed Department of Psychiatry Quarterly Peer Review Report and Data (July to September 2006).</p> <p>Reviewed PSH Medical Staff Bylaws, Rules and Regulations.</p> <p>Reviewed Audit for Timeliness and Completeness of Documentation Form.</p> <p>Reviewed AD #10.03 Suicide Prevention and Intervention.</p> <p>Reviewed DMH SO #115 Guidelines for Suicide Prevention.</p> <p>Reviewed AD#12.06 Intra-hospital Patient Transfers.</p> <p>Reviewed PSH form regarding transfer assessments.</p> <p>Reviewed Initial Admission Assessment Monitoring Form.</p> <p>Reviewed Initial Admission Monitoring Summary Data (October 2006).</p> <p>Reviewed Initial Medical Assessment Tally Worksheet.</p> <p>Reviewed Initial Medical Assessment Tally Worksheet Summary Data (September to October 2006).</p> <p>Reviewed Psychiatric Evaluation Monitoring Form.</p> <p>Reviewed Psychiatric Evaluation Monitoring Summary Data (October 2006).</p> <p>Reviewed Chart Audit Form.</p> <p>Reviewed Chart Audit Monitoring Summary Data (May to October 2006).</p> <p>Reviewed Annual Psychiatric Monitoring form.</p> <p>Reviewed Annual Psychiatric Monitoring Summary Data (October 2006).</p>
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		<p>Reviewed Psychiatry Monthly Progress Note Monitoring Form, Reviewed Psychiatry Monthly Progress Note Monitoring Summary Data (October 2006). Reviewed PRN Progress Notes Monitoring Form. Reviewed STAT Progress Notes Monitoring Form. Reviewed PRN & STAT Progress Notes Monitoring Summary Data (October 2006). Reviewed Transfer Audit Form. Reviewed Transfer Audit Summary Data (October 2006). Reviewed a list of all individuals at PSH, including name, diagnoses, current medications, name of attending physician and unit of residence.</p>
A	<p>Each State hospital shall use the diagnostic criteria in the most current Diagnostics and Statistical Manual of Mental Disorders ("DSM") for reaching the most accurate psychiatric diagnoses.</p>	<p>Findings: PSH used the Psychiatric Evaluation Monitoring Form to assess compliance with this requirement. During October 2006, 32 charts were randomly selected from all units and reviewed by peer psychiatrists. The review focused on the integrated psychiatric assessments. Compliance data are as follows:</p> <ol style="list-style-type: none"> 1. Diagnosis-DSM-IV-TR addresses five axes. (100%) 2. Diagnosis includes the diagnostic criteria for the given diagnosis. (72%) <p>The facility used the Initial Admission Assessment Monitoring Form to review the initial psychiatric assessments. In this process, 26 charts were randomly selected from all units and reviewed by peer psychiatrists. The reviews show the following compliance data:</p> <ol style="list-style-type: none"> 1. Admission diagnosis addresses axes I-V. (79%). 2. DSM diagnosis is consistent with history and presentation. (79%) <p>In addition, the Department of Psychiatry conducts quarterly</p>

		<p>psychiatric peer reviews. The reviews were used to assess compliance with the requirement. Peer psychiatrists reviewed 96 charts from July to September 2006. The data show the following compliance rates:</p> <ol style="list-style-type: none"> 1. Do the physician's diagnoses reflect the use of DSM-IV multi-axial nomenclature? (99%) 2. With respect to physician's assessment (s) or evaluation (s), do diagnostic impressions clearly correspond to data regarding relevant signs and symptoms? (100%) <p>PSH provides copies of the most current DSM to all hospital units and all psychiatrists and psychologists. The DSM-IV Symptom Checklist has been given to all psychiatrists.</p> <p>Chart reviews by this monitor indicate that, by and large, psychiatric diagnoses are stated in terminology that is consistent with the current version of the DSM. However, the quality of the admission psychiatric assessments is inconsistent and the information needed for adequate diagnostic formulations is either missing or does not provide the basis for reaching the most reliable diagnosis. Examples are provided under D.1.c.ii.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that the monitoring instruments are focused on the accuracy of psychiatric diagnoses. 2. Address all subsequent recommendations in section D.1. 3. Standardize the monitoring forms, sampling methods and other mechanisms of internal monitoring across state facilities. Ensure that compliance rates derived from internal monitoring
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		are based on a review of at least 20% sample monthly, stratified by physician/psychiatrist. This recommendation is relevant to all applicable items in section D.
b	Each State hospital shall ensure that all psychiatrists responsible for performing or reviewing psychiatric assessments:	Compliance: Partial.
b.i	are certified by the American Board of Psychiatry and Neurology ("ABPN") or have successfully completed at least three years of psychiatry residency training in an Accreditation Counsel for Graduate Medical Education accreditation program, and	Findings: At this time, PSH employs 57.75 FTE staff psychiatrists, two FTE psychiatrists in administrative/supervisory positions and two FTE consultants. With the exception of three staff psychiatrists, all staff has completed three years of psychiatry residency training in an accredited program. At this time, 51% of the psychiatry staff is board-certified. PSH currently requires that all applicants for psychiatry positions present documentation of satisfactory completion of psychiatry residency program approved by the ACGME Residency Review Committee (or osteopathic equivalent). Recommendations: Ensure that all psychiatry staff is in compliance with the requirement.
b.ii	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.	Findings: At present, PSH screens all psychiatry applicants for current licensure in California and evidence of completion of three years of psychiatry training in an accredited program. The applicants are required to present three peer references and the medical staff office conducts primary source verification of these references. All applicants are interviewed by a hiring panel that includes the Department Chairman (Acting Chief of Psychiatry), members of the medical staff, representative of program management and an EEO representative. The panel uses a standardized written questionnaire to assess competency in assessments and treatment strategies, including the use of clinical vignettes). The applicants receive a rating score with a

		<p>recommendation to the Medical Director to proceed with the civil service hiring process for qualified applicants.</p> <p>There is a reappointment process that reportedly incorporates results of the facility's current peer review system. The peer review indicators address assessments and reassessment, medication use and tardive dyskinesia detection, treatment and documentation. The facility has Medical Staff Reappointment/Reprivileging Profile. The profile is not well aligned with requirements of the EP.</p> <p>The facility does not have a Procedure Manual for the Department of Psychiatry.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Refine quality indicators to be used in the performance evaluations/peer reviews of Staff Psychiatrists and ensure that the indicators clearly address the requirements of the EP, including diagnosis, assessments, reassessments and medication management. 2. Develop a Department of Psychiatry Procedure Manual that includes clear performance expectations regarding the format and the content of all assessments and reassessments as required by the EP.
C	Each State hospital shall ensure that:	<p>Compliance: Partial.</p>
c.i	Within 24 hours of an individual's admission to each State hospital, the individual receives an Admission Medical Assessment that includes:	<p>Findings: The facility used the Initial Medical Assessment Tally Worksheet to assess compliance with this requirement. Nursing auditors reviewed a</p>

		<p>100% sample of initial medical assessments that were completed during September and October 2006 (#157). The compliance rates are listed for each applicable cell below.</p> <p>The Medical Staff Rules & Regulations include a statement that the admission history, physical examination, and psychiatric evaluation shall be completed within 24 hours.</p> <p>This monitor's review of 14 charts corroborates the facility's data regarding the timeliness of the medical assessment (LL, MS, BRA, HG, BSL, PS, MAT, TMH, LDG, CSL, AL, KAB, VGF and RA). However, this review reveals much lower compliance rates for the content components. The following are examples:</p> <ol style="list-style-type: none"> 1. The examination of male genitals and/or rectum was deferred for no documented reason (MAT) or due to individual's refusal (BRA, HG, BSL), without documented follow-up. 2. The neurological examination is incomplete (LL). 3. The examination of female genitals is deferred to GYN without documentation of timely follow-up (LL, PS, TMH and CSL) 4. The examination of female breasts is deferred to GYN without documentation of (timely) follow-up (PS, TMH and CSL). 5. There is no timely documentation of a plan of care or evidence of timely follow-up regarding presence of a testicular cystic mass (MAT). <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure completeness of the admission medical examination within the specified time frame. 2. Ensure that there is a rationale for deferral of items on the examination and that deferred items are subsequently addressed to ensure compliance with the intent of this item. 3. Ensure that monitoring of the admission physical examination
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		addresses completeness of the examination and that the overall compliance rate accounts for the content and quality of each item.
c.i.1	a review of systems;	93%.
c.i.2	medical history;	92%.
c.i.3	physical examination;	70%.
c.i.4	diagnostic impressions; and	97%.
c.i.5	management of acute medical conditions	76.5%.
c.ii	within 24 hours of an individual's admission to each State hospital, the individual receives an Admission Psychiatric Assessment that includes:	<p>Findings: Using the Initial Admission Assessment Monitoring Form, 33 charts were randomly selected from all units and reviewed by peer psychiatrists during October 2006. The facility reports 100% compliance with the timeliness of the assessment. Compliance rates and monitoring indicators for each component are listed below.</p> <p>Reviews by this monitor of the above-mentioned charts demonstrate lower compliance rates for the completeness and quality of the components of the assessment (admissions between November 2005 and August 2006). The following are examples:</p> <ol style="list-style-type: none"> 1. The initial assessment is missing from the chart (LL, BRA and HG). 2. There is evidence of incomplete mental status examination in most charts. The main deficiency is failure to complete the section that requires elaboration on positive mental status findings. Examples include MAT (suicidal ideations and delusions), RA (hopelessness), TMH, CSL, KAB, VGF and LDG

		<p>(delusions and hallucinations) and BSL (orientation and attention).</p> <ol style="list-style-type: none"> 3. There is no documentation of a plan of care to accompany the initial psychiatric assessment (BSL). 4. In general, the assessments of insight and judgment tend to be vague and subjective. <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that the mental status examinations are completed on all admission psychiatric assessments. 2. Ensure that the Department of Psychiatry Manual includes the requirements regarding D.1. c.ii.1 through D.1.c.ii.6. 3. Continue the practice of monitoring the admission psychiatric examination for timeliness, completeness and quality and ensure that overall compliance rate accounts for the completeness and quality of each item. 4. Ensure that psychiatric assessments include appropriate information regarding consultation referrals (for psychiatric/ neurological issues).
c.ii.1	psychiatric history, including a review of presenting symptoms;	Reason for admission/chief complaint noted: 91%. Pertinent history leading to admission: 88%.
c.ii.2	complete mental status examination;	100%.
c.ii.3	admission diagnoses;	79%.
c.ii.4	completed AIMS;	If psychiatrist does the Initial AIMS, was it completed? (94%).

c.ii.5	laboratory tests ordered; and	100%.
c.ii.6	consultations ordered.	95% (if applicable).
c.iii	within 7 days (60/72 hrs) of an individual's admission to each State hospital, the individual receives an Integrated Psychiatric Assessment that includes:	<p>Findings: Using the Psychiatric Evaluation Monitoring Form, the facility reports compliance data that are entered for each corresponding cell below. The monitoring indicators are listed, as appropriate.</p> <p>This monitor reviewed the above-mentioned 14 charts and found the following deficiencies:</p> <ol style="list-style-type: none"> 1. The integrated assessment is missing from the chart (MAT). 2. The psychosocial history is mostly missing (CSL, KAB and RA) or vague and uninformative (HG). 3. There is evidence of incomplete mental status examination in some charts. Examples include various domains of cognitive functions (CSL and HG). 4. The assessment of strengths is inadequate for the purpose of Wellness and Recovery Planning (RA, KAB and LL). 5. The admission risk assessment is inadequate (HG, RA and KAB). Although the risk assessments are present in most of the charts that this monitor reviewed, these assessments, by and large, do not include important information regarding how recent the risk is, the relevance of risk to current dangerousness, the assessment of mitigating factors and planned interventions to reduce the risks. 6. In general, the diagnostic formulation and differential diagnoses are inadequate. This deficiency is noted even in individuals who are in most need for this assessment. Examples are individuals who are receiving diagnoses listed as not otherwise specified (NOS).

		<p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that the assessment integrates information that cannot be obtained at the time of admission but becomes available during the first seven days of admission. 2. Address and correct the deficiencies outlined above. 3. Ensure that the Department of Psychiatry Manual includes the requirements regarding D.1. c.iii.1 through D.1.c.iii.10.
c.iii.1	psychiatric history, including a review of present and past history;	History of present illness/reason for admission includes statements from the individual: 84%. Past psychiatric history (is present): 94%.
c.iii.2	psychosocial history;	94%.
c.iii.3	mental status examination;	All components are rated at 100% compliance except: Perceptual alterations (97%); Fund of general knowledge (94%); Abstraction ability (88%); Judgment (94%); Insight (97%); and Mini mental status examination (84%).
c.iii.4	strengths;	Strengths/assets (are identified): 94%.
c.iii.5	psychiatric risk factors;	Risk assessment addresses: relevant demographic factors (56%), history of suicide attempts (84%), current clinical symptoms, including suicidal ideations/threats/plans to harm self (81%), psychosocial losses (56%), risk factors for seclusion/restraint (97%) and risk of

		<p>aggression/fire-setting/elopement/etc. (94%).</p> <p>In addition, the psychiatry peer review data (96 charts reviewed from July to September 2006) are as follows:</p> <p>Does the physician's assessment or evaluation address issues of suicide risk? (99%)</p> <p>Does the physician's assessment or evaluation address issues of risk of physical harm to others? (99%)</p>
c.iii.6	diagnostic formulation;	Diagnostic formulation (is present): 88%.
c.iii.7	differential diagnosis;	Diagnosis addresses findings which may support other diagnoses, including no diagnosis: 63%.
c.iii.8	current psychiatric diagnoses;	Diagnosis-DSM-IV-TR addresses five axes: 100%.
c.iii.9	psychopharmacology treatment plan; and	<p>Psychopharmacology plan identifies target symptoms: 69%.</p> <p>Psychopharmacology plan identifies reasons for continuing the medications individual came with: 59%.</p>
c.iii.10	management of identified risks.	91%
D	Each State hospital shall ensure that:	<p>Compliance:</p> <p>Partial.</p>
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>Findings:</p> <p>PSH has Chart Audit data to assess if Rule Out (R/O) or Deferred diagnoses were discontinued after 60 days. The facility reports a compliance rate of 28%.</p> <p>This monitor reviewed the charts of individuals that received NOS</p>

		<p>and/or R/O diagnoses for more than two months. Examples include JG and RR (Psychosis, NOS), LRN (Psychotic Disorder, NOS), CDS, RJ and EYB (Cognitive disorder, NOS), BLC and JCB (Dementia NOS). In general, the reviews showed deficiencies in the assessment of current status, differential diagnosis and finalization of diagnosis.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Provide continuing medical education to psychiatry staff to improve competency in the area of assessment of cognitive and other neuropsychiatric disorders. 2. Revise current monitoring process to address justification of diagnosis, differential diagnosis and updates of diagnoses, particularly those listed as NOS, as appropriate.
d.ii	<p>The documented justification of the diagnoses is in accord with the criteria contained in the most current DSM (as per DSM-IV-TR Checklist);</p>	<p>Findings:</p> <p>Using the Psychiatric Evaluation Monitoring Form, the facility reports the same monitoring data that are listed in D.1.a, D.1.c.iii.6 and D.1.c.iii.7.</p> <p>In addition, PSH used the Annual Psychiatric Monitoring Form (56 charts reviewed during October 2006) to assess if the diagnosis in the annual psychiatric assessment (five axes) matches the clinical presentation. The facility reports a compliance rate of 96% (</p> <p>This monitor's findings under D.1.a. and D.1.d.i are also applicable to this item.</p> <p>Recommendations:</p> <p>Same as D.1.a and D.1.d.i.</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</p>	<p>Findings:</p> <p>The facility's monitoring data and this monitor's findings are the same as in D.1.d.i.</p>

	60 days), through clinically appropriate assessments, and resolved in a clinically justifiable manner; and	<p>Recommendations: Same as D.1.d.i.</p>
d.iv	"no diagnosis" is clinically justified and documented.	<p>Findings: The facility's data are the same as in D.1.c.iii.7.</p> <p>This monitor reviewed the charts of two individuals (GCD and FB) who were identified by the facility as having received No Diagnosis (on Axis I) at some point since admission. The review revealed that the facility's database was inconsistent with the information in the chart in the case of GCD and that the diagnosis was appropriately finalized in the case of FB.</p> <p>Recommendations: Same as above.</p>
E	Each State hospital shall ensure that psychiatric reassessments are conducted at a frequency that reflects the individual's clinical needs. At a minimum the reassessments are completed weekly for the first 60 days on the admissions units and monthly on other units.	<p>Findings: PSH used the Monthly Psychiatry Progress Note Monitoring Form to assess this item. During October 2006, peer psychiatrists audited 109 charts of individuals with less than 60 days' length of stay (LOS) (14 applicable charts were reviewed). The facility reports a compliance rate of 50%. The facility does not have monitoring data regarding the frequency of reassessments after 60 days of admission.</p> <p>This monitor reviewed the charts of three individuals with more than 60 days' LOS (BP, CB and SMC). The review showed compliance with the required timeframes in all cases, but the quality of the reassessments indicated only partial compliance with the intent of this requirement.</p> <p>Compliance: Partial.</p>

		<p>Recommendations:</p> <ol style="list-style-type: none"> 1. Assess and correct factors related to low compliance with the requirement when LOS is less than 60 days. 2. Ensure monitoring when LOS is more than 60 days. 3. Ensure that compliance data consider both frequency and content of the reassessments.
F	<p>Each State hospital shall ensure that psychiatric reassessments are documented in progress notes that address the following:</p>	<p>Findings:</p> <p>Using the Psychiatry Progress Note Monitoring noted above, PSH assessed its compliance with items f.i. through f.v.ii. Under each of these items, the facility's monitoring indicators and corresponding compliance rates are listed below as relevant to the requirement. The sample sizes varied for each item.</p> <p>In almost all the charts reviewed by this monitor, there is a pattern of reassessments that do not meet the required elements. In general, the reassessments show the following deficiencies:</p> <ol style="list-style-type: none"> 1. The assessment of interval events is lacking and does not adequately cover significant clinical developments. Most of the reassessments are cross-sectional and more oriented towards current crisis events. 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

		<p>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.</p> <ol style="list-style-type: none"> 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 medications, the circumstances for the administration of these medications or the individual's response to this use. Ultimately, the regular treatment is not modified based on the use of PRN or Stat medications. 7. When behavioral interventions are provided, there is no documentation to indicate an integration of pharmacological and behavioral modalities. In addition, there is little or no discussion of the contextual basis and functional significance of the current symptoms. 8. There is no documentation of the scope and goals of individual psychotherapy and of the individual's progress in treatment when the WRP indicates that the psychiatrist is providing this intervention. <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Implement a format for psychiatric reassessments that addresses and corrects the deficiencies identified above. The format should be standardized for statewide use. 2. When the individuals receive both pharmacological and behavioral interventions, the reassessments need to address
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		<p>the following specific items:</p> <ul 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. <p>3. Ensure that the Department of Psychiatry Manual includes requirements regarding documentation of psychiatric reassessments.</p> <p>4. Ensure that monitoring instruments are clearly aligned with all of the above expectations.</p>
f.i	significant developments in the individual's clinical status and of appropriate psychiatric follow up;	Progress towards objectives in the WRP (86 charts): 52%. Response to non-pharmacologic treatments, including PBS, if applicable (60 charts): 63%.
f.ii	Timely and justifiable updates of diagnosis and treatment, as clinically appropriate;	Current diagnosis (changes if any, with evidence to support) includes resolution of NOS, Deferred and R/O diagnosis, if applicable (91 charts): 71%.
f.iii	Analyses of risks and benefits of chosen treatment interventions;	Benefits and risks of current psychopharmacologic treatment; includes benzodiazepines, anticholinergics and polypharmacy, if applicable.(91 charts): 58%. Benefits and risks of current psychopharmacological treatment: 58%.
f.iv	Assessment of, and attention to, high-risk behaviors (e.g., assaults, self-harm, falls) including appropriate and	Progress towards objectives in the WRP (86 charts): 52%. Risk behaviors-suicide, self-injurious behavior, aggression, elopement,

	timely monitoring of individuals and interventions to reduce risks;	falls, etc (100 charts): 82%.
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;	Benefits and risks of current psychopharmacologic treatment; includes benzodiazepines, anticholinergics and polypharmacy, if applicable.(91 charts): 58% Response to pharmacologic treatment (100 charts): 84%. Monitoring of side effects, including sedation (96 charts): 82%.
f.vi	Timely review of the use of "pro re nata" or "as-needed" ("PRN") and "Stat" (i.e., emergency psychoactive) medications and adjustment of regular treatment, as indicated, based on such use; and	Rationale for PRN medication and review of rationale for ongoing PRN/STAT medications used (50 charts): 52%. In addition, the facility used the PRN & STAT Progress Notes Monitoring Form. In this process, 20 charts were reviewed by peer psychiatrists during October 2006. The form has indicators that are aligned with the requirements of the EP. The facility reports an overall compliance rate of 55%.
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.	Response to non-pharmacologic treatments, including PBS, if applicable (60 charts): 63%.
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;	Findings: The facility has a Transfer Audit Form that reflects requirements of the EP. Using this form, the facility reviewed 25 charts to assess the presence of the following areas of assessment. The facility reports an overall compliance rate of 57%. The compliance rates for each area

	<p>and anticipated benefits of transfer.</p>	<p>are outlined as follows:</p> <ol style="list-style-type: none"> 1. Reason for transfer: 72%; 2. Five axes diagnosis: 20%; 3. Psychiatric course of hospitalization: 60% 4. Medical history and current medical problems: 72%. 5. Current target symptoms: 72%; 6. Psychiatric risk factors: 92%; 7. Review of medications: 64%; 8. Current barriers to discharge: 24%; and 9. Anticipated benefits of transfer: 25%%. <p>The discrepancies between these items appear to be to limitations in the current form that is used by the facility regarding transfer assessments.</p> <p>This monitor's review of the quality of transfer assessments show lower compliance rates than that reported by the facility. In general, the transfer assessments provide little information on the experience of the individuals on the unit of origin. Specifically, the assessments fail to adequately address the reasons for the transfer, current target symptoms, psychiatric risk factors, medication trials, barriers to discharge and anticipated benefits of the transfer. In general, these assessments do not provide the receiving psychiatrist and WRP team with necessary information to ensure continuity of care and to minimize the risk for individuals.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Revise the current transfer assessment form to facilitate implementation of this requirement.
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		<ol style="list-style-type: none"> 2. Ensure that the Department of Psychiatry Manual includes EP requirements regarding timeliness, completeness and quality of inter-unit transfer assessments. 3. Continue to monitor using current instrument and ensure that quality of clinical data is considered in the estimation of compliance. 4. 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 David Haimson, Ph.D., Psychologist, Acting Chief of Psychologist. Interviewed Allison Pate, Ph.D., Psychologist, Administrator Interviewed Susan Velasquez, Ph.D., Psychologist, Chair Positive Behavioral Support. Interviewed Dominique Kinney, Ph.D., Neuropsychologist. Reviewed 84 charts of individuals (RR, RW, CT, WG, DV, MS, CH, RR, MS, JF, EH, EL, TS, HH, CS, KR, BM, DG, PK, JG, RS, MK, LR, SH, KD, HA, CB, PD, AJ, JJ, GG, IR, AT, PM, JE, MG, FC, GE, JF, JC, LE, SB, GE, AB, AA, SG, DC, FC, KD, PA, DB, PC, EC, PM, JL, HN, LL, RB, JC, HC, BT, WF, MP, LP, MG, TH, CJ, LC, DC, CH, RG, JD, DH, DS, DS, WD, BC, AC, AJ, CM, VC, CC, MC, and JD). Reviewed psychological and neurological assessments (DL, VN, PL, GL, LL, CA, RA, AC, EW, JB, GB, KR, PR, VF, MC, BB, EL, KA, DE, CB, DB, AA and EB). Reviewed Wellness and Recovery Plans (MT, GJ, CH, MK, CS, EL, HH, GF, AL, AJ, DS, MK and CM). Reviewed Structural Assessments (JG, GA, KP, AA, MG, FS, SB, and LJ). Reviewed Functional Behavioral Assessments (MG, GB, GP, JP, ER, RT,</p>

		<p>JB, SD, and CC). Reviewed Positive Behavioral Support Plans (GM, CC, GB, RJ, DL, ER, LC, JG, and GP). Reviewed DMH Psychology Manual (draft) Reviewed PSH Psychology Department Manual Reviewed DMH PBS Manual Reviewed PSH Neuropsychology Manual Reviewed DMH Clinical Indicator List Reviewed DMH WRP Manual. Reviewed DMH psychology monitoring form. Reviewed DSM-IV-TR Checklists. Reviewed database on psychologists verifying education, training, privileges, certification and licensure. Reviewed Integrated Assessment-Psychology Section. Reviewed list of Individuals under 1:1 monitoring and/or User of Restraints/Seclusion. Reviewed List of Individuals Under the Age of 22. Reviewed PSH Tests Inventory and Manuals Reviewed PSH self-assessment. Reviewed Structured Assessments Reviewed Functional Analysis Assessment.</p>								
a	<p>Each State hospital shall develop and implement standard psychological assessment protocols, consistent with generally accepted professional standards of care. These protocols shall address, at a minimum, diagnostic neuropsychological assessments, cognitive assessments, and I.Q./achievement assessments, to guide psychoeducational (e.g., instruction regarding the illness or disorder, and the purpose or objectives of treatments for the same, including medications), educational, rehabilitation, and habilitation interventions, and behavioral assessments (including functional assessment of behavior in schools and other</p>	<p>Findings: PSH does not have sufficient numbers of psychologists to fully implement all the required assessments, treatments, and therapeutic services. A review of the list of assigned psychologists showed the following vacancies:</p> <table border="1" data-bbox="1014 1227 1808 1421"> <tr> <td>Administration</td> <td>7 (Senior Supervisors) 1 (BY CHOICE Coordinator)</td> </tr> <tr> <td>Program I</td> <td>7.0</td> </tr> <tr> <td>Program III</td> <td>4.25</td> </tr> <tr> <td>Program IV</td> <td>2.0</td> </tr> </table>	Administration	7 (Senior Supervisors) 1 (BY CHOICE Coordinator)	Program I	7.0	Program III	4.25	Program IV	2.0
Administration	7 (Senior Supervisors) 1 (BY CHOICE Coordinator)									
Program I	7.0									
Program III	4.25									
Program IV	2.0									

settings), and personality assessments, to inform positive behavior support plans and psychiatric diagnoses.

Program V	5.0
Program VI	4.0
Program VII	6.0
Program VIII	5.5
PBS Teams	2.0

The PSH Neuropsychology Manual does not include all aspects of EP requirements. The PSH Psychology Department Manual does not include all required elements of the EP relevant to psychological assessment and treatment protocols. The format for Integrated and Focused Assessments are not standardized. A standard statewide template is in development and is awaiting approval.

Interviews with psychologists, chart reviews, and observations showed significant differences among psychologists in their understanding of the required elements, such as integrated assessments, clinically indicated assessments, diagnostic assessments, development and implementation of interventions, and monitoring of outcomes.

Compliance:

Partial.

Recommendations:

1. Ensure that revised documents or manuals, where applicable, are aligned across DMH hospitals
2. Ensure that all psychologists understand, and can utilize the new clinical information included in the revised documents or manuals.
3. When approved, use the standardized focused assessment template
4. Ensure that there are sufficient numbers of psychologists to fulfill all requirements of the EP

b	<p>Each State hospital shall require the completion of cognitive and academic assessments within 30 days of admission of all school-age and other individuals, as required by law, unless comparable testing has been performed within one year of admission and is available to the interdisciplinary team.</p>	<p>Findings: PSH is severely deficient in this requirement. Psychologists at PSH were uncertain about their understanding of this requirement. This monitor reviewed charts of individuals below 22 years of age, who met criteria for academic and cognitive assessments to be conducted within 30 days of admission. This review showed that academic assessments were not conducted for these individuals and cognitive assessments not completed within 30 days of admission (e.g., LR, SH, KD, HA, CB, PD, ZY, AJ, JJ, GG, IR and AT).</p> <p>PSH's self-assessment data were very similar to this Monitor's findings.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that all individuals under the age of 22 have their academic and cognitive assessments conducted within 30 days, unless comparable testing has been performed within one year of admission, and is available for review by the interdisciplinary team, or the individuals have graduated from high school or obtained a GED. 2. Ensure that all psychologists understand this requirement. 3. Ensure that individuals who could not be tested within the first 30 days of admission, for medical or other reasons, are documented and followed up to make sure that such evaluations are completed when the individual is ready for assessment.
c	<p>Each State hospital shall ensure that all clinicians responsible for performing or reviewing psychological assessments and evaluations are verifiably competent in the methodology required to conduct the assessment.</p>	<p>Findings: All psychologists working in PSH have the necessary education and coursework in assessment.</p>

		<p>Eighty-seven percent (n = 45) of the psychologists in the facility (N = 52) have been privileged in assessment and treatment. The remaining seven new hires are in the process of receiving their privileges.</p> <p>The psychology department does not have its full complement of staffing.</p> <p>Interview of psychologists revealed that most are under stress and feel overwhelmed with their roles and responsibilities in the face of staff shortage, along with having to learn and apply EP requirements.</p> <p>This monitor's review of psychological assessments, neuropsychological assessments, PBS plans, and psychology Integrated Assessments showed significant variations in the quality of these assessments.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none">1. Fill all vacant psychology positions.2. Ensure that senior psychologists have the necessary administrative support in their roles of teaching, training, and evaluating other psychology staff.3. Ensure that senior psychologists have the necessary time to properly mentor and supervise psychology staff.4. Standardize assessment format and report writing templates to make it easier for psychologists to comply with the EP.5. Conduct regular reviews of assessments to check for compliance and provide corrective feedback, as necessary.6. Ensure that all psychologists have their necessary professional credentials, and training in all aspects of EP relevant to their field and scope of practice.
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d	Each State hospital shall ensure that all psychological assessments, consistent with generally accepted professional standards of care, shall:	Compliance: Partial.
d.i	expressly state the clinical question(s) for the assessment;	<p>Findings: All psychological assessments reviewed by this monitor had addressed this requirement. However, only 60% of these assessments met the criteria of clarity and specificity. The clinical question/reason for referral on the other assessments were wordy and/or vague (e.g., CB, SH, FC, and GE). Most psychological assessments showed great variability in their content and quality.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Continue with the current structure of psychological assessments where a section is dedicated to address reasons for referrals/clinical questions. 2. Ensure that the statements for the reasons for referral are concise and clear. 3. Ensure that there is continuity among the various sections that address referral questions to conclusions to appropriate recommendations and therapies available within PSH. 4. Use the newly standardized focus assessment template.
d.ii	include findings specifically addressing the clinical question(s), but not limited to diagnoses and treatment recommendations;	<p>Findings: Most of the assessments reviewed by this monitor met this criterion. A few (e.g., LR and SH) did not fully meet this criterion.</p> <p>PSH self-assessment data showed that 76% of the assessments met this criterion.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that psychologists fulfill this requirement. 2. Use the correct structure and format for conducting assessments.

d.iii	Specify whether the individual would benefit from individual therapy or group therapy in addition to attendance at mall groups;	<p>Findings: Psychological assessments reviewed by this monitor are deficient in this criterion. Many of the charts reviewed did not have any psychological and/or focused assessments (e.g., KD, HA, PD, AJ, GG, IR, and AT). Nearly 80% of the evaluations reviewed by this monitor failed to fully meet this criterion (e.g., PM, MG, FC, and GE).</p> <p>PSH self-assessment data reported a 39.6 % compliance with this criterion.</p> <p>Recommendation: Ensure that all psychological assessments include findings and recommendations pertaining to the individual's participation in therapeutic services.</p>
d.iv	be based on current, accurate, and complete data;	<p>Findings: A number of charts reviewed by this monitor did not have any psychological and/or focused assessments (e.g., KD, HA, PD, AJ, GG, IR, and AT). The assessments reviewed by this monitor showed that psychologists had used appropriate testing instruments necessary to address the referral question.</p> <p>PSH's self-assessment data showed that 177 of the 197 (90%) focused assessments met this criterion.</p> <p>Recommendation: Continue and improve on current practice.</p>
d.v	determine whether behavioral supports or interventions (e.g., behavior guidelines or mini behavior plans) are warranted or whether a full positive	<p>Findings: Eighty percent of the assessments reviewed by this monitor failed to address the need for Positive Behavior Support plans or behavior</p>

	behavior support plan is required;	<p>guidelines (e.g., PM, MG, FC, and GE).</p> <p>PSH's self-assessment data showed that 97% of the assessments failed to meet criterion.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that all psychological assessments of individuals with maladaptive behavior meet this requirement. 2. Ensure that psychologists conducting assessments attend to this item.
d.vi	include the implications of the findings for interventions;	<p>Findings:</p> <p>PSH's self-assessment showed 96.4% compliance to this requirement. This monitor's review of assessments showed a 77% compliance with this requirement.</p> <p>Recommendation:</p> <p>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>Findings:</p> <p>Chart reviews by this monitor showed that a high number of assessments failed to address this requirement in a satisfactory manner. This monitor noted a variety of deficiencies including:</p> <ol style="list-style-type: none"> 1. No reasons documented for "no diagnosis" (RW); 2. Failure to identify supporting documents when making references or when no testing was conducted (e.g., CT, CH, HH, and BM); 3. Not addressing diagnostic issues (e.g., MS and CS); and 4. No recommendations for additional testing when indicated (e.g., S, MG, CB, and JJ).

		<p>PSH's self-assessment showed that only 39% of the assessments reviewed by the facility met this criterion.</p> <p>While reviewing charts, this monitor noted that recommendations/ findings were incomplete in the individuals' WRPs (e.g., JR and KR) or that additional workup requested was not followed through upon (e.g., ZY).</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that all psychological assessments meet this requirement. 2. Ensure that WRP teams review and include appropriate recommendations in the individual's Wellness and Recovery Plan. 3. Ensure that additional workups be completed as requested.
d.viii	<p>Use assessment tools and techniques appropriate for the individuals assessed and in accordance with the American Psychological Association Ethical Standards and Guidelines for testing.</p>	<p>Findings:</p> <p>All assessments reviewed by this monitor employed assessment tools that were appropriate for the required goal/purpose of the assessments. Most assessments utilized appropriate techniques and, where necessary, used interpreters for individuals whose primary or preferred language is not English, and American Sign Language interpreters for hearing impaired individuals. However, it is not possible to determine from the charts and assessments if the testing was in accordance with the American Psychological Association's Ethical Standards and Guidelines for testing.</p> <p>PSH self-assessment does not adequately address this issue, and there is no indication that there is an adequate system in place to track this aspect of the assessment. The data revealed that 91% of focused assessments, and 86% of Integrated Assessments met this criterion.</p> <p>Recommendations:</p>

		<ol style="list-style-type: none"> 1. Continue and improve upon current practice. 2. Ensure that American Psychological Association's Ethical Standards and Guidelines for testing are followed.
e	<p>Each State hospital shall ensure that all psychological assessments of all individuals residing at each State hospital who were admitted there before the Effective Date hereof shall be reviewed by qualified clinicians with demonstrated current competency in psychological testing and, as indicated, revised to meet the criteria in § [IV.B.1 and IV.B.2], above.</p>	<p>Findings:</p> <p>PSH did not carry out the task of reviewing and revising the assessments that did not meet EP criteria.</p> <p>PSH's self-assessment showed that only 2% of the focused assessments met all EP requirements.</p> <p>This monitor reviewed 42 charts (JF, JC, LE, SB, GE, AB, AA, SG, DC, FC, KD, DB, PC, EC, JL, RB, JC, HC, WF, LP, MG, CJ, LC, DC, CH, JD, DS, CM, MC, JD, PA, PM, HN, BT, MP, TH, DH, DS, WD, BC, AJ, and CC). Of these, 71% of charts did not have Integrated Psychological Assessments, and the remaining 29% contained Integrated Psychological Assessments that were not conducted in a timely manner. The quality of assessments varied owing to elements that were not addressed or not addressed fully.</p> <p>A number of the psychologists interviewed by this monitor indicated that shortage of psychologists and the current workloads, as a function of the shortage, resulted in poor compliance with this requirement.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that psychological tests are completed in a timely manner, as specified in the EP. 2. Ensure that reports meet acceptable quality. 3. Review all psychological assessments of all individuals residing at PSH who were admitted prior to June 1, 2006, and complete further assessments as required by the EP.

f	Each State hospital shall ensure that all appropriate psychological assessments shall be provided in a timely manner whenever clinically indicated, consistent with generally accepted professional standards of care, including whenever there has been a significant change in condition, a lack of expected improvement resulting from treatment, or an individual's behavior poses a significant barrier to treatment, therapeutic programming, safety to self or others, or school programming, and, in particular:	Compliance: Partial.
f.i	before an individual's therapeutic and rehabilitation service plan is developed, a psychological assessment of the individual shall be performed that will:	<p>Findings: PSH's self-assessment showed poor compliance with this requirement. Their findings showed that only 37% of charts reviewed contained integrated psychological assessments and, of those that contained completed assessments, only 39% were completed in a timely manner.</p> <p>This monitor reviewed 42 charts (JF, JC, LE, SB, GE, AB, AA, SG, DC, FC, KD, DB, PC, EC, JL, RB, JC, HC, WF, LP, MG, CJ, LC, DC, CH, JD, DS, CM, MC, JD, PA, PM, HN, BT, MP, TH, DH, DS, WD, BC, AJ, and CC). Only 39% of the assessments contained Integrated Psychological Assessments, and of the remaining charts that contained psychological assessments none were conducted in a timely manner. The Acting Chief of Psychology indicated that additional psychologists were needed to enable the timely completion of psychological assessments.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that integrated psychological assessments are conducted in a timely manner as required. 2. Hire additional psychologists to ensure timely psychological assessments of individuals.
f.i.1	address the nature of the individual's impairments to inform the psychiatric diagnosis; and	<p>Findings: This monitor reviewed 16 charts (JF, PA, PM, HN, BT, MP, TH, CH, RG, DH, DS, WD, BC, AC, AJ, and CC). Only 57% of them met this</p>

		<p>requirement. The other assessments failed to adequately address the individuals' impairments to better explain their psychiatric diagnosis. A number of the psychologists interviewed by this monitor were uncertain as to what this requirement was.</p> <p>PSH's self-assessment showed a similar finding with only 41% of the assessments meeting this requirement.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that integrated psychological assessments address the nature of the individual's impairments that inform the psychiatric diagnosis. 2. Ensure that all psychologists conducting assessments understand the requirement of this cell.
f.i.2	provide an accurate evaluation of the individual's psychological functioning to inform the therapeutic and rehabilitation service planning process;	<p>Findings:</p> <p>This monitor reviewed 16 charts JF, PA, PM, BT, MP, TH, CH, RG, DH, DS, WD, BC, AC, AJ, CC, and RR), and found that only seven (43%) met this criterion. All the remaining either failed to consider this aspect or did not provide a complete and accurate evaluation of the individual's psychological functioning that would add to the therapeutic and rehabilitation service planning processes of the individual.</p> <p>PSH's self-assessment showed 59% compliance with this requirement.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Consider all elements that would affect understanding of an individual's psychological functioning when evaluating this item. 2. Ensure accurate evaluation of psychological functioning that informs WRP teams of the individual's rehabilitation needs.
f.ii	if behavioral interventions are indicated, a structural and functional assessment shall be performed,	<p>Findings:</p> <p>PSH's self-assessment showed that none of the seven behavior</p>

	<p>consistent with generally accepted professional standards of care, by a professional having demonstrated competency in positive behavior supports; and</p>	<p>guidelines they reviewed had any structural or functional assessments before the behavior guidelines were developed and implemented. The facility reviewed 37 PBS referrals, and found that 26 resulted in intervention plans. They also looked at 197 focused assessments in which six had recommended interventions or a full PBS plan, and yet only one of those six had resulted in any form of behavioral intervention.</p> <p>This monitor reviewed 15 charts (JF, PA, PM, HN, BT, TH, CH, RG, DH, DS, WD, BC, AC, AJ and CC). Few behavior guidelines and structural/functional assessments were developed and implemented for individuals with learned maladaptive behaviors. Only two (13%) of the 15 charts reviewed had made appropriate recommendations/referrals when further interventions or follow up work were indicated.</p> <p>Interviews with staff indicated that there were a number of reasons for the lack of referrals to the PBS teams including unclear criteria for referrals, lack of confidence in PBS teams, and lack of consultation between and among the BCC, PBS, and WRP teams. In addition, a number of good PBS plans have not been implemented due to non-acceptance by WRP teams.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that unit staff is familiar with referral criteria to the PBS team when individuals have significant learned maladaptive behaviors that were not amenable to intervention with behavior guidelines. 2. Ensure that PBS referrals get timely attention to assist unit staff to manage individuals with significant learned maladaptive behaviors. 3. Ensure appropriate structured and functional assessments are undertaken by a qualified psychologist.
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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>Findings: PSH's self-assessment showed severe deficiency in this requirement. The data showed that appropriate follow up necessary to fulfill this requirement was performed in 24% of cases with unresolved issues; 5% of cases with differential diagnosis, 6% of cases with rule-out diagnosis, 3% of cases with deferred diagnosis, 11% of cases with no-diagnosis, and 9% of cases with a NOS diagnosis.</p> <p>This monitor reviewed 18 charts (TS, HH, HS, KR, BM, DG, PK, JG, RS, MK, PA, PM, HN, CH, RG, DH, DS, and BC) that contained assessments with Axis II diagnosis requiring clarification, additional documentation, and/or further assessments. None of the cases had sufficient explanation and/or necessary follow-up evaluations to fulfill this requirement.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that additional psychological assessments are performed as required in this cell. 2. Ensure that the facility's monitoring instrument that address "no diagnosis" is aligned with the key requirement, i.e., that "no diagnosis" is backed up by clinical data, especially in individuals with forensic issues. 3. Ensure that supporting documents are recorded and referenced when using previous assessment results to address diagnosis-related matters.
g	<p>For individuals whose primary language is not English, each State hospital shall endeavor to assess them in their own language; if this is not possible, each State hospital will develop and implement a plan to meet the individuals' assessment needs, including, but not limited to the use of interpreters in the individual's primary language and dialect, if feasible.</p>	<p>Findings: PSH's self-assessment showed that this requirement was not met. Reviewing the integrated psychological assessments of the 25 individuals whose primary/preferred language was not English, the facility found that, on these assessments, only six (24%) were assessed in their indicated primary/preferred languages, and only two (11%) had appropriate plans implemented for a proper assessment.</p>

		<p>Further, only three of 15 (20%) focused Psychological Assessments involving individuals whose primary/preferred language was not English were conducted in their primary/preferred languages, and the remaining 12 did not meet this requirement.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that assessments conducted meet this requirement. 2. Ensure that individuals have access to providers who can communicate with the individuals in their preferred/primary mode of language and communication. 3. Ensure the availability of translation or interpretation services for non-English speaking individuals, and individuals' with communication disabilities.
3	Nursing Assessments	
		<p>Methodology:</p> <p>Interviewed Regina Olender, Coordinator of Nursing Services. Reviewed Medication Administration Monitoring data. Reviewed Statewide Medication Administration Monitoring raw data. Reviewed DMH Statewide 24-Hour NOC Audit Monitoring Form and raw data. Reviewed DMH Nursing Services PRN/Stat Medications Monitoring Form and instructions. Reviewed PSH Nursing Policy and Procedure Manual. Reviewed Nursing Policy and Procedure 538, PRN and STAT Medication. Reviewed Medication Pass Certification form. Reviewed Daily Report of PRN Medication Usage form. Reviewed Nursing Policy and Procedure 511, Medication Variance. Reviewed Nursing Policy and Procedure 536, Administration of</p>

		<p>Medication. Reviewed Memorandum dated November 18, 2006, Non-Compliance with Standards of Practice. Reviewed PSH Medication Variance Report, April, May, and June 2006. Reviewed Nursing Policy and Procedure 302, Nursing Care Plans. Reviewed Nursing Policy and Procedure vii, Change of Shift Procedure. Reviewed AD 15.30, Patient and Family Education. Reviewed Memorandum dated 8/10/06, Proposal: Restructuring the Staff Development Center. Reviewed DMH Monitoring Form for Bed-Bound Individuals. Attended shift report on unit EB 11.</p>
a	Each State hospital shall develop standard nursing assessment protocols, consistent with generally accepted professional standards of care. These protocols shall address, at a minimum:	<p>Compliance: Partial.</p>
a.i	a description of presenting conditions;	<p>Findings: The facility assessed its compliance with the requirements in D.3.a.i through a.ix. The compliance rate for this item was 23%. The rates for D.3.a.ii through a.ix are identified for each section below.</p> <p>From my review, Admission Nursing Assessments did not adequately address the description of presenting conditions, activities of daily living, currently prescribed medications, allergies, pain, use of assistive devices, immediate alerts, and conditions needing immediate nursing interventions. These findings are in alignment with PSH's findings.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement monitoring instruments and a tracking system addressing all elements of this requirement. 2. Ensure that nursing staff is competent in the protocols addressing this requirement. 3. Ensure that nursing staff adequately tracks, documents and

		monitors this requirement.
a.ii	current prescribed medications;	7%.
a.iii	vital signs;	84%.
a.iv	allergies;	59%.
a.v	pain;	54%.
a.vi	use of assistive devices;	55%.
a.vii	activities of daily living;	87%.
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	30%.
a.ix	conditions needing immediate nursing interventions.	35%.
b	Nursing may use a systems model (e.g., Johnson Behavioral System Model) for the nursing evaluation.	<p>Findings: PSH reported that Nursing will not be using the Johnson Behavioral System Model (JBSM) and will only utilize the Wellness and Recovery Model since the use of a medical nursing model does not lend to the integration of nursing practice to the Wellness and Recovery Planning system.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Revise policies and procedures to include WRP language. 2. Ensure that nursing assessments, integrated nursing assessments and documentation in the progress notes reflect Wellness and Recovery principles. 3. Align current training of nurses with the WRP system.
c	Each State hospital shall ensure that all nurses responsible for performing or reviewing nursing assessments are verifiably competent in performing the assessments for	<p>Findings: PSH has not developed a system to ensure that concurrent monitoring of the same assessment is done in order to compare rater reliability.</p>

	<p>which they are responsible. All nurses who are employed at Metropolitan State Hospital shall have graduated from an approved nursing program, shall have passed the NCLEX-RN and shall have a license to practice in the state of California.</p>	<p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a monitoring instrument and a tracking system to adequately address this requirement. 2. Develop, initiate and document regular monitoring, at least quarterly, of nursing assessment competency.
d	<p>Each State hospital shall ensure that nursing assessments are undertaken on a timely basis, and in particular, that:</p>	<p>Compliance: Partial.</p>
d.i	<p>Initial nursing assessments are completed within 24 hours of the individual's admission;</p>	<p>Findings: PSH reported 99% compliance with this requirement based on data collected from September to October 2006.</p> <p>From my review of seven initial nursing assessments, all were completed within the required timeframe.</p> <p>Recommendation: Continue to monitor this requirement.</p>
d.ii	<p>Further nursing assessments are completed and integrated into the individual's therapeutic and rehabilitation service plan within seven days of admission; and</p>	<p>Findings: PSH reported 45% compliance with this requirement. The tools developed to monitor for timeliness of assessment (within seven days) do not address the integration of the assessment into the WRP.</p> <p>Recommendation: Develop and implement a monitoring instrument and tracking system to address the elements of this requirement.</p>

d.iii	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>Findings: There is no system in place that monitors and tracks this requirement.</p> <p>Recommendation: Develop and implement a monitoring system to address the elements of this requirement.</p>
4 Rehabilitation Therapy Assessments		
		<p>Methodology: Interviewed Greg Siples, Chief of Rehabilitation Therapy Services. Reviewed AD 10.21, Activity Program for Patients. Reviewed Rehabilitation Therapy Service Written Plan for Activity Services. Reviewed Rehabilitation Service Staffing Plan. Reviewed Procedures for Physical Therapy Services. Reviewed Physical Therapy Treatment Procedures for Transfer Training and Gait Training. Reviewed Duty Statement for Rehabilitation Therapist, Recreation, Occupation, Music, Dance, and Art. Reviewed Philosophy Statement of Physical Therapy. Reviewed Physical/Occupational therapy monitoring form. Reviewed PSH Rehabilitation Services Manual. Reviewed charts of ten individuals GB, YW, CC, CR, RT, KY, JW, GG, BT, JW, GD, HM, DA, NT, AF, RB, JL, ER, EL, CN, DV, JJ, SD, SA, JB, BMC, KF, SF, PH, AV, KT, SP, EH, RC and MB. Reviewed list of individuals with adaptive equipments. Reviewed list of individuals at risk for choking. Reviewed list of individuals at risk for dysphagia. Reviewed list of individuals with hearing aids. Reviewed list of individuals who require wheelchairs for mobility. Observed individuals in wheelchairs on EB 11. Reviewed OT, PT, and Speech caseloads.</p>

		<p>Conducted walking rounds on EB 11 with Helen Dangiapo, RN, Shift Lead.</p>
a	<p>Each State hospital shall develop standard rehabilitation therapy assessment protocols, consistent with generally accepted professional standards of care, for satisfying the necessary components of a comprehensive rehabilitation therapy assessment.</p>	<p>Findings: From my review of the Rehabilitation Therapy assessments for the above-listed individuals, they did not include components to trigger an Occupational Therapy (OT), Physical Therapy (PT) and/or Speech Therapy referral when appropriate. In addition, PSH does not include OT, PT, and Speech Therapy under Rehabilitation Services. These therapy specialties are separated under medical and do not have integration with the Rehabilitation Department.</p> <p>In addition, the OT Manual, PT Manual, and the Speech Pathology Manual need to be reviewed for consistency with psychiatric rehabilitation and recovery model of service delivery.</p> <p>The Rehabilitation Chiefs have revised the Comprehensive Rehabilitation Assessment; however, there was no input provided from OT, PT and Speech Therapy.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Integrate OT, PT and Speech Therapy into the Rehabilitation Therapy Services. 2. Revise the Comprehensive Rehabilitation Assessment with input from OT, PT, and Speech Therapy to include functional abilities that would indicate a need for OT, PT and/or Speech Therapy. 3. Revise, update, and implement policies, procedures, operations manuals and ADs to address this requirement. 4. Develop and implement a monitoring system to address the elements of this requirement.

		5. Develop, review and revise OT, PT, and Speech Pathology Manuals to include Wellness and Recovery language.
b	Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:	Compliance: Partial.
b.i	Is accurate and comprehensive as to the individual's functional abilities;	<p>Findings: The current Rehabilitation Assessment tool does not provide an accurate and comprehensive assessment as to the individual's functional abilities, functional status, or life goals, strengths, and motivation for engaging in wellness activities related to these areas. As mentioned above, the Rehabilitation Assessment does not include indicators related to OT, PT, and Speech Therapy to trigger a referral to these therapies if needed. Referrals to these therapies are obtained only through a physician's order and have usually been based on an acute event.</p> <p>Currently, there is no system in place to proactively identify individuals with OT, PT, and/or Speech Therapy needs. In addition, the assessments conducted by PT, and Speech Therapy are not integrated into the PSH's Rehabilitation Assessments or the individual WRPs.</p> <p>From my observations of individuals on EB 11, there are several individuals who have significant unmet rehabilitation needs in the areas of OT, PT, and Speech Therapy regarding dysphagia, communication, positioning, mobility, risk of falls, and wheelchairs. The current interventions used are insufficient to promote appropriate, safe, and functional body alignment.</p> <p>Although PSH has a unit designated for individuals with hearing and vision impairments, there is no consistent system in place to monitor, track, document, and provide ongoing services to individuals who have these challenges. In addition, there are no assessments identifying</p>

communication issues and the need for augmentative/adaptive communication devices.

Recommendations:

1. Revise appropriate policies, procedures and manuals to be aligned with this requirement.
2. Ensure competency of Recreational Therapy staff regarding changes implemented.
3. Develop and implement a system for monitoring and tracking the elements of this requirement.
4. Include indicators related to OT and PT in the Rehabilitation Assessments to trigger referrals to these therapy specialties.
5. Identify, assess, develop and implement proactive interventions for individuals with OT, PT and/or Speech Therapy needs.
6. Integrate OT, PT and Speech Therapy assessments and interventions into the individual WRPs.
7. Assess and develop 24-hour, proactive interventions for individuals at risk for choking and aspiration.
8. Provide ongoing competency-based training to all team members regarding dysphagia.
9. Assess the mobility needs and provide individual wheelchairs that promote appropriate body alignment for individuals who depend on the use of wheelchairs for the majority of their mobility.
10. Streamline the process of obtaining adaptive equipment.
11. Provide and document training to individuals and staff regarding the appropriate use of adaptive equipment.
12. Develop a monitoring system to ensure that individuals have access to their adaptive equipment, that it is in proper working condition, and that it is being used appropriately.
13. Re-evaluate the adaptive equipment at least annually or in response to individuals' status changes to ensure that it is meeting the individuals' needs.

		<p>14. Develop and implement a system to identify, assess, monitor, track, document, and provide ongoing services to individuals who have significant vision and hearing problems and the need for augmentative/adaptive communication devices.</p> <p>15. Provide augmentative/adaptive communication devices for individuals with communications issues.</p>
b.ii	Identifies the individual's current functional status and the skills and supports needed to facilitate transfer to the next level of care; and	As above.
b.iii	Identifies the individual's life goals, strengths, and motivation for engaging in wellness activities.	As above.
c	Each State hospital shall ensure that all clinicians responsible for performing or reviewing rehabilitation therapy assessments are verifiably competent in performing the assessments for which they are responsible	<p>Findings: PSH reported that there is no formal process to ensure that clinicians who are responsible for performing or reviewing rehabilitation therapy assessments are competent in performing the assessments. New employees in the Rehabilitation Therapy Department are assigned a peer proctor for one year and have an orientation checklist to complete within six months. Although assessments are listed on the checklist, there is no formal procedure ensuring competency. However, OT, PT and Speech Therapy are not included in this process.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a system to ensure that Rehabilitation Therapists, including OT, PT and Speech therapists are verifiably competent in performing the assessments for which they are responsible. 2. Develop and implement a monitoring system to adequately address the elements of this requirement.

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>Findings: PSH reported that currently there is no formal process in place addressing this requirement.</p> <p>Compliance: Non-compliance.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Same as recommendations in section D.4.a. 2. Develop and implement a plan to ensure that all rehabilitation therapy assessments of individuals admitted to PSH prior to June 1, 2006 are reviewed by qualified clinicians and revised as needed.
5	Nutrition Assessments	
	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>Methodology:</p> <p>Interviewed Tai Kim, Director of Dietetics. Reviewed Nutrition Care Monitoring Tool (NCMT) and instructions sheet. Reviewed AD #8.01 Nutrition Services. Reviewed Nutritional Screening Referral For High Risk Patients. Reviewed Nutrition Care Process (NCP). Reviewed Nursing Policy and Procedure 100, Admission Process and History and Physical. Reviewed Nutrition Assessments for the following individuals: JA, AS, AR, KB, CB, RC, JB, YW, CC, CR, RT, KY, JW, GG and BT. Reviewed Department of Dietetics Policy and Procedure Manual. Reviewed Nutrition Status Type (NST) acuity and indicators form. Reviewed list of residents with dysphagia. Reviewed dietary data provided by PSH.</p>
a	For new admissions with high risk referral (e.g., type I diabetes mellitus, enteral/parenteral feeding,	<p>Findings: PSH reported that from a review of all admissions from September 1</p>

	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>to September 30, 2006, no individual met this criterion.</p> <p>At the time of this review, there were no additional individuals that met this criterion to review based on information provided by the facility.</p> <p>Compliance: Not applicable.</p> <p>Recommendations: Continue to monitor this requirement.</p>
b	For new admissions directly into the medical-surgical unit, a comprehensive Admission Nutrition Assessment will be completed within 3 days of admission.	<p>Findings: PSH does not have a medical-surgical unit.</p> <p>Compliance: Not applicable.</p> <p>Recommendations: None.</p>
c	For new admissions directly into the skilled nursing facility unit, a comprehensive Admission Nutrition Assessment will be completed within 7 days of admission.	<p>Findings: PSH does not have a skilled nursing facility unit.</p> <p>Compliance: Not applicable.</p> <p>Recommendations: None.</p>
d	For new admissions with identified nutritional triggers from Nursing Admission Assessment or physician's consult (e.g., for severe food allergies, tube feeding, extensive	<p>Findings: PSH reported 46% compliance with this requirement. This compliance percentage was based on a total of 13 individuals who met this</p>

	<p>dental problems or dental surgery, NPO/clear liquid diet for more than three days, uncontrolled diarrhea/vomiting more than 24hrs, and MAOI, as clinically indicated), a comprehensive Admission Nutrition Assessment will be completed within 7 days of admission.</p>	<p>criterion for October 2006.</p> <p>In addition, there were issues with the quality of the assessments in the areas of objective information addressed, subjective concerns addressed, estimated daily needs are appropriate, and utilizes findings from the assessment.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that new admissions with identified nutritional triggers from Nursing Admission Assessment or physician's consult (e.g., for severe food allergies, tube feeding, extensive dental problems or dental surgery, NPO/clear liquid diet for more than three days, uncontrolled diarrhea/vomiting more than 24 hours, and MAOI, as clinically indicated) are provided a comprehensive Admission Nutrition Assessment within 7 days. 2. Ensure staff competency regarding deficiencies and appropriate procedures for Admission Nutrition Assessments.
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>Findings: PSH reported 67% compliance with this requirement. A total of nine individuals met this criterion.</p> <p>In addition, the data that were presented demonstrated that the assessments in the areas of objective information, and nutrition diagnoses were inadequate in quality and/or incomplete.</p> <p>Compliance: Partial.</p>

		<p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that new admissions with therapeutic diet orders for medical reasons receive a comprehensive Admission Nutrition Assessment within seven days of admission. 2. Ensure staff competency regarding deficiencies and appropriate procedures for Admission Nutrition Assessments.
f	<p>For individuals with therapeutic diet orders for medical reason after admission, a comprehensive Admission Nutrition Assessment will be completed within 7 days of the therapeutic diet order but no later than 30 days of admission.</p>	<p>Findings: PSH reported 80% compliance with this requirement based on a review of 20 individuals who met the requirement.</p> <p>In addition, there were deficiencies in the quality of these Nutrition Assessments in the areas of accurate objective information, estimated daily needs are appropriate, utilizes findings from the assessment, nutrition diagnoses, and appropriate nutrition goals.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that individuals with therapeutic diet orders for medical reason after admission receive a comprehensive Admission Nutrition Assessment within seven days of the therapeutic diet order but no later than 30 days of admission. 2. Ensure staff competency regarding deficiencies and appropriate procedures for Admission Nutrition Assessments.
g	<p>For all other individuals, a comprehensive Admission Nutrition Assessment will be completed within 30 days of admission.</p>	<p>Findings: PSH reported 85% compliance with this requirement.</p> <p>From my review, I found that five out of six Admission Nutrition Assessments were in compliance with this requirement (JA, AS, AR, KB, CB, and RC).</p>

		<p>PSH's data indicated deficiencies with the quality of the Admission Assessments. This reviewer found similar issues regarding the quality of the Admission Nutrition Assessments.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Continue to monitor Admission Nutrition Assessments to ensure that they are completed in a timely manner. 2. Ensure staff competency regarding deficiencies and appropriate procedures for Admission Nutrition Assessments.
h	<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>Findings: PSH reported 81% compliance with this requirement. A sample of 200 assessments was collected for review. However, 50 of these assessments were found to be incomplete and not included in the sample. PSH reported that department staffing issues were a major barrier in completing many nutrition assessments.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Continue to monitor this requirement. 2. Evaluate the need for additional nutritional staff to ensure adequate nutritional services.
i	<p>The frequency of a comprehensive Nutrition Assessment Update will be determined by the NST. Updates should include, but not be limited to: subjective data, weight, body-mass index ("BMI"), waist circumference, appropriate</p>	<p>Findings: The current Nutrition Care Monitoring Tool (NCMT) does not address all the elements included in this requirement.</p>

	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>Compliance: Partial.</p> <p>Recommendations: Incorporate all elements of this requirement into the NCMT.</p>
j.i	Individuals will be reassessed when there is a significant change in condition.	<p>Findings: PSH reported 92% compliance with the requirement regarding reassessments when there is significant change in the individual's condition. This monitor's review of these assessments revealed deficiencies in the areas of accurate objective information, estimated daily nutritional needs and appropriate nutritional goals and progress in achieving the goals.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Continue to monitor compliance with this requirement. 2. Provide training on components of an adequate assessment for changes in conditions.
j.ii	Every individual will be assessed annually.	<p>Findings: PSH reported 50% compliance with completion of annual nutritional assessments. A total of 32 annual nutritional assessments were reviewed. However, 15 were not completed.</p> <p>From this monitor's review of 21 charts, ten were found to have an annual nutritional assessment timely completed. A lower compliance rate was found when the quality of the assessments was considered, which corroborates the facility's findings.</p>

		<p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that every individual will be assessed annually. 2. Continue monitoring and tracking this requirement. 3. Ensure staff competency regarding deficiencies and appropriate procedures for annual Nutrition Assessments.
6	Social History Assessments	
	Each State hospital shall ensure that each individual has a social history evaluation that, consistent with generally accepted professional standards of care:	<p>Methodology:</p> <p>Interviewed Veronica Kaufman, MSW., LCSW; Chief of Social Work Interviewed Rachel Strydom, LCSW, Social Worker Reviewed 26 charts (CV, HC, JJ, CB, GG, HA, PD, LF, DJ, KD, IR, KL, JR, AT, GM, BD, BC, JW, RJ, RG, JS, AJ, WD, BP, CW, and JB). Reviewed 30 Day Psychosocial Assessment, Instructional Manual. Reviewed 30 Day Psychosocial Assessment Monitoring Form. Reviewed Social Work Integrated 5-day Monitoring Form. Reviewed Social Work Assessment Monitoring Form and Instructions Reviewed AD #1.00-Written Plan for Professional Services (section 6) Reviewed Social Work self-assessment data Observed WRP team conferences.</p>
a	Is, to the extent reasonably possible, accurate, current and comprehensive;	<p>Findings:</p> <p>This monitor reviewed 26 charts and found that a high percentage of the assessments were not conducted, not found in the charts, or conducted but not in a timely fashion. Only eight (CV, JJ, GG, LF, GM, WD, BP, and CW) Social History assessments were conducted in a timely fashion. Thirteen charts did not have 30-day assessments (HC, HA, PD, KD, IR, KL, JR, BD, BC, JW, JS, AJ, and JB). Three did not have either a 5-day or a 30-day assessment (BC, RG, and RJ).</p> <p>PSH's self-assessment also evidenced poor compliance with this</p>

		<p>requirement. The facility found that the Social Work Integrated Assessment had 50% compliance, the 30-day psychosocial assessment had 27% compliance, and compliance with the annual update was at 40%.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Consistently implement the 5-day, 30-day, and annual social history reviews. 2. Develop, finalize and implement statewide annual social history evaluations. 3. Align monitoring tools with the EP. 4. Ensure that all social history assessments are conduct in a timely manner.
b	Expressly identifies factual inconsistencies among sources, resolves or attempts to resolve inconsistencies, and explains the rationale for the resolution offered;	<p>Findings: PSH's self-assessment does not specifically address this requirement. The data showed 0% compliance for the 30-day Psychosocial assessments, and 7% compliance for annual assessments.</p> <p>This monitor reviewed 15 charts (CV, HC, JJ, CB, GG, HA, PD, LF, DJ, KD, AT, GM, WD, BP, and CW). Many of the Social History Assessments were found to have incomplete or insufficient information in the areas of source of information, interpersonal and developmental history, medical psychiatric history, and summary and recommendation.</p> <p>Factual inconsistencies affect all aspects of the individual's services. As such, they should be carefully reviewed and resolved at the earliest possible time.</p>

		<p>Compliance: Non-compliance.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that Social History assessments contain all relevant information. 2. Ensure that social workers identify and address the inconsistencies in current assessments. 3. Monitor factual inconsistencies in social histories and revise to correct the inconsistencies. 4. Ensure that Social Work staff tracks and monitors this requirement.
c	Is included in the 7-Day integrated assessment and fully documented by the 30 th day of an individual's admission; and	<p>Findings: This monitor reviewed 26 charts (CV, JJ, GG, LF, GM, WD, BP, CW, HC, HA, PD, KD, IR, KL, JR, BD, BC, JW, JS, AJ, JB, BC, RG, RJ, CB, and DJ). The review showed that only eight of the Social History assessments were conducted in a timely fashion.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that all Social History Integrated assessments are completed in a timely fashion, and made available to the individuals' WRP teams before the 7-Day WRP conference. 2. Ensure that all 30-day social histories are completed and available to the individual's WRP team members by the 30th day of admission.
d	Reliably informs the individual's interdisciplinary team about the individual's relevant social factors and educational status.	<p>Findings: Nine of the 15 assessments (CV, HS, JJ, CB, GG, HA, PD, LF, DJ, KD, AT, GM, WD, BP and CW) reviewed by this monitor failed to provide</p>

		<p>sufficient information on the individual's social and/or educational factors.</p> <p>PSH self-assessment of this item showed 16% compliance.</p> <p>Compliance: Partial.</p> <p>Recommendation: Ensure that social history assessments contain sufficient information on the individual's social factors and educational status to reliably inform the individual's WRP team.</p>
7	Court Assessments	
		<p>Methodology: Interviewed Ai-Li Arias, M.D., Chair, Forensic Review Panel. Interviewed Wadsworth Murad, M.D., Acting Chief of Psychiatry. Reviewed charts of five individuals admitted under PC 1026 (RTN, RRI, GJW, YTP and BA). Reviewed charts of five individuals admitted under PC 1370 (WJV, MO, VVN, UL and KT). Reviewed PSH Court Reports Monitoring Form for PC 1026. Reviewed Summary Data for Court Reports Monitoring (pc 1026) during September and October 2006. Reviewed PSH Court Reports monitoring Form for PC 1370. Reviewed Summary Data for Court Reports Monitoring (PC 1370) during September and October 2006. Reviewed AD #2.03Y Forensic Review Panel. Reviewed AD #12.12 Court report and testimony Procedures. Reviewed medical Director Memorandum (September 20, 2006) regarding Forensic Review Panel and feedback on Court reports. Reviewed minutes of the Forensic review Panel meetings during the</p>

		<p>period August to November 2006. Reviewed AD # 1212A Requirements for PC 1370 Court Reports. Reviewed AD #12.12B Requirements for PC 1026 Court Reports. Reviewed examples of training material provided by Craig Lareau, Ph.D. Forensic psychology Consultant and Mendel Feldsher, M.D. Forensic Psychiatry Consultant.</p>
a	<p>Each State hospital shall develop and implement policies and procedures to ensure an interdisciplinary approach to the development of court submissions for individuals adjudicated "not guilty by reason of insanity" ("NGI") pursuant to Penal Code Section 1026, based on accurate information, and individualized risk assessments. The forensic reports should include the following, as clinically indicated:</p>	<p>Compliance: Partial.</p>
a.i	<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>Findings: PSH has two ADs (#1212A and #1212B) that address this requirement. DMH SOs #302 and 334 make reference to a PC 1026 court assessment policy but do not address an interdisciplinary approach to the development of court submissions for these individuals.</p> <p>The facility has developed and implemented a self-monitoring tool to assess its compliance with all provisions in section D.7.a. Using PSH Court reports monitoring Form for PC 1026, members of the FRP conducted a review of 35 charts (September 2006) and 54 charts (October 2006) representing samples of 47% and 67%, respectively of all reports submitted to the Medical Director's office for signature. Based on these reviews, the facility found overall compliance 100% compliance with this requirement.</p> <p>This monitor reviewed the charts of five individuals adjudicated NGRI. In reviewing item 7.a.i, this monitor found non-compliance in two charts (RTN and GJW), partial compliance in one (YTP) and compliance in one</p>

		<p>(RRI and BA).</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that the facility's AD codifies all plan requirements regarding the content of 1026 court submissions. 2. Ensure that the FRP reviews all PC 1026 reports and provide feedback to the WRP teams to achieve compliance. 3. Continue to use adequate monitoring sample in the self-assessment data.
a.ii	acts of both verbal and physical aggression and property destruction during the past year of hospitalization and, if relevant, past acts of aggression and dangerous criminal behavior;	<p>Findings: PSH found an overall compliance rate of 81% for this requirement.</p> <p>This monitor's reviews indicated non-compliance in three charts (RTN, GJW and BA) and compliance in two (RRI and YTP).</p> <p>Recommendations: Same as above.</p>
a.iii	understanding of potential for danger and precursors of dangerous/criminal behavior, including instant offense;	<p>Findings: The facility's monitoring data indicate 88% compliance (overall).</p> <p>This monitor found non-compliance in three charts (GJW, YTP and BA), partial compliance in one (RRI) and compliance in one (RTN).</p> <p>Recommendations: Same as above.</p>
a.iv	acceptance of mental illness and understanding of the need for treatment, both psychosocial and biological, and the need to adhere to treatment;	<p>Findings: The facility's monitoring data showed the following compliance rates::</p> <ol style="list-style-type: none"> 1. Acceptance of mental illness: 93%; 2. The individual's understanding of the need for treatment: 85%;

		<p>3. The evaluations noted the individual's understanding of the need to adhere to treatment: 100%.</p> <p>Reviews by this monitor demonstrated non-compliance in three charts (GJW, YTP and BA) and partial compliance in two (RTN and RRI)</p> <p>Recommendations: Same as above.</p>
a.v	development of relapse prevention plan (i.e., Personal Wellness Recovery Plan or Wellness Recovery Action Plan) for mental illness symptoms, including the individual's recognition of precursors and warning signs and symptoms and precursors for dangerous acts;	<p>Findings: The facility found 78% compliance with the development of relapse prevention, and 80% with the recognition of precursors and warning signs.</p> <p>This monitor found non-compliance in three charts (RTN, YTP and BA), partial compliance in one (GJW) and compliance in one (RRI).</p> <p>Recommendations: Same as above.</p>
a.vi	willingness to achieve understanding of substance abuse issues and to develop an effective relapse prevention plan (as defined above);	<p>Findings: The facility found an overall compliance rate of 78%.</p> <p>This monitor found non-compliance in the only case in which this requirement was applicable (GJW).</p> <p>Recommendations: Same as above.</p>
a.vii	previous community releases, if the individual has had previous CONREP revocations;	<p>Findings: The facility found 78% overall compliance with this requirement.</p> <p>This monitor found non-compliance in the only chart (BA) that met the</p>

		<p>criteria for this requirement.</p> <p>Recommendations: Same as above.</p>
a.viii	<p>social support, financial resources, family conflicts, cultural marginalization, and history of sexual and emotional abuse, if applicable; and</p>	<p>Findings: The facility's data indicate 0% compliance.</p> <p>This monitor corroborated the facility's finding.</p> <p>Recommendations: Same as above.</p>
a.ix	<p>relevant medical issues, all self-harm behaviors, risks for self harm and risk of harm to others, to inform the courts and the facility where the individual will be housed after discharge.</p>	<p>Findings: The facility reports an overall compliance rate of 48%.</p> <p>This monitor found non-compliance all the charts reviewed.</p> <p>Recommendations: Same as above.</p>
b	<p>Each State hospital shall develop and implement policies and procedures to ensure an interdisciplinary approach to the development of court submissions for individuals admitted to the hospital pursuant to Penal Code Section 1370, "incompetent to stand trial" ("IST"), based on accurate information and individualized risk assessments. Consistent with the right of an individual accused of a crime to a speedy trial, the focus of the IST hospitalization shall be the stabilization of the symptoms of mental illness so as to enable the individual to understand the legal proceedings and to assist his or her attorney in the preparation of the defense. The forensic</p>	<p>Compliance: Partial.</p>

	reports should include the following:	
b.i	relevant clinical description of initial presentation, if available, which caused the individual to be deemed incompetent to stand trial by the court;	<p>Findings: The FRP reviewed 41 reports (31%) in September and 78 reports (60%) in October, 2006 to determine its compliance with this requirement. A compliance rate of 92% was reported.</p> <p>This monitor reviewed the charts of five individuals admitted under PC 1370 (WJV, MO, VVN, UL and KT). In reviewing item D.7.b.i, the monitor found compliance in four charts (WJV, MO, KT and VVN) and non-compliance in one (UL).</p> <p>Recommendations: Same as D.7.a.i (as applicable to PC 1370).</p>
b.ii	clinical description of the individual at the time of admission to the hospital;	<p>Findings: The facility reports a compliance rate of 61%.</p> <p>This monitor found 0% compliance with this requirement in all charts reviewed.</p> <p>Recommendations: Same as above.</p>
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	<p>Findings: The facility's data indicate the following compliance rates with different components of this requirement:</p> <ol style="list-style-type: none"> 1. Description of the person's response to treatment: 93%; 2. Description of the person's current relevant mental status: 96%; 3. Progress or lack of progress: 100%; and 4. Reasoning provided to support the forensic recommendations:

		<p>82%.</p> <p>Chart reviews by this monitor show partial compliance in three charts (MO, VVN and KT), compliance in one (UL) and non-compliance in one (WJV).</p> <p>Recommendations: Same as above.</p>
b.iv	<p>all self-harm behaviors and relevant medical issues, to inform the courts and the facility where the individual will be housed after discharge.</p>	<p>Findings: The facility's reviews show 96% compliance with this requirement.</p> <p>This monitor found non-compliance in all five charts reviewed.</p> <p>Recommendations: Same as above.</p>
c	<p>Each State hospital shall establish a Forensic Review Panel (FRP) to serve as the internal body that reviews and provides oversight of facility practices and procedures regarding the forensic status of all individuals admitted pursuant to Penal Code 1026 and 1370. The FRP shall review and approve all forensic court submissions by the Wellness and Recovery Teams and ensure that individuals receive timely and adequate assessments by the teams to evaluate changes in their psychiatric condition, behavior and/or risk factors that may warrant modifications in their forensic status and/or level of restriction</p>	<p>Findings: PSH formed a FRP in August, 2006. AD#2.03Y specifies membership of the panel that comports with this requirement. The chair of the panel is a board-certified psychiatrist with forensic training, who is currently in the process of obtaining subspecialty certification in forensics. The AD requires that the panel reviews all forensic court submissions by the WRP teams.</p> <p>The FRP has been meeting regularly since August 22, 2006. During the month of November, the panel reviewed about 80% of all court submissions under PC 1026 and PC 1370. The panel plans to review 100% of the report by January.</p> <p>The panel is finalizing the process of providing feedback to the WRP teams regarding the timeliness and quality of court submissions.</p>

		<p>Compliance: Partial.</p> <p>Recommendation: Ensure that the panel performs the primary function of reviewing all court reports for individuals admitted under penal codes 1026 and 1370. The panel must provide feedback to WRP teams to ensure compliance with all above requirements.</p>
c.i	<p>The membership of the FRP shall include Director of Forensic Psychiatry, Facility Director or designee, Medical Director or designee, Chief of Psychology or designee, Chief of Social Services or designee, Chief of Nursing Services or designee, and Chief of Rehabilitation Services or designee. The Director of Forensic Psychiatry shall serve as the chair and shall be a board certified forensic psychiatrist. A quorum shall consist of a minimum of four FRP members or their designee.</p>	<p>Findings: As above.</p> <p>Compliance: Substantial.</p> <p>Recommendation: As above.</p>

E	Discharge Planning and Community Integration	
		<p>Summary of Progress:</p> <ol style="list-style-type: none"> 1. PSH has correctly recognized that discharge planning focus begins from the individual's first day of admission. 2. Social workers are provided training in the discharge process. 3. PSH has adopted WRP as an essential tool towards addressing the individual's rehabilitation needs and preparation of the individual for discharge and community integration. 4. PSH has developed and implemented ADs and SOs relevant to discharge planning and community integration. 5. AD is being revised to incorporate current practices and EP requirements.
	<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 Veronica Kaufman, MSW, LCSW, Chief of Social Work. Interviewed Rachel Striydem, LCSW, Social Worker. Interviewed Anthony Ortega, LCSW, Social Worker Reviewed 36 charts (FS, DP, GP, WP, TG, PD, TG, DB, TB, CD, SV, NV, JS, SM, MK, FS, DP, GP, RJ, CK, SD, LJ, MT, RK, BT, GM, AS, DH, AT, JE, ER, DK, HM, BB, LD, and MG). Reviewed Social Work credentialing and certifications. Reviewed CONREP placement lists. Reviewed PSH discharge list. Reviewed ADs and SOs Reviewed PSH self-assessment data. Observed WRP team meetings.</p>
1	<p>Each State hospital shall identify at the 7-Day therapeutic and rehabilitation service planning conference, and address at all subsequent planning conferences, the particular considerations for each individual bearing on discharge, including:</p>	<p>Findings:</p> <p>Chart audits of WRPs by this monitor showed significant deficiency in fulfilling this criterion.</p> <p>A number of the 7-Day WRP conferences and/or subsequent conferences fail to fully address this requirement. Discharge planning</p>

		<p>goals, criteria, barriers, progress and individuals' understanding of and participation in discharge are not in line with this requirement.</p> <p>Most charts reviewed by the monitor (e.g., WP, TG, DB, SM, and MK) failed to meet all required elements for any one individual. Most charts did not include much more than discharge criteria statements made in the relevant section. A number of Social Work notes (e.g., TG, DB, NV, SM, and MK) had relevant information that was not integrated in the individuals' WRP.</p> <p>PSH's ability to meet discharge planning and placement requirements are dependent on community standards of practice, the courts, and CONREP. Staff at PSH should become familiar with rules and roles of these agencies to better plan and prepare for the individual's discharge.</p> <p>Compliance: Partial compliance.</p> <p>Recommendations:</p> <ol style="list-style-type: none">1. Achieve continuity of the discharge process from admission to discharge through the WRP and WRP team process.2. Involve the individual in the discharge process through discussion of discharge criteria and how to meet them (e.g., by attending relevant PSR Mall groups, individual therapy and by practicing newly acquired skills in the therapeutic milieu, as needed)..3. Social workers must review discharge status with the WRP team and the individual at all scheduled WRP conferences involving the individual.4. Social work should coordinate discharge planning activities with CONREP.
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1a	<p>those factors that likely would foster successful discharge, including the individual's strengths, preferences, and personal life goals;</p>	<p>Findings: WRP meetings attended by this monitor failed to show evidence that teams pay sufficient attention to this requirement.</p> <p>There was minimal discussion about the individual's discharge criteria, progress, barriers, strengths and preferences. Life goals, where appropriate, were rarely included in the individual's discharge planning and/or psychosocial rehabilitation services (e.g., AS, GM, BT, and ER).</p> <p>None of the WRP conferences attended by this monitor addressed the following:</p> <ol style="list-style-type: none"> 1. Review all of the individual's discharge criteria. 2. Evaluate if the individual's current psychosocial rehabilitation services cover the necessary areas that when completed will result in the individual being ready for discharge 3. Evaluate if the individual understands what he/she has to do for each of the discharge criteria. 4. Discuss the individual's progress or lack thereof on each discharge criteria. 5. Discuss the barriers impeding the individual, be it on the part of the individual or the system, from achieving the discharge criteria. <p>PSH's self-evaluation showed only 4% compliance with this requirement.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that the individual's strengths and preferences are utilized to achieve discharge goals. These should be linked to the interventions that impact the individual's discharge
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		<p>criteria.</p> <ol style="list-style-type: none"> 2. The individual's life goals should be linked to one or more focus of hospitalization, with associated objectives and interventions. 3. Ensure that the individual's current WRP satisfies the necessary conditions to successfully meet discharge criteria.
1b	the individual's level of psychosocial functioning;	<p>Findings: None of the WRP team conferences observed by this monitor discussed the individual's GAF scores and/or included the individual in finalizing the score.</p> <p>Charts reviewed by this monitor (i.e., FS, DP, GP, RJ, CK, SD, LJ, MT, RK, BT, and GM) did not document discussion of the individual's psychosocial functioning and related information that may facilitate service planning and implementation.</p> <p>PSH's self-evaluation data showed the following:</p> <ol style="list-style-type: none"> 1. The team updated the person's Life Goals and valued role functions based on discussion prior to the conference and, when appropriate, linked them to treatment, rehabilitation and enrichment goals: 19% compliance. 2. WRP includes individual's Life Goals: 81% compliance. <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that the level of psychosocial functioning (functional status) is included in the individual's present status section of the case formulation section of the WRP. 2. Use the DMH WRP Manual in developing and updating the case formulation.

		<p>3. Ensure that team members are aware of and trained in elements to consider in updating GAF scores.</p>
1c	<p>any barriers preventing the individual from transitioning to a more integrated environment, especially difficulties raised in previously unsuccessful placements; and</p>	<p>Findings: There is evidence of general inattention given to this item. None of the WRP conferences observed by this monitor discussed and/or identified barriers to transition to a more integrated environment and/or discussed this among the interdisciplinary team members.</p> <p>Only one (AT) of the charts reviewed (i.e., AS, DH, AT, JE, ER, DK, HM, BB, LD, and MG) covered a number of related information required for this requirement.</p> <p>PSH's self-evaluation evidenced a very low (12%) compliance with this requirement.</p> <p>Compliance: Non-compliance.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that discharge barriers, especially difficulties in previously unsuccessful placements, are discussed with the individual at scheduled WRP conferences. 2. Ensure that the individual's progress with regards to behaviors/psychosocial problems is properly documented and available for review with CONREP. 3. Include all skills training and supports in the WRP so that the individual can overcome barriers and meet discharge criteria. 4. Discuss with the WRP team, on a monthly basis, the individual's progress in overcoming the barriers to discharge.
1d	<p>the skills and supports necessary to live in the setting in which the individual will be placed.</p>	<p>Findings: Most of the charts reviewed by this monitor failed to identify the</p>

		<p>necessary skills and supports necessary for the individual to live in the setting in which the individual will be placed, even when the placement can be anticipated or is known (e.g., CK, SD, LJ, LD, BB, HM, AS, and GM). Of course, it would be difficult to identify and/or equip the individual with specific skills and information when the next placement has yet to be identified (e.g., FS, DP, GP, RJ, MT, RK, MG, DL, ER, and JE), but generic skills can be taught for a specific class of community placement (e.g., IMD, group home).</p> <p>PSH did not have a tool to evaluate this requirement.</p> <p>Compliance: Non-compliance.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that the individual's next placement is identified as soon as possible, so as to equip the individual with appropriate planning and preparation of skills and supports. 2. Assess the skills and supports that will be needed by the individual for a successful transition to the identified setting. 3. Include these skills and supports in the individual's WRP and use this information to guide appropriate services for the individual. 4. Ensure that WRP team members focus on this requirement and update the individual's WRP plans when necessary. 5. Develop a tool to monitor and track this requirement
2	<p>Each State hospital shall ensure that, beginning at the time of admission and continuously throughout the individual's stay, the individual is an active participant in the discharge planning process, to the fullest extent possible, given the individual's level of functioning and legal status.</p>	<p>Findings: The WRP conferences observed by this monitor discussed this item, but at a cursory level. The individual, even those who were cognitively intact and lucid, were not engaged by the team to explore and discuss the individual's discharge planning.</p>

		<p>There was no evidence in the charts reviewed by this monitor (FS, CK, LD, HM, and ER), that the individual's life goals went beyond mere statements in the relevant section. For example, there was no evidence that the individual's life goals were included in the discharge goals, objectives or interventions, where appropriate.</p> <p>PSH does not have a tool to evaluate this requirement.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that the individual is an active participant in the discharge planning process. 2. Implement the DMH WRP Manual regarding the discharge process. 3. Prioritize objectives and interventions related to the discharge processes. 4. Ensure that the individual understands all of the discharge requirements before leaving the WRP conference.
3	<p>Each State hospital shall ensure that, consistent with generally accepted professional standards of care, each individual has a professionally developed discharge plan that is integrated within the individual's therapeutic and rehabilitation service plan, that addresses his or her particular discharge considerations, and that includes:</p>	<p>Findings: PSH reviewed AD #1.00 (Written Plan for Professional Services, section 10 - 14, 28 .3,36 .4, and 36 .5; AD #15.44, Release Policies and AD #15.42, Wellness & Recovery Plan, sections 12.4 and 29. The facility found that AD #15.42 needs to be brought in line with EP requirement.</p> <p>Many of the charts reviewed by this monitor (e.g., FS, DP, GP, RJ, CK, SD, LJ, MT, RK, BT, GM, AS, and DH) failed to show any evidence that individuals' discharge plans are integrated with their therapeutic and rehabilitation service plans. In some cases, JE for example, the psychosocial rehabilitation activity is aligned with discharge plans,</p>

		<p>however, JE is not attending the activities and there is no stated plan on how the team intends to get JE to attend.</p> <p>PSH's self-assessment showed only 13% compliance with this requirement. .</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Continue and strengthen training to WRP teams to ensure consistent implementation of this requirement. 2. Ensure that the monitoring tool addresses the documentation of the results of the team's review of progress in the present status section of the case formulation and of appropriate revisions of the WRP if no progress has been made (as required by the DMH WRP Manual). 3. Follow the established DMH WRP process for discharge planning to ensure that each individual has a professionally developed discharge plan that is integrated within the individual's WRP and Psychosocial Rehabilitation Services. 4. Ensure that ADs are updated to make them relevant and in line with EP requirements.
3a	measurable interventions regarding these discharge considerations;	<p>Findings:</p> <p>WRPs reviewed by this monitor (e.g., GB, ST, and MH) failed to develop objectives and interventions that are aligned with the individual's discharge criteria or indicate how the discharge criteria were to be measured.. In addition, these interventions were not always written in measurable and/or observable terms.</p> <p>PSH's self-evaluation showed only 8% compliance with this requirement.</p> <p>Compliance: Partial</p>

		<p>Recommendation: Write all interventions, including those dealing with discharge criteria, in behavioral and/or measurable terms as outlined in the DMH WRP Manual.</p>
3b	the staff responsible for implement the interventions; and	<p>Findings: Information as to who, what, when, where, and strength elements required to meet criteria for this cell were often missing. None of the WRPs reviewed by this monitor had interventions that fully met the required elements. Examples include the charts of CH, DJ and AH.</p> <p>PSH does not have a tool for tracking and monitoring this item.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that responsible staff members for each intervention are clearly identified in the individual's WRP. 2. Confirm that the staff to be listed in the WRP is actually involved in facilitating the activity, group, or intervention. 3. Ensure that all elements required for fulfilling the intervention section of the WRP are completed.
3c	The time frames for completion of the interventions.	<p>Findings: As outlined above, none of the interventions listed had any time frame for the completion of the interventions. These time frames are not required in the current format of the interventions section. Rather, time frame/target dates are required under the Objectives section. This is acceptable because it is the individual's progress on each objective that is being reviewed. Given that there is no scientific method for predicting completion dates, a review date is all that is required. The review date should be the individual's next scheduled WRP conference.</p>

		<p>Compliance: Partial.</p> <p>Recommendation: Ensure that the review date for each objective is the same as the individual's next scheduled WRP conference.</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:	<p>Compliance: Partial.</p>
4a	individuals who have met discharge criteria are discharged expeditiously, subject to the availability of suitable placements; and	<p>Findings: Interview with staff showed a number of concerns that impede timely placement of individuals who have met discharge criteria. These concerns include the following:</p> <ol style="list-style-type: none"> 1. CONREP's response time; 2. CONREP's agreement with PSH's data regarding the individual's readiness for discharge; 3. CONREP's ongoing participation during the individual's readiness for discharge preparations; and 4. Available community facilities for placement. <p>Chart reviews (WP, PD, DB, CD, NV, JS and SM) by the monitor confirmed some of the concerns identified by the Social Work staff regarding the difficulty of timely discharge of individuals who were deemed ready for discharge by PSH.</p> <p>The cases above indicate that PSH is dependent on community providers, primarily CONREP, for discharging individuals in a timely fashion. As most of the individuals recommended for discharge by PSH are placed under the care of CONREP (AD#1.00, Written Plan for Professional Services, August 30, 2004), a closer collaboration is called for between CONREP and the DMH hospitals.</p>

		<p>PSH should actively pursue court-ordered outpatient treatment, as this has shown that individual's were less likely to re-offend or decompensate under such court-ordered placement for treatment (AD#1.00, Written Plan for Professional Services, August 30, 2004; page 6, #13.1).</p> <p>PSH's self-evaluation showed that only 39% (13/33) of the individuals, who met discharge criteria from July 2006 through October 2006, were discharged. The others were not discharged for a variety of reasons including:</p> <ol style="list-style-type: none"> 1. Three were denied Conditional Outpatient treatment (OT). 2. Eight are awaiting a court order. 3. Six are waiting evaluation by CONREP. 4. One was put on a waiting list. 5. One was referred to another CONREP agency. 6. One was delayed due to unknown immigration status. <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Identify and address system factors that act as barriers to timely discharge. 2. Develop and implement a tracking and monitoring system for obtaining data on all individuals delayed from their discharge. 3. Ensure that detailed attention is given to reasons for admission, previous assessment, and possible discharge settings are taken into account when setting discharge criteria. 4. Use objective data for all discharge criteria and planning. 5. Ensure that ongoing discussion is held between the staff in the individual's next placement setting and staff in PSH. 6. Ensure that CONREP is involved in discharge planning during quarterly WRP conferences. This should alert both CONREP and PSH what each should be pursuing to ensure timely discharge of the individual.
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4b	Individuals receive adequate assistance in transitioning to the new setting.	<p>Findings: By policy, the hospital's responsibilities end when an individual is discharged from the facility. There is no clear way of identifying from the current documentation system if an individual was provided with adequate assistance when transitioning to a new setting.</p> <p>Interviews with Social Work staff indicated that, where possible, Social Workers attend to transition issues with the community representative and the individual's family on an as-needed basis.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a monitoring and tracking system to address the key elements of this requirement. 2. Ensure and document specific assistance provided to the individual when transitioned to a new setting. 3. Ensure that early in the discharge process support and assistance an individual may need to transition to the new setting is discussed with the individual and, where appropriate and possible, provide the support and assistance to the individual when discharged.
5	For all children and adolescents it serves, each State hospital shall:	PSH does not serve this population.
5a	develop and implement policies and protocols that identify individuals with lengths of stay exceeding six months; and	Not applicable
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.	Not applicable.

F	Specific Therapeutic and Rehabilitation Services	
		<p>Summary of Progress:</p> <ol style="list-style-type: none"> 1. PSH has a medication management system that includes reviews by a Pharmacy and Therapeutics (P&T) Committee and a Therapeutics Review Committee (TRC). 2. PSH has developed draft individualized medication guidelines that comport with current generally accepted professional standards of care and are derived from recent literature and relevant clinical experience. 3. PSH collects data regarding adverse drug reactions (ADRs). 4. PSH has a tracking system to aggregate ADR-related data. 5. PSH collects data regarding medication variances (errors). The current system contains several important categories of actual variances and some potential variances. 6. PSH has data regarding facility-wide trends in some actual variances and some remedial steps taken in response to this analysis. 7. PSH has initiated a Drug Utilization Evaluation (DUE) system and conducted several DUEs to assess its compliance with requirements of the EP. 8. PSH provides adequate medical services and has a network of medical specialty care and consultation services that can meet the needs of its individuals.
1	Psychiatric Services	<p>Methodology:</p> <p>Interviewed John Thiel, M.D., Chairman of the Pharmacy and Therapeutics (P&T) Committee.</p> <p>Interviewed Richard Plon, PharmD, Pharmacy Representative, P&T Committee.</p> <p>Interviewed Michael Cummings, M.D., Psychopharmacology Consultant and member, P&T Committee.</p> <p>Interviewed Robert DePalmer, HSS, Standards Compliance Department.</p> <p>Interviewed Valerie Pollard, RN, Nursing Performance Improvement</p>

		<p>Coordinator.</p> <p>Reviewed charts of 27 individuals (MDB, J JL, RBK, JL, DJ, JWC, HAG, TK, SNC, KT, ARB, KGT, LDL, MAS, JRB, ZAH, JC, KA, WML, PSS, NDS, JBC, GRR, LMA, EV, KJF, EJH).</p> <p>Reviewed Pharmacy and Therapeutics Manual.</p> <p>Reviewed current California Department of Mental Health Psychotropic Medication Guidelines.</p> <p>Reviewed AD #105.10 Tier System for Atypical Antipsychotics. Psychotropic Medication Guidelines and Clozapine Protocol.</p> <p>Reviewed AD#2.031 Pharmacy & Therapeutics committee.</p> <p>Reviewed Policy regarding Adverse Drug Reaction (ADR) Reporting.</p> <p>Reviewed last ten ADR Data Collection Tools.</p> <p>Reviewed revised Nursing Policy and Procedure regarding Medication Variance.</p> <p>Reviewed last ten Medication Error Special Incident Analysis forms.</p> <p>Reviewed Nursing Performance Improvement Medication Variance Reports January 2005 to September 2006.</p> <p>Reviewed list of individuals diagnosed with Tardive Dyskinesia.</p> <p>Reviewed Psychiatric Evaluation Monitoring Form.</p> <p>Reviewed Psychiatric Evaluation Monitoring Summary Data (October 2006).</p> <p>Reviewed Monthly Psychiatry Progress Notes Monitoring Form, Reviewed Monthly Psychiatry Progress Notes Monitoring Summary Data (October 2006).</p> <p>Reviewed PRN Progress Notes Monitoring Form.</p> <p>Reviewed STAT Progress Notes Monitoring Form.</p> <p>Reviewed PRN & STAT Progress Notes Monitoring Summary Data (October 2006).</p> <p>Reviewed Benzodiazepines, Anticholinergics and Polypharmacy Data Collection Sheets.</p> <p>Reviewed Benzodiazepines, Anticholinergics and Polypharmacy Monitoring Summary Data (October 2006).</p> <p>Reviewed New Generation Antipsychotic Medication Data Collection</p>
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		<p>Sheet. Reviewed New Generation Antipsychotic Medication Monitoring Summary Data (October 2006). Reviewed Tardive Dyskinesia Monitoring Form. Reviewed Tardive Dyskinesia Monitoring summary data (October 2006).</p>
1a	<p>Each State hospital shall develop and implement policies and procedures to ensure system-wide monitoring of the safety, efficacy, and appropriateness of all psychotropic medication use, consistent with generally accepted professional standards of care. In particular, policies and procedures shall require monitoring of the use of psychotropic medications to ensure that they are:</p>	<p>Findings: The facility utilizes the California Department of Mental Health guidelines that provide some general information on the use of psychotropic medications including antipsychotics, antimanics, antidepressants, anxiolytic and hypnotic agents, stimulants, anticonvulsants, and antiparkinsonians. In addition, PSH uses the California Department of Mental Health protocol regarding the use of clozapine.</p> <p>The facility has revised the DMH medication guidelines and developed draft individualized guidelines. The drafts include all antipsychotics, antidepressants, benzodiazepines, mood stabilizers and anticholinergics. These drafts comport with current generally accepted professional standards. The drafts have yet to be finalized and implemented.</p> <p>The Pharmacy and Therapeutics Committee oversees the medication practices of the Medical Staff, specifically regarding the following:</p> <ol style="list-style-type: none"> 1. Medication order monitoring 2. Polypharmacy 3. TRC requirements as stated in SO# 105.10 regarding compliance with DMH Medication guidelines 4. Monitoring of Formulary/Non-formulary medication 5. DUEs 6. Adverse Drug Reaction monitoring 7. PRN/STAT medication monitoring

		<p>The DMH medication guidelines currently in use still fall short of compliance with generally accepted professional standards. Specifically, they demonstrate the following significant deficiencies:</p> <ol style="list-style-type: none"> 1. The guidelines are not sufficiently individualized for most of the classes of psychotropic medications. 2. The outlines fail to outline, in any systematic fashion, the indications, contraindications, precautions in use, adverse effects and outcomes for different medications. In general, the guidelines lack adequate information regarding possible risks and adverse effects and monitoring for these risks. 3. Information regarding drug-drug interactions is generally incomplete. 4. The protocol regarding the use of clozapine does not include important information regarding the following: <ol style="list-style-type: none"> a) Therapeutic benefits for individuals suffering from polydipsia associated with mental illness; b) Specific monitoring for metabolic abnormalities; c) Clear guidance to staff regarding triggers for interventions to minimize the risk of myocarditis; d) The risk of delirium; e) Blood level interpretation; f) Interactions with other drugs, diet and tobacco smoking; and g) Guidelines for use in individuals who fail to respond satisfactorily. <p>The facility developed and implemented a variety of monitoring mechanisms to assess compliance with items 1.a.i through 1.a.viii. These mechanisms and compliance data are reviewed for each item below. This monitoring did not utilize guidelines that include complete information regarding indications, contraindications, screening and outcome criteria and that are derived from current literature, relevant experience and</p>
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		<p>professionally accepted guidelines. In addition, the deficiencies listed under Psychiatric Assessments (C.1.c), Diagnosis (C.1.d) and Reassessments (C.1.d) are such that monitoring by PSH of this item is not based on meaningful criteria. As a result, the facility is not in compliance with items F.1.a.i through F.1.a.viii.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Finalize 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 F.1.g. 3. Implement recommendations listed in C.1.c, C.1.d and C.1.e. 4. Standardize the monitoring forms and other mechanisms of review across state facilities. Ensure that compliance rates derived from internal monitoring are based on a monthly review of a stratified 20% sample. This recommendation applies to all relevant items in section F.
1a.i	specifically matched to current, clinically justified diagnoses or clinical symptoms;	<p>The facility used the Psychiatric Evaluation and Monthly Psychiatry Progress Notes Monitoring Forms to assess compliance with this requirement. The following are compliance data that are relevant to the requirement:</p> <ol style="list-style-type: none"> 1. Psychopharmacology plan identifies target symptoms: 69%. 2. Psychopharmacology plan includes reasons for continuing the medications individual came with: 59%.

		3. Current diagnosis (changes, if any, with evidence to support) includes resolution of NOS, Deferred and R/O diagnosis, if applicable: 71%.
1a.ii	prescribed in therapeutic amounts, as dictated by the needs of the individual served;	The facility does not have self-assessment data regarding this requirement.
1a.iii	tailored to each individual's symptoms;	The facility reports the same compliance data in F.1.a.i. In addition, the Department of Psychiatry peer review data, reported in D.1.a, are applicable to this requirement.
1a.iv	monitored for effectiveness against clearly identified target variables and time frames;	Using the Monthly Psychiatry Notes Monitoring Form, the facility reports 84% compliance with the documentation of response to pharmacological treatment. The facility has other data based on this form and on the Department of Psychiatry peer review. However, these data relate to indicators that are not aligned with this requirement.
1a.v	monitored appropriately for side effects;	The facility has monitoring data based on the Monthly Psychiatry Progress Notes Form. The following is an outline of the data: <ol style="list-style-type: none"> 1. Monitoring of side effects, including sedation (is documented): 82%. 2. AIMS (is documented) quarterly, if applicable (positive AIMS): 84%. 3. Mini Mental Status Examination (is documented) quarterly, if applicable (cognitive impairment): 76%.
1a.vi	modified based on clinical rationales;	Using the Monthly Psychiatry Progress Notes Monitoring Form, PSH reports 73% compliance. The indicator is based on the documentation of rationale for continuation or change of the psychopharmacology plan.
1a.vii	are not inhibiting individuals from meaningfully participating in treatment, rehabilitation, or	The facility reports the same compliance data in F.1.a.v (items 1 and 3).

	enrichment and educational services as a result of excessive sedation; and	
1a.viii	Properly documented.	<p>The facility monitored compliance with most of the indicators specified on the Monthly Psychiatry Progress Notes Monitoring Form. The selected indicators are aligned with this requirement. The data indicate an overall compliance rate of 73%. The following is an outline of the data:</p> <ol style="list-style-type: none"> 1. Subjective complaints: 89%; 2. Progress towards objectives in the WRP: 52%; 3. Mental Status Examination: 91%; 4. Rationale for current psychopharmacological plan: 65%; 5. Rationale for PRN medications/ review of rationale for ongoing PRN/Stat : 52%; 6. Benefits and risks of current pharmacological treatments: 58%; 7. Response to pharmacological treatments: 84%; 8. Monitoring of side effects, including sedation: 82%; 9. AIMS-quarterly if applicable (positive AIMS): 84%; 10. Mini Mental Status Examination-quarterly, if applicable (cognitive impairment) (76%); 11. Current diagnosis (changes, if any with evidence to support) includes resolution of NOS, Deferred and R/O diagnosis, if applicable: 71%; and 12. Pharmacologic plan (rationale for continuation or proposed plans): 73%
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>Findings: Using the Monthly Psychiatry Progress Notes Monitoring Form, PSH reports 52% compliance with the documentation of the rationale for PRN medications and review of rationale for ongoing PRN/STAT medications.</p> <p>In addition, the facility developed and implemented PRN and STAT Progress Notes Monitoring Forms. These two forms include indicators</p>

		<p>that are aligned with the requirement. Based on the indicators contained in these instruments, the facility conducted a DUE regarding the use of PRN and STAT medication. The data show overall compliance rates of 40% and 69%, respectively.</p> <p>As mentioned in D.1.f, chart reviews by this monitor demonstrate a pervasive trend of poor documentation of PRN and/or Stat medication use. The following are the main deficiencies:</p> <ol style="list-style-type: none"> 1. There is inadequate review of the administration of PRN and Stat medications, including the circumstances that required the administration of drugs, the type and doses of drugs administered or the individual's response to the drugs. 2. PRN medications are prescribed for generic indications, typically "agitation" without specific information on the nature of behaviors that require the drug administration. 3. At times, more than one drug is ordered on a PRN basis without specification of the circumstances that require the administration of each drug. 4. There is no evidence of a face-to-face assessment by the psychiatrist within one hour of the administration of Stat medication. 5. There is no evidence of a critical review of the use of PRN and/or Stat medications in order to modify scheduled treatment and/or diagnosis based on this use. 6. PRN medications are frequently ordered when the individual's condition, as documented in psychiatric progress notes, no longer requires this intervention. <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Standardize the monitoring instruments regarding the use of
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		<p>PRN and STAT medications across state facilities.</p> <ol style="list-style-type: none"> 2. Ensure that the Department of Psychiatry Manual includes all requirements in the EP regarding high-risk medication uses, including PRN and/or Stat medications. 3. Continue to monitor the use of PRN and Stat medications to ensure correction of the deficiencies listed under this monitor's findings.
c	<p>Each State hospital shall monitor the psychiatric use of benzodiazepines, anticholinergics, and polypharmacy to ensure clinical justification and attention to associated risks.</p>	<p>Findings: PSH used Data Collection Sheets to conduct DUEs regarding the use of benzodiazepines, anticholinergics and polypharmacy. The sheets contain indicators that are aligned with this requirement. The DUEs were based on sample sizes of 22, 9 and 63 charts, respectively. The reviews were conducted by peer psychiatrists during October 2006. The corresponding compliance rates are as follows:</p> <ol style="list-style-type: none"> 1. Benzodiazepine use: 14%; 2. Anticholinergic use: 9%; and 3. Polypharmacy (41% intra-class and 56% inter-class). <p>Reviews by this monitor of the charts of five individuals (MDB, J JL, RBK, JL, DJ and JWC) who are diagnosed with substance use disorder and receiving benzodiazepines as a long-term scheduled modality showed a pattern of failure to justify and/or address the risks of this treatment modality. A significant number of these individuals received treatment with a benzodiazepine agent that has relatively high propensity to induce and/or exacerbate drug dependency (MDB, RBK and DJ). Most of the individuals (J JL, JL, DJ and JWC) were diagnosed with cognitive dysfunction, which increases the risk of treatment.</p> <p>This monitor's review of the charts of five individuals receiving long-term anticholinergic treatment as a scheduled modality (HAG, TK, SNC, KT and ARB) showed a pattern of inadequate justification of treatment</p>

		<p>and/or monitoring of individuals for the associated risks. This included individuals with documented diagnoses of Tardive Dyskinesia (ARB and HAG) and cognitive disorders (TK and KT). These individuals are at increased risk of harm secondary to the long-term use of these medications. In some cases, the practice included the use of more than one anticholinergic medication (e.g., HAG), without justification.</p> <p>This monitor also reviewed the charts of five individuals who are receiving intra-class and interclass polypharmacy. The polypharmacy included regular combinations of the following psychotropic medications:</p> <ol style="list-style-type: none"> 1. Clozapine, clonazepam, and amitriptyline (KGT); 2. Clozapine, lorazepam, chlorpromazine, divalproex sodium and lithium (LDL); 3. Quetiapine, clonazepam and risperidone (MAS) 4. Quetiapine, clonazepam, risperidone and lamotrigine (JRB); 5. Haloperidol, olanzapine, lithium (ZAH). <p>In general, the review showed evidence of inadequate documentation of the indications and justification of treatment and monitoring for the associated risks.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that the Department of Psychiatry Manual includes all EP requirements regarding high-risk medication uses, including benzodiazepines, anticholinergics and polypharmacy. 2. Continue to use current monitoring instruments regarding the use of benzodiazepines, anticholinergics and polypharmacy. Ensure that the justification of use is consistent with current generally accepted standards.
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		<ol style="list-style-type: none"> 3. Consolidate the process of monitoring of all medications within the Drug Utilization Evaluation (DUE) Process. 4. Identify patterns and trends regarding high-risk medication uses and implement corrective and educational actions.
d	<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>Findings: PSH used the New Generation Antipsychotic Medication Data Collection Sheet to monitor its compliance with this requirement. As mentioned earlier, the indicators are not derived from individualized medication guidelines. In this process, peer psychiatrists reviewed 32 charts during October 2006. The compliance rates and corresponding indicators are as follows:</p> <ol style="list-style-type: none"> 1. Documentation of benefits of medications and tolerability: 68%; 2. Justification for use in individuals with diagnosis of dyslipidemia: 40%; 3. Justification for use in individuals with diagnosis of diabetes: 100%; 4. Justification for use in individuals with diagnosis of obesity: 100%; 5. Use of risperidone for individuals with hyperprolactinemia: no sample; 6. Appropriate baseline and periodic monitoring of Body Mass Index (BMI): 70%; 7. Appropriate baseline and periodic monitoring of waist circumference: 73%; 8. Appropriate baseline and periodic monitoring of fasting blood glucose: 100%; 9. Appropriate baseline and periodic monitoring of Glycosylated HgbA1c levels: 59%; 10. Appropriate baseline and periodic monitoring of menstrual cycle: 43%; and 11. Appropriate and baseline monitoring of breast signs: 14%.

		<p>This monitor reviewed the charts of eight individuals receiving new-generation antipsychotic medications, including clozapine (JG and KA), olanzapine (WML), risperidone (PSS and NDS), quetiapine (JBC), ziprasidone (GRR) and a combination of olanzapine and quetiapine (LMA).</p> <p>The reviews revealed inconsistent practice in the laboratory and clinical monitoring for the risks of treatment and in the physicians' documentation of this monitoring. There was evidence of adequate laboratory monitoring for metabolic and endocrine risks in almost all cases. However, there was lack of clinical monitoring for endocrine risks in the two individuals receiving risperidone (PSS and NDS). In general, the physicians' documentation of findings related to laboratory and clinical monitoring was inadequate. In the case of individuals receiving clozapine, there was evidence of inadequate monitoring of vital signs in one case (KA) and inadequate documentation of the status of monitoring for vital signs and for metabolic risks in both cases (JG and KA).</p> <p>This monitor also reviewed the charts of individuals who are diagnosed with diabetes mellitus and/or dyslipidemia and are receiving new generation antipsychotic medications. The review included individuals receiving olanzapine (EV) quetiapine (KJF) and risperidone (EJH). The review revealed adequate laboratory monitoring for the risks of treatment, but the documentation of efforts to use safer medication alternatives was generally lacking.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none">1. Same as in recommendation #1 in F.1.a2. Same as in C.1.g.
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		3. Same as in F.1.g.
e	<p>Each State hospital shall ensure regular monitoring, using a validated rating instrument (such as AIMS or DISCUS), of tardive dyskinesia (TD); a baseline assessment shall be performed for each individual at admission with subsequent monitoring of the individual every 12 months while he/she is receiving antipsychotic medication, and every 3 months if the test is positive, TD is present, or the individual has a history of TD.</p>	<p>Findings: PSH has database showing that 94 individuals at the facility are diagnosed with tardive dyskinesia (TD).</p> <p>Using the Initial Assessment Monitoring Form, the facility reviewed a random sample of the initial psychiatric assessments from admission units (19 charts) and found 74% compliance with the documentation of AIMS upon admission.</p> <p>As mentioned earlier, the facility used the Monthly Psychiatry Progress Notes Form and the data show 84% compliance with the documentation of AIMS quarterly, if applicable (Positive AIMS). The data were based on a review of 43 charts from randomly selected 120 charts.</p> <p>In addition, the facility used the Tardive Dyskinesia Monitoring Form to assess its compliance. The form contains indicators that are appropriate to this requirement. In this process, the facility randomly selected 120 charts during October 2006 and found an overall compliance rate of 53% for all applicable items. The relevant findings were as follows:</p> <ol style="list-style-type: none"> 1. Was an AIMS done on admission (all cases): 86%; 2. Was an AIMS done at the time of the last annual physical examination: 82%; 3. If the individual has TD, was a new AIMS done every three months (all cases): 17%; 4. If the individual has a history of TD, was an AIMS done every three months: 33%; 5. Do monthly progress notes for the past three months indicate that antipsychotic treatment has been modified for individuals with TD, history of TD or a positive AIMS test, to reduce the

		<p>risk: 59%.</p> <p>Reviews by this monitor of the charts of six individuals (CDT, ARB, JD, JDK, JL and AJP) diagnosed with TD shows the following significant deficiencies:</p> <ol style="list-style-type: none"> 1. There is no evidence of timely assessment using AIMS in all cases. 2. The WRP fails to recognize TD as a diagnosis in some cases (e.g., JL and AJP). 3. The WRP does not include appropriate treatment and rehabilitation interventions for TD in all cases. 4. There is evidence of long-term treatment with medications that are detrimental to this condition, without adequate justification, in some cases (e.g., ARB). <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Standardize the TD monitoring instrument across state facilities. 2. Ensure that the Department of Psychiatry Manual includes requirements regarding monitoring of individuals with TD. 3. Ensure that the diagnoses listed on the WRP are aligned with those listed in psychiatric documentation, including TD. 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. Improve compliance with this requirement.
f	Each State hospital shall ensure timely identification, reporting, data analyses, and follow up remedial action regarding all adverse drug reactions ("ADR").	<p>Findings: PSH has revised of its ADR policy to ensure appropriate notification of external agencies of ADRs.</p>

		<p>The current system of ADR reporting continues to be ineffective due the following deficiencies:</p> <ol style="list-style-type: none">1. The facility reported an average of 4.5 ADRs during the past year. This indicates that serious underreporting of ADRs continues to be a problem. In a facility with a census of about 1500 individuals, including a large number of individuals that require complex medication regimens and very high doses of psychotropic medications, one would expect much larger numbers of ADRs to be reported.2. PSH fails to provide adequate instruction to its clinical staff regarding the proper reporting, investigation and analysis of ADRs. Specifically, the facility does not provide information or have written guidelines regarding the requirements for :<ol style="list-style-type: none">a) Classification of reporting discipline;b) Proper description of details of the reaction;c) Additional circumstances surrounding the reaction, including how reaction was discovered, relevant history, allergies, etc;d) Review of all medications that the individual was actually receiving at the time of the ADR;e) Information about all medications that are suspected or could be suspected of causing the reaction;f) A probability rating if more than one drug is suspected of causing the ADR;g) Information about type of reaction (e.g., dose-related, withdrawal, idiosyncratic, allergic, etc);h) Information regarding future screening;i) Physician notification and review of the ADR;j) Information on the clinical review process, including the clinical review person or team, determination of need for intensive case analysis and other actions; and
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		<p>k) Information regarding the timeliness and format of the Intensive Case Analysis of serious reactions. In the past year, the psychopharmacology reviewed ADRs that met severity criteria as defined in the ADR policy and procedure. However, at this time, the facility is unable to provide documentation of these reviews.</p> <p>3. Overall, the above deficiencies of both methodology and content in the reporting, investigation and analysis of medication variances renders the ADR system seriously inadequate for performance improvement purposes.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Increase reporting of ADRs and provide instruction to all clinicians regarding significance of and proper methods in reporting ADRs. 2. Revise the policy and procedure regarding ADRs to include an updated data collection tool. The procedure and the tool must correct the deficiencies identified above. 3. Improve current tracking log and data analysis systems to provide adequate basis for identification of patterns and trends of ADRs. 4. Develop and implement a format for the intensive case analysis to include proper discussion of history/circumstances, preventability, contributing factors and recommendations.
g	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	<p>Findings: As mentioned earlier, PSH conducted DUEs regarding the use of benzodiazepines, anticholinergics and polypharmacy (October 2006). The facility has yet to finalize the draft medication guidelines and to develop a DUE policy and procedure to outline parameters for the DUE</p>

	<p>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>process based on the guidelines.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a policy and procedure to codify a DUE system based on established individualized medication guidelines. 2. Ensure systematic review of all medications, with priority given to high-risk, high-volume uses. 3. Determine the criteria by which the medications are evaluated, the frequency of evaluation, the indicators to be measured, the DUE data collection form, acceptable sample size, and acceptable thresholds of compliance. 4. Ensure proper aggregation and analysis of DUE data to determine practitioner and group patterns and trends. 5. Ensure that the individualized medication guidelines are continually updated to reflect current literature, relevant clinical experience and current professional practice guidelines.
h	<p>Each State hospital shall ensure documentation, reporting, data analyses, and follow up remedial action regarding actual and potential medication variances ("MVR") consistent with generally accepted professional standards of care.</p>	<p>Findings: PSH collects data regarding medication variances (errors). The current system addresses the important categories of prescribing, dispensing, administration, transcription and complex variances. During the past year, PSH has revised its policy and procedure regarding medication variances to add categories for missing signatures, missing initials, potential transcription errors and medication security/found medications. The data collection tool known as Medication Error Special Incident Analysis contains a severity scale of the outcome of the variance. The facility has data regarding facility-wide trends in some actual variances and some remedial steps taken in response to this analysis. The facility has a policy and procedure that describes the</p>

		<p>current system.</p> <p>The current system of medication variance reporting (MVR) continues to be ineffective due to the following deficiencies:</p> <ol style="list-style-type: none"> 1. PSH fails to ensure that clinical staff is educated regarding the proper methods of reporting medication variances and of providing information that aids the proper investigation and analysis of the variances. 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) Physician notification both in actual and in potential variances; e) Description of the full chain of events involving the variance; f) Classification of potential and actual variances; g) All medications involved and their classification; and h) The route of medication administration. 2. The system is focused on limited categories of actual variances and ignores several important categories that have critical significance in performance improvement. These categories include most potential medication variances and several actual variances. Examples include information regarding: <ol style="list-style-type: none"> a) Failure by prescribing physician to include proper or any parameters for clinical monitoring by clinical monitoring by the nursing staff; b) Variances in the ordering and/or procurement of the drug; c) Variances in the storage of the medication; d) Administration variances such as wrong technique, lack
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		<p>of clinical monitoring, etc.;</p> <p>e) Documentation variances such as medication not being charted as given; and</p> <p>f) Variances in medication security, including found medications (facility recently added this category).</p> <p>3. The medication variance data collection tool does not include information on critical breakdown points in the common situations that involve more than one variance. This failure seriously limits the ability of PSH to direct its performance improvement efforts to the root variance.</p> <p>4. The data collection tool does not include an outline of factors contributing to the variance (e.g., human, environmental, communication, dispensing/storage/administration system variables and product-related issues.</p> <p>5. Regarding individual's outcomes, the data collection tool is limited to three categories of no treatment required, treatment required but no significant outcome and life threatening/permanent adverse consequences. This classification is not aligned with the current generally accepted nine categories of outcome that facilitate analysis for performance improvement purposes.</p> <p>6. PSH fails to implement a system of intensive case analysis of medication variances based on established thresholds.</p> <p>7. The current system is not integrated in any meaningful fashion in the activities of the P&T Committee, the Therapeutic Review Committee (TRC), the Department of Psychiatry or the Department of Medicine.</p> <p>8. PSH fails to collect and analyze data regarding individual and group practitioner trends and patterns in medication variances. As a result, there is no evidence of performance improvement activity based on actual analysis.</p> <p>Overall, the above deficiencies of both methodology and content in the</p>
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		<p>reporting, investigation and analysis of medication variances renders the current medication variance system seriously inadequate for performance improvement purposes.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a data collection tool to assist staff in reporting potential and actual variances in all possible categories of variances. 2. Provide instruction to all clinicians regarding the significance of and proper methods in MVR. 3. Revise the current a policy and procedure regarding MVR that includes a data collection tool. The procedure and the tool must correct the deficiencies identified above. 4. Develop and implement adequate tracking log and data analysis systems to provide the basis for identification of patterns and trends related to medication variances. 5. Develop and implement an intensive case analysis procedure based on established severity/outcome thresholds. The analysis must include proper discussion of history/ circumstances, preventability, contributing factors and recommendations. 6. Ensure that MVR is a non-punitive process.
i	<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>Findings: PSH did not present data to indicate proper tracking, identification and integration of individual and group practitioner trends regarding the areas identified in this section.</p> <p>The above mentioned deficiencies in F.1.a through F.1.h must be addressed and corrected prior to the development of meaningful practitioner trend data.</p>

		<p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Same as in F.1.a. through F.1.h. 2. Improve IT resources to the pharmacy department to facilitate the development of databases regarding medication use.
j	Each State hospital shall ensure feedback to the practitioner and educational/corrective actions in response to identified trends consistent with generally accepted professional standards of care.	<p>Findings: Same as in F.1.b. and F.1.i.</p> <p>Compliance: Non-compliance.</p> <p>Recommendations: Same as above.</p>
k	Each State hospital shall ensure integration of information derived from ADRs, DUE, MVR, and the Pharmacy & Therapeutics, Therapeutics Review, and Mortality and Morbidity Committees consistent with generally accepted professional standards of care.	<p>Findings: Same as above.</p> <p>Compliance: Non-compliance.</p> <p>Recommendations: Same as above.</p>
l	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>Findings: As mentioned earlier, PSH has a peer review mechanism that is utilized in the evaluation of physicians' performance. However, the facility does not have a data-driven process that is aligned with the different requirements of the EP and that can be used to address this requirement. The findings outlined in team leadership (C.1.b),</p>

		<p>interdisciplinary functioning (C.1.c.), the integration of behavioral and pharmacological treatments (D.1.f.v.iii.) and medication management (F.1.a through F.1.h.) are applicable to this item.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a physician's performance quality profile with indicators that address and integrate all the medication management requirements outlined in section F. 2. Ensure that the Department of Psychiatry Manual includes clear expectations regarding medication management that are aligned with all the requirements in section F. 3. Same as in C.1.b., C.1.c., D.1.f.viii. and F.1.a. through F.1.h.
m	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>Findings: The facility has monitoring data based on the Anticholinergic Data Collection Sheet (peer psychiatrists reviewed 20 charts during October 2006). The facility found 0% compliance with the following indicator: Anticholinergic use for more than two months continuously includes documentation in the PPN (Physicians/Progress Notes) of risks (sedation, gait unsteadiness/falls) This indicator adequately addresses the requirements, but the examples of risks are not delineated adequately. The facility's data and findings by this monitor (same as in F.1.c) indicate that the current system of clinical oversight is inadequate.</p>

		<p>Recommendations:</p> <ol style="list-style-type: none"> 1. Same as in F.1.c. 2. Ensure that this practice is triggered for review by the appropriate clinical oversight mechanism, with corrective follow-up actions by the psychiatry department.
m.ii	all elderly individuals and individuals with cognitive disorders who are prescribed continuous anticholinergic treatment regardless of duration of treatment;	<p>The facility used the above process and found 0% compliance with the documentation of risks regarding the use of anticholinergic medications for individuals over 60.</p> <p>This monitor's findings are the same as in F.1.c.</p>
m.iii	all individuals prescribed benzodiazepines as a scheduled modality for more than two months;	<p>PSH used the Benzodiazepine Data Collection Sheet (peer psychiatrist reviewed 14 charts during October 2006). The compliance data are as follows:</p> <ol style="list-style-type: none"> 1. Use of benzodiazepines for more than two months continuously (includes) clear documentation of the risk of sedation (7%). 2. Use of benzodiazepines for more than two months continuously (includes) clear documentation of the risk of drug dependence (15%). 3. Use of benzodiazepines for more than two months continuously (includes) clear documentation of the risk of cognitive decline (7%). <p>This monitor's findings are the same as in F.1.c.</p>
m.iv	all individuals prescribed benzodiazepines with diagnoses of substance abuse or cognitive impairments, regardless of duration of treatment; and	<p>Using the above mentioned process, the facility reports the following:</p> <ol style="list-style-type: none"> 1. Benzodiazepines' use for individuals with alcohol/drug use problems (is) justified in PPN documentation (11%). 2. Benzodiazepines' use for individuals with cognitive disorders (is) justified in PPN documentation (0%).

		This monitor's findings are the same as in F.1.c.
m.v	all individuals with a diagnosis or evidencing symptoms of tardive dyskinesia.	<p>Findings: The facility's findings are the same as in F.1.e.</p> <p>This monitor's findings listed in F.1.e indicate that PSH does not have an adequate clinical oversight system that ensures timely and appropriate monitoring of all individuals suffering from TD and the recognition of TD as one of the foci of hospitalization that require specialized treatment and/or rehabilitation objectives and interventions.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Same as in F.1.e. 2. Ensure the proper identification and management of TD as well as proper frequency of clinical assessments. The management should include follow-up at a specialized movement disorders clinic run by a neurologist with relevant training and experience. 3. Ensure that the facility's monitoring data are based on a review of all individuals diagnosed with TD.
m.vi	all individuals diagnosed with dyslipidemia, and/or obesity, and/or diabetes mellitus who are prescribed new generation antipsychotic medications	<p>Findings: Refer to F.1.d for the findings by the facility and this monitor.</p> <p>Recommendations: Same as in F.1.d. and F.1.g.</p>
n	Each State hospital shall ensure that the medication management of individuals with substance abuse disorders is provided consistent with generally accepted professional standards of care.	<p>Findings: The facility has monitoring data to assess the appropriateness of benzodiazepine use for individuals diagnosed with substance use disorders (same as in F.1.m.iv).</p> <p>This monitor's findings in C.2.o and F.1.c. indicate a pattern of</p>

		<p>deficiencies that must be addressed and corrected to ensure compliance with this section.</p> <p>Compliance: Partial.</p> <p>Recommendations: Same as in C.2.o and F.1.c.</p>
o	Metropolitan State Hospital shall provide a minimum of 16 hours per year of instruction, through conferences, seminars, lectures and /or videotapes concerning psychopharmacology. Such instruction may be provided either onsite or through attendance at conferences elsewhere.	
2	Psychological Services	
	Each State hospital shall provide adequate and appropriate psychological supports and services that are derived from evidence-based practice or practice-based evidence and are consistent with generally accepted professional standards of care, to individuals who require such services; and:	<p>Methodology: Interviewed Wadsworth Murad, M.D., Chief of Psychiatry. Interviewed Raafat Girgis, M.D., Chief of Medicine. Interviewed Joseph Malancharuvil, Ph.D., ABPP, Clinical Administrator. Interviewed: David Haimson, Ph.D., Acting Chief of Psychology. Interviewed James Harvey Kelley III, Rehabilitation Therapist, Acting BY CHOICE coordinator. Interviewed Jennifer Utley, Graduate student assistant. Interviewed Mark Williams, Ph.D., psychologist. Interviewed Susan Velasquez, Ph.D., Psychologist. Interviewed Jetta L. Warka, Ph.D., Psychologist. Interviewed Carson Chambers, Psychologist. Interviewed Clarence Diller, PT. Interviewed Michelle Sefers, PT. Interviewed Coqueece Hibinski, PT. Interviewed Jeff Chambliss, PT. Interviewed Brian Correll, PT.</p>

		<p>Interviewed Don Brown, RN.</p> <p>Interviewed Terry Richardson, RT.</p> <p>Interviewed individuals.</p> <p>Reviewed charts of 59 individuals (GA, JB, GJ, GB, AL, ST, VB, MH, CM, DG, MG, NP, LB, JC, CT, CA, FS, JO, HC, PD, JD, EH, TG, LT, DJ, CR, KT, PH, GD, LM, KH, ME, RJ, JC, SH, SL, KG, RA, SC, HE, TB, JZ, BB, KD, JR, CS, MO, DJ, RH, AS, SS, EV, CF, JS, MB, JQ, RC, JT, and KR).</p> <p>Reviewed Behavior Treatment Plans of five individuals (LR, JS, HA, JC, DP).</p> <p>Reviewed DMH Psychology Department Manual (draft)</p> <p>Reviewed PSH Psychology Department Manual</p> <p>Reviewed APA Code of Ethics and Standards of Practice</p> <p>Reviewed Current Staffing levels for Psychology</p> <p>Reviewed PSH self-assessment data.</p> <p>Reviewed BY CHOICE manual</p> <p>Reviewed Memberships of PBS Teams.</p> <p>Reviewed APA Ethics Standards of Practice.</p> <p>Reviewed Mall Curriculum.</p> <p>Reviewed Psychology Protocols and Assessment Tools.</p> <p>Reviewed Functional Assessments</p> <p>Reviewed DMH audit forms.</p> <p>Reviewed WRP audit forms.</p> <p>Reviewed list of individuals on PBS plans.</p> <p>Reviewed personnel CVs.</p> <p>Reviewed PBS monitoring form.</p> <p>Reviewed PBS Integrity checklist.</p> <p>Reviewed Mall Activity Schedule.</p> <p>Observed unit Mall sessions (Cognitive Skills Building, Transition Skills for CONREP, Health and Wellness, Collaborative Recovery).</p> <p>Observed WRP team conferences,</p>
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a	<p>Each State hospital shall ensure that it has positive behavior support teams (with 1 team for each 300 individuals, consisting of 1 clinical psychologist, 1 registered nurse, 2 psychiatric technicians (1 of whom may be a behavior specialist), and 1 data analyst (who may be a behavior specialist) that have a demonstrated competence, consistent with generally accepted professional standards of care, in the following areas:</p>	<p>Findings: Staff interviews, chart reviews, and review of PSH self-assessment data by this monitor revealed the following:</p> <ol style="list-style-type: none"> 1. The State has established guidelines on the composition, duties, responsibilities and regulations governing the PBS teams. The guidelines are aligned with the requirements of the EP. 2. PSH administration is fully behind the EP mandate. 3. The PBS team members are highly motivated and eager to serve in their capacity and to assist individuals improve their behaviors collaboratively with the unit staff and the Behavioral Consultation Committee. 4. PSH currently has two full PBS teams, but the third team does not have a psychologist or a registered nurse. 5. The current team to individual ratio is not in line with the EP requirement of a ratio of 1:300. 6. The PBS team members interviewed demonstrated varying levels of understanding and competence in PBS, but all need further training in PBS and principles of Recovery. 7. The current PBS team members have received training through a number of sources including consultants, workshops, peer reviews, journal articles, and on the job training. 8. Information from PBS team members and BCC members showed that the referral process to the PBS teams is not properly understood or followed by WRP teams and unit staff. 9. PBS training has been provided across all units and programs, but not all staff members have attended the training. 10. Staff shortage is a barrier to fulfilling EP mandates. <p>PBS team members expressed confusion regarding what they perceived as conflicting information as written in SO #129 and AD #15.09. In SO #129, the words "PBS plan by the unit psychologist" seems to be the confusion. As for PBS response time, SO #129 and AD #15.09 do read</p>
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		<p>differently.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Complete revision of the PBS manual to include clear guidelines on the referral process (i.e., what triggers a referral, who is responsible for making the referral, what is expected once a referral is made and timelines). 2. Include in the PBS manual clear guidelines on how structural and functional assessments are to be performed. 3. Identify in the manual specific evidence-based tools for use with each type of assessment. 4. Recruit additional staff to meet the 1:300 ratio as required by EP. 5. Train all direct care staff in PBS principles. 6. Ensure that the Chief of Psychology and the PBS coordinator are given the necessary clinical and administrative authority to carry out their tasks to improve the quality of life of individuals served in PSH. 7. Clarify and resolve differences found in the Administrative Directive (AD#15.09) and Special Order (SO#129).
a.i	<p>the development and use of positive behavior support plans, including methods of monitoring program interventions and the effectiveness of the interventions, providing staff training regarding program implementation, and, as appropriate, revising or terminating the program; and</p>	<p>Findings:</p> <p>Staff interviews and chart reviews by this monitor revealed the following:</p> <ol style="list-style-type: none"> 1. The relationship between PBS and the Recovery Model of service delivery is weak. 2. The number of PBS teams do not fulfill EP requirement. 3. Individuals needing PBS support services were either not being served, service is untimely, or not provided in the best possible manner to meet acceptable professional standards. 4. The culture at PSH seems to be one of a lack of cooperation and communication among staff from within and between certain

		<p>disciplines, and this is a barrier to proper implementation of PBS plans to achieve the desired goals.</p> <ol style="list-style-type: none"> 5. Unit Behavior Guidelines often are not preceded by structural/functional assessments to derive data for hypothesis generation. 6. Training of unit staff was completed, but this training has not translated into effective practice due to a host of factors including those pointed out in #1, #2, and #3 above. 7. The tasks of monitoring interventions, effectiveness of interventions, and revising and terminating interventions/program is not satisfactory. 8. A broader contextual approach is not taken when evaluating factors that may affect an individual's behaviors. <p>The following are examples in support of the findings:</p> <ol style="list-style-type: none"> 1. GA: PBS assessment was not found in the chart, no psychologist was in the unit to implement interventions and three structural assessments have not been followed up. 2. JB: There are no Behavior Guidelines even though he exhibits severe behaviors and no PBS assessment was found in chart. 3. GJ: PBS recommendations were not found in chart and the psychiatrist's request to restructure the individual's Mall groups was not followed through. 4. GB: PBS plan was not followed through by unit staff, even though the plan was effective for two weeks. 5. VB: No discussion of PBS plan and/or progress was documented in his WRP. 6. ST: Present status indicates continued difficulty with behavior but the unit psychologist indicated that ST was doing better and did not need PBS involvement. PBS was not discussed in WRP, and no other information about PBS involvement was found in chart.
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		<p>Most of the monitor's findings were in agreement with PSH's self-evaluation.</p> <p>This monitor reviewed 14 structural and functional assessments, and 4 PBS plans using the PBS Monitoring Tool. The following patterns were identified:</p> <ol style="list-style-type: none">1. The individual's WRP Team is involved in the assessment and intervention process—100% in compliance.2. Broad goals of intervention were determined—14% in compliance, 71% in partial compliance and 14% not in compliance.3. At least one specific behavior of concern was defined in clear, observable and measurable terms—86% showed full compliance and 14% partial compliance.4. Baseline estimate of the maladaptive behavior was established in terms of objective measure—43% showed full compliance, 43% partial compliance and 14% not in compliance.5. Pertinent records were reviewed—21% in full compliance, 72% in partial compliance and 7% 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— 93% in partial compliance and 7% 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—14% in full compliance, 72% in partial compliance and 14% not in compliance.8. Direct observations were conducted across relevant circumstances (e.g., multiple settings, over time) and by more than one observer, as appropriate—36% in partial compliance and 64% not in compliance.9. Other assessment tools (e.g., rating scales, checklists) were
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		<p>used to produce objective information regarding events preceding and following the behavior of concern, as well as ecological and motivational variables that may be affecting the individual's behavior. 14% in full compliance, 43% in partial compliance, 43% not in compliance.</p> <p>10. Patterns were identified from the data collected that included (1) circumstances in which the behavior was most and least (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)-71% partial compliance and 29% not in compliance.</p> <p>11. Broader variables (e.g., activity patterns, curriculum) that may be affecting the individual's behavior were identified—100% in partial compliance.</p> <p>12. Patterns were summarized into written hypotheses based on structural and/or functional assessments. These statements were clear, concise, and based on data—71% in partial compliance and 29% not in compliance.</p> <p>13. Intervention strategies were clearly linked to the hypotheses derived from the structural and/or functional assessments—100% in partial compliance.</p> <p>14. The individual's PBS Team designed a PBS plan collaboratively with the individual's WRP Team that includes: Description of the behavior, patterns identified through the structural and functional assessments and goals of intervention—100% in partial compliance.</p> <p>15. Modifications to the social, environmental or cultural milieu that may prevent the behavior and/or increase the likelihood of alternative appropriate behavior(s)—100% in partial compliance.</p> <p>16. Specific behaviors (skills) to be taught and/or reinforced that will: (i) achieve the same function as the maladaptive behavior, and (ii) allow the individual to cope more effectively with his/her circumstances—50% full compliance and 50% in partial</p>
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		<p>compliance.</p> <p>17. Strategies for managing consequences so that reinforcement is maximized for positive behavior and minimized for behavior of concern, without the use of aversive or punishment contingencies—50% in full compliance and 50% in partial compliance.</p> <p>18. The PBS plan is clearly specified in the Objective and Intervention sections of the individual's WRP Plan. The PBS Plan itself need not be included in the individual's WRP—25% in full compliance, 25% in partial compliance and 50% not in compliance.</p> <p>19. If necessary to insure safety and rapid de-escalation of the individual's maladaptive behavior, crisis management procedures and criteria for their use and termination were determined and documented—25% in full compliance, 25% in partial compliance ,25% not in compliance and 25% not applicable.</p> <p>20. Everyone working with the individual on a regular basis is familiar with the PBS plan and implements its strategies with high degree of fidelity (>90%)—100% 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—25 % in full compliance, 50%, partial compliance and 25% not in compliance.</p> <p>23. Increases in replacement skills and/or alternative behaviors 25% full compliance, 50% in partial compliance and 25% not in compliance.</p> <p>24. Achievement of broader goals—25% full compliance, 50% partial compliance and 25% not in compliance.</p> <p>25. Durability of behavior change—100% not in compliance.</p> <p>26. The individual's WRP team reviews, at scheduled WRP conferences, the individual's progress and a PBS Team member</p>
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		<p>or the WRP Team psychologist makes necessary adjustments to the PBS plan, as needed—25% in full compliance, 25% partial compliance and 50% not in compliance.</p> <p>PSH's self-evaluation showed similar patterns with varying percentages of performances across items. These differences were a function of the numbers of assessments and plans reviewed. The monitor reviewed plans that were developed only within the last 6 months.</p> <p>Compliance: Partial</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that all relevant staff receives systematic training in all aspects of the PBS plans. 2. Conduct treatment implementation fidelity checks regularly. 3. Develop a systematic way of evaluating treatment outcomes and reporting those outcomes. 4. Revision of treatment plans should be directly related to the outcome data and reported at all scheduled WRP conferences. 5. Data should be reviewed regularly to determine treatment effectiveness and to decide if plans should be revised, terminated, or if further training of unit staff is necessary to improve treatment implementation. 6. The PBS teams, WRP teams and the BCC require better understanding of their interdisciplinary roles. 7. Ensure that Unit Behavior Guidelines are developed through data derived from structural and/or functional assessments. 8. Develop a training protocol for all PBS plans to ensure that staff responsible for implementing the plans are appropriately trained (and certified) prior to implementation of the plans. 9. Integrate a response to triggers in the referral process. Ensure that appropriate and timely entry is made into the
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		individuals' WRPs.
a.ii	the development and implementation of a facility-wide behavioral incentive system, referred to as "BY CHOICE" that encompasses self-determination and choice by the individuals served.	<p>Findings: PSH has a very enthusiastic and energetic BY CHOICE Coordinator. PSH has implemented the BY CHOICE program to all units in the system. Review of the BY CHOICE Manual by this monitor showed that the manual is not fully aligned with EP.</p> <p>Chart review, observation of WRP conferences, and interview of staff and individuals by this monitor revealed the following:</p> <ol style="list-style-type: none"> 1. Staff was knowledgeable of the implementation of the BY CHOICE program. 2. Some individuals determined their point allocation, and with few exceptions such as for medical reasons, allocated and spent their earned points as they saw fit. 3. Allocation of points in Present Status of the Case Formulation of the individuals' WRP is not well documented. The facilitators of the groups observed by the monitor used levels of participation of the individuals to allocate points. However, most individuals received the same point allocation and facilitators seemed to have difficulty determining the levels (non-participation, moderate participation, and full participation) of participation of the individuals to properly allocate points. 4. Operation of the BY CHOICE stores/incentive exchange mechanism is satisfactory with both staff and individuals. 5. A number of individuals indicated that the effort to accumulate the needed points was sometimes too much. 6. Individuals are able to exchange points for incentives from a store or through a catalog and both the BY CHOICE coordinator and the individuals interviewed by this monitor expressed satisfaction with the process and procedures for exchanging their BY CHOICE points for incentives.

This monitor reviewed 23 WRPs (CM, DG, MG, NP, SH, LB, JC, CT, CA, KT, FS, TB, JO, HC, PD, SL, CR, EH, LT, TG, JD, JB, and DJ). The review showed that four had stock phrases in more than one conference, six had no mention of the individual's BY CHOICE program, and the rest had some mention of BY CHOICE with varying degrees of discussion and completion.

Three (MS, PC, and GA) of the individuals interviewed by this monitor had their BY CHOICE card with them, and the other (ST) had lost his card two days earlier and was yet to receive a replacement card. Only one (GA, a Spanish speaking individual with some understanding of simple English) could explain what he had to do for earning appropriate points. This interview was conducted with the assistance of an interpreter. All the individuals reported that they liked the BY CHOICE program, which motivated them to learn/perform activities/requirements that they may not otherwise have the motivation to achieve/comply with. None of the four individuals reported any difficulty with the BY CHOICE program, including exchange of incentives from the catalog or the store. All but one (ST) was able to explain the situation when the staff holds the card for them.

According to the BY CHOICE Coordinator, a number of difficulties including staff shortage, limited resources, and lack of time for meetings and training are barriers to the smooth operation of the BY CHOICE program.

Further, there appears to be, in the words of the BY CHOICE Coordinator, 'staff ambiguity' about the BY CHOICE system (e.g., ability of individuals to carry their BY CHOICE cards, and to allocate their BY CHOICE points).

		<p>PSH self-evaluation showed data were similar to the monitor's findings. The following is an outline of the facility's findings:</p> <ol style="list-style-type: none"> 1. There is poor discussion (3% of the time) by the team of the individual's point allocation. 2. The point allocation or preferences are reviewed by teams only 1.6% of the time. 3. Modification of the point allocation occurs very infrequently, about 3% of the time. 4. BY CHOICE was discussed in the present status section 62% of the time (self-evaluation did not consider the quality of the discussion found in the present status). <p>PSH reviewed the BY CHOICE Fidelity Survey Report and identified the following:</p> <ol style="list-style-type: none"> 1. A high percentage (84%) of the staff can correctly state the point assigning procedure. 2. A high percentage (92%) of the individuals can discuss how they are to spend their points. 3. Only 43% of the individuals can discuss the expectations on them to earn points. 4. Modifications of points allocation in units to better serve individuals is very poor (3%). 5. The teams discuss individuals' point allocation (3%). <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Train all staff in correctly implementing the BY CHOICE program. 2. Implement the program as per the manual.
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		<ol style="list-style-type: none"> 3. Ensure that the program receives adequate resources. 4. Assure that the individuals have the final choice in allocating points per cycle, ranging from 0 to 100 per cycle. 5. Report BY CHOICE point allocation in the Present Status section of the individual's case formation and update at every scheduled WRP conference. 6. Ensure that individuals know their performance requirements to earn full points.
b	Each State Hospital shall ensure that the Chief of Psychology has the clinical and administrative responsibility for the Positive Behavior Supports Team and the BY CHOICE incentive program.	<p>Findings: PSH's policy is in line with EP requirement for this cell.</p> <p>ADs, SOs, and Manuals available for review by this monitor clearly state this requirement.</p> <p>Currently, David Haimson, Ph.D., Acting Chief of Psychology has both the clinical and administrative responsibility for the Positive Behavior Supports Teams, but only the clinical responsibility for the BY CHOICE incentive program.</p> <p>Compliance: Substantial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Implement the AD. 2. Follow the requirements of the EP.
c	Each State Hospital shall ensure that:	<p>Compliance: Partial.</p>
c.i	behavioral assessments include structural and functional assessments and, as necessary, functional analysis;	<p>Findings: A large numbers of individuals needing behavioral assessments are not receiving the services. This monitor reviewed 25 charts (i.e., EH, TG,</p>

		<p>LT, DJ, CR, JD, Kt, HC, JB, PH, GD, LM, KH, ME, RJ, JC, SH, JO, SL, KG, RA, SC, HE, TB, and JZ) of individuals who were reported to have severe behaviors under Focus 1 and/or 3. At least 13 of these individuals (i.e., KG, JO, SH, JC, RJ, ME, KH, LM, GD, HC, KT, CR, and EH) failed to have any structural and/or functional assessments to address their challenging behaviors.</p> <p>PSH's self-evaluation determined that 614 individuals would benefit from unit based behavioral assessments and/or treatments. Yet, only 36 were referred over the past six months, from which 21 structural/functional assessments were evident.</p> <p>In addition, the PBS-BCC checklist was not used when making referrals.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure staff is fully trained in structural and functional assessment, data collection, data analysis, graphing, plan implementation and data interpretation. 2. Develop a system for identifying and tracking individuals in the hospital who are in need of behavioral interventions. 3. Use the PBS-BCC pathway for all consultations.
c.ii	hypotheses of the maladaptive behavior are based on structural and functional assessments;	<p>Findings:</p> <p>Many behavioral plans did not have any structural and/or functional assessments that could be used to generate hypothesis (e.g., LR, DP, JC, and HA).</p> <p>This monitor reviewed 12 charts (i.e., JB, FS, RJ, BB, ER, DL, JE, CA, PA, AL, SC, and LD) and all of them had one or more shortcomings. For example, there were no structural or functional assessments for FS, no assessment for RJ, and not discussed in present status for BB.</p> <p>In the case of LR, the hypothesis was derived from the individual's</p>

		<p>statement as to why he was behaving the way he did. Staff was asked to reinforce LR by stating, "Thank you for not horse playing Mr. R. You have almost won your video game. I am proud of you."</p> <p>PSH's self-evaluation showed that this requirement is severely deficient. Their finding were that:</p> <ol style="list-style-type: none"> 1. Functional Behavioral Assessments were not based on current PBS standards. 2. Hypotheses were not data driven. 3. Functional assessments failed to meet current professional standards. 4. Unit Behavior Guidelines were not based on structural or functional assessments. <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that proper assessments are conducted prior to developing and implementing intervention plans 2. Ensure that hypotheses of the maladaptive behaviors are based on structural and functional assessments and clearly stated in the PBS documentation.
c.iii	There is documentation of previous behavioral interventions and their effects;	<p>Findings: A number of assessments (e.g., EH, TG, JB and LR,) reviewed by this monitor failed to document previous interventions and their effects.</p> <p>PSH's self-evaluation confirms the monitor's findings. PSH reviewed 27 assessments and found that none of them addressed this requirement.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Document previous behavioral interventions. 2. Document effectiveness of previous interventions.

c.iv	behavioral interventions, which shall include positive behavior support plans, are based on a positive behavior supports model and do not include the use of aversive or punishment contingencies;	<p>Findings: PSH's self-evaluation showed that behavior intervention plans are not always based on a PBS model, and that some of the unit-based plans are punishment-based using response cost and establishing unattainable contingencies as consequences. The monitor's review confirmed these findings.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that all behavioral interventions are based on a PBS model without any use of aversive or punishment contingencies. 2. Ensure that all available support systems within PSH including PBS, BCC, Recovery Encouragement Group, PSR Mall groups, BY CHOICE, and individual therapies to address individuals' maladaptive behaviors use positive contingencies.
c.v	behavioral interventions are consistently implemented across all settings, including school settings;	<p>Findings: Interviews with unit staff and PBS team members showed that this requirement is not met. PBS team members have no authority over the implementation of plans, and they have difficulty getting staff to implement plans and/or collect accurate data.</p> <p>Interviews of Mall staff showed that they were not aware of individuals with behavior plans in their groups.</p> <p>Many plans are not implemented at all or not implemented fully, and data are not collected with a high degree of integrity.</p> <p>There is no documentation to indicate that behavioral interventions are consistently implemented as designed across all settings.</p> <p>PSH's self-evaluation found that direct care staff was unfamiliar with individual PBS plans. In addition, there was no evidence of any training on the plans in the PSR Malls.</p>

		<p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that staff across settings is aware of individuals' behavior plans, and that they receive written plans and training. 2. Ensure that all behavioral interventions are consistently implemented across all settings, including the PSR Mall, and vocational and education settings. 3. Conduct training across settings so that staff in those settings has the knowledge and skill to implement interventions for individuals who are on such plans. 4. Conduct regular fidelity checks.
c.vi	<p>triggers for instituting individualized behavioral interventions are specified and utilized, and that these triggers include excessive use of seclusion, restraint, or psychiatric PRN and Stat medication for behavior control;</p>	<p>Findings:</p> <p>PSH has a trigger process, but it is obvious that the system is not working well, given the discrepancy between the large numbers of individuals in seclusion, restraints, PRNs and Stat medications for behavior control, and the small number of individuals' with PBS referrals, BCC referrals, and behavioral interventions.</p> <p>It appears that not all staff is aware of the trigger process and flow of information for reporting.</p> <p>Chart reviews by this monitor (BB, KD, JR, CS and MO) showed non-compliance with this requirement.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure staff understands the nature and functions of triggers 2. Refine the implementation of the trigger system. 3. Ensure that individuals with maladaptive behaviors receive appropriate structural and/or functional assessment followed by proper treatment plans to address the behaviors. 4. Ensure proper documentation.

c.vii	positive behavior support teams and team psychologists integrate their therapies with other treatment modalities, including drug therapy;	<p>Findings: Report from staff revealed that there is no integration of their therapies with other treatment modalities. None of the charts reviewed by this monitor showed presence of any joint protocols with other modalities, including drug therapy. None of the PBS consultations considered and addressed other treatment modalities.</p> <p>PSH's self-assessment results are in agreement with this monitor's findings.</p> <p>Compliance: Non-compliance</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Conduct appropriate structural and functional assessments to derive data based hypothesis that will guide specific treatment options. 2. Ensure that treatment modalities are integrated to better serve individuals, as indicated.
c.viii	all positive behavior support plans are specified in the objectives and interventions sections of the individual's Wellness and Recovery Plan;	<p>Findings: PBS plans are specified in the Objective and Intervention sections of the individual's WRP only 50% of the time. For example, PBS plans for VB and ST were not specified in their WRP.</p> <p>PSH's self-evaluation found 60% compliance to this requirement.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Specify PBS plans in the objectives and interventions sections of the individual's WRP Plan, as outlined in the DMH WRP Manual. 2. Ensure that WRP teams use the DMH WRP Manual. 3. PBS senior Psychologists may need to attend the first WRP

		<p>conference of individuals' once a PBS plan has been implemented to make certain that this requirement is met. In addition, this will give an opportunity for the PBS team member to provide training and/or information to the individual's WRP team.</p>
c.ix	<p>all positive behavior support plans are updated as indicated by outcome data and reported at least quarterly in the Present Status section of the case formulation in the individual's Wellness and Recovery Plan</p>	<p>Findings: Review of 13 charts (GA, JB, GJ, GB, AL, ST, VB, FS, RJ, BB, ER, DL, and MH) by this monitor evidenced a number of deficiencies, including missing PBS plans, and infrequent updates in WRPs. Examples include:</p> <ol style="list-style-type: none"> 1. FS: There were no structural or functional assessments in the charts. It was mentioned that the individual had improved but no supporting data were documented. 2. RJ: PBS plan was not found in the chart and there was no assessment. However, progress was discussed in the present status, and revision noted. 3. BB: PBS plan was not included in the present status. 4. ER: There was no assessment in the chart. 5. DL: There was no assessment or plan in chart. <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that all PBS plans are updated using outcome data in the individual's Present Status section of the WRP. 2. Ensure that necessary assessments and PBS plans are filed in the individual's chart. 3. Ensure that assessments and PBS plans are not purged from the charts, when the charts are "thinned".
c.x	<p>all staff has received competency-based training on implementing the specific behavioral interventions for which they are responsible, and performance improvement measures are in place for monitoring the implementation of such interventions.</p>	<p>Findings: PBS team members interviewed by this monitor reported that most staff at PSH has been trained. However, there is evidence that staff was not trained to competency.</p>

		<p>Monitoring of performance and improvement is lacking. Review of unit based plans showed that hypotheses are not derived from structural and functional assessments.</p> <p>It appears that PBS teams and unit staff have difficulty working together. Unit staff complains that PBS plans are not feasible for implementation because some of the intervention strategies cause disruption and raise safety concerns (e.g., allowing individuals to go out of their units as reinforcement).</p> <p>Unit staff is dissatisfied with having to choose an intervention plan from many suggested intervention plans by the PBS team. The unit staff would rather that the PBS team recommend one intervention plan, test the plan, and then train the unit staff for continued implementation of the plan by the unit staff.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Provide competency-based PBS training to all staff 2. Ensure that performance improvement measures are in place for monitoring the implementation of such interventions. 3. Ensure that PBS plans are fully implemented once the plans are 'tested' in the unit by the PBS team and the unit staff is trained.
c.xi	all positive behavior support team members shall have as their primary responsibility the provision of behavioral interventions;	<p>Findings:</p> <p>The existing PBS team members have as their primary responsibility the provision of behavioral interventions. However, PSH does not have the required number of PBS teams mandated by the EP. As such, the current PBS team members are unable to fully serve all individuals who would benefit from PBS services.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that all PBS team members provide PBS services fulltime

		<p>until the needs of all individuals requiring behavioral interventions is met.</p> <ol style="list-style-type: none"> 2. Ensure that the Chief of Psychology has responsibility to determine PBS team members' duties. 3. Ensure required number of PBS teams to meet the 1:300 ratio.
c.xii	<p>the BY CHOICE point allocation is updated monthly in the individual's Wellness and Recovery Plan.</p>	<p>Findings: BY CHOICE point allocation is often not updated in the individual's Wellness and Recovery Plan. WRPs reviewed by this monitor (DG, NP, SH, LB, JC, CT, CA, KT, TB, JO, HC, SL, CR, KT, JB, and DJ) showed non-compliance with this requirement.</p> <p>PSH's self-evaluation fidelity survey report (January-March 2006) showed that:</p> <ol style="list-style-type: none"> 1. WRP teams had discussed the individual's point allocation or modified the allocation only 3% of the time. 2. There was evidence that the BY CHOICE point allocation was discussed in the Present Status section of the WRP in 63% of the charts reviewed.. 3. The WRP teams reviewed BY CHOICE allocation or preferences 1.6% of the time.. <p>Recommendations: Ensure that BY CHOICE point allocation is updated monthly in the individual's Wellness and Recovery Plan.</p>
d	<p>Each State hospital shall ensure that it has at least one developmental and cognitive abilities team (DCAT; consisting of 1 clinical psychologist, 1 registered nurse, 1 social worker, 1 psychiatric technician, and 1 data analyst (who may be a behavior specialist) who have a demonstrated competence, consistent with generally</p>	<p>Findings: PSH does not have a Developmental and Cognitive Abilities Team (DCAT).</p> <p>PSH self-evaluation showed that at least 302 individuals were identified with probable intellectual challenges that would benefit from</p>

	<p>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>assessment, and be helped in their service planning.</p> <p>Compliance: Non-compliance</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a full DCAT, consisting of a clinical psychologist, registered nurse, social worker, psychiatric technician, and data analyst. 2. Ensure that all individuals with cognitive challenges are assessed by the DCAT team. 3. Ensure that all DCAT team members are available for consultation to other staff to assist with planning individuals' therapeutic activities at the cognitive functioning level of the individuals. 4. Ensure that DCAT team members' primary responsibility is consistent with EP. 5. Ensure that all DCAT team members receive appropriate training.
e	<p>Each State Hospital shall develop and implement a Behavioral Consultation Committee (BCC), chaired by the Chief of Psychology, and co-chaired by the Chief of Psychiatry, to review the Wellness and Recovery Plan and maladaptive behavior(s) of the individuals who have not made timely progress on positive behavior support plans. The Chief of Psychology is responsible for the functions of this committee, together with members of the positive behavior support team (in functions of the committee that relate to individuals under the care of those team members). The committee membership shall include all clinical discipline heads, including the medical director, as well as the clinical administrator of the facility.</p>	<p>Findings:</p> <p>PSH has Behavioral Consultation Committee (BCC) to provide support to individuals' with severe maladaptive behaviors through collaboration with the individual's WRP team and the PBS teams in the development of treatment plans to manage the individuals' maladaptive behaviors.</p> <p>The Behavioral Consultation Committee (BCC) is chaired by the Acting Chief of Psychology, David Haimson, Ph.D.; and co-chaired by Wadsworth Murad, M.D., Chief of Psychiatry. However, the committee has not been functioning and has met only twice in the past two years.</p> <p>The PBS-BCC checklist is not utilized for referrals. Low referrals to BCC might indicate a lack of clear criteria and/or incomplete</p>

		<p>understanding and application of triggers. Low referrals can also mean that individuals who exhibit severe learned maladaptive behaviors are subjected to more severe management strategies including seclusions and restraints.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that the BCC functions as intended by the Enhancement Plan. 2. Ensure that staff is informed regarding the sequence of steps for referrals to the BCC (PBS-BCC Checklist). 3. Schedule regular meetings and ensure that all standing members of the BCC attend the meetings regularly. 4. Include PBS team members and WRP team members at BCC team meetings. 5. Set up a system of accountability to ensure that BCC recommendations are implemented.
f	<p>Each State Hospital shall ensure that it has sufficient neuropsychological services for the provision of adequate neuropsychological assessment of individuals with persistent mental illness.</p>	<p>Findings: There currently are two full-time and one half-time neuropsychologists at PSH. This small number of neuropsychologists in a system with around 1500 individuals, a large number of them showing probable neurological deficits (as evidenced by their Axis I and Axis II diagnoses) would not fully serve the needs of all the individuals in the system.</p> <p>Despite the shortage of staff, the neuropsychologists participate in cognitive remediation and individual cognitive therapy on the units. One Mall group, "Cognitive Rehabilitation" is offered once a week; another group, "Functional Rehabilitation Education Experience" is offered twice a week over a six-month cycle.</p>

		<p>Interview with the neuropsychologists indicated that they are meeting about 10% of the care individuals need. Re-testing and follow-up testing are not conducted or not conducted in a timely fashion.</p> <p>PSH self-evaluation provided the following information:</p> <ol style="list-style-type: none">1. Between April and October 2006, 65 neuropsychological referrals were received, of which 48 were completed, one withdrawn, one individual left PSH, three individuals refused testing, eight evaluations are under progress, and three have yet to be assigned.2. A total of 350 individuals were screened using the Repeatable Battery for the Assessment of Neuropsychological Status (RBANS), and 157 (45%) of those required follow-up neuropsychological testing. <p>As noted, a large number of individuals should be receiving neuropsychological assessments and cognitive interventions. Yet, as evidenced from the small number of referrals received and evaluated, it is obvious that a large number of individuals in PSH are not receiving this service. The lack of proper assessments could affect an individual's psychosocial rehabilitation services and their readiness for discharge.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none">1. Ensure that WRP teams, especially psychiatrists and psychologists, make referrals, when appropriate, for neuropsychological assessments.2. Ensure that neuropsychologists provide cognitive remediation and cognitive retraining groups in the PSR Mall.
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		<ol style="list-style-type: none"> 3. Increase the number of neuropsychologists to meet the anticipated demand for neuropsychological services. 4. Ensure that re-testing and follow-up neuropsychological evaluations are conducted in a timely fashion.
g	All clinical psychologists with privileges at any State Hospital shall have the authority to write orders for the implementation of positive behavior support plans, consultation for educational or other testing, and positive behavior support plan updates.	<p>Findings: Most psychologists at PSH are credentialed, or are in the process of being credentialed and under appropriate supervision in the interim.</p> <p>Psychologists in PSH do not have the authority to write orders for the implementation of PBS plans, consultation for educational or other testing, and PBS plan updates.</p> <p>According to David Haimson, Ph.D., Acting Chief of Psychology, this requirement is currently being discussed with the PSH Medical Executive Committee and Policy Committee to grant psychologists at PSH the necessary authority to be in compliance with EP.</p> <p>Compliance: Non-compliance.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. The hospital and/or State must provide psychologists the authority to write orders as specified in the EP. 2. Ensure that this authority is fully approved and implemented.
3	Nursing Services	
	Each State hospital shall provide adequate and appropriate nursing care and services consistent with generally accepted professional standards of care to individuals who require such services.	<p>Methodology: Interviewed Regina Olender, Coordinator of Nursing Services. Reviewed Medication Administration Monitoring data. Reviewed Statewide Medication Administration Monitoring raw data. Reviewed DMH Statewide 24-Hour NOC Audit Monitoring Form and raw data.</p>

		<p>Reviewed DMH Nursing Services PRN/Stat Medications Monitoring Form and instructions.</p> <p>Reviewed PSH Nursing Policy and Procedure Manual.</p> <p>Reviewed Nursing Policy and Procedure 538, PRN and STAT Medication.</p> <p>Reviewed Medication Pass Certification form.</p> <p>Reviewed Daily Report of PRN Medication Usage form.</p> <p>Reviewed Nursing Policy and Procedure 511, Medication Variance.</p> <p>Reviewed Nursing Policy and Procedure 536, Administration of Medication.</p> <p>Reviewed Memorandum dated November 18, 2006, Non-Compliance with Standards of Practice.</p> <p>Reviewed PSH Medication Variance Report, April, May, and June 2006.</p> <p>Reviewed Nursing Policy and Procedure 302, Nursing Care Plans.</p> <p>Reviewed Nursing Policy and Procedure vii, Change of Shift Procedure.</p> <p>Reviewed AD 15.30, Patient and Family Education.</p> <p>Reviewed Memorandum dated 8/10/06, Proposal: Restructuring the Staff Development Center.</p> <p>Reviewed DMH Monitoring Form for Bed-Bound Individuals.</p> <p>Attended shift report on unit EB 11.</p>
a	Each State hospital shall develop and implement policies and protocols regarding the administration of medication, including pro re nata ("PRN") and "Stat" medication (i.e., emergency use of psychoactive medication), consistent with generally accepted professional standards of care, to ensure:	<p>Compliance:</p> <p>Partial.</p>
a.i	safe administration of PRN medications and Stat medications;	<p>Findings:</p> <p>PSH reported that nursing policies need to be revised to adequately reflect the requirements of this cell. In addition, training is needed addressing this requirement.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Continue to develop and implement policies and procedures that

		<p>ensure the safe administration of PRN medications and Stat medications.</p> <ol style="list-style-type: none"> 2. Continue to monitor the administration and documentation of medication administration, including PRN and Stat medications. 3. Report PRN medication data and Stat medication data separately. 4. Ensure staff competency regarding deficiencies and appropriate procedures for safe administration of PRN medications and Stat medications. 5. Revise Statewide Medication Administration Monitoring Tool to reflect PRN medication and Stat medication data separately.
a.ii	documentation of the circumstances requiring PRN and Stat administration of medications;	<p>Findings:</p> <p>PSH reported 100% compliance for September/October 2006 using the Statewide Medication Monitoring Form. However, data obtained from the DMH Statewide 24 Hour NOC Audit Monitoring Form for the same time frame indicated 63% compliance.</p> <p>In addition to the conflicting data, I noted that PRN and Stat medication data were not monitored or tracked separately on either monitoring tool.</p> <p>From my review of three individuals (JR, GH and JW) who received PRN medications, none were found to have adequate documentation relating to this requirement. From my review of five individuals (NL, TL, KL, HC, and KK) who received a Stat medication, all five had inadequate documentation regarding the medication.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Revise all monitoring forms to reflect PRN and Stat data separately. 2. Ensure the reliability of the data. 3. Revise policies and procedures to reflect this requirement.

		4. Provide staff training on policy and procedure revisions.
a.iii	documentation of the individual's response to PRN and Stat medication.	<p>Findings: PSH reported conflicting data regarding this requirement. Data from the Statewide Medication Administration Monitoring Tool indicated 100% compliance while data from the Statewide 24-Hour NOC Audit Monitoring Form indicated 88% compliance. However, PRN and Stat medication data were reported together on both monitoring instruments.</p> <p>From my review of the three individuals listed above who received a PRN, all three only had the word "effective" documented as to the individual's response. From review of the seven individuals who received a Stat medication, the only indication that the medication may have been effective was that the individuals were released from 5-point restraints.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure staff competency regarding the documentation of specific indicators describing an individual's response to PRN and Stat medications. 2. Clarify and specify auditing criteria regarding what should be documented regarding an individual's response to PRN and Stat medications to ensure consistent data. 3. Ensure staff competency regarding deficiencies and appropriate procedures for safe administration of PRN medications and Stat medications. 4. Revise all monitoring forms to reflect PRN and Stat data separately.
b	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	<p>Findings: PSH's current policies and procedures do not adequately address this requirement. A memo addressing this requirement was initiated June 7,</p>

	<p>variances, and that appropriate follow-up occurs to prevent recurrence of such variances.</p>	<p>2006. Data resulting from an evaluation by Standards Compliance staff in November 2006 indicated that a total of 849 initials were missing from the MTRs and two signatures were missing from the controlled medication logs. The monitoring instrument addressing this requirement indicated 100% compliance. The conflicting data needs to be addressed.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Revise monitoring tools to include this requirement. 2. Ensure reliability of the data. 3. Revise policies and procedures regarding medication variances to include failures to properly sign the MTR or the controlled medication log as reportable medication variances. 4. Develop and implement a system to monitor appropriate follow-up to prevent recurrence of such variances. 5. Provide training to staff regarding the above.
c	<p>Each State hospital shall ensure that all nursing interventions are fully integrated into the therapeutic and rehabilitation service plan and that nursing interventions are written in a manner aligned with the rest of the interventions in the therapeutic and rehabilitation service plan, in particular, in observable, behavioral, and/or measurable terms. No nursing care plans other than the nursing interventions integrated in the therapeutic and rehabilitation service plan are required. No nursing diagnoses other than as specified in the therapeutic and rehabilitation service plan, in terms of the current DSM criteria, are required.</p>	<p>Findings: PSH reported the following compliance data:</p> <ol style="list-style-type: none"> 1. Nursing interventions are fully integrated into WRP: 41%. 2. Nursing interventions are written in a manner aligned with the rest of the interventions in the therapeutic and rehabilitation service plan: 35%. 3. Interventions are written in observable, behavioral, and/or measurable terms: 27%. 4. There are no separate nursing care plans: 50%. 5. There are no nursing diagnoses other than as specified in the therapeutic and rehabilitation service plan: 50%. <p>From my review, many of the nursing interventions reviewed that were</p>

		<p>included in the WRPs were not proactive and included meaningless interventions such as "will monitor" without specifying what was to be monitored, how often, where it should be documented, when it would be reviewed and by whom.</p> <p>In addition, there is generally little clinical objective data that are generated from most of the nursing interventions to determine if individuals are better or worse. I also noted that many of the interventions contained in the WRPs were not written in observable, behavioral, and/or measurable terms. Finally, nursing policies and procedures need to be revised to include elements of this requirement.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Revise policies and procedures to reflect this requirement. 1. Ensure that all nursing and psychiatric technicians are competent with regard to the WRP and the Recovery Model. 2. Ensure that interventions are written in observable, behavioral, and/or measurable terms. 3. Develop and implement proactive interventions related to the individuals' needs and risks.
d	All nursing staff working with an individual shall be familiar with the goals, objectives and interventions for that individual.	<p>Findings: PSH reported the following compliance data:</p> <ol style="list-style-type: none"> 1. Nursing staff is aware of individual's life goals: 41%. 2. Nursing staff is able to state one objective for selected focus: 31%. 3. Nursing staff is able to state Mall service and/or interventions 32%. 4. Nursing staff is able to state therapeutic milieu intervention(s)

		<p>for objective: 28%.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Provide training to nursing staff regarding therapeutic interactions to improve staff's ability to interact with individuals. 2. Continue to monitor this requirement.
e	<p>Each State hospital shall ensure that nursing staff timely monitor, document and report the status of symptoms, target variables, health, and mental health status, of individuals in a manner that enables interdisciplinary teams to assess each individual's status, and response to interventions, and to modify, as appropriate, individuals' therapeutic and rehabilitation service plans. Each State Hospital shall ensure that all nursing shift changes include a review of changes in status of individuals on the unit.</p>	<p>Findings: PSH does not have an adequate monitoring instrument or tracking system in place addressing all the elements of this requirement.</p> <p>I observed a shift change report on unit EB 11 for day and evening change of shift. There appeared to be no consistent system in place guiding what information should be passed along to the oncoming shift. The Shift Lead who was giving the shift report stated that much of the detailed information, such as diagnoses and health status, was provided because I was present. However, this information was not normally part of the regular shift reports.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a system for monitoring and tracking the elements of this requirement. 2. Develop and implement policies and procedures addressing criteria for shift change reports.

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>Findings: At PSH, the program HSS or designee reportedly certifies staff and the Medication Administration Competency Validation Practicum Check Sheet is place in the employee's personnel file. The initial monitoring is completed one time for competency and every year thereafter staff is trained to competence (in a class room skills lab). However, there is no ongoing audit or monitoring system in place.</p> <p>Using the statewide Medication Administration Monitoring form PSH reported the following compliance rates and corresponding indicators:</p> <ol style="list-style-type: none"> 1. Verbalizing generic and trade names of medications administered: 60%; 2. Describing therapeutic effects, usual doses, and routes of medications: 58%; 3. Differentiating expected side effects from adverse reactions: 52%; 4. Explaining sliding scale for regular insulin: 80%; and 5. Verbalizing symptoms and interventions of hypo-hyperglycemia: 76%. <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a monitoring and tracking system to ensure nursing staff are knowledgeable regarding each individual's prescribed medications. 2. Develop and implement system to ensure that every nurse that administers medication is observed on a quarterly basis.
f.ii	education is provided to individuals during medication administration;	Findings: PSH reported that there is no ongoing monitoring or data collection

		<p>process addressing this requirement. However, limited data were collected.</p> <p>PSH reported 23% compliance with this requirement.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Same as above. 2. Ensure staff competency regarding the implementation of this requirement.
f.iii	nursing staff are following the appropriate medication administration protocol; and	<p>Findings:</p> <p>PSH reported the following compliance rates with components of this requirement:</p> <ol style="list-style-type: none"> 1. Applies principles of asepsis: 54%. 2. Organizes medications no more than one hour prior to administration: 75%. 3. Identifies individual by name and photograph: 92%. 4. Checks for allergies: 75%. 5. Measures, interprets, records BP and pulse prior to administration of cardiac and hypertensive medications; withholds as indicated: 99%. 6. Opens/pours medication in front of individual: 98%. 7. Correctly administers crushed and liquid medications: 95%. 8. Checks medication with MAR 3 times: 67%. 9. Ensures individual swallowed medications: 90%. 10. Applies proper technique with syringes: 100%. 11. Ensures privacy and confidentiality: 96%. 12. Properly administers eye-ear drops and inhalers/spray: 100%. <p>The numbers of responses applicable to each above item were variable.</p> <p>Recommendations:</p> <p>Same as in F.3.f.i</p>

f.iv	medication administration is documented in accordance with the appropriate medication administration protocol.	<p>Findings: PSH reported the following compliance rates with the following indicators:</p> <ol style="list-style-type: none"> 1. Documents and signs out controlled medications: 97%. 2. Documents on MTR immediately after administration: 100%. 3. Documents on MTR when medication not given and notifies physician: 100%. 4. Documents telephone order, read back order to physician, noting order in medical order, and transcribing orders: 100%. <p>Recommendation: Continue to monitor this requirement.</p>
g	Each State hospital shall ensure that individuals remain in a "bed-bound" status only for clinically justified reasons.	<p>Findings: PSH does not currently have any bed-bound individuals. The Statewide CNS group developed a "DMH Bed Bound individuals Monitoring Form" but PSH does not currently use this monitoring instrument or have a policy or a tracking system in place to address this requirement.</p> <p>Compliance: Non-compliance.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Revise policies and procedures to address this requirement. 2. Develop and implement a monitoring instrument and tracking system to address this requirement.
h	Each State hospital shall ensure that, before they work directly with individuals, all nursing and psychiatric technicians have successfully completed competency-based training regarding:	<p>Compliance: Partial.</p>

h.i	mental health diagnoses, related symptoms, psychotropic medications and their side effects, monitoring of symptoms and target variables, and documenting and reporting of the individual's status;	<p>Findings: PSH reported there is no monitoring instrument or tracking system in place addressing this requirement.</p> <p>Recommendations: Develop and implement a monitoring instrument and tracking system to address this requirement.</p>
h.ii	the provision of a therapeutic milieu on the units and proactive, positive interventions to prevent and de-escalate crises; and	<p>Findings: The Statewide Therapeutic Milieu Group developed the "Therapeutic Milieu Monitoring Tool" for interdisciplinary use. The Statewide nursing group developed the "Nursing Therapeutic Milieu Monitoring Form" for use by the nursing. PSH used both forms to assess its compliance with this requirement. The facility's compliance data for September and October 2006 are at 51% and 56% respectively.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that there are training classes to specifically address therapeutic milieu on the units and proactive, positive interventions to prevent and de-escalate crises. 2. Monitor and track this requirement using the interdisciplinary tool.
h.iii	positive behavior support principles.	<p>Findings: PSH reported that hospital wide training of PBS has been conducted. However, the use of PBS principles is limited and not widespread throughout the hospital.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a system to adequately monitor and track this requirement. 2. Continue to monitor and track attendance at PBS training.

i	Each State hospital shall ensure that, prior to assuming their duties and on a regular basis thereafter, all staff responsible for the administration of medication has successfully completed competency-based training on the completion of the MTR and the controlled medication log.	<p>Findings: PSH reported that staff is initially certified and then re-trained every two years. The certification includes documentation of administration of medication, by post-test and by observation of competency by HSS. However, there is no regular, ongoing audit or monitoring system in place.</p> <p>Compliance: Partial.</p> <p>Recommendations: Develop and implement system to ensure compliance with this requirement.</p>
4 Rehabilitation Therapy Services		
	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>Methodology: Interviewed Greg Siples, Chief of Rehabilitation Therapy Services. Reviewed AD #10.21, Activity Program for Patients. Reviewed Rehabilitation Therapy Service Written Plan for Activity Services. Reviewed Rehabilitation Service Staffing Plan. Reviewed Procedures for Physical Therapy Services. Reviewed Physical Therapy Treatment Procedures for Transfer Training and Gait Training. Reviewed Duty Statement for Rehabilitation Therapist, Recreation, Occupation, Music, Dance, and Art. Reviewed Philosophy Statement of Physical Therapy. Reviewed Physical/Occupational therapy monitoring form. Reviewed PSH Rehabilitation Services Manual. Reviewed charts of the following charts: GB, YW, CC, CR, RT, KY, JW, GG, BT, JW, GD, HM, DA, NT, AF, RB, JL, ER, EL, CN, DV, JJ, SD, SA, JB, BMC, KF, SF, PH, AV, KT, SP, EH, RC and MB. Reviewed list of individuals with adaptive equipment.</p>

		<p>Reviewed list of individuals at risk for choking. Reviewed list of individuals at risk for dysphagia. Reviewed list of individuals with hearing aids. Reviewed list of individuals who require wheelchairs for mobility. Observed individuals in wheelchairs on EB 11. Reviewed OT, PT, and Speech caseloads.</p>
a	Each State hospital shall develop and implement policies and procedures, consistent with generally accepted professional standards of care, related to the provision of rehabilitation therapy services that address, at a minimum:	<p>Compliance: Partial.</p>
a.i	the provision of direct services by rehabilitation therapy services staff; and	<p>Findings: PSH reported that the rehabilitation therapy services policies and procedures do not consistently include the principles and language of the Wellness and Recovery Model, psychiatric rehabilitation, or principles of recovery. In addition, OT, PT and Speech Therapy are not integrated into the Rehabilitation Department.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Revise policies and procedures to include principles and language of the Wellness and Recovery Model, psychiatric rehabilitation, and recovery principles. 2. Integrate OT, PT, and Speech Therapy into the Rehabilitation Department as well as into the WRP and team process.
a.ii	the oversight by rehabilitation therapists of individualized physical therapy programs implemented by nursing staff.	<p>Findings: PSH reported that current policies and procedures do not include oversight by rehabilitation therapists, including the specialty therapies OT, PT and Speech Therapy, of individualized programs that are implemented by nursing staff.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a system to provide regular oversight by

		<p>rehabilitation therapists to nursing staff implementing individualized programs.</p> <p>2. Develop and implement a monitoring system to ensure that oversight by rehabilitation therapists of individualized rehabilitation therapy programs implemented by nursing staff is occurring.</p>
b	<p>Each State hospital shall provide competency-based training to nursing staff, as appropriate, on the use and care of adaptive equipment, transferring, and positioning, as well as the need to promote individuals' independence.</p>	<p>Findings: PSH reported that the majority of training addressing this requirement is done informally and without supporting documentation nor is it competency-based.</p> <p>There is no system in place to monitor this requirement.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a system to provide and document competency-based training on this requirement. 2. Develop and implement a monitoring system to ensure that competency-based training is provided for this requirement.
c	<p>Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.</p>	<p>Findings: There is no system in place to ensure compliance with the elements of this requirement. As mentioned in the Rehabilitation Therapy Assessment section of this report, there are many unmet therapy needs at PSH. In addition, there is no system in place to review the adequacy of the specialty therapies (OT, PT and Speech Therapy).</p> <p>Compliance: Non-compliance.</p>

		<p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a system to adequately monitor this requirement. 2. See Recommendations for Rehabilitation Therapy Assessments.
d	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>Findings: There is no monitoring system in place to ensure compliance with the elements of this requirement.</p> <p>Compliance: Non-compliance.</p> <p>Recommendation: Develop and implement a system to monitor the elements of this requirement.</p>
5	Nutrition Services	
	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>Methodology: Interviewed Tai Kim, Director of Dietetics. Reviewed Nutrition Care Monitoring Tool (NCMT) and instructions sheet. Reviewed AD #8.01 Nutrition Services. Reviewed Nutritional Screening Referral For High Risk Patients. Reviewed Nutrition Care Process (NCP). Reviewed Nursing Policy and Procedure 100, Admission Process and History and Physical. Reviewed Nutrition Assessments for the following individuals: JA, AS, AR, KB, CB, RC, JB, YW, CC, CR, RT, KY, JW, GG and BT. Reviewed Department of Dietetics Policy and Procedure Manual. Reviewed Nutrition Status Type (NST) acuity and indicators form. Reviewed list of residents with dysphagia. Reviewed dietary data provided by PSH.</p>

a	<p>Each State hospital shall modify policies and procedures to require that the therapeutic and rehabilitation service plans of individuals who experience weight problems and/or related health concerns include adequate strategies and methodologies to address the identified problems and that such strategies and methodologies are implemented in a timely manner, monitored appropriately, and revised, as warranted, consistent with generally accepted professional standards of care.</p>	<p>Findings: PSH reported that policies and procedures, monitoring systems and training programs need to be developed and implemented as required by the EP.</p> <p>In addition, PSH reported that strategies and methodologies by which weight-related and other health concerns are not addressed by the WRP teams. Nearly 70% of PSH has a BMI indicating obesity. Triggers related to weight issues have not been implemented.</p> <p>Compliance: Non-compliance.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Revise policies, procedures, protocols, and ADs to address this requirement. 2. Implement a system addressing weight-related triggers. 3. Ensure staff competency Provide training to staff regarding weight-related triggers. 4. Develop and implement a monitoring instrument and tracking system addressing the elements of this requirement.
b	<p>Each State hospital shall ensure that one or more treatment team members demonstrate competence in the dietary and nutritional issues affecting the individuals they serve and the development and implementation of strategies and methodologies to address such issues.</p>	<p>Findings: There is no system in place that ensures that one or more treatment team members demonstrate competence in the dietary and nutritional issues affecting the individuals they serve and the development and implementation of strategies and methodologies to address such issues.</p> <p>A statewide training tool has not been completed addressing this requirement.</p> <p>Review of item #22 on the NCMT data addressing current RNs' competency-based training in dietary and nutritional issues affecting</p>

		<p>individuals were 0% compliance.</p> <p>Compliance: Non-compliance.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a monitoring system to ensure that one or more treatment team members demonstrate competence in the dietary and nutritional issues affecting the individuals they serve and the development and implementation of strategies and methodologies to address such issues. 2. Develop and implement a statewide tool for the training of staff regarding this requirement.
c	<p>Each State hospital shall develop and implement policies and procedures to address the needs of individuals who are at risk for aspiration or dysphagia, including but not limited to, the development and implementation of assessments and interventions for mealtimes and other activities involving swallowing.</p>	<p>Findings: The current PSH policies and procedures regarding risk of aspiration and dysphagia are inadequate to guide the provision of safe care to this population. The SLP, OT, PT, nurses, and other disciplines have little experience and expertise in this particular area. There is no system in place to ensure that a comprehensive, integrated, 24-hour dysphagia care plan is developed and implemented.</p> <p>PSH reported an overall compliance rate of 0% regarding nutrition services having a current policy and procedure for aspiration/dysphagia. The state has secured a consultant with expertise in dysphagia to provide training. This process has been implemented.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that this requirement is met. 2. Revise policies and procedures in accordance with generally

		<p>accepted standards of practice regarding risk of aspiration/dysphagia.</p> <ol style="list-style-type: none"> 3. Develop and implement 24-hour, individualized dysphagia care plans. 4. Provide competency-based training to staff regarding risk of aspiration/dysphagia. 5. Provide competency-based training on individualized, 24-hour dysphagia care plans to staff working with individuals at risk of aspiration/dysphagia. 6. Develop and implement a monitoring system for this requirement.
d	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>Findings: PSH reported 0% compliance with this requirement. However, there is a plan to begin general training regarding monitoring, assessment, and interventions regarding aspiration and dysphagia.</p> <p>Compliance: Non-compliance.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure staff competency-based training regarding the implementation of this requirement. 2. Develop and implement a monitoring system regarding this requirement.
e	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>Findings: The current policies and procedures at PSH do not address all the elements of this requirement.</p> <p>Compliance: Partial.</p>

		<p>Recommendations:</p> <ol style="list-style-type: none"> 1. Revise policies and procedures to reflect the elements of this requirement. 2. Develop and implement a system to monitor this requirement.
6	Pharmacy Services	
	<p>Each State hospital shall provide adequate and appropriate pharmacy services consistent with generally accepted professional standards of care. Each State hospital shall develop and implement policies and procedures that require:</p>	<p>Methodology:</p> <p>Interviewed Phung Chau, RPh Pharmacy Services Manager. Interviewed Carlos Luna, Executive Director. Reviewed Administrative Directive (AD) 2.03H, Therapeutic Review Committee. Reviewed AD 2.03I, Pharmacy & Therapeutics Committee. Reviewed AD 10.15, Pharmaceutical Services. Reviewed AD 10.16, Use of Psychotropic Medications. Reviewed pharmacy raw data provided by PSH. Reviewed PSH Pharmacy Policy and Procedure Manual. Reviewed pharmacy recommendations for the following individuals: LW, KC, RB, MH, WP, CR, RW, DH, CD, MM, TT, SV, WB, HS, KJ, GL, RA, EH, BM, DB and LJ.</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>Findings:</p> <p>PSH currently has 5.5 full-time pharmacists. An additional two full-time pharmacists are on medical leave. The department has six vacant pharmacist positions. In addition, there are 10 pharmacy techs. At the current staffing level, the PSH pharmacists are not able to conduct quarterly medication regimen reviews. Currently, the Nursing Department is conducting these reviews.</p> <p>The current PSH pharmacy policies, procedures, and Administrative Directives (ADs) are being revised to address the elements of this requirement.</p>

		<p>PSH reported reviewing 100% of new orders for September and October 2006. However the data presented did not report compliance scores for the elements of this requirement. There is no monitoring tool or system in place that ensures that all elements of this requirement are adequately addressed. In addition, there is no documentation in the medical records regarding the pharmacists' recommendation or the response from the physician. The current practice by pharmacy is to document the identified issue on a copy of the physician's order sheet. I reviewed 21 individuals' pharmacy recommendations that were noted on copies of the physicians' orders (see Methodology for list). However, there was no documentation found indicating when these issues were addressed.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Revise pharmacy policies and procedures to address this requirement. 2. Develop and implement an electronic system for documentation. 3. Provide IT assistance to pharmacy regarding electronic database and data collection systems. 4. Develop and implement a monitoring tool to ensure the elements of this requirement are adequately addressed.
b	Physicians to consider pharmacists' recommendations, and for any recommendations not followed, document in the individual's medical record an adequate clinical justification.	<p>Findings: The current PSH pharmacy policies and procedures do not address this requirement.</p> <p>PSH reported that most interactions between pharmacy and prescribers are informal and not consistently documented.</p> <p>There is no system in place to ensure that physicians consider</p>

		<p>pharmacists' recommendations, and for any recommendations not followed, document in the individual's medical record an adequate clinical justification.</p> <p>Compliance: Non-compliance.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement policies and procedures in collaboration with pharmacy and medical/psychiatry to address this requirement. 2. Assign responsibility and accountability to medical/psychiatry for plans of corrections for problems identified. 3. Develop and implement a monitoring system for this requirement.
7	General Medical Services	
		<p>Methodology: Interviewed Ronald Hattis, M.D., Director, Medical Services. Interviewed Cung Nguyen, M.D., Staff Physician and Surgeon. Interviewed Rahima Afghan, M.D., Staff Psychiatrist. Interviewed Timmy Alder, M.D., Staff Physician and Surgeon. Interviewed Niculina Tanase, M.D., Staff Psychiatrist. Interviewed Dien Mach, M.D., Staff Physician and Surgeon. Interviewed Paul Cratofil, M.D., Staff Psychiatrist. Interviewed Khue Nguyen, M.D., Staff Physician and Surgeon. Interviewed Gari-Lynn Richardson, Director, Standards Compliance. Interviewed Katherine Smith, R.N Auditor, Standards Compliance. Reviewed the charts of six individuals (RV, FLL, JB, HFD, HLS and HHD) that required transfer to an outside medical facility during the past year. Reviewed Duty Statement of the Medical Staff. Reviewed Minutes of the Emergency Care Committee (September 20</p>

		<p>and October 18, 2006)</p> <p>Reviewed Emergency Care Committee Triage Review/Monitoring Checklist.</p> <p>Reviewed PSH Protocol Evaluation and Treatment of HIV Seropositive Hospitalized Individuals.</p> <p>Reviewed PSH Guidelines of Care for Chronic Viral Hepatitis B and C.</p> <p>Reviewed PSH Protocol regarding Hepatitis C Screening and Management Program.</p> <p>Reviewed PSH Methicillin Resistant Staphylococcus Aureus (MRSA) Protocol.</p> <p>Reviewed PSH Sexually Transmitted Diseases (STDs) Management Guidelines.</p> <p>Reviewed PSH Tuberculosis Exposure Control Plan</p> <p>Reviewed PSH Guideline for Pain Management.</p> <p>Reviewed PSH Guidelines for Care of COPD and Asthma.</p> <p>Reviewed PSH Guidelines for Management of Status Epilepticus.</p> <p>Reviewed PSH Guideline for Hypertensive Urgency and Emergency Management.</p> <p>Reviewed PSH Standard of Care for Diabetes Mellitus.</p> <p>Reviewed PSH Patient Care Monitoring Forms regarding Antibiotic Usage evaluation, Polydipsia, Polyuria/Hyponatremia, Optometry Criteria, Medical/Surgical Evaluation, Diabetic Flow Sheet/Record and Urinary Tract Infection Criteria.</p> <p>Reviewed PSH Protocol regarding Smoking Cessation.</p> <p>Reviewed AD #10.12 Medical Officer Of The Day.</p> <p>Reviewed Nursing Policy and Procedure Laboratory Procedures.</p> <p>Reviewed revised Nursing Policy and Procedure Radiology Procedures.</p> <p>Reviewed Nursing Policy and Procedure Medical Emergency.</p> <p>Reviewed nursing Policy and Procedure Emergency Medical Equipment.</p> <p>Reviewed Nursing Policy and Procedure Monitor/Defibrillator.</p> <p>Reviewed AD# 10.25 Medical Emergencies.</p> <p>Reviewed AD# 10.30 Medical treatment At Other Facilities.</p> <p>Reviewed Nursing Policy and Procedure #601 Laboratory Procedures.</p>
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		<p>Reviewed Initial Medical Assessment Tally Work Sheet.</p> <p>Reviewed Initial Medical Assessment Monitoring Summary Data (September and October 2006).</p> <p>Reviewed data regarding audits of Annual Physical Assessments during the past year.</p> <p>Reviewed data regarding audits of STAT tests and critical laboratory values (August to October 2006).</p> <p>Reviewed data regarding audits of radiology logs (October 2006).</p> <p>Reviewed data regarding audits of specialty clinics.</p> <p>Reviewed Quality Of Care: Asthma/COPD Tally Report.</p> <p>Reviewed Asthma/COPD Monitoring Summary Data (August to October 2006).</p> <p>Reviewed Quality of Care Monitoring Instrument: Diabetes.</p> <p>Reviewed Diabetes Monitoring Summary Data (July to October 2006).</p> <p>Reviewed Quality of Care Monitoring Instrument: Hypertension.</p> <p>Reviewed Hypertension Monitoring Summary Data (July to October 2006).</p> <p>Reviewed PSH Quality Assessment/Improvement Quarterly Report.</p> <p>Reviewed Quality Assessment/Improvement Monitoring Summary Data (July to September 2006).</p>
a	<p>Each State hospital shall provide adequate, appropriate, and timely preventive, routine, specialized, and emergency medical care to all individuals in need of such services, consistent with generally accepted professional standards of care. Each State hospital shall ensure that individuals with medical problems are promptly identified, assessed, diagnosed, treated, monitored and, as monitoring indicates is necessary, reassessed, diagnosed, and treated, consistent with generally accepted professional standards of care.</p>	<p>Findings:</p> <p>PSH has a Medical Services Department that employs a Chief Physician and Surgeon, 17.9 FTE Staff Physicians and Surgeons and four FTE Nurse Practitioners. All physicians are licensed in California. Twelve of the physicians are board-certified in various specialties, four are board-eligible and two did not complete residency training requirements for board eligibility. The Medical Staff bylaws require board certification or eligibility in all new hires.</p> <p>The specialties of physicians include Internal Medicine, Gastroenterology, Family Medicine, General Surgery, Preventive Medicine, Neurology and Infectious Disease.</p>

		<p>The staff physicians include one who serves as the Public Health Officer; all others have regular unit responsibilities. All units are assigned a medical-surgical physician but most physicians cover more than one unit. The physicians also have coverage in the Admission suite and Employee Clinic that are shared with the Nurse Practitioners.</p> <p>The Nurse Practitioners function under the supervision of physicians and have a manual of protocols to follow that are reviewed and approved by the Interdisciplinary Practice Committee, which includes three physicians. Duties assigned to the Nurse Practitioners include admission and annual histories and physical examinations, Gynecology Screening Clinic, and to a limited extent, assisting physicians with sick call responsibilities.</p> <p>The after-hours coverage (Medical Officer of the Day or MOD) scheduling is assigned to a physician who assures that there is both psychiatric and medical-surgical physician coverage every weekday from 1630 to 0800 the next morning, and 24 hours on weekends and holidays. The medical staff requires all MODs to be current in ACLS training.</p> <p>The facility has a range of on-site specialty clinics that includes including General/Internal Medicine, Gastroenterology, Neurology, Gynecology, Infectious Diseases (including separate clinics for HIV and Tuberculosis Latent Infections) and General Surgery. Additional clinic services are provided on-site by non-physicians. These clinics include Audiology, Speech Pathology, EKG, EEG, Physical Therapy, Optometry and Occupational Therapy. The laboratory specimens are sent to Community Hospital of San Bernardino.</p> <p>PSH also has contractual arrangements with a range of external outpatient services at Arrowhead Regional Medical Center, San Bernardino Community Hospital and St. Bernandines Hospital. Outside clinics include Sleep medicine, Radiology and Renal Dialysis.</p>
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Individuals who require a level of care not available on-site are transferred to regional medical centers including St. Bernardines Hospital, Community Hospital of San Bernardino, Arrowhead Regional medical Center, Loma Linda Medical Center and Riverside County regional Medical Center. Two contracted physicians provide inpatient services at San Bernardino Medical Center and Community Hospital of San Bernardino. Skilled Nursing Services are provided by Crestview Convalescent Center.

At this time, the medical service at PSH has adequate staffing levels and a range of consultation services and contractual arrangements that can meet the needs of the individuals served.

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
RV	Acute Pneumonia	9/24/2006 (1130)	9/26/2006 (1143)
FLL	Chest pain	10/1/2006 (2300)	10/1/2006 (2330)
JB	Gastrointestinal bleeding	4/4/2005 (0820)	4/4/2005 (0945)
HFD	Supraventricular tachycardia	Undocumented	6/15/2006.
HLS	R/O Cerebro-	10/31/2006	10/31/2006

	Vascular Accident	(1045)	(time undocumented)
HHD	Head Injury	11/25/2006 (0719)	11/25/2006 (time undocumented)

The review shows substantial compliance with plan requirements in four cases (FLL, HLS, HHD and JB), and non-compliance in two (RV and HFD). The review of RV demonstrates inadequate documentation of the timeliness and appropriateness of the initial medical evaluation that resulted in a verbal order (without face-to-face assessment). In the case of HFD, there is no evidence of a documented medical evaluation upon the medical transfer of the individual. The time of transfer is not documented in the charts of HLS and HHD.

PSH has AD (#10.25) that describes the facility's medical emergency response system. All physicians who provide on-call coverage, all the HSSs and all Coordinators of Nursing Services have ACLS certification. The facility requires that at least one ACLS certified staff member is on the scene during an emergency. All clinical staff receives CPR training at least every two years, including the use of AED. The facility conducts medical emergency response drills but does not have a procedure that describes the frequency of the drills. The facility does not have a requirement to ensure regular review of drill results by the Medical Emergency Committee.

The facility PSH has an Emergency Medical Committee that includes representatives of the medical, nursing, pharmacy, safety and hospital police. Review of all cases that required transfer to an outside facility on an emergency basis as well as all cases requiring emergency medical response on-site. Emergency. The committee reviewed 100% sample of all cases mid-August to mid-October 2006. for adequacy of medical and nursing management. The facility found that 94% of the cases had

		<p>proper medical and nursing management. Two cases (6%) with some questionable aspect of medical management were referred for further review to the Chief of Staff in accordance with Medical Executive Committee policy.</p> <p>Peer physicians reviewed a 26% sample of the 35 emergency medical cases from the period mid-August to mid-October 2006, and two cases from MOD log from same period. The review focused on the quality of medical care, utilizing Medical Quality Management Monitor: Urgent and Emergent Care Form. This tool was developed by Metropolitan State Hospital. Of 8 non-life-threatening cases, there were no deficiencies on 7 of the 8 indicators. One case had a deficiency on one indicator (0.2% of cells; 12.5% imperfect cases). Of three life-threatening cases, there was one case in which paramedics did not arrive within the required 15 minutes despite timely notification.</p> <p>The physician reviewers assessed the quality of ongoing medical care during the period August-October 2006, utilizing Monitoring for Ongoing Medical Care Form. This monitoring tool was adapted by Department of Medicine from Metropolitan State Hospital. Of eight charts reviewed, the only defects were one chart (12.5%) in which the most recent annual history and physical exam had not been timely, and two charts (25%) in which medical conditions had not been integrated into the WRP. Of 64 cells, the overall compliance rate was 95%.</p> <p>PSH does not have a policy and procedure that outlines and integrates facility's standards and expectations regarding the following areas:</p> <ol style="list-style-type: none"> 1. Requirements regarding completeness of all sections 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;
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		<ol style="list-style-type: none"> 4. Proper physician-nurse communications and physician response within timeframes that reflect the urgency of the condition; 5. Emergency medical response system, including drill practice; 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. 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; and 10. Parameters for physician participation in the WRP process to improve integration of medical and mental health care. <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Continue current practice. 2. Develop and implement policy and procedure to codify facility's standards and expectations regarding the areas outlined above. 3. 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. 4. Ensure easy access by physicians to the laboratory information system, radiology data/reports, chart notes and consultation reports.
b	Each State hospital shall develop and implement protocols and procedures, consistent with generally accepted professional standards of care, that:	Compliance: Partial.
b.i	require the timely provision of initial and ongoing assessments relating to medical care, including but not	Findings: The facility has protocols regarding the care of individuals suffering

<p>limited to, vision care, dental care, and laboratory and consultation services;</p>	<p>from a variety of disorders, including HIV, hepatitis B and C, STDs, Hypertensive Emergencies, tuberculosis, osteoporosis, polydipsia, COPD and asthma. The facility also has guidelines regarding antibiotic use, pain management and smoking cessation. The facility has a number of policies and procedures that address different aspects of the medical emergency response.</p> <p>To assess compliance with this requirement, the Director of Medical Services reviewed 14 Administrative Directives (ADs) relating to medical services. The purpose of the review was to ensure that all ADs have been updated at least once in the past two years. The review showed that 43% of the ADs have been updated within the past 24 months and are current and that 57% are in process of update or have not been updated. Of 29 nursing policies closely related to medical services, only seven (24%) have been updated within the past 24 months.</p> <p>Using the Initial Medical Assessment Tally Worksheet, a nurse auditor reviewed 100% of admission medical history and physical assessments to assess completion of major components (September and October 2006). The following is a summary of the compliance data (excluding individuals that refused the examination):</p> <ol style="list-style-type: none"> 1. Medical History: 92%; 2. Review of Systems: 93%; 3. Physical Examination: 70%; 4. Diagnostic Impressions: 97%; and 5. Management of acute medical problems: 77%. <p>The facility has a Clinical Information System (CIS) Database that tracks completion of annual history and physical assessments. ("Physical Detail Report"). Data from August to September 2006 indicate 100% compliance (excluding individuals that refused the</p>
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		<p>examination).</p> <p>A nursing auditor reviewed 100% of charts in one program (VIII), for presence of annual history and physical assessment within the last 12 months, and co-signature by a physician of nurse practitioner assessments (as of October 9, 2006). Of 203 individuals, there were 20 documented refusals. Of the remaining 183 individuals, the deficiencies were one physical examination documented as having been done in progress note but not found filed in the chart, one assessment apparently was missing, and four examinations by nurse practitioners were not co-signed by a physician.</p> <p>This monitor's findings are the same as in D1.c.i</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. As in F.7.b. 2. As in D.1.c.i.
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>Findings:</p> <p>The facility audited laboratory logs regarding timely notification of units of STAT tests and critical lab values that were reported during regular hours (August to October 2006). The required timeframe (four hours) is identified in Nursing Policy and Procedure Laboratory Procedures. The following is a summary of the facility's compliance data:</p> <p>STAT tests: 91%; and Critical laboratory values: 100%</p> <p>In addition, the facility audited radiology logs regarding notification of units and physicians of abnormal results in the same day (153 individuals were monitored during a three week period in October 2006). The facility reports 100% compliance rate. There were no instances</p>

		<p>reported of a wrong individual or a wrong body part being x-rayed.</p> <p>The facility audited logs and database of specialty clinics including gynecology, surgery, vision, neurology, and external specialist gastroenterology services, for appointments not kept and reasons for those not completed, including refusals. However, the facility's data are difficult to interpret due to absence of the standard used to determine compliance.</p> <p>Recommendations: As above.</p>
b.iii	define the duties and responsibilities of primary care (non-psychiatric) physicians;	<p>Findings: The facility reports that as of October 31, 2006, 100% of duty statements of primary care (medical-surgical) physicians have been updated within the past 12 months. The duty statement outlines the duties and responsibilities, but does not clearly or adequately address the performance standards and expectations outlined in the EP.</p> <p>Recommendation: Ensure that the duty statement outlines the performance standards and expectations as above.</p>
b.iv	ensure a system of after-hours coverage by primary care physicians with formal psychiatric training (i.e., privileging and proctorship) and psychiatric backup support after hours; and	<p>Findings: PSH provides after-hours coverage using three physicians, including at least one psychiatrist and one physician and surgeon on-site. However, each physician covers one section of the facility, including both psychiatric and medical problems. PSH reports that the psychiatrist on call for one section provides back-up for psychiatric problems in other sections. However, the facility does not monitor if this mechanism ensures psychiatric input in all situations that involve psychiatric emergencies. The facility's AD #1.12 Medical Officer Of The Day states "The MOD must provide all needed medical and psychiatric</p>

		<p>services and must handle any unusual patient, staff or environmental problems." The AD also states that the "MOD should consult with other MODs when uncertainties arise." This language fails to ensure compliance with this requirement given that the MODs at PSH do not receive formal psychiatric training.</p> <p>The facility audited the MOD coverage schedules of August, September, and October 2006, for listing of both a psychiatrist and a primary care physician for each night. The results indicate that this configuration occurred 100% of the time.</p> <p>Recommendation: Ensure psychiatric input in all psychiatric emergencies that occur after-hours in all sections of the facility.</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>Findings: The facility conducted a query of external referral database for return of external records (based on copy sent to Medical Services Office), by the main external clinic provider Arrowhead Regional Medical Center (ARMC) (January to September 2006). The monitoring data do not address the expectation regarding timeframes for receipt of the records. The results indicated the following compliance rates:</p> <p>ARMC Clinics: 37%; ARMC Emergency room: 18%;and ARMC Radiology: 17%.</p> <p>The above percentages are based on appointments made and do not take into account cancelled appointments or refusals of individuals to be seen (if these are deducted from denominator, the rates of record return would be higher).</p>

		<p>Recommendation: Develop and implement adequate tracking system and specify facility's expectations regarding time frames..</p>
c	<p>Each State hospital shall ensure that physicians monitor each individual's health status indicators in accordance with generally accepted professional standards of care, and, whenever appropriate, modify their therapeutic and rehabilitation service plans to address any problematic changes in health status indicators.</p>	<p>Findings: The facility screened 736 charts for individuals with history of asthma and/or COPD (109 cases were found). The applicable cases were audited (by a nurse practitioner) for the period of August through October 2006. The audit utilized the Quality of Care: Asthma/COPD Total Tally Report (adapted from Metropolitan State Hospital). The following is a summary of the facility's compliance data:</p> <ol style="list-style-type: none"> 1. Is asthma/COPD included in focus #6? 100%. 2. Is smoking cessation intervention discussed and included in the individual's WRP? 62%. 3. Was asthma/COPD reevaluated quarterly by medical provider and documented? 27%. 4. Is documentation evident of yearly flu vaccination? 51%. 5. Was a peak expiratory flow rate checked and recorded? 0%. <p>PSH modified the Quality of Care Monitoring Instruments for Diabetes and Hypertension (developed by Metropolitan State Hospital). The revised version was used to assess compliance with this item. Peer physicians reviewed a sample of 13 charts of individuals with Diabetes (July to October 2006) and found the following:</p> <ol style="list-style-type: none"> 1. Is Diabetes diagnosis discussed and included in the WRP? 100%. 2. Is blood glucose currently monitored at least weekly? 100%. 3. Is quarterly HgA1c done? 100%. 4. If dyslipidemia present, has been treated? 75%. 5. Has urine microalbuminuria ordered at least annually? 50%. 6. If urine microalbumin was >30 microgram, has (appropriate treatment) been ordered? 75%.

		<p>7. Has dietary consultation been ordered? 82%.</p> <p>8. Has Diabetes education been given? 83%.</p> <p>9. Has ophthalmologist/optometrist completed an eye examination at least annually? 83%.</p> <p>10. Has foot care been given at least annually? 70%.</p> <p>Physician peer review of the management of hypertension showed the following compliance data (24 charts reviewed):</p> <p>1. Is hypertension diagnosis discussed and included in the WRP? 68%.</p> <p>2. Is blood pressure <140/90 with treatment? 79%.</p> <p>3. Has a lipid profile been checked at least annually? 91%.</p> <p>4. If dyslipidemia is present, has it been treated? 70%.</p> <p>5. If individual has a BMI ≥ 27, has it been addressed? 33%.</p> <p>6. Has a dietary consultation been ordered within 30 days of diagnosis? 57%.</p> <p>7. If individual is currently a smoker, is smoking cessation discussed by the physician/nursing staff? 40%.</p> <p>8. Unless contraindicated, and if individual is age 50 or older, has aspirin been ordered? 25%.</p> <p>In addition, peer physicians reviewed 45 charts for quality of general medical care (July to September 2006) utilizing PSH Department of Medicine indicators for Medical/Surgical Evaluation. The facility reported 100% compliance with all the indicators regarding:</p> <p>1. Timely recognition of problems;</p> <p>2. Documentation of progress notes in SOAP format;</p> <p>3. Ordering of appropriate diagnostic tests;</p> <p>4. Timely checking of test results;</p> <p>5. Establishing a correct medical diagnosis;</p> <p>6. Timely referral for consultation services;</p>
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		<ol style="list-style-type: none"> 7. Review of specialists' recommendations; 8. Proper management of medical conditions; and 9. Proper treatment of complications (if any). <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Continue current monitoring. 2. Address and correct above-mentioned areas of low compliance. 3. Develop and implement formalized mechanisms to improve integration of medical staff into the interdisciplinary functions of the WRP.
d	<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>Findings: PSH does not have a system to monitor, on a comprehensive basis, general outcome indicators to identify practitioner and system related trends and patterns regarding management of the individual's health status. The hospital has developed a system to collect data on medical care triggers identified in the Key Indicators, but has yet to improve reliability of the data regarding several indicators.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a formalized physician peer review system that utilizes indicators aligned with the standards and expectations outlined in F.7.a. 2. Continue monitoring of physicians' adherence to practice guidelines and expand these guidelines to address areas outlined in the triggers/key indicators for medical care. 3. Ensure reliability of data on all the medical triggers/key

		<p>indicators.</p> <p>4. Identify trends and patterns based on clinical and process outcomes.</p> <p>5. Expedite efforts to automate data systems to facilitate data collection and analysis.</p>
8	Infection Control	
	<p>Each State hospital shall develop and implement infection control policies and procedures to prevent the spread of infections or communicable diseases, consistent with generally accepted professional standards of care.</p>	<p>Methodology: Interviewed H.D. Bui, M.D., Public Health Officer. Interviewed Donna Rowe, PHN II. Interviewed Chloe Cummings, PHN II. Interviewed Maria Remetir, RN, Infection Control Nurse. Reviewed Infection Control Manual. Reviewed AD 10.06, Infection Control Program. Reviewed AD 2.03, Infection Control Committee. Reviewed Nursing Policy and Procedure 1200, Infection Control Program. Reviewed Duty Statement for Public Health Nurse (PHN) II. Reviewed Duty Statement for Public Health Officer. Reviewed PSH Infection Control Surveillance Forms. Reviewed PSH Infection Control Report for September 2006 data. Reviewed PSH HIV Testing Data for October 2006. Reviewed Employee Tuberculosis Report. Reviewed Patient Tuberculosis Report. Reviewed PSH Infection Control Plan, July 2006-June 2007. Reviewed Evaluation of the Effectiveness of the Patton State Hospital Infection Program, 2005 report. Reviewed Departments of Medicine/Psychiatry Minutes August 23, 2006. Reviewed Infection Control Manual</p>
a	<p>Each State hospital shall establish an effective infection control program that:</p>	<p>Compliance: Partial.</p>

a.i	actively collects data regarding infections and communicable diseases;	<p>Findings: Although the Infection Control Department at PSH provided a significant amount of data such as meeting minutes, monthly and quarterly reports supporting their active involvement in collecting, assessing, tracking and trending data regarding the elements of this requirement, there are no monitoring instruments or systems in place to track data regarding the EP requirements for Infection Control.</p> <p>In addition, PSH has identified that there is not a consistent system for documenting immunizations and that there is a high rate for individuals refusing to attend the viral and public health clinic appointments.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a monitoring system for the elements of these requirements. 2. Develop and implement statewide monitoring instruments to monitor the elements for Infection Control. 3. Provide training on the above recommendations to Infection Control staff. 4. Revise policies and procedures to reflect the elements in the requirements for Infection Control.
a.ii	assesses these data for trends;	<p>Findings: There are no monitoring instruments or system in place to track data regarding the EP requirements for Infection Control.</p> <p>Recommendations: Same as above.</p>
a.iii	initiates inquiries regarding problematic trends;	As above.
a.iv	identifies necessary corrective action;	As above.
a.v	monitors to ensure that appropriate remedies are	As above.

	achieved; and	
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 Amy Santimalapong, Chief Dentist. Reviewed Extraction Cases Report. Reviewed Administrative Directive (AD) 10.14: Dental Services. Reviewed Report from Peer Review, 11/15/06. Reviewed PSH Memorandum 9/12/06, Patient Care Monitoring-1st Quarter (July - September 2006). Reviewed PSH Dental Evaluation (peer review tool). Reviewed Average Dental Clinical Report, January-September 2006. Reviewed Reports from Dental Appointments from January-October, 2006. Reviewed PSH Intervention Request for refusals. Reviewed Dental Services Patient Dental Refusal Form. Reviewed PSH Dental Department Self-Assessment Monitoring Survey. Reviewed Dental Services Emergency Appointment Log. Reviewed PSH Dental Internal Appointments records. Reviewed PSH Dental Monitoring Plan and raw data. Reviewed Dental Services Policy and Procedure Manual.</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>Findings: PSH currently has two full-time staff Dentists, and one Dentist who is half-time clinical and half-time administrative (Chief Dentist). The ratio of dentist to patient is 1:600 individuals. In addition, there are four Dental Assistants comprised of two Registered Dental Assistants and two Dental Assistants. PSH reported that for the past 20 years</p>

		<p>they have been unable to recruit a Dental Hygienist due to budget constraints to provide more preventative dental services. Although PSH reported needing additional staff, it was also noted that the space limitations at both the dental clinics would not accommodate an increased number of staff.</p> <p>PSH also reported that there is no clerical staff in the Dental department to assist with data collection and data entry. Consequently, the Amy Santimalapong, Chief Dentist reported that a considerable amount of time was taken from providing services to the individuals. The dental staff, without the availability of automation, has conducted data collection and tool development basically by hand.</p> <p>In addition, there is no system in place to track and monitor individuals diagnosed with Periodontal Disease. From my discussion with Amy Santimalapong, Chief Dentist, this diagnosis is not included in the Axis III diagnoses listed in the medical records. Consequently, individuals diagnosed with Periodontal Disease are not seen for cleanings and/or treatment as often as needed.</p> <p>Also, PSH as well as MSH, NSH, and ASH do not have an adequate system in place to ensure that the current dental information contained in the individuals' dental chart in the dental clinic is also included in the individuals' medical records kept on the units. A noted revision, June 23, 2006, of the PSH Dental Services Policy and Procedure Manual requires that "All individuals presenting for appointments at the dental clinic must be accompanied by his/her medical record." This revision should assist in ensuring that accurate information is contained in the medical records.</p> <p>PSH reported that dental emergencies reported during business hours are seen within 24-48 hours. Dental emergencies that occur in the evening or during weekends/holidays are evaluated by the Medical</p>
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		<p>Officer of the day (MOD) and if necessary, are sent to a community clinic.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Evaluate the need for additional dentists, dental auxiliary staff, and clerical staff for the dental department. 2. Obtain a dental management software package to reduce time spent on recordkeeping and to ensure accurate data. 3. Develop and implement a system to ensure that current and accurate information regarding dental care and services provided to individuals is included in the unit medical records.
b	Each State hospital shall develop and implement policies and procedures that require:	<p>Compliance: Partial.</p>
b.i	comprehensive and timely provision of dental services;	<p>Findings: The Dental Clinic Policy and Procedure Manual do not adequately address comprehensive provision of dental services. The revised PSH Dental Services Policy and Procedure Manual indicates that Guidelines for Care and Service is "Based on staff availability."</p> <p>A review of 398 dental records was conducted.</p> <p>Currently, there is currently no formal instrument that addresses comprehensive dental services.</p> <p>PSH reported 89% compliance for new admissions seen within 90 days and timeliness of annual exams. However, these data were not analyzed separately for compliance for each of these assessments types.</p>

		<p>Recommendations:</p> <ol style="list-style-type: none"> 1. Review and revise policies and procedures as need to address this requirement. 2. Develop and implement a system to monitor and track comprehensive dental services. 3. Report data for new admissions seen within 90 days and timeliness of annual exams separately.
b.ii	documentation of dental services, including but not limited to, findings, descriptions of any treatment provided, and the plans of care:	<p>Findings: PSH reported 100% compliance for the documentation of findings and 88% compliance with documentation of plans of care. The current instrument used did not include auditing for the descriptions of any treatment provided, however this item was included in the raw data provided by PSH.</p> <p>As noted in the above cell a., the dental information kept in the individuals' charts is not always consistent with the information kept in the dental department. Consequently, information regarding dental care and services is not accurately reflected.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that dental information contained in individuals' records is accurate and up to date. 2. Report compliance with all elements of this requirement.
b.iii	use of preventive and restorative care whenever possible; and	<p>Findings: There is no system in place to adequately address the elements of this requirement.</p> <p>Recommendation: Develop and implement a system to monitor and track the elements of this requirement.</p>

b.iv	tooth extractions be used as a treatment of last resort, which, when performed, shall be justified in a manner subject to clinical review.	<p>Findings: PSH reported 100% compliance with the elements of this requirement. A tool was developed and implemented, Dental Services Extraction Case Review, which addresses the necessary criteria required for tooth extractions. A total of 25 cases were reviewed from July-September 2006.</p> <p>Recommendation: Continue monitoring the elements of this requirement.</p>
c	Each State hospital shall ensure that dentists demonstrate, in a documented fashion, an accurate understanding of individuals' physical health, medications, allergies, and current dental status and complaints.	<p>Findings: There is no monitoring instrument that adequately addresses this requirement.</p> <p>Although PSH reported 100% compliance in the areas of understanding of individuals' physical health, 100% compliance understanding individuals' medication, and 96% compliance understanding of individuals' allergies, the current instrument used by PSH does not indicate how these elements were evaluated. In addition, the instrument did not include all the required elements of this cell.</p> <p>Compliance: Partial.</p> <p>Recommendation: Develop and implement a monitoring system that adequately addresses this requirement.</p>
d	Each State hospital shall ensure that transportation and staffing issues do not preclude individuals from attending dental appointments, and individuals' refusals are addressed to facilitate compliance.	<p>Findings: There is no monitoring instrument that adequately addresses this requirement.</p> <p>PSH currently is piloting an escort service through Medical Services to</p>

		<p>escort individuals to their clinic appointments. This is still on a trial basis and data have not been generated as of yet.</p> <p>Compliance: Partial.</p> <p>Recommendation: Develop and implement a system to monitor and track the elements of this requirement.</p>
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>Findings: PSH reported that the current procedure for refusals for dental services included sending a memo to the units when an individual refuses dental services. However, there has been no follow-up by the WR teams. In addition, there is no system in place to monitor and track actions taken by the teams.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a system to monitor and track interventions and outcomes for dental refusals. 2. Develop and implement a facility-wide system to facilitate communication with dental and the Wellness and Recovery teams regarding individualized strategies to address refusals of dental appointments and treatments.
10	Special Education	
	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.	
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 <i>et seq.</i> (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.

G	Documentation	
		<p>Summary of Progress:</p> <ol style="list-style-type: none"> 1. The DMH WRP manual includes criteria for the proper documentation of the main components of the new WRP model. 2. PSH has implemented the required formats for the WRP model in most of its programs. 3. PSH has adequate requirements regarding the timeliness and completeness of the initial and integrated psychiatric assessments, reassessments and inter-unit transfer assessments. 4. PSH has completed a thorough self-assessment process and identified a variety of patterns that require performance improvement in the documentation of assessments, reassessments and WRP. 5. Many of the discipline-specific assessments are completed in a timely manner.
	<p>Each State hospital shall ensure that an individual's records accurately reflect the individual's response to all treatment, rehabilitation and enrichment activities identified in the individual's therapeutic and rehabilitation service plan, including for children and adolescents, their education plan, consistent with generally accepted professional standards of care. Each State hospital shall develop and implement policies and procedures setting forth clear standards regarding the content and timeliness of progress notes, transfer notes, school progress notes, and discharge notes, including, but not limited to, an expectation that such records include meaningful, accurate, and coherent assessments of the individual's progress relating to treatment plans and treatment goals, and that clinically relevant information remains readily accessible.</p>	<p>Findings:</p> <p>The previously mentioned findings of deficiencies in the documentation of admission and integrated assessments (D.1. through D.7) and the main components of integrated therapeutic and rehabilitation services (C.2.b through C.2.i) and specific therapeutic and rehabilitation services (F.1 through F.7) indicate that the documentation of these systems is generally inadequate.</p> <p>The current charting system requires major overhaul in order to ensure proper implementation of the EP. The charts must be reorganized in a manner that facilitates access by clinicians to needed data, especially in an emergency. The current system is archaic, overly redundant and the physical structure of the charts precludes review of needed data. The practice of thinning the charts is inconsistent and erratic. Lack of automation is a major barrier.</p>

		<p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none">1. Revise, update, and implement policies and procedures related to documentation to address all the requirements of the EP.2. Develop and implement a system to monitor and track the quality of documentation.3. Ensure staff competency in the implementation of documentation requirements.4. Reorganize the charting system to correct the above mentioned deficiencies.
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H	Restraints, Seclusion, and PRN and Stat Medication	
		<p>Summary of Progress:</p> <ol style="list-style-type: none"> 1. PSH has made significant gains in the overall reduction of the use of seclusion and restraints. 2. A majority of PSH staff have adopted the Wellness and Recovery Model to guide provision of services to individuals with serious mental illness. 3. PSH has actively initiated the process to identify and implement needed revisions in its policies and procedures regarding seclusion, restraints, PRN and Stat medications to ensure compliance with the EP. 4. Monitoring and tracking systems are currently being put in place to ensure that proper procedures are being implemented. 5. PSH is beginning to thoughtfully and critically identify some of its deficits through the process of self-assessment. 6. Many of the PSH staff members are committed and enthusiastic to make the needed changes to enhance the lives of the individuals they serve at PSH. 7. Many of the disciplines at PSH are critically reviewing their systems in order to make the necessary changes.
	<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 Dr. Murad, M.D., Acting Medical Director Interviewed Carlos Luna, Executive Director. Reviewed Special Order 119.06, Seclusion and Behavioral Restraint. Reviewed Special Order 902.01, Prevention And Management Of Assaultive Behavior (PMAB). Reviewed AD 15.14, Seclusion or Restraint. Reviewed PSH Outcome Indictors data. Reviewed Nursing Policy and Procedure 811, Managing Aggressive Behavior. Reviewed Nursing Service Quality Performance Improvement Focus Study, Care of the Patient Placed in Seclusion or Restraints.</p>

		<p>Reviewed Standards and Compliance Department (SCD) Focus Study with AD 15.14 data.</p> <p>Reviewed PSH Seclusion and Restraints Monitoring Tool and data.</p> <p>Reviewed Self-Assessment Seclusion or Restraints Monitoring Tool and data.</p> <p>Reviewed PSH SCD Seclusion or Restraint Integrity Audit data.</p> <p>Reviewed DMH Statewide 24 Hour NOC Audit Monitoring data.</p> <p>Reviewed PSH STAT Progress Notes Monitoring data.</p> <p>Reviewed PSH PRN Progress Notes Monitoring data.</p> <p>Reviewed Nursing Policy and Procedure 327, Protective Mechanical Support.</p> <p>Reviewed medical records for the following individuals: NL, TL, JR, KL, HC, KK, MW, GH and JW.</p>
1	<p>Each State hospital shall revise, as appropriate, and implement policies and procedures regarding the use of seclusion, restraints, psychiatric PRN medications, and Stat Medications consistent with generally accepted professional standards of care. In particular, the policies and procedures shall expressly prohibit the use of prone restraints, prone containment and prone transportation and shall list the types of restraints that are acceptable for use.</p>	<p>Findings:</p> <p>Sarla Gnanamuthu, M.D, who compiled the information for this section, was not available for interview during the site visit. Instead, Dr. Murad was designated to present the data.</p> <p>Currently, PSH reported that policy and procedures were under review for compliance with this requirement. Policies that contain the use of prone restraint, prone containment, and prone transportation are being changed to prohibit its use. From my review, policy #15.14 section 39 permits the use of prone containment "if unavoidable" as an exception to the general prohibition of its use. This is in conflict with the elements of this requirement. From my discussion with Dr. Murad and Carlos Luna, it was described that in an emergency situation during a takedown followed by a brief period of stabilizing the individual, the person may be in a prone position during this time. However, once secured, it was reported that the individual was then placed in a supine position and monitored throughout the process. This situation does not constitute containment or transportation.</p>

		<p>In addition, the other PSH policies need revision to be in compliance with this requirement. PSH reported that no persons are ever restrained in a prone position.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Review and revise policies and procedures that currently allow the use of prone restraints. 2. Prohibit the use of prone restraints, prone containment, and prone transportation immediately.
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>Findings: PSH reported 84% compliance for the indication only when individuals pose an imminent danger to self or others. PSH reported 74% and 97% compliance rates for September and October 2006 respectively regarding hierarchy of less restrictive measures has been considered. PSH provided data using two different methodologies and had significantly different results for each method.</p> <p>From my review of the charts of seven individuals (GH, MO, KK, HC, KL, JR and NL) who experienced the use of restraints, I found that all contained documentation of imminent danger and none included documentation that a hierarchy of less restrictive measures was tried. The checkbox found on the Initial Seclusion and Restraint Physician Order and Documentation form is inadequate in meeting compliance with the requirement of this cell.</p>

		<p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a monitoring instrument and a tracking system to adequately address the elements of this requirement. 2. Ensure that policies and procedures include implementing seclusion and restraints only after a hierarchy of less restrictive measures have been considered in a clinically justifiable manner or exhausted with supporting documentation to be logged in the medical record.
b	are not used in the absence of, or as an alternative to, active treatment, as punishment, or for the convenience of staff;	<p>Findings: PSH monitoring instrument combines the elements of this requirement. Each element should be addressed independently to provide meaningful data. For example, reviewing hours of treatment provided for individuals experiencing restraints would provide information regarding the use of restraints as an alternative to active treatment.</p> <p>Recommendation: Develop and implement a system to monitor the elements of this requirement.</p>
c	are not used as part of a behavioral intervention; and	<p>Findings: PSH reported 70% compliance with this requirement. However, I was unable to determine what criteria were used to obtain this percentage. The current monitoring instrument did not include instruction regarding criteria for review of each item.</p> <p>Recommendation: Develop and implement a system to monitor and track this requirement.</p>
d	are terminated as soon as the individual is no longer an imminent danger to self or others.	<p>Findings: PSH reported 63% compliance with this requirement. The current monitoring instrument did not include instruction regarding criteria for</p>

		<p>review of each item.</p> <p>From my review I noted that incidents of seclusion and/or restraint continued when the individual was documented to be calm and/or asleep. In addition, some nursing assessments were inadequate in terms of documenting continuous dangerousness and mental status. Release criteria were noted to be unrealistic in some cases.</p> <p>Recommendation: Develop and implement a system to monitor and track this requirement.</p>
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>Findings: PSH reported 43% and 74% compliance for assessments by a physician or licensed clinical professional of any individual placed in seclusion or restraints within one hour for September and October 2006. However, this data were only based on assessment by a physician rather than other licensed clinical professionals such as a nurse.</p> <p>PSH reported 66% and 71% compliance regarding continuous monitoring by competency-based trained staff.</p> <p>Compliance: Partial.</p> <p>Recommendation: Develop and implement a consistent system to monitor and ensure compliance with all 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>Findings: PSH reported that each month Standards and Compliance Department reviews 50% of individuals placed in seclusion or restraints. The data for August and September indicated 43% and 41% compliance respectively.</p>

		<p>Currently, there is no monitoring instrument or tracking system in place for PRN and STAT medications.</p> <p>Compliance: Partial.</p> <p>Recommendation: Develop and implement a system to monitor and ensure compliance with all elements of this requirement.</p>
5	<p>Each State hospital shall revise, as appropriate, and implement policies and procedures to require the review within three business days of individuals' therapeutic and rehabilitation service plans for any individuals placed in seclusion or restraints more than three times in any four-week period, and modification of therapeutic and rehabilitation service plans, as appropriate.</p>	<p>Findings: PSH reported 18% compliance with this requirement from a random sample of 11 records in October 2006. Currently, there is no policy or procedure in place regarding the elements of this requirement.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Revise appropriate policies and procedures to ensure compliance with this requirement. 2. Develop and implement a monitoring system to ensure that there is documentation of a review within three business days of WRPs for any individuals placed in seclusion or restraints more than three times in any four-week period and modification of therapeutic and rehabilitation service plans, as appropriate.
6	<p>Each State hospital shall develop and implement policies and procedures consistent with generally accepted professional standards of care governing the use of psychiatric PRN medication and Stat medication, requiring that:</p>	<p>Compliance: Partial.</p>

a	such medications are used in a manner that is clinically justified and are not used as a substitute for adequate treatment of the underlying cause of the individual's distress.	<p>Findings: The data provided by PSH did not address the elements of this requirement. There is no monitoring instrument or tracking system in place addressing this requirement.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement policy/procedure to outline facility's standards regarding PRN/Stat medication use consistent with the requirements of the EP. 2. Develop and implement triggers for review and follow-through by medical and nursing leadership. 3. Develop and implement a monitoring and tracking system addressing the elements of this requirement.
b	PRN medications, other than for analgesia, are prescribed for specified and individualized behaviors.	The facility reports 36% compliance.
c	PRN medications are appropriately time limited.	The facility reports it is not monitoring this element.
d	nursing staff assess the individual within one hour of the administration of the psychiatric PRN medication and Stat medication and documents the individual's response.	<p>Findings: PSH reported 49% compliance. However, the documentation consisted of either "effective" or "not effective" and did not consistently have an associated progress note in the chart. This data only included STAT medications. PRN medication data need to be collected separately and reported separately.</p> <p>Recommendation: Develop and implement a monitoring instrument to accurately monitor this requirement.</p>
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,	<p>Findings: Same as in D.1.f.</p>

	adjustment of current treatment and/or diagnosis.	Recommendations: Same as in D.1.f.
7	Each State hospital shall ensure that all staff whose responsibilities include the implementation or assessment of seclusion, restraints, psychiatric PRN medications, or Stat medications successfully complete competency-based training regarding implementation of all such policies and the use of less restrictive interventions.	<p>Findings: PSH reported a range of 15% to 50% compliance for Prevention and Management of Assaultive Behavior (PMAB) competency-based training No data was presented regarding compliance with competency-based training for medication certification.</p> <p>PSH does not have an adequate monitoring system in place for this requirement. In addition, there has been no competency-based training for each of the applicable policies.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement competency-based training on this requirement. 2. Develop and implement a monitoring instrument and tracking system to accurately monitor this requirement.
8	Each State hospital shall:	Compliance: Non-compliance.
a	develop and implement a plan to reduce the use of side rails as restraints in a systematic and gradual way to ensure individuals' safety; and	<p>Findings: PSH does not have a monitoring instrument or tracking system in place for the elements of this requirement.</p> <p>The facility has reported that side rail use has been for the prevention of falls or for seizure disorders and not as a type of restraint. However, from my observations on EB 11, I noted that side rails were</p>

		<p>being used as a restraint and in place of 1:1 staff as assigned. Clarification and review of this issue is needed to determine the parameters of side rail use.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement policy/procedure to outline facility's standards regarding side rail use consistent with the requirements of the EP. 2. Develop and implement a monitoring instrument to accurately monitor this requirement.
b	<p>ensure that, as to individuals who need side rails, their therapeutic and rehabilitation service plans expressly address the use of side rails, including identification of the medical symptoms that warrant the use of side rails, methods to address the underlying causes of such medical symptoms, and strategies to reduce the use of side rails, if appropriate.</p>	<p>Findings: PSH does not have a monitoring system in place addressing the elements of this requirement. There has been no system developed and implemented in accordance with the EP.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a system to ensure that, as to individuals who need side rails, their therapeutic and rehabilitation service plans expressly address the use of side rails, including identification of the medical symptoms that warrant the use of side rails, methods to address the underlying causes of such medical symptoms, and strategies to reduce the use of side rails, if appropriate. 2. Develop and implement an instrument to accurately monitor this requirement.

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. PSH has a Standards Compliance Office that is well staffed and which functions under strong leadership. The Office has demonstrated its competence in the work on key indicators and in the strong self-evaluation on the Protection from Harm requirements of the EP. The self-assessment identifies the need to revise a substantial number of Administrative Directives and other informational material so that they include requirements of the Enhancement Plan and recovery language, develop an integrated incident management system, and enhance training related to incident identification and reporting and individuals' rights. 2. PSH has policies that require the reporting of incidents and forms for this purpose. All incidents are reported on an SIR (Special Incident Report) and logged in on the SIR database kept by the Standards Compliance Office. Presently this system is not used to produce incident data reports on a regular basis. There is presently no structure for the review of serious incidents, investigations, aggregate data, patterns and trends. 3. Trigger data on issues related to protection from harm is collected from reliable sources and is presented at the monthly Quality Improvement meetings. The Standards Compliance Office is able to produce data on all of the triggers. The hospital is working on, but has not yet implemented, guidelines and timelines for anticipated responses to triggers, a system for reviewing the response from the unit, and a method for sampling implementation. 4. The work of data collection and analyses of incidents and triggers is hampered by inadequate information technology. The discrepancies between the trigger data and the SIR database indicate problems in the SIR database.

		<p>5. The hospital has an active Central Council that provides individuals a forum for directing concerns to the hospital administration.</p> <p>6. The hospital has an Environment of Care (EOC) team that inspects units on a rotating basis. PSH has identified environmental suicide hazards, has corrected some, and has requested funds to address others.</p> <p>7. The vast majority of investigations I reviewed were competently completed, however many did not meet all of the requirements of the Enhancement Plan. I concur with the hospital's own recommendation that Special Investigators receive training on the Protection from Harm section of the Enhancement Plan.</p>
1	Incident Management	
	<p>Each State hospital shall develop and implement across all settings, including school settings, an integrated incident management system that is consistent with generally accepted professional standards of care.</p>	<p>Methodology: Interviewed G. Richardson, Standards Compliance Director. Interviewed J. Olive, Supervising Special Investigator. Interviewed C. Loop, Senior Special Investigator. Interviewed G. Hahn, Hospital Administrator. Interviewed B. Sherer, Human Resources Director. Interviewed P. McCord, Patients Rights Advocate. Interviewed J. Gill, Psychiatric Nurse Education Director. Interviewed V. Martinez, Acting Training Officer. Interviewed E. Loo, Special Investigator. Interviewed C. Luna, Executive Director. P. McCord, Patient Rights Advocate. Reviewed 20 SI (Special Investigator) investigations and eight of the corresponding SIRs (Special Incident Reports). Reviewed hospital data on staff training. Reviewed mandatory reporting acknowledgements in six employee personnel files. Reviewed Rights training for six staff.</p>

a	Each State hospital shall review, revise, as appropriate, and implement incident management policies, procedures and practices that are consistent with generally accepted professional standards of care. Such policies, procedures and practices shall require:	Compliance: Partial.
a.i	that each State hospital not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of individuals;	<p>Findings: The language in AD #15.13 entitled "Patient Abuse" does not provide a vigorous statement that the hospital will not tolerate abuse or neglect. It does state "Patient abuse is never condoned" and is "considered a serious infraction of hospital and department policy." It notes that all employees must sign form MH 5411 indicating that they are aware of their responsibility to report dependent adult abuse and will comply. The AD also provides procedures for reporting abuse. This AD was last revised in May 2002.</p> <p>Problems in the completion of SIR forms are discussed in I.1. a.ii and a.viii.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Revise AD #15.13 with vigorous language that expresses zero tolerance for abuse and neglect. Include the possible consequences of failure to report. 2. Review the procedures outlined in AD15.13 to ensure their continued applicability.
a.ii	identification of the categories and definitions of incidents to be reported, and investigated; immediate reporting by staff to supervisory personnel and each State hospital's executive director (or that official's designee) of serious incidents, including but not limited to, death, abuse, neglect, and serious injury, using	<p>Findings: There is some evidence, as illustrated below, that SIRs are not being completed in all circumstances when they should be. I draw this conclusion from a comparison of the data from the SIR database and the trigger data, which is generated from the SIR database plus the daily HHS reports.</p>

standardized reporting across all settings, including school settings;

	June	July	Aug	Sept	Oct
Aggression to self w/ major injury	SIR=4 T= 4	SIR=4 T=5	SIR=7 T=9	SIR=3 T=2	SIR=6 T=5
Aggression to peer w/ major injury	SIR=0 T=2	SIR=5 T=9	SIR=3 T=4	SIR=17 T=16	SIR=7 T=7
Suicide attempt	SIR=1 T=2	SIR=1 T=6	SIR=0 T=2	SIR=1 T=3	SIR=0 T=0
T=trigger data					

The state is working on more clear definitions of "sexual incidents."

See also I.1.a.viii and b.iv.1.

Recommendations:

1. Identify the source of discrepancy in data between the SIR data and the trigger data and take appropriate measures to correct the problem.
2. Continue work on incident definitions.

a.iii

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;

Findings:

In several of the cases reviewed there was documentation that the alleged perpetrator (staff member) was removed from contact with the individual [incident involving KL (date of incident could not be determined) and an August incident involving JF]. In a conversation with the Executive Director, I verified that Program Directors have the authority to reassign staff to positions within their unit. Moving a staff to a position where there is no contact with individuals requires the approval of the Clinical Administrator. The Executive Director is advised/consulted when this decision is made. There are no written guidelines on when a staff member should be removed, rather the decision is made on a case-by-case basis, although the Executive Director indicated that in all credible cases of physical abuse (injury and witnesses), the staff member would be removed.

		<p>I saw no evidence in the investigations and SIRs reviewed that individuals who sustained an injury were not evaluated and afforded treatment as necessary.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Describe in writing the specific circumstances under which a staff member will be removed from the alleged victim and/or from all contact with individuals to ensure consistent decision-making. Removal must continue until the investigation is closed with a finding that does not support the allegation. 2. Include in all abuse investigations the fact that removal was considered and the reason why it was or was not implemented.
a.iv	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>Findings:</p> <p>Presently there is no Abuse/Neglect Awareness and Prevention training module in the new employee orientation (NEO) curriculum. The Patient Rights Advocate conducts a class on the rights of individuals in the hospital, which touches on the right to be free of abuse and neglect. At orientation, AD #2.09 is reviewed and questions answered in a class of about 40 minutes duration. In addition, the Office of the Special Investigator makes a one-hour presentation that includes a description of those actions by an employee that will result in investigations, specifically acts of abuse and other criminal actions. Each year employees with direct contact with individuals are provided the Patients Rights booklet, instructed to read it and complete a post-test.</p> <p>The hospital's self-assessment indicates that one third of the staff had not completed the Patients Rights training within the last year and a similar number had not completed training on how to complete the SIR (incident report). The Psychiatric Nursing Education Director explained that the core trainings, such as Patients Rights, are in</p>

		<p>competition with trainings on Wellness and Recovery and mall trainings. Beginning in January 2007, the training by the Office of the Special Investigator will increase to two hours with an additional focus on recognizing abuse/neglect/criminal acts and reporting responsibilities, as well as on the complete and accurate completion of the SIRs, which has been a significant problem. In the spring, the hospital will expand the 40-minute training on AD #2.09 to an hour.</p> <p>In order to increase compliance with mandated training, the Staff Development Office initiated block training in May 2006, where staff receives all of the core courses in a single day during the month before their birthday. This reduces scheduling problems and, since performance evaluations are supposed to be done annually during the employee's birthday month, attendance at training can be addressed in the evaluation.</p> <p>The Acting Training Officer is on a statewide workgroup to develop standardized Abuse/Neglect Awareness training for the four hospitals covered by the Enhancement Plan.</p> <p>In my review of the training records of six employees who should have completed Individual Rights training on an annual basis, four of the six had not completed the training in the period from November 2003- November 2006. Two of the six staff members completed Rights training in 2004.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Consolidate training on abuse/neglect awareness and prevention, individuals' rights and reporting responsibilities and procedures. Ensure that NEO training provides adequate attention to how abuse and neglect is manifested in an institutional setting, with specific examples. 2. Convert the self-taught annual refresher course on Individual
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		<p>Rights to a live course with an instructor. Continue to give the post-test.</p> <ol style="list-style-type: none"> 3. Advise the administration of the lack of response to requests to Program Directors to send "overdue" staff to training, so that follow-up can occur. 4. Ensure that Program Directors are aware of the advantages of the block training initiative and that their cooperation is essential, particularly during this initiation phase when some staff will be taking annual training twice in the same year. 5. Revise the method for monitoring compliance with the block training initiative, so that the Staff Development Office identifies the staff members who should have attended training in a specific month and those who failed to attend. Continue to send this information to Program Directors.
a.v	<p>notification of all staff when commencing employment and adequate training thereafter of their obligation to report abuse or neglect to each State hospital and State officials. All staff persons who are mandatory reporters of abuse or neglect shall sign a statement that shall be kept with their personnel records evidencing their recognition of their reporting obligations. Each State hospital shall not tolerate any mandatory reporter's failure to report abuse or neglect;</p>	<p>Findings:</p> <p>All employees of PSH are mandated reporters of dependent adult abuse. I reviewed the personnel records of six employees. The acknowledgement of mandatory reporting responsibility was present in five of the six records. The HR Director explained that in 2002 all staff was asked to sign the acknowledgement to ensure that long-time employees had signed and the acknowledgment was in their files. The hospital's self-assessment reviewed 486 personnel records and found that 71% contained the mandatory reporter acknowledgement.</p> <p>The one investigation I reviewed involving failure to report was handled appropriately by the hospital. A staff member was aware of a sexual relationship between an individual and a staff member, failed to report it, and threatened the individual for reporting it. Appropriate adverse actions were taken against both the staff member who failed to report the incident and the staff member who engaged in relations with the individual (see I.1.c).</p>

		<p>Recommendations:</p> <ol style="list-style-type: none"> 1. Identify those staff members who have not signed the mandatory reporter acknowledgement and ensure they sign. 2. During investigations, ask individuals to whom they made the first report of the allegation. Take appropriate action if there is reason to suspect that an employee has failed to report an allegation. 3. Ensure that the revised staff training for new employees and the annual refresher provides clear guidance on the responsibility to report abuse/neglect and the possible consequences for the failure to report. 4. Consider including an individual as a speaker in the abuse/neglect awareness and prevention training.
a.vi	mechanisms to inform individuals and their conservators how to identify and report suspected abuse or neglect;	<p>Findings:</p> <p>Individuals receive the "Patients' Rights Informational Handout" supplied by the Office of Patients' Rights when they are admitted to the hospital. This information includes how to make a complaint to the Office. Individuals are supposed to sign an acknowledgement that they have received notification of their rights upon admission and annually thereafter. I reviewed the records of six individuals on admission units (GR, TR, BW, JM, KD and JS). All had signed the acknowledgement on the day they were admitted or very shortly thereafter. In a review of the records of nine individuals who should have signed the acknowledgement within the last year, six had not signed, five had last signed in 2005 (ML, DE, SH, SM and JD), and one individual had last signed in 2002 (WM).</p> <p>Each of the five units I toured (Units 70, 75, 36, 34 and 35) had a supply of forms for making a complaint to the Patient Rights Advocate.</p> <p>There is presently no mechanism to advise private conservators how to identify and report suspected abuse or neglect unless they specifically</p>

		<p>request this information.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. At the WRP meeting closest to the anniversary of the individual's admission date, ask him/her to again review and sign the rights statement. 2. Follow the recommendations of the statewide workgroup dealing with methods for informing conservators on how to make a complaint on behalf of an individual.
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>Findings:</p> <p>There was a posting advising individuals how to report violations of their rights in each unit I visited. This poster was available in both English and Spanish. The hospital's own assessment indicated that posters were available on all units.</p> <p>Recommendation:</p> <p>Continue current practice.</p>
a.viii	procedures for referring, as appropriate, allegations of abuse or neglect to law enforcement; and	<p>Findings:</p> <p>All incidents that may involve a crime, including allegations of staff-to-individual abuse and individual-to-individual battery are investigated by the Office of the Special Investigator. Appropriate cases are referred to the District Attorney's Office and when appropriate to the Attorney General's Office for prosecution.</p> <p>The Supervising Special Investigator reported that until recently there was a significant problem in ensuring that his office received all of the SIRs, so that investigators could initiate a timely investigation. Considerable time was spent tracking down SIRs when his office was called to report on the status of an investigation but had not received notice of the incident. In a self-assessment, the Office found it had not received 20% of the SIRs. This situation has now improved and</p>

		<p>the Office of the Special Investigator is getting a daily copy of the incident log compiled by Central Nursing.</p> <p>The Supervising Special Investigator also explained that too often SIRs are incomplete, inaccurate, or illegible and this causes delays in determining what response is appropriate. The Standards Compliance Director indicated that there are no plans for unit staff to be able to complete the SIR electronically in the near future.</p> <p>The SIR training (how to complete the form, under what circumstances, etc.) provided annually to employees is a self-taught module (read the booklet and take the post-test). This training may be inadequate.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Convert training on how to complete an SIR to a face-to-face training module and provide a competency- based evaluation that considers legibility as well as accuracy. 2. Accelerate placing the SIR on line to the degree possible.
a.ix	<p>mechanisms to ensure that any staff person, individual, family member or visitor who in good faith reports an allegation of abuse or neglect is not subject to retaliatory action, including but not limited to reprimands, discipline, harassment, threats or censure, except for appropriate counseling, reprimands or discipline because of an employee's failure to report an incident in an appropriate or timely manner.</p>	<p>Findings:</p> <p>Sections 43-45 of AD #6.06 address "Retribution Against Persons Reporting Illegal Acts." It states, "No director, administrator, manager, supervisor, or employee at PSH shall take any retaliatory action against any employee, agent, parent, relative, state hospital patient, or volunteer in any service for reporting an alleged criminal, lawful act or an alleged violation of a DMH or PSH directive." It further states that allegations of retribution will be investigated as violations of California Penal Law. AD #15.13 "Patient Abuse" also states, "Hospital employees may not be subject to retaliation for reporting known or alleged abuse."</p>

		<p>Recommendations:</p> <ol style="list-style-type: none"> 1. Continue current practice. 2. Ensure that retaliation and how it will be handled are covered in new employee orientation and in annual refresher training.
b	Each State hospital shall review, revise, as appropriate, and implement policies and procedures to ensure the timely and thorough performance of investigations, consistent with generally accepted professional standards of care. Such policies and procedures shall:	<p>Compliance: Partial.</p>
b.i	require investigations of all deaths, as well as allegations of abuse, neglect, serious injury, and theft. The investigations shall be conducted by qualified investigator(s) who have no reporting obligations to the program or elements of the facility associated with the allegation and have expertise in conducting investigations and working with persons with mental disorders;	<p>Findings:</p> <p>All investigations of death, allegations of abuse, neglect, serious injury and any other actions that may constitute a crime are investigated by the Office of the Special Investigator. The investigators are independent and do not report to any service program or department. The Supervising Special Investigator, the Senior Special Investigator and the two Special Investigators have completed, at a minimum, the POST (Peace Officer Standard and Training) certification course. The Supervising and Senior Special Investigator have had advanced training and conduct trainings. Two hospital police officers are on loan to the Office of the Special Investigator; they do not have this training (and are not eligible for it because of their lack of civil service status). Their work is closely supervised by the Supervising Special Investigator.</p> <p>I reviewed the investigations of three deaths. The March 8, 2006 suicide death of HA included a psychological autopsy that recommended close monitoring of newly admitted individuals prior to their being allowed to attend mall groups. It also recommended moving wardrobes so they do not obstruct the line of vision. This recommendation was implemented, as evidenced in my tour of the units.</p> <p>The death of MS was an anticipated death. He died with family</p>

		<p>members present in hospice care at the local hospital.</p> <p>The April 7, 2006 death of JB raises questions about his care at San Bernardino Medical Center related to the administration of medications and the use of restraints as contributory to cardiopulmonary arrest.</p> <p>The death of SJ on October 26, 2006 is still under investigation. SJ's death was caused by a cerebral hemorrhage, sustained during a fight with another individual. Questions remain about the actions of staff on the night in question, and interviews are continuing.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Conduct a physicians' review of the treatment of JB at the local hospital, if this has not already been done. 2. Continue the investigation of the death of SJ.
b.ii	<p>ensure that only the State Hospital staff who have successfully completed competency-based training on the conduct of investigations be allowed to conduct investigations of allegations of petty theft and all other unusual incidents;</p>	<p>Findings:</p> <p>All serious incidents are investigated by the Office of the Special Investigator, including allegations of theft. Other incidents, which do not result in injury requiring more than first-aid, are investigated at the unit level. The staff members that conduct these investigations are not trained in investigation techniques.</p> <p>Recommendation:</p> <p>Review the training of unit supervisors and program directors who may be called upon to investigate incidents and provide training as necessary.</p>
b.iii	<p>investigations required by paragraph I.1.b.i, (above) provide for the safeguarding of evidence;</p>	<p>Findings:</p> <p>The requirement that investigators provide for safeguarding of evidence is found in AD 6.06, "Special Investigations," sections 33 and 34. In several of the investigations I reviewed, photographs were</p>

		<p>properly labeled and included in the investigation file. During the death investigation of HA, physical evidence was processed. I have no information to indicate that investigators are not safeguarding evidence.</p> <p>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>Findings: AD #6.06 guides many of the actions of the Special Investigators. It states the expectation that the Office of Special Investigator will investigate all allegations of abuse/neglect, deaths, escapes, headquarter reportable incidents, assaults, and employee injuries. The guidance provided in the AD reflects accepted professional standards for the conduct of investigations.</p> <p>With only one exception, the investigations that I read met generally accepted professional standards. The exception was the investigation of the June 15, 2006 allegation of attempted rape involving RS. The alleged victim dismissed the significance of the unwanted sexual advance, saying it was "no big deal" during the interview. The investigator, considering all of the circumstances, reasonably concluded that he could not prove attempted rape. The investigation failed to investigate the allegation that the perpetrator threatened the victim. The Shift Lead heard the alleged perpetrator threaten to "get" the victim because she reported the incident.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Revise AD #6.06 to bring it into compliance with the Enhancement Plan, which requires the investigation of all serious injuries of individuals and allegations of all types of abuse of individuals. 2. Ensure through the supervision of investigations that all

		threats to an individual's safety are identified, investigated, and appropriate actions taken.
b.iv.1	investigations commence within 24 hours or sooner, if necessary, of the incident being reported	<p>Findings: In a number of the investigations reviewed, the failure to complete the investigation within 30 working days was due, in part, to the late start of the investigation. For example, investigation of a 6/20/06 incident involving TY began on June 29, 2006, and the interviews for a March 19, 2006 incident involving DW began on April 13, 2006. Interviews began on October 17 for an investigation involving JT opened on October 4. The hospital self-assessment indicates 100% compliance with this portion of the Enhancement Plan. My findings are not in agreement.</p> <p>See also I.1. a.iii.</p> <p>Recommendation: Consider the advisability of adding an investigation start date (date interviews or documentation reviews began) to the database maintained in the Office of Special Investigations.</p>
b.iv.2	investigations be completed within 30 business days of the incident being reported, except that investigations where material evidence is unavailable to the investigator, despite best efforts, may be completed within 5 business days of its availability;	<p>Findings: In my review of 16 completed Special Investigator investigations, six (37.5%) were not completed within 30 business days. The hospital's self-assessment conducted in September and October 2006 indicated that 89% were completed within 30 business days. Since the investigations I reviewed were completed between March-November 2006, it may be that the rate of successful completion has risen in the more recent months.</p> <p>Recommendation: Continue to monitor compliance with this section of the Enhancement Plan. Document the reason for late investigations, perhaps in a log kept</p>

		by the Supervising Special Investigator.
b.iv.3	each investigation result in a written report, including a summary of the investigation, findings and, as appropriate, recommendations for corrective action. The report's contents shall be sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly and separately:	<p>Findings: All investigations resulted in a written report, but these reports did not identify corrective actions. [See I.1. c]. In four of the 20 investigations reviewed, the case file was incomplete. Each of these cases contained the statement that the case was forwarded to the Office of the Special Investigator, but no further work was done to complete the investigation. It is unclear whether the Special Investigator actually received these cases. [Cases: May incident involving MB, July incidents involving SW and ST and an August incident involving MG].</p> <p>No investigations identified programmatic corrective actions. Some investigations ended in adverse actions for staff members, but the investigation report did not indicate that the case has been forwarded to Human Resources. The Senior Special Investigator was in agreement that in those cases, this information would be included henceforth.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Ensure the timely transfer and acceptance of all investigations begun by hospital police and which require further investigation by the Office of the Special Investigator to avoid investigations that are lost in the process. 2. Form an Incident Review Committee to ensure that programmatic corrective actions are identified. 3. Assign to the Standards Compliance Department the responsibility to monitor implementation of corrective actions.
b.iv.3(i)	each allegation of wrongdoing investigated;	<p>Findings: The investigations reviewed all contained a statement of the allegation of wrongdoing under investigation, and the vast majority were</p>

		<p>competently investigated.</p> <p>Recommendation: Continue current practice.</p>
b.iv.3(ii)	the name(s) of all witnesses;	<p>Findings: The names of all witnesses interviewed were identified in the investigation reports reviewed. However, there was no documentation in most of the investigation files to indicate that the investigator attempted to find witnesses not identified on the SIR. The hospital self-assessment found 77% compliance with this section of the EP.</p> <p>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>Findings: All investigations reviewed identified the names of alleged victims and perpetrators.</p> <p>Recommendation: Continue current practice.</p>
b.iv.3(iv)	the names of all persons interviewed during the investigation;	<p>Findings: All investigations reviewed included the names of all persons interviewed.</p> <p>Recommendation: Continue current practice.</p>
b.iv.3(v)	a summary of each interview;	<p>Findings: Each investigation reviewed included a summary of each interview.</p>

		<p>There is no way to determine if other individuals or staff should have been interviewed because there is no listing of all staff and individuals who may have seen or heard the incident.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Question and document where staff were when the incident occurred. 2. Identify and interview any individual who may have seen or heard the incident.
b.iv.3(vi)	a list of all documents reviewed during the investigation;	<p>Findings:</p> <p>Compliance with this section of the EP was variable. [The hospital's self-assessment indicated 70% compliance.] Some investigation reports I reviewed identified documents reviewed. For example, in the investigation report involving GP [May 2006] the actions of the hospital police were determined to be counter-productive. The investigator identified and quoted Hospital Police Sensitivity Training. Two other investigations reviewed did not explicitly identify the documents reviewed during the investigation. In an investigation [JZ in May 2006] there is mention that neither the individual nor the staff person had been involved in prior abuse complaints, suggesting that the investigator had a source for this information, but the source was not identified.</p> <p>In a January 2006 allegation involving FW, the investigator noted that the individual has a history of making false allegations, but made no mention of having reviewed any documentation to substantiate this claim. Additionally, the investigator reportedly reviewed FW's financial accounts and found no problems. There was no copy of the financial document reviewed in the investigation report or any specific information, e.g., quoted journal entries, to substantiate the finding.</p>

		<p>Recommendations:</p> <ol style="list-style-type: none"> 1. Include in the investigation report copies of or direct quotes (with proper citation) from documents that form the basis for conclusions regarding the substantiation or lack of foundation of an allegation. 2. Avoid making findings about individuals' and staff involvement in previous investigations without providing the source of this information.
b.iv.3(vii)	all sources of evidence considered, including previous investigations and their results, involving the alleged victim(s) and perpetrator(s);	<p>Findings: Same as I.1. b.iv.3 (vi).</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Develop the capacity for the SI and relevant administrators to review the incident history of any individual or staff member. 2. Look for similarities in type of incidents, circumstances (e.g., language or gestures used) as well as the number of incidents when reviewing an individual's or staff member's incident history.
b.iv.3(viii))	the investigator's findings, including findings related to the substantiation of the allegations as well as findings about staff's adherence to programmatic requirements; and	<p>Findings: All of the completed investigations reviewed identified the determination in the case (substantiated or unfounded). Not all investigations included a concise summary of the relevant facts that supported the determination. Because the investigations are completed by peace officers, there is little likelihood that the investigation will touch on programmatic requirements, e.g., whether the situation was handled as required by the individual's WRP. It is for this reason that improving the quality of the Level 1 and Level 2 reviews is important and why review by an Incident Review Committee, composed of various disciplines and administration, is necessary.</p>

		<p>Recommendations:</p> <ol style="list-style-type: none"> 1. Write a clear and concise statement of findings that supports the disposition. 2. Indicate at the close of the relevant investigations that they have been referred to Human Resources. 3. As recommended previously, form an Incident Review Committee to review serious incidents and investigations to consider, among other things, whether staff responded appropriately and whether the incident could have been avoided or its seriousness mitigated.
a.iv.3(ix)	<p>the investigator's reasons for his/her conclusions, including a summary indicating how potentially conflicting evidence was reconciled; and</p>	<p>Findings: None of the investigation reports I reviewed included second interviews to clarify conflicting information. The hospital's self-assessment of this section of the Enhancement Plan indicated 69% compliance.</p> <p>Recommendation: Improve documentation of attempts to reconcile conflicting evidence.</p>
b.iv.4	<p>staff supervising investigations review the written report, together with any other relevant documentation, to ensure that the investigation is thorough and complete and that the report is accurate, complete, and coherent. Any deficiencies or areas of further inquiry in the investigation and/or report shall be addressed promptly. As necessary, staff responsible for investigations shall be provided with additional training and/or technical assistance to ensure the completion of investigations and investigation reports consistent with generally accepted professional standards of care.</p>	<p>Findings: All investigations completed by less experienced staff of the Office of the Special Investigator are reviewed by the Supervising Special Investigator. This review process does not address programmatic or administrative issues. As stated previously, with one exception, the completed investigations reviewed were competently performed and reported.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Invest in Standards Compliance the duty to ensure that recommended corrective actions have been effectively implemented in a timely manner and report the results of this

		<p>monitoring to the unit/programs involved and to the hospital administration.</p> <p>2. Review of investigation reports by senior staff of the Office of Special Investigator should address all elements required by the Enhancement Plan.</p>
c	<p>Each State Hospital shall ensure that whenever disciplinary or programmatic action is necessary to correct a situation or prevent reoccurrence, each State hospital shall implement such action promptly and thoroughly, and track and document such actions and the corresponding outcomes.</p>	<p>Findings:</p> <p>The Special Investigator investigations reviewed did not identify programmatic actions. Some investigations stated that matters were forwarded to Human Resources [June incident involving TB]. This investigation found a staff member had physically and verbally abused an individual and had failed to tell the truth during the investigation. The staff member was terminated. Other investigations did not contain this information. This is not to say that disciplinary actions were not taken. In a June 2006 investigation involving PN, a staff member who developed an unprofessional relationship with PN was terminated. In the same incident, compensation was reduced for the staff member who failed to report the unprofessional relationship (as mentioned in I.1.a.v).</p> <p>A review of eight SIRs (matched to the investigations) indicated that the Level 1 and Level 2 reviews did not always focus on programmatic corrective actions, but rather reiterated the circumstances of the incident or deferred to the Special Investigator, who does not make programmatic recommendations. For example, the Level 1 and Level 2 reviews of a May 2006 incident involving GP both state only that the incident is being investigated by the Special Investigator. The Level 2 review of a June incident involving TB stated only that a second SIR had been completed. The problem with the Level 1 and 2 reviews, together with the fact that there is presently no Incident Review Committee, means that the hospital is not identifying programmatic recommendations for corrective actions.</p>

		<p>The hospital's self-assessment also identified the need for a process for identifying and monitoring implementation of programmatic corrective actions. The identification of such recommendations should begin at the unit level and should culminate in a review by an Incident Review Committee, composed of staff members from several disciplines, that meets regularly to review serious incidents and investigations as well as incident data reports. This is particularly important when investigations are completed by peace officers who are not clinicians.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Institute an Incident Review Committee as described above and as recommended in b.iv.3(viii). 2. Ensure that all investigations that conclude with a finding of staff misconduct state that the matter is being referred to Human Resources. See b.iv.3(viii) 3. Assign the Standards Compliance Department the responsibility to track programmatic and administrative recommendations and the effective implementation of corrective actions.
d	Each State hospital shall have a system to allow the tracking and trending of investigation results. Trends shall be tracked by at least the following categories:	<p>Compliance: Non-compliance.</p>
d.i	type of incident;	<p>Findings: PSH is not presently using incident data to identify high-risk individuals and situations. It has not produced reports analyzing incident data. The hospital has a database that contains many of the elements necessary for trending and pattern identification and further has the capability in the Standards Compliance Department of</p>

		<p>producing incident data reports on a regular basis.</p> <p>In my review of the SIR log for the months of May-October 2006, I found instances where some information appeared to be incorrect. The Director of Standards Compliance indicated her agreement with this assessment. For example, on June 4, June 15, July 10, September 27, October 26, October 28 and October 29, 2006, incidents involving <i>threats</i> of suicide were assigned a level three injury. It appears that the individual was attended by a physician and staff therefore used a code three, without recognizing that the code relates to the level of injury.</p> <p>The hospital has been tracking the accuracy of the SIR data base and has been providing daily feedback to Central Nursing, which puts the data into the computer. Accuracy has been increasing, according to this assessment, rising from about 70% accuracy in August to about 84% accuracy in September.</p> <p>The Standards Compliance Director indicated that there are no plans for unit staff to be able to complete the SIR electronically in the near future.</p> <p>Recommendations:</p> <ol style="list-style-type: none">1. Identify those elements that the SIR database can report on and begin producing a monthly report that identifies basic incident information, such as type of incident, date, location, conclusion (substantiation or not), individual involved.2. Later display this information in a meaningful form that will facilitate the identification of patterns and trends.3. Ensure that final investigation determinations (substantiated or unfounded) are reported to Standards Compliance, so that it can be included in data reports.
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d.ii	staff involved and staff present;	<p>Findings: The investigation reports and the SIRs reviewed identified the staff members involved in the incident. The investigation reports did not identify all staff present.</p> <p>Recommendation: Ensure that the SIR database can provide information on the staff persons involved. These names will not be part of the monthly data reports that are distributed, but will be reviewed by the Incident Review Committee and by designated administrators to identify staff members who are frequently named, so that further investigation can be initiated.</p>
d.iii	individuals directly and indirectly involved;	<p>Findings: The investigation reports and the SIRs reviewed identified individuals involved in the incident. A review of the SIR log for selected incident types for the period May-October 2006 does not show a corresponding entry for the victim in incidents of peer-to-peer aggression. The hospital needs to ensure that it can identify and take appropriate action to protect those individuals who are victims, particularly those who are repeatedly victimized.</p> <p>Recommendation: Determine the best way to identify individuals in the SIR data base who are victims in order to monitor them and ensure their protection.</p>
d.iv	location of incident;	<p>Findings: The Special Incident Reports log can identify incident location.</p> <p>Recommendation: Analyze incident data using the location variable.</p>

d.v	date and time of incident;	<p>Findings: Information regarding the time of the incident is available on the SIR. Tracking of the time of incidents by shift or several hour spans is possible.</p> <p>Recommendation: Track incidents by shift and high activity times (meals, change of shift, etc.) initially when the hospital undertakes incident tracking and trending.</p>
d.vi	cause(s) of incident; and	<p>Findings: The incident database cannot identify the cause of an incident in those few instances when it is different from the type.</p> <p>Recommendation: Ensure that the narrative accompanying the SIR identifies the cause of the incident.</p>
d.vii	outcome of investigation.	<p>Findings: The Office of the Special Investigator maintains a database that contains outcome information (substantiated, unfounded), but presently that information is not shared with the hospital administration on a regular basis, nor is it provided to Standards Compliance for input into the SIR database. Data on the 20 abuse investigations closed between June 1 and December 5, 2006 indicates one case was substantiated.</p> <p>The Supervising Senior Special Investigator identified as one reason for the low rate of substantiation the code of silence that often prevails, meaning that staff will not report the misconduct of other staff. See also I.1.a.iv. for recommendations regarding additional staff training.</p>

		<p>Recommendation: Use the substantiation rate data to initiate discussion of the code of silence that investigators confront in their investigations.</p>
e	<p>Each State hospital shall ensure that before permitting a staff person to work directly with any individual, each State hospital shall investigate the criminal history and other relevant background factors of that staff person, whether full-time or part-time, temporary or permanent, or a person who volunteers on a regular basis. Facility staff shall directly supervise volunteers for whom an investigation has not been completed when they are working directly with individuals living at the facility. The facility shall ensure that a staff person or volunteer may not interact with individuals at each State hospital in instances where the investigation indicates that the staff person or volunteer may pose a risk of harm to such individuals.</p>	<p>Findings: All potential staff members are fingerprinted and their criminal history is investigated prior to hiring. I reviewed the personnel records of seven staff members and the report that he/she had no criminal record was present in each file.</p> <p>If an applicant's background check reveals a problem, the application is reviewed by the Service chief/Department Head Director, Hospital Administrator or Clinical Administrator, and the Executive Director makes the final decision whether to hire.</p> <p>According to the Human Resource Director, all volunteers must undergo a criminal background check as well. If a volunteer has contact with individuals before the background check is complete, the volunteer remains under the direct supervision of a staff member. These stipulations were documented in a November 14, 2006 memo to all Employment Applicants and Non-Paid Volunteers.</p> <p>Compliance: Partial</p> <p>Recommendation: Continue current practice.</p>
2	Performance Improvement	
	<p>Each State hospital shall develop, revise as appropriate, and implement performance improvement mechanisms that enable it to comply fully with this Plan, to detect timely and adequately problems with the provision of protections,</p>	<p>Methodology: Interviewed G. Richardson, Director of Standards Compliance. Reviewed aggregate trigger information.</p>

	<p>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>	
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>Findings: PSH is collecting data on all of the key indicators and has been doing so since June 2006. Much of the non-medical and non-clinical data is derived from the SIR database and review of the daily HSS report. The hospital is hampered in these efforts by insufficient information technology support.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Advance computer use for maintaining centralized databases and on the units as quickly as possible. 2. Continue the review of the HSS daily report as a source of information.
a.ii	<p>establishment of triggers and thresholds that address different levels of risk, as set forth in Appendix A; and</p>	<p>Findings: Same as I.2. a.iii.</p> <p>Recommendation: Continue current practice.</p>

a.iii	identification of systemic trends and patterns of high risk situations.	<p>Findings:</p> <p>Standards Compliance staff reviews the HSS daily report and identifies individuals who have hit non-medical triggers. The individual's team is notified by E-mail, and the same information is written in the day book that is available to all nursing staff on the unit.</p> <p>The Chief of Staff at PSH has designated each trigger as a low or high trigger and is developing a form that lists appropriate responses that the unit should consider in response to the trigger. This form should be available by the end of January 2007. It will be the expectation that the unit will complete this form, indicating what action was taken, and return it within a specified period of time to Standards Compliance. Standards Compliance will choose a sample of 20% of the responses for auditing to ensure their implementation. The failure of a unit to respond in the specified time limit will be brought to the hospital leaders' morning meeting.</p> <p>On a state-wide level, meetings are held weekly to get the WARMSS (Wellness and Recovery Support System) operational. This will include a "Quick Hits" database that will identify when a trigger has been reached. This database will be available to clinical and nursing staff. This system will also use E-mail notifications when a trigger has been reached.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Implement the plan to provide a feed-back loop to Standards Compliance on the actions taken in response to an individual meeting a trigger. Monitor the effective implementation of a sample of these measures as planned. 2. Continue work on the WARMSS system. 3. Consider the advisability of establishing a uniform set of possible responses for certain triggers to be used at all four hospitals.
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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:	Compliance: Partial.
b.i	a hierarchy of interventions by clinical teams that correspond to triggers and thresholds;	Findings: See a.iii for the plan for introducing the hierarchy of interventions and the feed-back loop to report implementation of corrective actions. Recommendation: Continue work on the development of a form identifying possible responses to triggers and requiring the documentation of the unit response.
b.ii	timely corrective actions by teams and/or disciplines to address systemic trends and patterns;	Findings: See a.iii for the hospital's plan to soon introduce a system for ensuring the effective implementation of corrective actions directed at individuals who have hit triggers. The Quality Improvement Team soon be in a position to begin to look at trends and patterns now that data for five months (June-October at the time of our tour) is available for review. Recommendations: 1. Investigate the most useful format for information and request that Standards Compliance produce these reports on a regular basis. 2. Compile a distribution list so that units and programs share in the information. 3. Charge the Quality Improvement Team or another appropriate entity with identifying measures directed at decreasing the frequency of trigger attainment and alerting the unit/program of the need to implement the measure. 4. Charge Standards Compliance with monitoring the effective implementation of these measures.

b.iii	formalized systems for the notification of teams and needed disciplines to support appropriate interventions and other corrective actions;	<p>Findings: Same as above.</p> <p>Recommendations: Same as above.</p>
b.iv	formalized systems for feedback from teams and disciplines to the standards compliance department regarding completed actions; and	<p>Findings: As noted above, PSH is formulating a list of possible responses to triggers and will be identifying procedures to receive feedback from the units on the measures taken. Standards Compliance plans to review implementation of a sample of these responses.</p> <p>Recommendation: Place a high priority on completion of the list of possible trigger responses and the training necessary to engage the clinical staff.</p>
b.v	monitoring and oversight systems to support timely implementation of interventions and corrective actions and appropriate follow up.	<p>Findings: Same as above.</p> <p>Recommendation: Proceed with the full development of the trigger identification, response and oversight system.</p>
c	Utilize, on an ongoing basis, appropriate performance improvement mechanisms to assess and address the facility's compliance with its identified service goals.	<p>Findings: The hospital will be in a position to assess compliance with its service goals once the complete trigger management system is in place. In the meantime, the Quality Assurance Team should consider setting its service goals as related to the key indicators.</p> <p>Compliance: Partial</p>

		<p>Recommendations:</p> <ol style="list-style-type: none"> 1. Initiate the trigger management system. 2. Set service goals.
3	Environmental Conditions	
	<p>Each State hospital shall develop and implement a system to review regularly all units and areas of the hospital to which individuals being served have access to identify any potential environmental safety hazards and to develop and implement a plan to remedy any identified issues, consistent with generally accepted professional standards of care. Such a system shall require that:</p>	<p>Methodology:</p> <p>Interviewed with: C. Brown, Risk Manager. Interviewed B. Sherer, HR Director and Team Leader for Environment of Care. Interviewed B. Ray, Health and Safety Officer. Interviewed G. Hahn, Hospital Administer. Interviewed V. Martinez, Acting Training Officer. Toured five units, most in the company of B. Sherer and J. St. John, Chief of Plant Operations. Interviewed R. Olender, Coordinator of Nursing Services. Reviewed inspection records.</p>
a	<p>Potential suicide hazards are identified and prioritized for systematic corrective action, and such action is implemented on a priority basis as promptly as feasible;</p>	<p>Findings:</p> <p>The hospital began using the state form for reviewing the environment in June 2005. It has taken measures to correct several suicide hazards, such as the relocation and stabilization of wardrobes, the substitution of flexible hoses in sinks to replace rigid hoses, replacement of beds with metal bed springs with pan beds, replacement of shower grab bars, and the distribution of several hundred foam mattresses.</p> <p>The hospital has identified other suicide hazards and has requested capital funds in its 2006 budget submission for budget year 2008/2009. This will allow the hospital to change the shower and sink faucets and the bathroom stalls—identified as suicide (hanging) hazards on all of the units.</p>

		<p>Compliance: Partial.</p> <p>Recommendation: Continue current practice.</p>
b	All areas of the hospital that are occupied by individuals being served have adequate temperature control and deviations shall be promptly corrected;	<p>Findings: The temperature of the units I visited was comfortable. Water temperature in the bathroom sinks was appropriately warm. HVAC was updated in 2006 in parts of the hospital. Temperature is monitored and regulated centrally. The hospital has requested capital funds to update other parts of the facility for budget year 2008/2009.</p> <p>Compliance: Partial.</p> <p>Recommendation: Continue current plans to update HVAC in other parts of the hospital.</p>
c	Each State hospital reviews, revises, as appropriate, and implements procedures and practices so that individuals who are incontinent are assisted to change in a timely manner;	<p>Findings: The Nursing Services Coordinator acknowledged that the hospital began tracking individuals with incontinence in October 2006. Health Services staff made rounds and quizzed staff asking them to identify individuals with this problem. Auditors reviewed records. There is presently no way to keep this list current except to repeat the process. No database is presently available. The list of individuals with problems of incontinence has not been distributed to the units and there has been no feedback on what, if any, measures are being taken to address the problem with each individual.</p> <p>Compliance: Partial.</p>

		<p>Recommendations:</p> <ol style="list-style-type: none"> 1. Treat incontinence as though it were a key indicator, so that tracking will be done by Standards Compliance. [This wise recommendation was made by the Coordinator of Nursing Services.] 2. Distribute the list of individuals with incontinence with the expectation that unit nurses will ensure that all individuals listed have a plan addressing incontinence. Include bathroom schedules and other measures as appropriate that help preserve the individual's dignity. 3. Require assurance that a plan is in place for each individual and monitor on a sample basis to ensure implementation.
d	<p>Each State hospital thoroughly reviews and revises, as appropriate, its policy and practice regarding sexual contact among individuals served at the hospital. Each State hospital shall establish clear guidelines regarding staff response to reports of sexual contact and monitor staff response to incidents. Each State hospital documents comprehensively therapeutic interventions in the individual's charts in response to instances of sexual contact; and</p>	<p>Findings: The hospital discourages sexual activity between individuals. When staff members come upon individuals engaging in consensual sexual activity they are instructed to interrupt the conduct in a manner that maintains the dignity of the individuals. The individuals are then counseled on safe sex practices and the risk of contracting HIV and hepatitis. Condoms are available to individuals.</p> <p>Staff reported that individuals are provided HIV education on the Admissions Unit. An HIV curriculum has been developed by the Infection Control Dept. and is provided to individuals.</p> <p>Compliance: Partial.</p> <p>Recommendation: Continue present practice.</p>
e	<p>Each State hospital develops and implements clear guidelines stating the circumstances under which it is</p>	<p>Findings: The hospital has determined that non-clinical staff members who</p>

	<p>appropriate to utilize staff that is not trained to provide mental health services in addressing incidents involving individuals. Each State hospital ensures that persons who are likely to intervene in incidents are properly trained to work with individuals with mental health concerns.</p>	<p>provide mall services will receive training in PMAB (Prevention and Management of Assaultive Behavior), CPR, First Aid, Recovery, and BY CHOICE. Nine staff members are presently in this position. Fifty-six percent of these staff members (5/9) have completed PMAB, and fewer than half have completed the other training courses, according to the hospital's self-assessment.</p> <p>There is no introductory course on mental illness provided to staff that do not have this knowledge and no requirement for Individuals' Rights training for these staff members.</p> <p>Compliance: Partial.</p> <p>Recommendations:</p> <ol style="list-style-type: none">1. Consider adding basic training on mental illness.2. Require non-clinical staff providing services to receive instruction on Individuals' Right that includes the identification and reporting of abuse and neglect.3. Ensure that all staff in this position completes the required training.
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J	First Amendment and Due Process	
		<p>Summary of Progress:</p> <ol style="list-style-type: none"> 1. PSH has active Central Council that provides individuals a forum for expressing concerns and bringing issues to the attention of the administration. The Central Council has developed a list of top ten concerns for 2007. The first five concerns are: a). need for mall activities to emphasize quality over quantity, b). need to address unchecked violence, c). need to embrace recovery philosophy with actions as well as talk, d). need for all staff to treat individuals with respect, and e). need for CONREP to be more directly involved in Wellness and Recovery teams. 2. There is concern that individuals have insufficient opportunity to phone family when a long-distance call is involved and neither the individual nor the family can pay for the charges. 3. The Central Council conducted a 17-question survey to which as many as 148 individuals responded.
	<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 December Central Council meeting. Interviewed seven individuals on the units. Interviewed V. Kaufman, Chief of Social Work Reviewed the minutes of the Council and the Top Ten List of Senate Concerns.</p>
		<p>Findings: In interviews, seven individuals were asked to rate how safe they felt on a scale from 1-10, with 10 being most safe. The responses ranged from scores of 2-10. When asked why they felt safe or unsafe, two individuals said they felt safe when staff was out in the units, but they did not feel safe when staff were clustered in the nurses' station. Almost unanimously in the interviews I conducted, individuals expressed a good understanding of the goals of the recovery model and</p>

		<p>their acceptance and appreciation of the mall structure. They praised groups that provided skills they needed for recovery and community living and strongly objected to groups that were irrelevant, disorganized (had no discernable curriculum) and which discounted their intelligence. These same sentiments were strongly expressed at the Central Council, and this is the Number one issue for the Council in 2007.</p> <p>A partial list of the survey results conducted by the Central Council follows:</p> <p>Feel safe? Yes= 49% of the 148 respondents Environment clean and safe? Yes= 75% of 128 respondents Access to personal hygiene supplies? Yes= 86% of 123 respondents Treated with respect? Yes=70% of 93 respondents Have input into service planning? Yes=62% of 129 respondents Services address needs? Yes =47% of 129 respondents Medication education provided? Yes=72% of 119 respondents Taught what constitutes A/N? Yes =64% of 108 respondents Taught your rights? Yes=71% of 109 respondents</p> <p>In an interview, the Chief of Social Work explained that in many instances individuals are assisted to call their family once a month when a long-distance call is involved and neither party is able to pay the toll. This is not, however, a universal practice.</p> <p>Compliance: Partial</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Continue to equip the Council to survey individuals on various issues. 2. Heed the Council's concerns about mall activities.
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